

Therapeutic Groups

Alimentary Tract and Metabolism	3
Blood and Blood Forming Organs	44
Cardiovascular System	75
Dermatologicals 1	106
Genito-Urinary System 1	112
Hormone Preparations 1	117
Infections 1	131
Musculoskeletal System	223
Nervous System 2	233
Oncology Agents and Immunosuppressants	
Respiratory System and Allergies 4	169
Sensory Organs 4	183
Various4	186
Special Foods 4	
Vaccines 5	515
Index of form numbers 5	542
Index of titles 5	545

Alimentary Tract and Metabolism



PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Calcium carbonate		
INITIATION Prerequisites (tick box where appropriate)		
Only when prescribed for patients unable to swallow calcium carbonate tablets or where calcium carbonate tablets are inappropriate.		

Page 5

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.

PRESCRI	BER			PATIENT:
Name:				Name:
Ward:				NHI:
Budesor	nide			
			's disease oxes where appropriate)	
and		Mild	to moderate ileal, ileocaecal or proximal Crohn's disease	
	or	0	Diabetes	
	or	0	Cushingoid habitus	
	or	0	Osteoporosis where there is significant risk of fracture	
	or	0	Severe acne following treatment with conventional cortic	costeroid therapy
	or	0	History of severe psychiatric problems associated with o	orticosteroid treatment
	or	0	History of major mental illness (such as bipolar affective causing relapse is considered to be high	disorder) where the risk of conventional corticosteroid treatment
	OI OI	0	Relapse during pregnancy (where conventional corticos	teroids are considered to be contraindicated)
		_	genous and lymphocytic colitis (microscopic colitis) oox where appropriate)	
0	Patier	nt has	a diagnosis of microscopic colitis (collagenous or lympho	ocytic colitis) by colonoscopy with biopsies
INITIATIO	DN – G	aut G	raft versus Host disease	
Prerequis	sites	(tick b	oox where appropriate)	
0	Patier	nt has	gut Graft versus Host disease following allogenic bone n	narrow transplantation

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Budesonide - continued	
INITIATION – non-cirrhotic autoimmune hepatitis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
Patient has autoimmune hepatitis* and Patient does not have cirrhosis and	
O Diabetes or O Cushingoid habitus or O Steoporosis where there is significant risk of fracture or O Severe acne following treatment with conventional cor or History of severe psychiatric problems associated with	ticosteroid therapy a corticosteroid treatment we disorder) where the risk of conventional corticosteroid treatment esteroids are considered to be contraindicated)
Note: Indications marked with * are unapproved indications. CONTINUATION – non-cirrhotic autoimmune hepatitis	
Re-assessment required after 6 months Prerequisites (tick box where appropriate) Or Treatment remains appropriate and the patient is benefitting from the second content of the patient is benefitting from the second content of the patient is benefitting from the patient is benefit in the patient in the patient is benefit in the patient in the patient in the patient is benefit in the patient in	the treatment
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Signed.	Date:	
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Form RS1703 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 7

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.

PRES	SCRI	BER	PATIENT:
Name	e:		Name:
Ward	:		NHI:
Rani	itidi	ne	
INITI Prer		ON sites (tick boxes where appropriate)	
		O For continuation use	
	or	O Routine prevention of allergic reactions.	

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Omeprazole - Tab dispersible 10 mg and 20 mg	
INITIATION Prerequisites (tick box where appropriate)	
O Only for use in tube-fed patients	

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Form RS1261 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 9

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
L-ornithine L-aspartate	
INITIATION	
Prerequisites (tick box where appropriate)	
O For patients with chronic hepatic encephalopathy who have not resp is contraindicated	onded to treatment with, or are intolerant to lactulose, or where lactulose

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rifaximin	
INITIATION Prerequisites (tick box where appropriate)	
O For patients with hepatic encephalopathy despite an adequate trial of	of maximum tolerated doses of lactulose

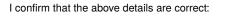
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Form RS1028 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 11

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Diazoxide	
INITIATION Prerequisites (tick box where appropriate)	
O For patients with confirmed hypoglycaemia caused by hyperinsulinis	m



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Signed.	Date.
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PR	ESCRIE	BER		PATIENT:
Nar	ne:			Name:
Wa	rd:			NHI:
Du	laglut	ide		
	TIATIO erequis		ick b	oxes where appropriate)
	or	Ог	or c	ontinuation use
	and		О О	Patient has type 2 diabetes Target HbA1c (of 53 mmol/mol or less) has not been achieved despite the regular use of all of the following funded blood glucose lowering agents for a period of least 6 months, where clinically appropriate: empagliflozin, metformin, and vildagliptin
		and	or or or	Patient is Māori or any Pacific ethnicity* Patient has pre-existing cardiovascular disease or risk equivalent (see note a)* Patient has an absolute 5-year cardiovascular disease risk of 15% or greater according to a validated cardiovascular risk assessment calculator* Patient has a high lifetime cardiovascular risk due to being diagnosed with type 2 diabetes during childhood or as a young adult* Patient has diabetic kidney disease (see note b)*
	Pre-exi	isting o	ardi rven	ded to describe patients at high risk of cardiovascular or renal complications of diabetes. ovascular disease or risk equivalent defined as: prior cardiovascular disease event (i.e. angina, myocardial infarction, percutaneous ion, coronary artery bypass grafting, transient ischaemic attack, ischaemic stroke, peripheral vascular disease), congestive heart hypercholesterolaemia.
	sample Funded	es over d GLP-	' a 3. ·1a tı	sease defined as: persistent albuminuria (albumin:creatinine ratio greater than or equal to 3 mg/mmol, in at least two out of three 6 month period) and/or eGFR less than 60 mL/min/1.73m2 in the presence of diabetes, without alternative cause identified. eatment is not to be given in combination with funded (empagliflozin / empagliflozin with metformin hydrochloride) unless receiving ozin or empagliflozin in combination with metformin hydrochloride) for the treatment of heart failure.
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PRI	SCRIE	BER			PATIENT:
Nar	ne:				Name:
Waı	'd:				NHI:
Lira	agluti	de			
	TIATIO		ick b	oxes	where appropriate)
	or	О	or c	ontinu	uation use
		and	or or or	Targe	ent has type 2 diabetes et HbA1c (of 53 mmol/mol or less) has not been achieved despite the regular use of all of the following funded blood ose lowering agents for a period of least 6 months, where clinically appropriate: empagliflozin, metformin, and vildagliptin Patient is Māori or any Pacific ethnicity* Patient has pre-existing cardiovascular disease or risk equivalent (see note a)* Patient has an absolute 5-year cardiovascular disease risk of 15% or greater according to a validated cardiovascular risk assessment calculator* Patient has a high lifetime cardiovascular risk due to being diagnosed with type 2 diabetes during childhood or as a young adult* Patient has diabetic kidney disease (see note b)*
a) b)	Pre-exi corona failure Diabeti	isting or ry inte or fam ic kidn	cardi rven ilial ey d	ovasc ition, c hyperc isease	o describe patients at high risk of cardiovascular or renal complications of diabetes. cular disease or risk equivalent defined as: prior cardiovascular disease event (i.e. angina, myocardial infarction, percutaneous coronary artery bypass grafting, transient ischaemic attack, ischaemic stroke, peripheral vascular disease), congestive heart cholesterolaemia. de defined as: persistent albuminuria (albumin:creatinine ratio greater than or equal to 3 mg/mmol, in at least two out of three nth period) and/or eGFR less than 60 mL/min/1.73m2 in the presence of diabetes, without alternative cause identified.
					ent is not to be given in combination with funded (empagliflozin / empagliflozin with metformin hydrochloride) unless receiving or empagliflozin in combination with metformin hydrochloride) for the treatment of heart failure.

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of less than or equal to 40% reating practitioner the patient would benefit from treatment ailure treatment
of less than or equal to 40% reating practitioner the patient would benefit from treatment
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alent (see note a)* of 15% or greater according to a validated cardiovascular liagnosed with type 2 diabetes during childhood or as a spite the regular use of at least one blood-glucose lowering
olications of diabetes. Ar disease event (i.e. angina, myocardial infarction, percutaneous chaemic stroke, peripheral vascular disease), congestive heart greater than or equal to 3 mg/mmol, in at least two out of three presence of diabetes, without alternative cause. It be given in combination with a funded GLP-1 unless receiving trailure.
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Signeg	 Date	

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Ursodeoxycholic acid			
INITIATION – Alagille syndrome or progressive familial intrahepatic chol Prerequisites (tick boxes where appropriate)	estasis		
O Patient has been diagnosed with Alagille syndrome O Patient has progressive familial intrahepatic cholestasis			
INITIATION – Chronic severe drug induced cholestatic liver injury Prerequisites (tick boxes where appropriate)			
O Patient has chronic severe drug induced cholestatic liver injury			
Cholestatic liver injury not due to Total Parenteral Nutrition (TF and			
Treatment with ursodeoxycholic acid may prevent hospital adr	nission or reduce duration of stay		
INITIATION – Primary biliary cholangitis Prerequisites (tick boxes where appropriate)			
Primary biliary cholangitis confirmed by antimitochondrial anti- without raised serum IgM or, if AMA is negative by liver biopsy and Patient not requiring a liver transplant (bilirubin > 100 umol/l;			
INITIATION – Pregnancy Prerequisites (tick box where appropriate) Patient diagnosed with cholestasis of pregnancy			
INITIATION – Haematological transplant Prerequisites (tick boxes where appropriate)			
O Patient at risk of veno-occlusive disease or has hepatic impair cell or bone marrow transplantation and	ment and is undergoing conditioning treatment prior to allogenic stem		
O Treatment for up to 13 weeks			
INITIATION – Total parenteral nutrition induced cholestasis Prerequisites (tick boxes where appropriate)			
O Paediatric patient has developed abnormal liver function as in and	dicated on testing which is likely to be induced by TPN		
O Liver function has not improved with modifying the TPN comp	osition		
INITIATION – prevention of sinusoidal obstruction syndrome Prerequisites (tick box where appropriate)			
O The individual has leukaemia/lymphoma and requires prophylaxis for syndrome	r medications/therapies with a high risk of sinusoidal obstruction		

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Methylnaltrexone bromide	
INITIATION – Opioid induced constipation Prerequisites (tick boxes where appropriate)	
O The patient is receiving palliative care and	
Oral and rectal treatments for opioid induced constipation	on are ineffective
Oral and rectal treatments for opioid induced constipation	on are unable to be tolerated
INITIATION – Opioid induced constipation outside of palliative care Re-assessment required after 14 days Prerequisites (tick boxes where appropriate)	
O Individual has opioid induced constipation and	
	luding bowel-cleansing preparations, are ineffective or inappropriate
Mechanical bowel obstruction has been excluded	

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Signed.	Date:	
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PRES	CRIBER		PATIENT:
Name	:		Name:
Ward:			NHI:
sodi	um pico	osulfate	
	ATION equisites	(tick boxes where appropriate)	
The patient is a child with problematic constipation despite an adequate trial of other oral pharmacotherapies including many where practicable and			adequate trial of other oral pharmacotherapies including macrogol
	O	The patient would otherwise require a high-volume bowel clea	nsing preparation

I confirm that the above details are correct:		
Signed:	Date:	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Betaine	
NZ Hospital.	ordance with a protocol or guideline that has been endorsed by the Health
The patient has a confirmed diagnosis of homocystinuria and A cystathionine beta-synthase (CBS) deficiency or A 5,10-methylene-tetrahydrofolate reductase (MTHFR) or A disorder of intracellular cobalamin metabolism	deficiency
An appropriate homocysteine level has not been achieved des	spite a sufficient trial of appropriate vitamin supplementation
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a metabolic physician, or in accommod NZ Hospital. and The treatment remains appropriate and the patient is benefiting from	ordance with a protocol or guideline that has been endorsed by the Health

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Form RS1035 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 19

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Levocarnitine	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a neurologist, metabolic physician or metabolic disorders dietitian, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

PRESCRIBI	ER	PATIENT:
Name:		Name:
Ward:		NHI:
Sodium p	henylbutyrate	
Prerequisition Property No.	ment required after 12 months tes (tick box where appropriate) rescribed by, or recommended by a metabolic physician, or in acco Z Hospital.	ordance with a protocol or guideline that has been endorsed by the Health ciciency of carbamylphosphate synthetase, ornithine transcarbamylase or
Prerequisit	ment required after 12 months tes (tick box where appropriate)	ordance with a protocol or guideline that has been endorsed by the Health treatment
·		

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Biotin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a metabolic physician or metabolic been endorsed by the Health NZ Hospital.	olic disorders dietitian, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pyridoxal-5-phosphate	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a neurologist, metabolic physician or metabolic disorders dietitian, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

PRESCRIBER	t	PATIENT:
Name:		Name:
Ward:		NHI:
Galsulfase		
Prerequisites	ent required after 12 months s (tick boxes where appropriate)	ardones with a protocol or guideline that has been and good by the Health
	The patient has been diagnosed with mucopolysaccharidosis Diagnosis confirmed by demonstration of N-acetyl-galac enzyme activity assay in leukocytes or skin fibroblasts	ordance with a protocol or guideline that has been endorsed by the Health VI ctosamine-4-sulfatase (arylsulfatase B) deficiency confirmed by either has a sibling who is known to have mucopolysaccharidosis VI
Prerequisites Pres	ent required after 12 months s (tick boxes where appropriate) scribed by, or recommended by a metabolic physician, or in according to the patient and the patient has not had severe infusion-related adverse reactions adjustment of infusion rates	which were not preventable by appropriate pre-medication and/or isease where the long term prognosis is unlikely to be influenced by

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PRESCRIBER	PATIENT:
Name:	
Ward:	NHI:
Alglucosida	se Alfa
INITIATION Re-assessment Prerequisites Pres	It required after 12 months (tick boxes where appropriate) cribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health lospital. The patient is aged up to 24 months at the time of initial application and has been diagnosed with infantile Pompe disease Diagnosis confirmed by documented deficiency of acid alpha-glucosidase by prenatal diagnosis using chorionic villus biopsies and/or cultured amniotic cells Documented deficiency of acid alpha-glucosidase, and urinary tetrasaccharide testing indicating a diagnostic elevation of glucose tetrasaccharides Documented deficiency of acid alpha-glucosidase, and documented molecular genetic testing indicating a disease-causing mutation in the acid alpha-glucosidase gene (GAA gene) Documented urinary tetrasaccharide testing indicating a diagnostic elevation of glucose tetrasaccharides, and molecular genetic testing indicating a disease-causing mutation in the GAA gene Patient has not required long-term invasive ventilation for respiratory failure prior to starting enzyme replacement therapy (ERT) Patient does not have another life-threatening or severe disease where the prognosis is unlikely to be influenced by ERT or might be reasonably expected to compromise a response to ERT Alglucosidase alfa to be administered at doses no greater than 20 mg/kg every 2 weeks
Prerequisites O Pres	on hat required after 12 months (tick boxes where appropriate) cribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health lospital.
and	The treatment remains appropriate for the patient and the patient is benefiting from treatment Alglucosidase alfa to be administered at doses no greater than 20 mg/kg every 2 weeks Patient has not had severe infusion-related adverse reactions which were not preventable by appropriate pre-medication and/or adjustment of infusion rates Patient has not developed another life threatening or severe disease where the long term prognosis is unlikely to be influenced by ERT Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT There is no evidence of life threatening progression of respiratory disease as evidenced by the needed for > 14 days of invasive ventilation There is no evidence of new or progressive cardiomyopathy

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PRES	CRIB	ER		PATIENT:
Name	:			Name:
Ward:				NHI:
ldurs	ulfa	se		
	ssessi equisi	men i tes Presc	t required after 24 weeks (tick boxes where appropriate) ribed by, or recommended by a metabolic physician, or in acco ospital.	ordance with a protocol or guideline that has been endorsed by the Health
	(and	C	The patient has been diagnosed with Hunter Syndrome (mucc	opolysacchardosis II)
	unu	or	Diagnosis confirmed by demonstration of iduronate 2-sucultured skin fibroblasts Detection of a disease causing mutation in the iduronate	Ilfatase deficiency in white blood cells by either enzyme assay in e 2-sulfatase gene
	and (and	\mathcal{C}	would be bridging treatment to transplant Patient has not required long-term invasive ventilation for resp	insplant (HSCT) within the next 3 months and treatment with idursulfase iratory failure prior to starting Enzyme Replacement Therapy (ERT) ent to 12 weeks pre- and 12 weeks post-HSCT) at doses no greater than
			0.5 mg/kg every week	g. and g.

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					PATIENT:
Name	e:				Name:
Ward	:				NHI:
Laro	nida	se			
Re-a	equis	mer ites Preso	(tick b		rdance with a protocol or guideline that has been endorsed by the Health
and	and	O	The	patient has been diagnosed with Hurler Syndrome (mucop	polysacchardosis I-H) Idase deficiency in white blood cells by either enzyme assay in cultured
		or	0	skin fibroblasts	L-iduronidase gene and patient has a sibling who is known to have
	and (0		ent is going to proceed with a haematopoietic stem cell tra d be bridging treatment to transplant	nsplant (HSCT) within the next 3 months and treatment with laronidase
	and and	O O	Laroi		ratory failure prior to starting Enzyme Replacement Therapy (ERT) ent to 12 weeks pre- and 12 post-HSCT) at doses no greater than

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Signed.	Date:	
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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.

	BER	PATIENT:
e:		Name:
		NHI:
luce	eras	se alfa
	smen	nt required after 12 months (tick boxes where appropriate)
		cribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Heal lospital.
and		The patient has a diagnosis of symptomatic type 1 or type 3* Gaucher disease confirmed by the demonstration of specific deficiency of glucocerebrosidase in leukocytes or cultured skin fibroblasts, and genotypic analysis
and	O 	Patient does not have another life-threatening or severe disease where the prognosis is unlikely to be influenced by enzyme replacement therapy (ERT) or the disease might be reasonably expected to compromise a response to ERT
		O Patient has haematological complications of Gaucher disease
	or	O Patient has skeletal complications of Gaucher disease
	or	O Patient has significant liver dysfunction or hepatomegaly attributable to Gaucher disease
	or	O Patient has reduced vital capacity from clinically significant or progressive pulmonary disease due to Gaucher disease
	or	O Patient is a child and has experienced growth failure with significant decrease in percentile linear growth over a 6-12 month period
and	0	Taliglucerase alfa is to be administered at a dose no greater than 30 unit/kg every other week rounded to the nearest whole vial (200 units)
Indi	icatio	on marked with * is an unapproved indication
ssess equis	sites Preso	on the required after 3 years (tick boxes where appropriate) cribed by, or recommended by a metabolic physician or any relevant practitioner on the recommendation of a metabolic physician, or in redance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
		Patient has demonstrated a symptomatic improvement and has maintained improvements in the main symptom or symptoms for which
		therapy was started
and	0	
and and		therapy was started Patient has demonstrated a clinically objective improvement or no deterioration in haemoglobin levels, platelet counts and liver and spleen size
and		therapy was started Patient has demonstrated a clinically objective improvement or no deterioration in haemoglobin levels, platelet counts and liver and spleen size RRadiological (MRI) signs of bone activity performed at two years since initiation of treatment, and five yearly thereafter, demonstrate

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Signed.	Date.
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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.

PRES	CRIBE	ER	PATIENT:
Name:			Name:
Nard:			NHI:
Sapro	opter	rin d	lihydrochloride
Re-as		nent i	required after 1 month ick boxes where appropriate)
			ibed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health spital.
	and) F	Patient has phenylketonuria (PKU) and is pregnant or actively planning to become pregnant
	and) T	Treatment with sapropterin is required to support management of PKU during pregnancy
	and) s -	Sapropterin to be administered at doses no greater than a total daily dose of 20 mg/kg
	and) s	Sapropterin to be used alone or in combination with PKU dietary management
		т С 9	Total treatment duration with sapropterin will not exceed 22 months for each pregnancy (includes time for planning and becoming pregnant) and treatment will be stopped after delivery
Re-as	equisit	nent i tes (ti	required after 12 months ick boxes where appropriate)
Re-as	ssessn equisit	ment i tes (ti	required after 12 months ick boxes where appropriate) ibed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health
Re-as	ssessn equisit	ment i tes (ti	required after 12 months ick boxes where appropriate) ibed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health spital.
Re-as	Pr NZ	ment i tes (ti	required after 12 months ick boxes where appropriate) ibed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health
Re-as	Pr NZ	ment (tites (tit	required after 12 months ick boxes where appropriate) ibed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health spital. Following the initial one-month approval, the patient has demonstrated an adequate response to a 2 to 4 week trial of
Prere and	Pr NZ	ment (tites (tit	required after 12 months ick boxes where appropriate) sibed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health spital. Following the initial one-month approval, the patient has demonstrated an adequate response to a 2 to 4 week trial of sapropterin with a clinically appropriate reduction in phenylalanine levels to support management of PKU during pregnancy On subsequent renewal applications, the patient has previously demonstrated response to treatment with sapropterin and
Re-as Prere	Pr NZ	rescriz Hos	required after 12 months ick boxes where appropriate) sibed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health spital. Following the initial one-month approval, the patient has demonstrated an adequate response to a 2 to 4 week trial of sapropterin with a clinically appropriate reduction in phenylalanine levels to support management of PKU during pregnancy On subsequent renewal applications, the patient has previously demonstrated response to treatment with sapropterin and
Prere Prere and	Pr N2	ment (tes (till or rescriptor)) or (tes or (tes or rescriptor))	required after 12 months ick boxes where appropriate) sibed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health spital. Following the initial one-month approval, the patient has demonstrated an adequate response to a 2 to 4 week trial of sapropterin with a clinically appropriate reduction in phenylalanine levels to support management of PKU during pregnancy On subsequent renewal applications, the patient has previously demonstrated response to treatment with sapropterin and maintained adequate phenylalanine levels to support management of PKU during pregnancy
Prere Prere and	Pr N2	rescriz Hos	required after 12 months ick boxes where appropriate) ibed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health spital. Following the initial one-month approval, the patient has demonstrated an adequate response to a 2 to 4 week trial of sapropterin with a clinically appropriate reduction in phenylalanine levels to support management of PKU during pregnancy On subsequent renewal applications, the patient has previously demonstrated response to treatment with sapropterin and maintained adequate phenylalanine levels to support management of PKU during pregnancy Patient continues to be pregnant and treatment with sapropterin will not continue after delivery
Re-as Prere	and	or (required after 12 months ick boxes where appropriate) sibed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health spital. Following the initial one-month approval, the patient has demonstrated an adequate response to a 2 to 4 week trial of sapropterin with a clinically appropriate reduction in phenylalanine levels to support management of PKU during pregnancy On subsequent renewal applications, the patient has previously demonstrated response to treatment with sapropterin and maintained adequate phenylalanine levels to support management of PKU during pregnancy Patient continues to be pregnant and treatment with sapropterin will not continue after delivery Patient is actively planning a pregnancy and this is the first renewal for treatment with sapropterin Treatment with sapropterin is required for a second or subsequent pregnancy to support management of their PKU during
Re-as Prere	and	or (required after 12 months lick boxes where appropriate) ibed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health spital. Following the initial one-month approval, the patient has demonstrated an adequate response to a 2 to 4 week trial of sapropterin with a clinically appropriate reduction in phenylalanine levels to support management of PKU during pregnancy On subsequent renewal applications, the patient has previously demonstrated response to treatment with sapropterin and maintained adequate phenylalanine levels to support management of PKU during pregnancy Patient continues to be pregnant and treatment with sapropterin will not continue after delivery Patient is actively planning a pregnancy and this is the first renewal for treatment with sapropterin Treatment with sapropterin is required for a second or subsequent pregnancy to support management of their PKU during pregnancy

Page 29

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
Carglur	mic Acid	
INITIATION Prerequisites (tick box where appropriate)		
NZ Hospital.		ordance with a protocol or guideline that has been endorsed by the Health
and	For the acute in-patient treatment of organic acidaemias as an altern	native to haemofiltration

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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	PATIENT:
Name:	Name:
Ward:	NHI:
Coenzyme Q10	
INITIATION Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a metabolic physician, or in acconn NZ Hospital. and O The patient has a suspected inborn error of metabolism that may res	rdance with a protocol or guideline that has been endorsed by the Health pond to coenzyme Q10 supplementation
CONTINUATION Re-assessment required after 24 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a metabolic physician, or in acconduction NZ Hospital.	rdance with a protocol or guideline that has been endorsed by the Health
The patient has a confirmed diagnosis of an inborn error of me and The treatment remains appropriate and the patient is benefiting	

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.

Schedule. For community funding, see the Special Authority Criteria.				
PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Riboflavin				
INITIATION Re-assessment required after 6 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by a metabolic physician or neurology by the Health NZ Hospital. and O The patient has a suspected inborn error of metabolism that may reserved.	gist, or in accordance with a protocol or guideline that has been endorsed spond to riboflavin supplementation			
CONTINUATION Re-assessment required after 24 months Prerequisites (tick boxes where appropriate)				
Prescribed by, or recommended by a metabolic physician or neurolog by the Health NZ Hospital.	gist, or in accordance with a protocol or guideline that has been endorsed			
The patient has a confirmed diagnosis of an inborn error of metabolism that responds to riboflavin supplementation and The treatment remains appropriate and the patient is benefiting from treatment				

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.

Schedule. For community funding, see the Special Authority Criteria.			
PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Taurine			
INITIATION Re-assessment required after 6 months Prerequisites (tick box where appropriate) Prescribed by, or recommended by a metabolic physician, or in accommod NZ Hospital. and The patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitochondrial disorder that many the patient has a suspected specific mitoch	ordance with a protocol or guideline that has been endorsed by the Health by respond to taurine supplementation		
CONTINUATION Re-assessment required after 24 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and The patient has a confirmed diagnosis of a specific mitochondrial disorder which responds to taurine supplementation and The treatment remains appropriate and the patient is benefiting from treatment			

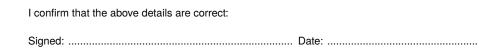
PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Trientine		
Patient has confirmed Wilson disease Treatment with D-penicillamine has been trialled and discontinued because the person has experienced intolerable side effects or has not received sufficient benefit Treatment with zinc has been trialled and discontinued because the person has experienced intolerable side effects or has not received sufficient benefit, or zinc is considered clinically inappropriate as the person has symptomatic liver disease and requires copper chelation		

PRES	CRIBER		PATIENT:
Name	e:		Name:
Ward:			NHI:
Сор	per chlo	pride	
INITIATION – Moderate to severe burns Re-assessment required after 3 months			
Prerequisites (tick boxes where appropriate)			
	and	Patient has been hospitalised with moderate to severe burns	
	Treatment is recommended by a National Burns Unit speci		t

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Ferric carboxymaltose				
INITIATION Prerequisites (tick box where appropriate)				
O Treatment with oral iron has proven ineffective or is clinically inappro	priate			



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.

PRES	SCRIBER	PATIENT:
Name	D:	Name:
Ward	:	NHI:
Sele	nium	
	ATION – Moderate to severe burns assessment required after 3 months	
Prer	equisites (tick boxes where appropriate)	
	O Patient has been hospitalised with moderate to severe burns and	
	Treatment is recommended by a National Burns Unit specialist	t

I confirm that the above details are correct:

Signed: Date:

Form RS1175 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 37

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Sodium hyaluronate	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by an otolaryngologist, or in accord Hospital.	ance with a protocol or guideline that has been endorsed by the Health NZ

PRES	SCR	IBER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Mult	ivit	amin	s - Cap	
INITI Prer			(tick boxes where appropriate)	
		O	Patient has cystic fibrosis with pancreatic insufficiency	
	or	0	Patient is an infant or child with liver disease or short gut synd	rome
	or	\circ	Patient has severe malabsorption syndrome	

C:	D-1	
Signed.	Date:	
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Form RS1178 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 39

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	PATIENT:
Name:	Name:
Ward:	NHI:
Multivitamins – Powder	
INITIATION Prerequisites (tick box where appropriate)	
O Patient has inborn errors of metabolism	

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	. Name:
Ward:	. NHI:
Multivitamin and mineral supplement	
INITIATION Re-assessment required after 3 months Prerequisites (tick boxes where appropriate) Patient was admitted to hospital with burns	
Burn size is greater than 15% of total body surface ar or Burn size is greater than 10% of BSA for mid-dermal or Or Nutritional status prior to admission or dietary intake in	or deep dermal burns

C:	D-1	
Signed.	Date:	
Oigilica.	 Daic.	

PRES	SCR	IBER		PATIENT:
Name	e:			Name:
Ward	l:			NHI:
Mult	ivit	amir	n renal	
INIT Prer			(tick boxes where appropriate)	
		0	The patient has chronic kidney disease and is receiving either	peritoneal dialysis or haemodialysis
	or	0	The patient has chronic kidney disease grade 5, defined as pa body surface area (BSA)	atient with an estimated glomerular filtration rate of < 15 ml/min/1.73m ²

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Alpha tocopheryl acetate	
INITIATION – Cystic fibrosis Prerequisites (tick boxes where appropriate)	
Cystic fibrosis patient	
O Patient has tried and failed the other available funded fail	soluble vitamin A,D,E,K supplement (Vitabdeck)
The other available funded fat soluble vitamin A,D,E,K s the patient	upplement (Vitabdeck) is contraindicated or clinically inappropriate for
INITIATION – Osteoradionecrosis Prerequisites (tick box where appropriate) Or For the treatment of osteoradionecrosis	
INITIATION – Other indications Prerequisites (tick boxes where appropriate)	
O Infant or child with liver disease or short gut syndrome and	
Requires vitamin supplementation	
O Patient has tried and failed the other available funded failed	soluble vitamin A,D,E,K supplements (Vitabdeck)
The other available funded fat soluble vitamin A,D,E,K s patient	upplement (Vitabdeck) is contraindicated or clinically inappropriate for

I confirm that the above details are correct:

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PRESCRIB	ER	PATIENT:
Name:		Name:
Ward:		NHI:
Alpha too	copheryl	
	I – Cystic fibrosis tes (tick boxes where appropriate)	
and	O Cystic fibrosis patient	
		ed fat soluble vitamin A,D,E,K supplement (Vitabdeck)
	The other available funded fat soluble vitamin A,D,I the patient	E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for
Prerequisi	I – Osteoradionecrosis tes (tick box where appropriate) or the treatment of osteoradionecrosis	
	I – Other indications tes (tick boxes where appropriate)	
and	Infant or child with liver disease or short gut syndrome	
and	Requires vitamin supplementation	
		ed fat soluble vitamin A,D,E,K supplements (Vitabdeck)
	The other available funded fat soluble vitamin A,D,I patient	E,K supplement (Vitabdeck) is contraindicated or clinically inappropriate for

I confirm that the above details are correct:

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Signed.	Date:	
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Blood and Blood Forming Organs



PRESCRIBER	PATIENT:
Name:	
Ward:	NHI:
Epoetin beta	a
_	chronic renal failure (tick boxes where appropriate)
	Patient in chronic renal failure
and and	Haemoglobin is less than or equal to 100g/L
	O Patient does not have diabetes mellitus and O Glomerular filtration rate is less than or equal to 30ml/min
or	O Patient has diabetes mellitus and
	Glomerular filtration rate is less than or equal to 45ml/min
or	O Patient is on haemodialysis or peritoneal dialysis
Re-assessmer	myelodysplasia* It required after 12 months (tick boxes where appropriate)
and	Patient has a confirmed diagnosis of myelodysplasia (MDS)
and	Has had symptomatic anaemia with haemoglobin < 100g/L and is red cell transfusion-dependent
and	Patient has very low, low or intermediate risk MDS based on the WHO classification-based prognostic scoring system for myelodysplastic syndrome (WPSS)
	Other causes of anaemia such as B12 and folate deficiency have been excluded
and	Patient has a serum epoetin level of < 500 IU/L
and	The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week
Re-assessmer	DN – myelodysplasia* Int required after 2 months (tick boxes where appropriate)
and	The patient's transfusion requirement continues to be reduced with epoetin treatment
and	Transformation to acute myeloid leukaemia has not occurred
	The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Epoetin beta - continued	
INITIATION – all other indications Prerequisites (tick boxes where appropriate)	
O Haematologist	
For use in patients where blood transfusion is not a viable treater	tment alternative
*Note: Indications marked with * are unapproved indications	

C:	D-1	
Signed.	Date:	
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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Epoetin alfa	
	chronic renal failure (tick boxes where appropriate)
O	Patient in chronic renal failure
and	Haemoglobin is less than or equal to 100g/L
	O Patient does not have diabetes mellitus and O Glomerular filtration rate is less than or equal to 30ml/min
or	O Patient has diabetes mellitus and
or	Glomerular filtration rate is less than or equal to 45ml/min
or	O Patient is on haemodialysis or peritoneal dialysis
Re-assessmen	myelodysplasia* nt required after 2 months (tick boxes where appropriate)
and	Patient has a confirmed diagnosis of myelodysplasia (MDS)
and	Has had symptomatic anaemia with haemoglobin < 100g/L and is red cell transfusion-dependent
and	Patient has very low, low or intermediate risk MDS based on the WHO classification-based prognostic scoring system for myelodysplastic syndrome (WPSS)
and	Other causes of anaemia such as B12 and folate deficiency have been excluded
O	Patient has a serum epoetin level of < 500 IU/L
and	The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week
Re-assessmen	DN – myelodysplasia* It required after 12 months (tick boxes where appropriate)
and	The patient's transfusion requirement continues to be reduced with epoetin treatment
and	Transformation to acute myeloid leukaemia has not occurred
	The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

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	PATIENT:
Name:	Name:
Ward:	NHI:
Epoetin alfa - continued	
INITIATION – all other indications Prerequisites (tick box where appropriate) Prescribed by, or recommended by a haematologist, or in accordance Hospital. and For use in patients where blood transfusion is not a viable treatment Note: Indications marked with * are unapproved indications	ce with a protocol or guideline that has been endorsed by the Health NZ alternative

PRES	SCRI	BER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Apro	otin	in		
INITIATION Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a cardiac anaesthetist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. and				
	or	0	Paediatric patient undergoing cardiopulmonary bypass proced	ure
	JI	0	Adult patient undergoing cardiac surgical procedure where the effects of the drug	significant risk of massive bleeding outweighs the potential adverse

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Eltrombopag	
INITIATION – idiopathic thrombocytopenic purpura - post-splenectomy Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a haematologist, or in accordar Hospital. and O Patient has had a splenectomy and Two immunosuppressive therapies have been trialled and fail and O Patient has a platelet count of 20,000 to 30,000 plateletor	ts per microlitre and has evidence of significant mucocutaneous bleeding 000 platelets per microlitre and has evidence of active bleeding
, , , , , , , , , , , , , , , , , , , ,	
INITIATION – idiopathic thrombocytopenic purpura - preparation for spl Re-assessment required after 6 weeks Prerequisites (tick box where appropriate) Orescribed by, or recommended by a haematologist, or in accordant Hospital. and The patient requires eltrombopag treatment as preparation for sple	nce with a protocol or guideline that has been endorsed by the Health NZ
Hospital. The patient has obtained a response (see Note) from treatment during treatment is required	ring the initial approval or subsequent renewal periods and further
Note: Response to treatment is defined as a platelet count of > 30,000 plate	ets per microlitre
INITIATION – idiopathic thrombocytopenic purpura contraindicated to s Re-assessment required after 3 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a haematologist, or in accordar Hospital.	nce with a protocol or guideline that has been endorsed by the Health NZ
Patient has a significant and well-documented contraindication and Two immunosuppressive therapies have been trialled and fair and Patient has immune thrombocytopenic purpura* with a or	

PRES	PRESCRIBER PATIENT:	
Name	Name: Name:	
Ward	Ward: NHI:	
Eltro	Eltrombopag - continued	
Re-a	CONTINUATION – idiopathic thrombocytopenic purpura contraindicated to splenectomy Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Or Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has be Hospital. and The patient's significant contraindication to splenectomy remains and The patient has obtained a response from treatment during the initial approval period and	en endorsed by the Health NZ
	O Patient has maintained a platelet count of at least 50,000 platelets per microlitre on treatment	
	Further treatment with eltrombopag is required to maintain response	
Re-a Prer	Two immunosuppressive therapies have been trialled and failed after therapy of at least 3 months durat	ion per microliter
Re-a	CONTINUATION – severe aplastic anaemia Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has be Hospital.	en endorsed by the Health NZ
and		seline during the initial approval

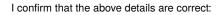
I confirm that the above details are correct:		
Signed:	Date:	

Form RS1500 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 52

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Aluminium chloride	
INITIATION Prerequisites (tick box where appropriate)	
O For use as a haemostatis agent	



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Signed.	Date:	
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PRES	CRIBER		PATIENT:
Name	e:		Name:
Ward	:		NHI:
Emi	cizumat)	
	equisites		re with a protocol or guideline that has been endorsed by the Health NZ
2%)		·	eding phenotype (endogenous factor VIII activity less than or equal to
	and	Emicizumab is to be administered at a dose of no greater than weekly	3 mg/kg weekly for 4 weeks followed by the equivalent of 1.5 mg/kg

I confirm that the above details are correct:		
Signed:	Date:	

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Idarucizumab			
INITIATION			
Prerequisites (tick box where appropriate)			
O For the reversal of the anticoagulant effects of dabigatran when required in situations of life-threatening or uncontrolled bleeding, or for emergency surgery or urgent procedures			

Form RS1706 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 55

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	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Moroctocog alfa [Recombinant factor VIII]			
INITIATION Prerequisites (tick box where appropriate)			
O For patients with haemophilia. Rare Clinical Circumstances Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group, subject to criteria			

Form RS1707 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 56

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	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Octocog alfa [Recombinant factor VIII] (Advate)			
Prerequisites (tick box where appropriate) O For patients with haemophilia. Preferred Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group			

Form RS1708 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 57

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	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Octocog alfa [Recombinant factor VIII] (Kogenate FS)			
INITIATION Prerequisites (tick box where appropriate) Or For patients with haemophilia. Rare Clinical Circumstances Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group, subject to criteria			
manager by manager by manager and manager by	- Indep, outjobile official		

Form RS1679 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 58

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Nonacog gamma		
INITIATION Prerequisites (tick box where appropriate)		
O For patients with haemophilia. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group		

Page 59

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Rurioctocog alfa pegol [Recombinant factor VIII]			
INITIATION Prerequisites (tick box where appropriate)			
O For patients with haemophilia A receiving prophy in conjunction with the National Haemophilia Mar	rlaxis treatment. Access to funded treatment is managed by the Haemophilia Treaters Group nagement Group		

Form RS1684 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 60

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Eftrenonacog alfa			
INITIATION			
Prerequisites (tick box where appropriate)			
O For patients with haemophilia B receiving prophylaxis treatment. Ac in conjunction with the National Haemophilia Management Group	cess to funded treatment is managed by the Haemophilia Treaters Group		

Form RS1705 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 61

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Factor eight inhibitor bypassing fraction			
INITIATION Prerequisites (tick box where appropriate)			
O For patients with haemophilia. Preferred Brand of bypassing agent for > 14 days predicted use. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group			

Form RS1704 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 62

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Eptacog alfa		
INITIATION Prerequisites (tick box where appropriate) For patients with haemophilia. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group. Rare Clinical Circumstances Brand of bypassing agent for > 14 days predicted use. Access to funded treatment for > 14 days predicted use is by named patient application to the Haemophilia Treaters Group, subject to access criteria		

PRES	SCRI	BER	PATIENT:
Name	e:		Name:
Ward:	:		NHI:
Biva	liru	din	
INITI Prer		Sites (tick boxes where appropriate)	
	O For use in heparin-induced thrombocytopaenia, heparin resistance or heparin intolerance		
	or	O For use in patients undergoing endovascular procedures	

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Signed.	Date:	
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Form RS1182 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 64

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	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Danaparoid				
INITIATION Prerequisites (tick box where appropriate)				
O For use in heparin-induced thrombocytopaenia, heparin resistance of	or heparin intolerance			

I confirm that the above details are correct:

Signed: Date:

Form RS1183 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 65

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.

PRESCRIE	BER	PATIENT:
Name:		Name:
Ward:		NHI:
Defibrot	ide	
INITIATIO Prerequis	oN sites (tick box where appropriate)	
	Prescribed by, or recommended by a haematologist, or in accordance Hospital.	ce with a protocol or guideline that has been endorsed by the Health NZ
and	Patient has moderate or severe sinusoidal obstruction syndrome as	a result of chemotherapy or regimen-related toxicities

I confirm that the above details are correct:

Signed: Date:

Form RS1184 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 66

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	PATIENT:
Name:	Name:
Ward:	NHI:
Fondaparinux sodium	
INITIATION	
Prerequisites (tick box where appropriate)	
O For use in heparin-induced thrombocytopaenia, heparin resistance of	or heparin intolerance

I confirm that the above details are correct:

Signed: Date:

PRES	CRIBER		PATIENT:
Name	e:		Name:
Ward	:		NHI:
Lysii	ne acety	ylsalicylate	
	ATION equisites	(tick boxes where appropriate)	
	and	For use when an immediate antiplatelet effect is required prior procedure	to an urgent interventional neuro-radiology or interventional cardiology
		Administration of oral aspirin would delay the procedure	

I confirm that the above details are correct:	
Signed:	Date:

PRES	CRI	IBER		PATIENT:
Name	e:			Name:
Ward:	:			NHI:
Eptif	iba	tide		
INITI Prere			(tick boxes where appropriate)	
		0	For use in patients with acute coronary syndromes undergoing	g percutaneous coronary intervention
	or	0	For use in patients with definite or strongly suspected intra-cor	ronary thrombus on coronary angiography
	or	0	For use in patients undergoing intra-cranial intervention	

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.

PRES	SCRII	BER	PATIENT:
Name	ə:		Name:
Ward	:		NHI:
Tica	grel	or	
	O	sites Restr an S1	d to treatment of acute coronary syndromes specifically for patients who have recently (within the last 60 days) been diagnosed with evation or a non-ST-elevation acute coronary syndrome, and in whom fibrinolytic therapy has not been given in the last 24 hours and anned
Re-a	asses	smen	pmbosis prevention neurological stenting quired after 12 months k boxes where appropriate)
		or	Patient has had a neurological stenting procedure* in the last 60 days Patient is about to have a neurological stenting procedure performed*
	and	or	Patient has demonstrated clopidogrel resistance using the P2Y12 (VerifyNow) assay or another appropriate platelet function assay and requires antiplatelet treatment with ticagrelor
			O Clopidogrel resistance has been demonstrated by the occurrence of a new cerebral ischemic event O Clopidogrel resistance has been demonstrated by the occurrence of transient ischemic attack symptoms referable to the stent.
Re-a	asses	smen	- thrombosis prevention neurological stenting quired after 12 months k boxes where appropriate)
	and	0	tient is continuing to benefit from treatment eatment continues to be clinically appropriate
Re-a	asses	smen	cutaneous coronary intervention with stent deployment quired after 12 months k boxes where appropriate)
	and	\circ	tient has undergone percutaneous coronary intervention tient has had a stent deployed in the previous 4 weeks tient is clopidogrel-allergic**
	equi	sites	nt thrombosis k box where appropriate) as experienced cardiac stent thrombosis whilst on clopidogrel
Re-a	equi:	smen sites	ccardial infarction quired after 1 week k box where appropriate) t term use while in hospital following ST-elevated myocardial infarction
I conf			pove details are correct:

Signed: Date:

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Ticagrelor - continued				
INITIATION – acute minor stroke or high-risk transient ischemic attack (Terrequisites (tick boxes where appropriate)	ΓΙΑ)*			
O Patient has been diagnosed with a minor stroke (NIHSS† scor	re 3 or less), high-risk TIA (ABCD2 score 4 or more) or Crescendo TIA			
O Patient is expected to be a poor metaboliser of clopidogrel, with documented clinical rationale O Patient is allergic to clopidogrel**				
and O Ticagrelor to be prescribed for a maximum of 21 days following	g minor stroke or TIA			
CONTINUATION – subsequent minor stroke or high-risk transient ischen Re-assessment required after 1 month Prerequisites (tick box where appropriate) Patient has been diagnosed with a minor stroke (NIHSS score 3 or I Crescendo TIA	nic attack less), high-risk transient ischemic attack (ABCD2 score 4 or more) or			
Note: Indications marked with * are unapproved indications. Note: Note:** Clopidogrel allergy is defined as a history of anaphylaxis, urtic non-asthmatic patients) developing soon after clopidogrel is started and is any other treatment				

I confirm that the above details are correct:

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Zigneg.	i jate:	
Oigilica.	 Duic.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Plerixafor	
Hospital. Patient is to undergo stem cell transplantation Patient is a donor for stem cell transplantation and Patient has not had more than one previous unsuccessful more and Patient is undergoing G-CSF mobilisation A Has a suboptimal peripheral blood CD34 contreatment Oregin Patient is undergoing chemotherapy and G-CSF and Has rising white blood cell counts of and Has a suboptimal peripheral blood C Oregin Patient is undergoing chemotherapy and G-CSF and Oregin Patient is undergoing chemot	ount of less than or equal to $20 \times 10^6/L$ on day 5 after 4 days of G-CSF ave failed after one apheresis procedure mobilisation > $2 \times 10^9/L$ D34 count of less than or equal to $20 \times 10^6/L$ ave failed after one apheresis procedure decreasing before the target has been received

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Signed.	Date:	
Oigilica.	 Daic.	

Use this checklist to determine it a patient meets the restrictions for fun Schedule. For community funding, see the Special Authority Criteria.	iding in the hospital setting . For more details, refer to Section H of the Pharmaceutica
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pegfilgrastim	
	isk chemotherapy for cancer (febrile neutropenia risk greater than or equal to 5%*)
Note: *Febrile neutropenia risk greater than or equal to 5% after takin Research and Treatment of Cancer (EORTC) guidelines	ng into account other risk factors as defined by the European Organisation for

I confirm that the above details are correct:

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Signed.	Date:	
Oigilica.	 Daic.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Filgrastim	
INITIATION Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a haematologist or oncologist, o Health NZ Hospital.	r in accordance with a protocol or guideline that has been endorsed by the

Page 74

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Sodium chloride – Inj	
INITIATION	
Prerequisites (tick box where appropriate)	
O For use in flushing of in-situ vascular access devices only	

Cardiovascular System



PRES	SCR	IBER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Capt	top	ril - C	Oral liq 5 mg per ml	
INITI Prer			(tick boxes where appropriate)	
	0 r	0	For use in children under 12 years of age	
O For use in tube-fed patients			For use in tube-fed patients	
O For management of rebound transient hypertension following cardiac surgery				cardiac surgery

PRESCRIB	ER			PATIENT:
Name:				Name:
Ward:				NHI:
Sacubitri	l w	ith v	alsartan	
INITIATION Prerequisi		(tick b	poxes where appropriate)	
(and	C	Patie	ent has heart failure	
		0	Patient is in NYHA/WHO functional class II	
	or	0	Patient is in NYHA/WHO functional class III	
	or	0	Patient is in NYHA/WHO functional class IV	
and		_		
	or	\bigcirc	Patient has a documented left ventricular ejection fraction	on (LVEF) of less than or equal to 35%
		0	An ECHO is not reasonably practical, and in the opinion	of the treating practitioner the patient would benefit from treatment
and (C	Patie	ent is receiving concomitant optimal standard chronic hea	rt failure treatments

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Signed.	Date:	
Oigilica.	 Daic.	

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	PATIENT:
Name:	Name:
Ward:	NHI:
Adenosine - Inj 3 mg per ml, 10 ml vial	
INITIATION	
Prerequisites (tick box where appropriate)	
O For use in cardiac catheterisation, myocardial perfusion scans, elect	trophysiology and MRI

Form RS1001 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 79

	PRESCR	IBER	PATIENT:	
	Name:		Name:	
Ward:			NHI:	
1	Ajmalin	ne		
	INITIATI	ON		
	Prerequ	isites (tick box where appropriate)		
	0	Prescribed by, or recommended by a cardiologist, or in accordance Hospital.	with a protocol or guideline that has been endorsed by the Health NZ	

I confirm that the above details are correct:		
Signed:	Date:	

PRES	CRIB	ER		PATIENT:
Name	:			Name:
Ward:				NHI:
lvabr	adir	ne		
INITI. Prere			(tick boxes where appropriate)	
	and	O	Patient is indicated for computed tomography coronary angiog	raphy
	O Patient has a heart rate of greater than 70 beats per minute while taking a maximally tolerated dose of beta blocker			
	O Patient is unable to tolerate beta blockers			

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Zigneg.	i jate:	
Oigilica.	 Duic.	

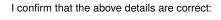
Form RS1427 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 81

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	PATIENT:
Name:	Name:
Ward:	NHI:
Midodrine	
INITIATION Prerequisites (tick box where appropriate)	
O Patient has disabling orthostatic hypotension not due to drugs	



PRES	CRI	BER	PATIENT:
Name	e:		Name:
Ward:	:		NHI:
Nica	rdip	oine hydrochloride	
INITI Prero	equi	Sites (tick boxes where appropriate) Prescribed by, or recommended by an anaesthetist, intensivist, cardiguideline that has been endorsed by the Health NZ Hospital.	ologist or paediatric cardiologist, or in accordance with a protocol or
	or or	O Patient has hypertension requiring urgent treatment with an int O Patient has excessive ventricular afterload O Patient is awaiting or undergoing cardiac surgery using cardio	

PRES	CRIB	ER		PATIENT:
Name):			Name:
Ward:	·			NHI:
Eple	reno	ne		
1	ATION equisi	-	(tick boxes where appropriate)	
	and	C	Patient has heart failure with ejection fraction less than 40%	
			O Patient is intolerant to optimal dosing of spironolactone	
		or	O Patient has experienced a clinically significant adverse e	effect while on optimal dosing of spironolactone

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Zigneg.	i jate:	
Oigilica.	 Duic.	

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.

PRES	SCRII	BER		PATIENT:	
Name	me:Name:				
Ward	l:			NHI:	
Tolv	apta	ın			
Re-a	asses: requis	Preso with a	Patient has a confirmed diagnosis of autosomal dominant poly Patient has an estimated glomerular filtration rate (eGFR) of groups of the patient's disease is rapidly progressing, with a decline in	cystic kidney disease	
Re-a	asses: requis	smen sites	ON – autosomal dominant polycystic kidney disease t required after 12 months (tick boxes where appropriate)		
and			cribed by, or recommended by a renal physician or any relevant a protocol or guideline that has been endorsed by the Health NZ	practitioner on the recommendation of a renal physician, or in accordance 7 Hospital.	
	and		Patient has not developed end-stage renal disease, defined as Patient has not undergone a kidney transplant	an eGFR of less than 15 mL/min/1.73 m ²	

I confirm that the above details are correct:

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Signed.	Date:	
Oigilica.	 Daic.	

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	PATIENT:	
Name:	Name:	
Ward:	. NHI:	
Rosuvastatin		
INITIATION – cardiovascular disease risk Prerequisites (tick boxes where appropriate)		
Patient is considered to be at risk of cardiovascular diand Patient is Māori or any Pacific ethnicity	sease	
Patient has a calculated risk of cardiovascular disease and LDL cholesterol has not reduced to less than 1.8 mm and/or simvastatin	e of at least 15% over 5 years ol/litre with treatment with the maximum tolerated dose of atorvastatin	
INITIATION – familial hypercholesterolemia Prerequisites (tick boxes where appropriate)		
Patient has familial hypercholesterolemia (defined as a Duto and LDL cholesterol has not reduced to less than 1.8 mmol/litre simvastatin	ch Lipid Criteria score greater than or equal to 6) with treatment with the maximum tolerated dose of atorvastatin and/or	
INITIATION – established cardiovascular disease Prerequisites (tick boxes where appropriate)		
O Patient has proven coronary artery disease (CAD) or O Patient has proven peripheral artery disease (PAD) or O Patient has experienced an ischaemic stroke		
and LDL cholesterol has not reduced to less than 1.4 mmol/litre simvastatin	with treatment with the maximum tolerated dose of atorvastatin and/or	
INITIATION – recurrent major cardiovascular events Prerequisites (tick boxes where appropriate)		
revascularisation, hospitalisation for unstable angina) in the	vent (defined as myocardial infarction, ischaemic stroke, coronary last 2 years with treatment with the maximum tolerated dose of atorvastatin and/or	

I confirm that the above details are correct:

Page 86

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	PATIENT:
Name:	Name:
Ward:	NHI:
Levosimendan	
INITIATION – Heart transplant Prerequisites (tick boxes where appropriate)	
Or For use as a bridge to heart transplant, in patients who have Or For the treatment of heart failure following heart transplant	been accepted for transplant
INITIATION – Heart failure Prerequisites (tick box where appropriate)	
Health NZ Hospital.	n accordance with a protocol or guideline that has been endorsed by the
O For the treatment of severe acute decompensated heart failure that	is non-responsive to dobutamine

I confirm that the above details are correct:

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Zigneg.	i jate:	
Oigilica.	 Duic.	

Form RS1992 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 87

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.

PRES	SCRIBER		PATIENT:		
Name	ə:		Name:		
Ward	:		NHI:		
Alpr	ostadil				
	IATION equisites	(tick boxes where appropriate)			
	O	Patient has erectile dysfunction			
	and	Patient is to receive a penile Doppler ultrasonography			

I confirm that the above details are correct:

C:	D-1	
Signed.	Date:	
Oigilica.	 Daic.	

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.

PRES	SCR	IBER		PATIENT:
PRESCRIBER Name: Ward: Ward:			Name:	
Ward	:			NHI:
Hydi			hydrochloride - Tab 25 mg	
			(tick boxes where appropriate)	
	or	0	For the treatment of refractory hypertension	
	Ji	0	For the treatment of heart failure, in combination with a nitrate and/or angiotensin receptor blockers	, in patients who are intolerant or have not responded to ACE inhibitors

I confirm that the above details are correct:

PRESCRIB	BER	PATIENT:
Name:		
Ward:		NHI:
Bosentar	n	
Prerequisi	ment r ites (ti Prescri	AH monotherapy required after 6 months ick boxes where appropriate) bed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of ratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and (and and (О р О р	Patient has pulmonary arterial hypertension (PAH)* PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications 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) A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵) APAH 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 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool** Patient has PAH other than idiopathic / heritable or drug-associated type
and	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 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	Bosentan is to be used as PAH monotherapy O Patient has experienced intolerable side effects on sildenafil Or Patient has an absolute contraindication to sildenafil O Patient is a child with idiopathic PAH or PAH secondary to congenital heart disease

I confirm that the above details are correct:

SCRIBER	PATIENT:
ıe:	Name:
d:	NHI:
sentan - contir	nued
requisites (tick	dual therapy uired after 6 months boxes where appropriate) d by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of bry specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
PAH and PAH	ent has pulmonary arterial hypertension (PAH)* I is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications I is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
aı	PAH has been confirmed by right heart catheterisation A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵) 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 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool** Patient has PAH other than idiopathic / heritable or drug-associated type 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 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	Bosentan is to be used as part of PAH dual therapy Patient has tried a PAH monotherapy (sildenafil) for at least three months and has experienced an inadequate therapeutic response to treatment according to a validated risk stratification tool** Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would likely benefit from initial dual therapy

I confirm that the above details are correct:

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.

CRIBER	PATIENT:
·	
	NHI:
entan - conti	nued
Prescriber a respirate Hospital. Pati and PAF	triple therapy uired after 6 months boxes where appropriate) d by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation by specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health Nent has pulmonary arterial hypertension (PAH)* H is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications
and	His in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
a	PAH has been confirmed by right heart catheterisation A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵) 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 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool** Patient has PAH other than idiopathic / heritable or drug-associated type 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 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 o	O Patient is presenting in NYHA/WHO functional class IV

I confirm that the above details are correct:

Signed: Date:

Form RS2160 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 92

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	PATIENT:
Name:	Name:
Ward:	NHI:
Bosentan - continued	
CONTINUATION Re-assessment required after 2 years Prerequisites (tick box where appropriate)	
	rgist, rheumatologist or any relevant practitioner on the recommendation of ance with a protocol or guideline that has been endorsed by the Health NZ
O Patient is continuing to derive benefit from bosentan treatment acco	ording to a validated PAH risk stratification tool**

Note: ** 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.

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	PATIENT:
Name:	
Ward:	NHI:
Ambrisentan	
Prescribed by a respiratory Hospital. Patient and PAH is and	and after 6 months were appropriate) An or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ has pulmonary arterial hypertension (PAH) in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV PAH has been confirmed by right heart catheterisation A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵) 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
or O F	Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool** Patient has PAH other than idiopathic / heritable or drug-associated type Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung isorders including chronic neonatal lung disease Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the ontan circulation requiring the minimising of pulmonary/venous filling pressures Patient has experienced intolerable side effects with both sildenafil and bosentan Patient has an absolute contraindication to sildenafil and an absolute or relative contraindication to bosentan (e.g. due to current use of a combined oral contraceptive or liver disease) Patient is a child with idiopathic PAH or PAH secondary to congenital heart disease

I confirm that the above details are correct:

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.

CRIBE	ER	PATIENT:	
:			
		NHI:	
risen	ıtan -	ontinued	
ssessn equisit Pr a	nent re tes (tic rescrib	dual therapy lired after 6 months boxes where appropriate) by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendary specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Hea	
and) Pa	ent has pulmonary arterial hypertension (PAH)	
and) PA	is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications	
and) PA	is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV	
		O PAH has been confirmed by right heart catheterisation	
		nd A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)	
		A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg	
		O Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵)	
		O PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, a defined in the 2022 ECS/ERS Guidelines for PAH	ıs
		O Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**	
		O Patient has PAH other than idiopathic / heritable or drug-associated type	
	or C	Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lur disorders including chronic neonatal lung disease Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication or Fontan circulation requiring the minimising of pulmonary/venous filling pressures	
and			
	and	Ambrisentan is to be used as PAH dual therapy	
		O Patient has experienced intolerable side effects on bosentan	i
		O Patient has an absolute or relative contraindication to bosentan (e.g. due to current use of a combined oral contrace or liver disease)	ptive
		O Patient is presenting in NYHA/WHO functional class III or IV, and would benefit from initial dual therapy in the opinior of the treating clinician and has an absolute or relative contraindication to bosentan (eg. due to current liver disease use of a combined oral contraceptive)	

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
lame:	
Vard:	NHI:
Ambrisentan - continued	
	5 months
Patient has puln	monary arterial hypertension (PAH)
and	o 1, 4 or 5 of the WHO (Venice 2003) clinical classifications York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
or OPatient is disorders OPatient ha	H has been confirmed by right heart catheterisation nean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) ulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg monary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵) 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 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool** Patient has PAH other than idiopathic / heritable or drug-associated type a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung including chronic neonatal lung disease as palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the roulation requiring the minimising of pulmonary/venous filling pressures
and	tan is to be used as PAH triple therapy ient is on the lung transplant list Patient is presenting in NYHA/WHO functional class IV Patient has an absolute or relative contraindication to bosentan (e.g. due to current use of a combined oral contraceptive or liver disease) Patient has tried PAH dual therapy for at least three months and remains in an unacceptable risk category according to a validated risk stratification tool** Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario

I confirm that the above details are correct:

Signed: Date:

Form RS2159 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 96

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	PATIENT:
Name:	Name:
Ward:	NHI:
Ambrisentan - continued	
CONTINUATION Re-assessment required after 2 years Prerequisites (tick box where appropriate)	
a respiratory specialist, cardiologist or rheumatologist, or in according Hospital.	ogist, rheumatologist or any relevant practitioner on the recommendation of ance with a protocol or guideline that has been endorsed by the Health NZ
The patient is continuing to derive benefit from ambrisentan treatm	ent according to a validated PAH risk stratification tool**

Note: ** 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.

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	PATIENT:	
me: Name:		
Ward:	NHI:	
Sildenafil (Vedafil)		
INITIATION – tablets Raynaud's Phenomenon Prerequisites (tick boxes where appropriate)		
digital ulcers; or gangrene) and Patient is following lifestyle management (proper body insulati of sympathomimetic drugs) and	equiring hospital admission or with a high likelihood of digital ulceration; ion, avoidance of cold exposure, smoking cessation support, avoidance in calcium channel blockers and nitrates (unless contraindicated or not	
	gist, rheumatologist or any relevant practitioner on the recommendation of nce with a protocol or guideline that has been endorsed by the Health NZ	
PAH is non-responsive in vasoreactivity ass Guidelines for PAH Patient has not experienced an acceptable risk stratification tool** Patient has PAH other than idiopathic / herit or Patient is a child with PAH secondary to congenital hear disorders including severe chronic neonatal lung diseas	eater than 20 mmHg Part is less than or equal to 15 mmHg Part wood Units or at least 160 International Units (dyn s cm ⁻⁵) Ressment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Response to calcium antagonist treatment, according to a validated Part disease or PAH due to idiopathic, congenital or developmental lung Resease and elevated pulmonary pressures or a major complication of the	

I confirm that the above details are correct:

Signed: Date:

PRES	CRIE	BER	PATIENT:	
Name	:		Name:	
Ward:			NHI:	
Silde	nafi	I (V	dafil) - continued	
			blets other conditions ick boxes where appropriate)	
	or or	0	For use in weaning patients from inhaled nitric oxide For perioperative use in cardiac surgery patients For use in intensive care as an alternative to nitric oxide For use in the treatment of erectile dysfunction secondary to spinal cord injury in patients being treated in a spinal unit	
			jection ick boxes where appropriate)	
	and	0	For use in the treatment of pulmonary hypertension in infants or children being treated in paediatric intensive care units and neonatal ntensive care units when the enteral route is not accessible	
		or or	For perioperative use following cardiac surgery For use in persistent pulmonary hypertension of the newborn (PPHN)	
			For use in congenital diaphragmatic hernia	<u>J</u>

Note: ** 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.

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	PATIENT:
Name:	Name:
Ward:	NHI:
Epoprosten	ol
Prerequisites Pres	PAH dual therapy Int required after 6 months (tick boxes where appropriate) cribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of piratory specialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.
and and and	Patient has pulmonary arterial hypertension (PAH) PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class III or IV 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 ⁻⁵) 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 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**
or or and	Patient has PAH other than idiopathic / heritable or drug-associated type 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 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 Epoprostenol is to be used as part of PAH dual therapy with either sildenafil or an endothelin receptor antagonist Patient is presenting in NYHA/WHO functional class IV
ar	

I confirm that the above details are correct:

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	R	PATIENT:
e:		
:		NHI:
proste	nol - co	ntinued
assessmerequisite Pre	ent requires (tick boses)	ple therapy red after 6 months exes where appropriate) by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation or expecialist, cardiologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health No.
and) Patien	t has pulmonary arterial hypertension (PAH)
C	PAH is	s in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications
and	PAH is	s in New York Heart Association/World Health Organization (NYHA/WHO) functional class III or IV
	and	O 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 ⁻⁵)
		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
		Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**
		O Patient has PAH other than idiopathic / heritable or drug-associated type
		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 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		Epoprostenol is to be used as PAH triple therapy
	or or	O Patient is on the lung transplant list O Patient is presenting in NYHA/WHO functional class IV
		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 Patient does not have major life threatening comorbidities and triple therapy is not being used in a palliative.
		Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario

I confirm that the above details are correct:

Form RS2162 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 101

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.

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
Epopro	stenol - continued	
	UATION ssment required after 2 years isites (tick box where appropriate)	
0		gist, rheumatologist or any relevant practitioner on the recommendation of nce with a protocol or guideline that has been endorsed by the Health NZ
and	Patient is continuing to derive benefit from epoprostenol treatment a	ccording to a validated PAH risk stratification tool
	Patient is continuing to derive benefit from epoprostenoi treatment a	ccording to a validated PAH risk stratification tool

Note: ** 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.

PRESCRIBER	PATIENT:
Name:	
Vard:	NHI:
oprost	
a respiratory specialist, card Hospital.	
PAH is in Group 1, 4	ry arterial hypertension (PAH) or 5 of the WHO (Venice 2003) clinical classifications Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
and A mean pand A pulmor and	been confirmed by right heart catheterisation pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) mary capillary wedge pressure (PCWP) less than or equal to 15 mmHg mary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵) H has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as fined in the 2022 ECS/ERS Guidelines for PAH tient has not experienced an acceptable response to calcium antagonist treatment, according to a validated a stratification tool** tient has PAH other than idiopathic / heritable or drug-associated type
or disorders included Description O Patient has pall	d with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung ding severe chronic neonatal lung disease liated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the ion requiring the minimising of pulmonary/venous filling pressures
and Iloprost is to be	as experienced intolerable side effects on sildenafil and both the funded endothelin receptor antagonists (i.e.
or	entan and ambrisentan) as an absolute contraindication to sildenafil and an absolute or relative contraindication to endothelin receptor sts

I confirm that the above details are correct:	
Signed:	Date:

SCRIBER	PATIENT:
e:	
d:	NHI:
rost - cont	tinued
assessment requisites (PAH dual therapy t required after 6 months (tick boxes where appropriate) ribed by, or recommended by a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of biratory specialist, cardiologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
Hospit	ital.
and	Patient has pulmonary arterial hypertension (PAH)
0	PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications
and and	PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
	O PAH has been confirmed by right heart catheterisation and
	O A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)
	A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg
	A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵) 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
	Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool**
	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 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	O Iloprost is to be used as PAH dual therapy with either sildenafil or an endothelin receptor antagonist
and	
	O Patient has an absolute contraindication to or has experienced intolerable side effects on sildenafil or
	O 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**
	Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would benefit

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.

SCRIBER	PATIENT:
e:	
d:	NHI:
rost - continu	ued
Prescribe a respiral Hospital.	
and	tient has pulmonary arterial hypertension (PAH)
and	H is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications H is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV
8	PAH has been confirmed by right heart catheterisation A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm ⁻⁵) 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 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool** Patient has PAH other than idiopathic / heritable or drug-associated type 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 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	Patient is on the lung transplant list Patient is presenting in NYHA/WHO functional class IV 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** Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario

I confirm that the above details are correct:

Signed: Date:

Form RS2163 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 105

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.

PRESCR	IBER	PATIENT:		
Name:		Name:		
Ward:		NHI:		
llopros	t - continued			
Re-asse	IUATION ssment required after 2 years iisites (tick box where appropriate)			
0	O 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 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.

Dermatologicals

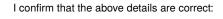


Form RS1299 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 107

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Mafenide acetate	
INITIATION Prerequisites (tick box where appropriate)	
O For the treatment of burns patients	



C:	D-1	
Signed.	Date:	
Oigilica.	 Daic.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Betamethasone valerate with clioquinol INITIATION Prerequisites (tick boxes where appropriate)	
For the treatment of intertrigo or For continuation use	

Page 109

PRE	SCR	IBER		PATIENT:	
Nam	e:			Name:	
Ward	l:			NHI:	
Pim	ecro	olimu	ıs		
	0	isites Preso	(tick boxes where appropriate) cribed by, or recommended by a dermatologist, paediatrician or reed by the Health NZ Hospital.	ophthalmologist, or in accordance with a protocol or guideline that has been	
	and	Patient has atopic dermatitis on the eyelid O Patient has at least one of the following contraindications to topical corticosteroids: periorificial dermatitis, rosacea, documented epidermal atrophy, documented allergy to topical corticosteroids, cataracts, glaucoma, or raised intraocular pressure			
			epidermai alrophy, documented allergy to topical corticosteroic	as, catalacts, glaucoma, or raised intraocular pressure	

I confirm that the above details are correct:	
Signed:	Date:

Page 110

PRES	CRIBEI	3	PATIENT:			
Name	e:		Name:			
Ward:			NHI:			
Tacro	olimus	Ointment				
INITIATION Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a dermatologist or paediatrician, Health NZ Hospital.		scribed by, or recommended by a dermatologist or paediatrician,	or in accordance with a protocol or guideline that has been endorsed by the			
	and	Patient has atopic dermatitis on the face Patient has at least one of the following contraindications to to epidermal atrophy or documented allergy to topical corticoster	o topical corticosteroids: periorificial dermatitis, rosacea, documented steroids			

PRESCRI	BER	PATIENT:			
Name:		Name:			
Ward:		NHI:			
Methyl a	minolevulinate hydrochloride				
	INITIATION Prerequisites (tick box where appropriate)				
	Prescribed by, or recommended by a dermatologist or plastic surged the Health NZ Hospital.	on, or in accordance with a protocol or guideline that has been endorsed by			

Genito-Urinary System



Form RS1130 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 113

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Terbutaline	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by an obstetrician, or in accordance Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ

PRES	CRIB	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Fina	steri	de		
	ATIOI equis		(tick boxes where appropriate)	
	and	0	Patient has symptomatic benign prostatic hyperplasia	
		or	O The patient is intolerant of non-selective alpha blockers	or these are contraindicated
			O Symptoms are not adequately controlled with non-select	tive alpha blockers

PRES	CRIBER		PATIENT:	
Name	e:		Name:	
Ward			NHI:	
Tam	Tamsulosin			
	ATION equisites	(tick boxes where appropriate)		
	and	Patient has symptomatic benign prostatic hyperplasia		
		The patient is intolerant of non-selective alpha blockers or the	se are contraindicated	

0:	D - 1 - 1	
Zigneg.	i jate:	
Oigilica.	 Duic.	

PRES	CRIBER		PATIENT:
Name):		Name:
Ward			NHI:
Pota	ssium (citrate	
	ATION equisites	(tick boxes where appropriate)	
	and	The patient has recurrent calcium oxalate urolithiasis	
		The patient has had more than two renal calculi in the two year	ars prior to the application

0:	D - 1 - 1	
Zigneg.	i jate:	
Oigilica.	 Duic.	

Hormone Preparations



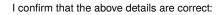
Form RS1302 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 118

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.

PATIENT:
Name:
NHI:



PATIENT:
NHI:
parathyroid carcinoma or calciphylaxis ent required after 6 months solved to both the patient has been diagnosed with a parathyroid carcinoma (see Note) The patient has persistent hypercalcaemia (serum calcium greater than or equal to 3 mmol/L) despite previous first-line treatments including sodium thiosulfate (where appropriate) and bisphosphonates The patient has been diagnosed with calciphylaxis (calcific uraemic arteriolopathy) The patient has been diagnosed with calciphylaxis (calcific uraemic arteriolopathy) The patient has symptomatic (e.g. painful skin ulcers) hypercalcaemia (serum calcium greater than or equal to 3 mmol/L) The patient has symptomatic (e.g. painful skin ulcers) hypercalcaemia (serum calcium greater than or equal to 3 mmol/L) The patient has symptomatic (e.g. painful skin ulcers) hypercalcaemia (serum calcium greater than or equal to 3 mmol/L) The patient's condition has not responded to previous first-line treatments including bisphosphonates and sodium thiosulfate
ION – parathyroid carcinoma or calciphylaxis s (tick boxes where appropriate) scribed by, or recommended by a nephrologist or endocrinologist, or in accordance with a protocol or guideline that has been endorsed by Health NZ Hospital. The patient's serum calcium level has fallen to < 3mmol/L The patient has experienced clinically significant symptom improvement ones not include parathyroid adenomas unless these have become malignant.
- primary hyperparathyroidism s (tick boxes where appropriate)
Patient has primary hyperparathyroidism O Patient has hypercalcaemia of more than 3 mmol/L with or without symptoms O Patient has hypercalcaemia of more than 2.85 mmol/L with symptoms O Surgery is not feasible or has failed Patient has other comorbidities, severe bone pain, or calciphylaxis

I confirm that the above details are correct:

Cianad.	Doto.	
Siurieu.	 Date.	

PRES	CRIB	ER			PATIENT:
Name):				Name:
Ward					NHI:
Cina	calc	et -	continued		
			econdary or a required after	tertiary hyperparathyroidism r 6 months	
				ere appropriate)	
			O Patient	has tertiary hyperparathyroidism and marke	edly elevated parathyroid hormone (PTH) with hypercalcaemia
		or	O Patient	has symptomatic secondary hyperparathyro	roidism and elevated PTH
	and (and	С	Patient is on r	renal replacement therapy	
		or	O Residua	al parathyroid tissue has not been localised	despite repeat unsuccessful parathyroid explorations
			O Parathy	roid tissue is surgically inaccessible	
		or	O Parathy	roid surgery is not feasible	
Re-a	ssess	men	required after		
Prer	equisi	ites	tick boxes wh	ere appropriate)	
	(С		as had a kidney transplant, and following a t H) level to support ongoing cessation of trea	treatment free interval of at least 12 weeks a clinically acceptable parathyroid atment has not been reached
	or (The patient ha	as not received a kidney transplant and trial	l of withdrawal of cinacalcet is clinically inappropriate

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Cabergoline	
INITIATION Prerequisites (tick boxes where appropriate)	
O Inhibition of lactation	
O Patient has hyperprolactinemia	
O Patient has acromegaly	
Note: Indication marked with * is an unapproved indication.	

I confirm that the above details are correct:

0:	D - 1 - 1	
Zigneg.	i jate:	
Oigilica.	 Duic.	

RS1826 - Somatropin

Prader-Willi syndrome - INITIATION	126
Prader-Willi syndrome - CONTINUATION	126
Turner syndrome - INITIATION	123
Turner syndrome - CONTINUATION	124
Adults and adolescents - INITIATION	127
Adults and adolescents - CONTINUATION	128
Growth hormone deficiency in children - INITIATION	123
Growth hormone deficiency in children - CONTINUATION	123
Short stature due to chronic renal insufficiency - INITIATION	125
Short stature due to chronic renal insufficiency - CONTINUATION	125
Short stature without growth hormone deficiency - INITIATION	124
Short stature without growth hormone deficiency - CONTINUATION	124

PRES	CRI	IBER	P.	ATIENT:
Name	e:		N	ame:
Ward	·		N	HI:
Som	atro	opin		
Re-a	sses	ssmen	growth hormone deficiency in children nt required after 12 months (tick boxes where appropriate)	
and	С		cribed by, or recommended by an endocrinologist or paediatric endorsed by the Health NZ Hospital.	docrinologist, or in accordance with a protocol or guideline that has been
	or	0		t, or with other significant growth hormone deficient sequelae (e.g. 5 mcg/l on at least two random blood samples in the first 2 weeks of ood glucose < 2 mmol/l using a laboratory device)
		and	standards of Tanner and Davies (1985)	oone age/pubertal status if appropriate over 6 or 12 months using the
		and	O A current bone age is < 14 years (female patients) or < 16	years (male patients)
		and	O Peak growth hormone value of < 5.0 mcg per litre in responsive who are 5 years or older, GH testing with sex steroid primin	nse to two different growth hormone stimulation tests. In children ng is required
			If the patient has been treated for a malignancy, they shoul laboratory and radiological imaging appropriate for the mal not necessary or appropriate	d be disease free for at least one year based upon follow-up ignancy, unless there are strong medical reasons why this is either
		and	Appropriate imaging of the pituitary gland has been obtained	ed
Re-a	sses	ssmen isites Presc	ON – growth hormone deficiency in children nt required after 12 months (tick boxes where appropriate) cribed by, or recommended by an endocrinologist or paediatric endorsed by the Health NZ Hospital.	docrinologist, or in accordance with a protocol or guideline that has been
and	an	-	A current bone age is 14 years or under (female patients) or 16	years or under (male patients)
	an	0	Height velocity is greater than or equal to 25th percentile for age hormone treatment, as calculated over six months using the stan	(adjusted for bone age/pubertal status if appropriate) while on growth dards of Tanner and Davis (1985)
	and	\circ	Height velocity is greater than or equal to 2.0 cm per year, as cale	culated over 6 months
	an	\circ	No serious adverse effect that the patients specialist considers is	likely to be attributable to growth hormone treatment has occurred
		O	No malignancy has developed since starting growth hormone	
Re-a	sses	ssmen	Turner syndrome nt required after 12 months (tick boxes where appropriate)	
and	C		cribed by, or recommended by an endocrinologist or paediatric endorsed by the Health NZ Hospital.	docrinologist, or in accordance with a protocol or guideline that has been
	and	O	The patient has a post-natal genotype confirming Turner Syndror	ne
	and	\circ	Height velocity is < 25th percentile over 6-12 months using the st	andards of Tanner and Davies (1985)
		O	A current bone age is < 14 years	
Lonfi	rm †	hat the	e above details are correct:	

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.

PRES	CRIBER	BER PATIENT:	
Name	:	Name:	
Ward:		NHI:	
Som	atropir	ppin - continued	
Re-a	ssessme	JATION – Turner syndrome sment required after 12 months sites (tick boxes where appropriate)	
and		Prescribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordate endorsed by the Health NZ Hospital.	nce with a protocol or guideline that has been
	and _	Ranke's Turner Syndrome growth velocity charts)	culated over 6 to 12 months using the
	and _	Height velocity is greater than or equal to 2 cm per year, calculated over six months	
	and	A current bone age is 14 years or under	
	and	O No serious adverse effect that the specialist considers is likely to be attributable to growth he	ormone treatment has occurred
	O	O No malignancy has developed since starting growth hormone	
Re-a	ssessme equisites Pres	N – short stature without growth hormone deficiency sment required after 12 months sites (tick boxes where appropriate) Prescribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordate endorsed by the Health NZ Hospital.	nce with a protocol or guideline that has been
	and	O The patient's height is more than 3 standard deviations below the mean for age or for bone or delay	age if there is marked growth acceleration
	and	O Height velocity is < 25th percentile for age (adjusted for bone age/pubertal status if appropri using the standards of Tanner and Davies(1985)	ate), as calculated over 6 to 12 months
	and	A current bone age is < 14 years (female patients) or < 16 years (male patients)	
		The patient does not have severe chronic disease (including malignancy or recognized severed medications known to impair height velocity	re skeletal dysplasia) and is not receiving
CON	ΤΙΝΙΙΔΤΙ	JATION – short stature without growth hormone deficiency	
Re-a	ssessme	sment required after 12 months sites (tick boxes where appropriate)	
Prere	`		
and		Prescribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordate endorsed by the Health NZ Hospital.	nce with a protocol or guideline that has been
	and	Height velocity is greater than or equal to 50th percentile (adjusted for bone age/pubertal statement of 12 months using the standards of Tanner and Davies (1985)	atus if appropriate) as calculated over 6 to
	and	O Height velocity is greater than or equal to 2 cm per year as calculated over six months	
	and	O Current bone age is 14 years or under (female patients) or 16 years or under (male patients	s)
		O No serious adverse effect that the patient's specialist considers is likely to be attributable to	growth hormone treatment has occurred

I confirm that the above details are correct:

ard:	
aıu	NHI:
omatropin	- continued
NITIATION – Re-assessmer Prerequisites Pres	short stature due to chronic renal insufficiency It required after 12 months It (tick boxes where appropriate) cribed by, or recommended by an endocrinologist, paediatric endocrinologist or renal physician on the recommendation of a endocrinologist aediatric endocrinologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. The patient's height is more than 2 standard deviations below the mean Height velocity is < 25th percentile (adjusted for bone age/pubertal status if appropriate) as calculated over 6 to 12 months using the standards of Tanner and Davies (1985) A current bone age is to 14 years or under (female patients) or to 16 years or under (male patients) The patient is metabolically stable, has no evidence of metabolic bone disease and absence of any other severe chronic disease The patient has a GFR less than or equal to 30 ml/min/1.73 m² as measured by the Schwartz method (Height(cm)/plasma creatinine (umol/l)) × 40 = corrected GFR (ml/min/1.73 m²) in a child who may or may not be receiving dialysis
	creatinine (umol/l)) × 40 = corrected GFR (ml/min/1.73 m²) in a child who may or may not be receiving dialysis
	ON – short stature due to chronic renal insufficiency
	nt required after 12 months (tick boxes where appropriate)
	cribed by, or recommended by an endocrinologist, paediatric endocrinologist or renal physician on the recommendation of a endocrinologis aediatric endocrinologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
and	Height velocity is greater than or equal to 50th percentile (adjusted for bone age/pubertal status if appropriate) as calculated over 6 to 12 months using the standards of Tanner and Davies (1985)
and	Height velocity is greater than or equal to 2 cm per year as calculated over six months
and	A current bone age is 14 years or under (female patients) or 16 years or under (male patients)
and	No serious adverse effect that the patients specialist considers is likely to be attributable to growth hormone has occurred
and	No malignancy has developed after growth hormone therapy was commenced
and	The patient has not experienced significant biochemical or metabolic deterioration confirmed by diagnostic results
and	The patient has not received renal transplantation since starting growth hormone treatment If the patient requires transplantation, growth hormone prescription should cease before transplantation and a new application should
	be made after transplantation based on the above criteria

I confirm that the above details are correct:

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.

PRES	SCRIB	ER	PATIENT:
Name	e:		Name:
Ward	:		NHI:
Som	atro	pin	- continued
INIT Re-a	IATION assess equis	N - Filmen ites Prescendor	Prader-Willi syndrome t required after 12 months (tick boxes where appropriate) pribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been resed by the Health NZ Hospital. The patient has a diagnosis of Prader-Willi syndrome that has been confirmed by genetic testing or clinical scoring criteria The patient is aged six months or older A current bone age is < 14 years (female patients) or < 16 years (male patients) Sleep studies or overnight oximetry have been performed and there is no obstructive sleep disorder requiring treatment, or if an obstructive sleep disorder is found, it has been adequately treated under the care of a paediatric respiratory physician and/or ENT surgeon
		or	The patient is aged two years or older There is no evidence of type II diabetes or uncontrolled obesity defined by BMI that has increased by greater than or equal to 0.5 standard deviations in the preceding 12 months The patient is aged between six months and two years and a thorough upper airway assessment is planned to be undertaken prior to treatment commencement and at six to 12 weeks following treatment initiation
Re-a	assess equisi	men ites Presc	ON – Prader-Willi syndrome t required after 12 months (tick boxes where appropriate) pribed by, or recommended by an endocrinologist or paediatric endocrinologist, or in accordance with a protocol or guideline that has been resed by the Health NZ Hospital. Height velocity is greater than or equal to 50th percentile (adjusted for bone age/pubertal status if appropriate) as calculated over 6 to 12 months using the standards of Tanner and Davies (1985) Height velocity is greater than or equal to 2 cm per year as calculated over six months A current bone age is 14 years or under (female patients) or 16 years or under (male patients)
	and (and)))	No serious adverse effect that the patient's specialist con siders is likely to be attributable to growth hormone treatment has occurred No malignancy has developed after growth hormone therapy was commenced The patient has not developed type II diabetes or uncontrolled obesity as defined by BMI that has increased by greater than or equal to 0.5 standard deviations in the preceding 12 months

I confirm that the above details are correct:

Signed: Date:

al

lame:		PATIENT:
		Name:
Vard:		NHI:
omatropin	- continued	
	dults and adolescents	
	t required after 12 months (tick boxes where appropriate)	
	cribed by, or recommended by an endocrinologistsed by the Health NZ Hospital.	st or paediatric endocrinologist, or in accordance with a protocol or guideline that has been
O	The patient has a medical condition that is kno treatment of a pituitary tumour)	wn to cause growth hormone deficiency (e.g. surgical removal of the pituitary for
	The patient has undergone appropriate treatme	ent of other hormonal deficiencies and psychological illnesses
and and	The patient has severe growth hormone deficie	ency (see notes)
	The patient's serum IGF-I is more than 1 stand	lard deviation below the mean for age and sex
	The patient has poor quality of life, as defined I growth hormone deficiency (QoL-AGHDA®)	by a score of 16 or more using the disease-specific quality of life questionnaire for adult
an additional te The dose of so for age and sex	st is required, an arginine provocation test can matropin should be started at 0.2 mg daily and c; and	be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre, be titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal value.
isolated growth an additional te The dose of so for age and sex The dose of so	st is required, an arginine provocation test can lest matropin should be started at 0.2 mg daily and c; and matropin not to exceed 0.7 mg per day for male cement of treatment for hypopituitarism, patient	be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre. be titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal value.
isolated growth an additional te The dose of so for age and sex The dose of so At the commen	st is required, an arginine provocation test can lest matropin should be started at 0.2 mg daily and c; and matropin not to exceed 0.7 mg per day for male cement of treatment for hypopituitarism, patient	be titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal value patients, or 1 mg per day for female patients.
isolated growth an additional te The dose of so for age and sex The dose of so At the commen	st is required, an arginine provocation test can lest matropin should be started at 0.2 mg daily and c; and matropin not to exceed 0.7 mg per day for male cement of treatment for hypopituitarism, patient	be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre. be titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal value patients, or 1 mg per day for female patients.
isolated growth an additional te The dose of so for age and sex The dose of so At the commen	st is required, an arginine provocation test can lest matropin should be started at 0.2 mg daily and c; and matropin not to exceed 0.7 mg per day for male cement of treatment for hypopituitarism, patient	be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre, be titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal value patients, or 1 mg per day for female patients.
isolated growth an additional te The dose of so for age and sex The dose of so At the commen	st is required, an arginine provocation test can lest matropin should be started at 0.2 mg daily and c; and matropin not to exceed 0.7 mg per day for male cement of treatment for hypopituitarism, patient	be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre. be titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal value patients, or 1 mg per day for female patients.
isolated growth an additional te The dose of so for age and sex The dose of so At the commen	st is required, an arginine provocation test can lest matropin should be started at 0.2 mg daily and c; and matropin not to exceed 0.7 mg per day for male cement of treatment for hypopituitarism, patient	be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre. be titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal value patients, or 1 mg per day for female patients.
isolated growth an additional te The dose of so for age and sex The dose of so At the commen	st is required, an arginine provocation test can lest matropin should be started at 0.2 mg daily and c; and matropin not to exceed 0.7 mg per day for male cement of treatment for hypopituitarism, patient	be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre. be titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal value patients, or 1 mg per day for female patients.
isolated growth an additional te The dose of so for age and sex The dose of so At the commen	st is required, an arginine provocation test can lest matropin should be started at 0.2 mg daily and c; and matropin not to exceed 0.7 mg per day for male cement of treatment for hypopituitarism, patient	be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre. be titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal value patients, or 1 mg per day for female patients.
isolated growth an additional te The dose of so for age and sex The dose of so At the commen	st is required, an arginine provocation test can lest matropin should be started at 0.2 mg daily and c; and matropin not to exceed 0.7 mg per day for male cement of treatment for hypopituitarism, patient	be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre. be titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal value patients, or 1 mg per day for female patients.
isolated growth an additional te The dose of so for age and sex The dose of so At the commen	st is required, an arginine provocation test can lest matropin should be started at 0.2 mg daily and c; and matropin not to exceed 0.7 mg per day for male cement of treatment for hypopituitarism, patient	be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre. be titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal value patients, or 1 mg per day for female patients.
isolated growth an additional te The dose of so for age and sex The dose of so At the commen	st is required, an arginine provocation test can lest matropin should be started at 0.2 mg daily and c; and matropin not to exceed 0.7 mg per day for male cement of treatment for hypopituitarism, patient	be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre. be titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal value patients, or 1 mg per day for female patients.
isolated growth an additional te The dose of so for age and sex The dose of so At the commen	st is required, an arginine provocation test can lest matropin should be started at 0.2 mg daily and c; and matropin not to exceed 0.7 mg per day for male cement of treatment for hypopituitarism, patient	be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre. be titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal value patients, or 1 mg per day for female patients.
isolated growth an additional te The dose of so for age and sex The dose of so At the commen	st is required, an arginine provocation test can lest matropin should be started at 0.2 mg daily and c; and matropin not to exceed 0.7 mg per day for male cement of treatment for hypopituitarism, patient	be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre. be titrated by 0.1 mg monthly until it is within 1 standard deviation of the mean normal value patients, or 1 mg per day for female patients.

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRES	CRIB	ER		PATIENT:
Name:				Name:
Ward:				NHI:
Soma	atro	pin - con	tinued	
Re-as	sess	ment requ	dults and adolescents ired after 12 months oxes where appropriate)	
and			by, or recommended by an endocrinologist or paediatric y the Health NZ Hospital.	endocrinologist, or in accordance with a protocol or guideline that has been
		and	The patient has been treated with somatropin for < 12 r	nonths
		O	There has been an improvement in the Quality of Life As Life Assessment of Growth Hormone Deficiency in Adult	ssessment defined as a reduction of at least 8 points on the Quality of ts (QoL-AGHDA®) score from baseline
		and and	Serum IGF-I levels have increased to within ±1SD of the	mean of the normal range for age and sex
		O	The dose of somatropin does not exceed 0.7 mg per day	y for male patients, or 1 mg per day for female patients
	or	O	The patient has been treated with somatropin for more t	han 12 months
		and	The patient has not had a deterioration in Quality of Life score on treatment (other than due to obvious external for	defined as a 6 point or greater increase from their lowest QoL-AGHDA® actors such as external stressors)
		and	Serum IGF-I levels have continued to be maintained with for obvious external factors)	nin ±1SD of the mean of the normal range for age and sex (other than
		and	The dose of somatropin has not exceeded 0.7 mg per da	ay for male patients or 1 mg per day for female patients
	or			
		and	The patient has had a Special Authority approval for sor renewal criteria under this indication	natropin for childhood deficiency in children and no longer meets the
		and	The patient has undergone appropriate treatment of other	er hormonal deficiencies and psychological illnesses
		and	The patient has severe growth hormone deficiency (see	
		and	The patient's serum IGF-I is more than 1 standard devia	tion below the mean for age and sex
		O	The patient has poor quality of life, as defined by a score for adult growth hormone deficiency (QoL-AGHDA®)	e of 16 or more using the disease-specific quality of life questionnaire
equal Patier isolate an ad The d mean The d At the	to 3 ints with the distriction of the distriction o	mcg per lith one or owth horm all test is referenced by the control of the contro	re during an adequately performed insulin tolerance test more additional anterior pituitary hormone deficiencies ar one deficiency require two growth hormone stimulation to equired, an arginine provocation test can be used with a pin should be started at 0.2 mg daily and be titrated by 0 or age and sex; and pin not to exceed 0.7 mg per day for male patients, or 1 mg per day for male patients, or 1 mg per day for male patients, or 1 mg per day for male patients.	id a known structural pituitary lesion only require one test. Patients with ests, of which, one should be ITT unless otherwise contraindicated. Where peak serum growth hormone level of less than or equal to 0.4 mcg per litre. 1 mg monthly until the serum IGF-I is within 1 standard deviation of the

PRESCRIBER	PATIENT:					
Name:	Name:					
Ward:	NHI:					
Liothyronine sodium - Tab 20 mcg						
INITIATION Prerequisites (tick box where appropriate)						
O For a maximum of 14 days' treatment in patients with thyroid cancer	who are due to receive radioiodine therapy					

I confirm that the above details are correct:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Propylthiouracil	
INITIATION Prerequisites (tick boxes where appropriate)	
O The patient has hyperthyroidism	
The patient is intolerant of carbimazole or carbimazole is co	ontraindicated

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Signed.	Date:	
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Infections



PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Streptomycin sulphate		
INITIATION		
Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

Form RS1041 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 133

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	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Amikacin		
INITIATION		
Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

Form RS1044 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 134

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Tobramycin		
INITIATION		
Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

PATIENT:
Name:
NHI:

Form RS1475 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 136

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	PATIENT:
Name:	Name:
Ward:	NHI:
Tobramcyin	
INITIATION Prerequisites (tick box where appropriate)	
O For addition to orthopaedic bone cement	

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Paromomycin	
INITIATION	
Prerequisites (tick box where appropriate)	
Prescribed by, or recommended by a clinical microbiologist, infection or guideline that has been endorsed by the Health NZ Hospital.	us disease specialist or gastroenterologist, or in accordance with a protocol

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Imipenem with cilastatin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

Form RS1045 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 139

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	PATIENT:
Name:	Name:
Ward:	NHI:
Ertapenem	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

Form RS1047 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 140

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	PATIENT:
Name:	Name:
Ward:	NHI:
Meropenem	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist been endorsed by the Health NZ Hospital.	or infectious disease specialist, or in accordance with a protocol or guideline that has

PRES	CRIB	ER			PATIENT:
Name	e:				Name:
Ward:	:				NHI:
Cefta	azidi	me	with	avibactam	
	ATIOI equis	ites	Preso		infectious disease specialist, or in accordance with a protocol or
	and Quideline that has been endorsed by the Health NZ Hospital O Proven infection with a carbapenem-resistant micro-organism, based on microbiology report O Probable infection with a carbapenem-resistant micro-organism, based on assessment by a clinical microbiologist or infectious disease specialist.		anism, based on microbiology report		
			Ō	Probable infection with a carbapenem-resistant micro-org	

Form RS1048 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 142

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	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Ceftazadime				
INITIATION				
Prerequisites (tick box where appropriate)				
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				

Form RS1049 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 143

PRESCRIBER	PATIENT:				
Name:	Name:				
Ward:	NHI:				
Cefepime					
INITIATION					
Prerequisites (tick box where appropriate)					
O Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that I been endorsed by the Health NZ Hospital.					

Page 144

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.

PRES	SCRI	BER		PATIENT:		
Name	e:			Name:		
Ward:				NHI:		
Ceftaroline						
INITIATION – multi-resistant organisn salvage therapy Prerequisites (tick boxes where appropriate)						
and		Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guide been endorsed by the Health NZ Hospital.				
	or	0	For patients where alternative therapies have failed			
	Ji	0	For patients who have a contraindication or hypersensitivity to	standard current therapies		

 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	PATIENT:
Name:	Name:
Ward:	NHI:
Roxithromycin tab dispersible 50 mg	
INITIATION Prerequisites (tick box where appropriate)	
O Only for use in patients under 12 years of age	

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Clarithromycin	
INITIATION – Tab 250 mg and oral liquid Prerequisites (tick boxes where appropriate)	
Atypical mycobacterial infection Or Of Mycobacterium tuberculosis infection where there is drug resistor Or Helicobacter pylori eradication or Of Prophylaxis of infective endocarditis associated with surgical contents.	
INITIATION – Tab 500 mg Prerequisites (tick box where appropriate) Helicobacter pylori eradication	
INITIATION – Infusion Prerequisites (tick boxes where appropriate) O Atypical mycobacterial infection or O Mycobacterium tuberculosis infection where there is drug resisor O Community-acquired pneumonia	stance or intolerance to standard pharmaceutical agents

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Signed.	Date:	
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I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:
ame: Name:	
Ward:	. NHI:
Azithromycin	
INITIATION – bronchiolitis obliterans syndrome, cystic fibrosis and aty Prerequisites (tick boxes where appropriate)	pical Mycobacterium infections
or obliterans syndrome* O Patient has received a lung transplant and requires prophyla or	or bone marrow transplant and requires treatment for bronchiolitis axis for bronchiolitis obliterans syndrome* eudomonas aeruginosa or Pseudomonas related gram negative organisms*
INITIATION – non-cystic fibrosis bronchiectasis* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a respiratory specialist or paed endorsed by the Health NZ Hospital. and	diatrician, or in accordance with a protocol or guideline that has been
For prophylaxis of exacerbations of non-cystic fibrosis bronce and Patient is aged 18 and under and Patient has had 3 or more exacerbations of their bronce or Patient has had 3 acute admissions to hospital for treating and the second seco	
Note: Indications marked with * are unapproved indications. A maximum of in the community.	f 24 months of azithromycin treatment for non-cystic fibrosis will be subsidised
endorsed by the Health NZ Hospital. The patient has completed 12 months of azithromycin treatmand Following initial 12 months of treatment, the patient has not bronchiectasis for a further 12 months, unless considered cland The patient will not receive more than a total of 24 months' and	received any further azithromycin treatment for non-cystic fibrosis linically inappropriate to stop treatment

Form RS1598 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 148

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Azithromycin - continued	
CONTINUATION – other indications Re-assessment required after 5 days	
Prerequisites (tick box where appropriate)	
O For any other condition	

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Ticarcillin with clavulanic acid		
INITIATION		
Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Piperacillin with tazobactam	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Ciprofloxacin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

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	PATIENT:
Name:	Name:
Ward:	NHI:
Moxifloxacin	
and O Active tuberculosis and O Documented resistance to one or more first-line more	dications (tuberculosis assumed to be contracted in an area with other second-line agents
or Significant pre-existing liver disease or hepatotoxi or Significant documented intolerance and/or side ef Or Mycobacterium avium-intracellulare complex not responding to	fects following a reasonable trial of first-line medications
Patient is under five years of age and has had close contact w INITIATION – Pneumonia Prerequisites (tick boxes where appropriate)	rith a confirmed multi-drug resistant tuberculosis case
INITIATION – Penetrating eye injury Prerequisites (tick box where appropriate) O Prescribed by, or recommended by an ophthalmologist, or in accord Hospital. and Five days treatment for patients requiring prophylaxis following a per	ance with a protocol or guideline that has been endorsed by the Health NZ
INITIATION – Mycoplasma genitalium Prerequisites (tick boxes where appropriate)	
Has nucleic acid amplification test (NAAT) confirmed Mycopla and Has tried and failed to clear infection using azithromycin or Has laboratory confirmed azithromycin resistance and Treatment is only for 7 days	
I confirm that the above details are correct:	

Signed: Date:

Page 153

PRESCR	IIBER	PATIENT:	
Name: .		Name:	
Ward:		NHI:	
Moxiflo	xacin - continued		
	ON – severe delayed beta-lactam allergy isites (tick box where appropriate)		
and	Prescribed by, or recommended by an infectious disease specialist or clinical microbiologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
	Individual has a history of severe delayed beta-lactam allergy		

Form RS1059 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 154

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Tigecycline	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Daptomycin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

Form RS1065 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 156

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Lincomycin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

Form RS1066 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 157

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Linezolid	
INITIATION	· ·
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Sulphadiazine	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or maternal-foetal medicine specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

Page 159

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Teicoplanin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

Page 160

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Fosfomycin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pivmecillinam	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

Form RS1069 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 162

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Vancomycin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Aztreonam, Chloramphenicol	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

Form RS1061 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 164

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Clindamycin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

Form RS1064 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 165

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	PATIENT:
Name:	Name:
Ward:	NHI:
Fusidic acid	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
Colistin	sulphomethate [Colestimethate]	
INITIATI Prerequ	ON isites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Ketoconazole - Tab 200 mg	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by an oncologist, or in accordance Hospital.	with a protocol or guideline that has been endorsed by the Health NZ

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.

PRES	CRIE	BER			PATIENT:
Name	e:				Name:
Ward	:				NHI:
Amp	hote	ericin	В	- Inj (liposomal) 50 mg vial	
	Э г	sites (t	bed	by, or recommended by a clinical microbiologist, haemato specialist, or in accordance with a protocol or guideline that	ologist, infectious disease specialist, oncologist, respiratory specialist or at has been endorsed by the Health NZ Hospital.
unu	O Proven or probable invasive fungal infection, to be prescribed under an established protocol O Possible invasive fungal infection and O A multidisciplinary team (including an infectious disease physician or a clinical microbiologist) considers the treatment to be appropriate				
	$\overline{}$				

I confirm that the above details are correct:

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Signed.	Date:	
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PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Amphotericin B - Inj 50 mg vial				
INITIATION Prerequisites (tick box where appropriate)				
O Prescribed by, or recommended by a clinical microbiologist, haematologist, infectious disease specialist, oncologist, respiratory specialist or transplant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				

Form RS1072 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 170

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Fluconazole	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a consultant, or in accordance w Hospital.	rith a protocol or guideline that has been endorsed by the Health NZ

Form RS1073 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 171

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Itraconazole				
INITIATION				
Prerequisites (tick box where appropriate)				
O Prescribed by, or recommended by a clinical immunologist, clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Voriconazole				
INITIATION – Proven or probable aspergillus infection Prerequisites (tick boxes where appropriate)				
O Prescribed by, or recommended by a clinical microbiologist, haemat guideline that has been endorsed by the Health NZ Hospital.	ologist or infectious disease specialist, or in accordance with a protocol or			
Patient is immunocompromised and Patient has proven or probable invasive aspergillus infection				
INITIATION – Possible aspergillus infection Prerequisites (tick boxes where appropriate)				
O Prescribed by, or recommended by a clinical microbiologist, haemat guideline that has been endorsed by the Health NZ Hospital.	ologist or infectious disease specialist, or in accordance with a protocol or			
O Patient is immunocompromised				
Patient has possible invasive aspergillus infection				
A multidisciplinary team (including an infectious disease physic	cian) considers the treatment to be appropriate			
INITIATION – Resistant candidiasis infections and other moulds Prerequisites (tick boxes where appropriate)				
Prescribed by, or recommended by a clinical microbiologist, haemat guideline that has been endorsed by the Health NZ Hospital.	ologist or infectious disease specialist, or in accordance with a protocol or			
O Patient is immunocompromised and				
O Patient has fluconazole resistant candidiasis or				
O Patient has mould strain such as Fusarium spp. and Sc	edosporium spp			
A multidisciplinary team (including an infectious disease physic	cian or clinical microbiologist) considers the treatment to be appropriate			
INITIATION – Invasive fungal infection prophylaxis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)				
O Prescribed by, or recommended by any relevant practitioner, or in act NZ Hospital.	ecordance with a protocol or guideline that has been endorsed by the Health			
The patient is at risk of invasive fungal infection				
Voriconazole is prescribed by, or recommended by a hat paediatric haematologist or paediatric oncologist	ematologist, transplant physician, infectious disease specialist,			
O Prescribing voriconazole is in accordance with a protoco	ol or guideline that has been endorsed by the Health New Zealand - Te is a greater than 10% risk of invasive fungal infection (IFI)			

PRES	CRIB	ER			PATIENT:
Name	:				Name:
Ward:					NHI:
Vori	ona	zol	e - cc	ontinued	
Re-a	ssess equis T	men ites Presc	t requ (tick b		cordance with a protocol or guideline that has been endorsed by the Health
The patient is at risk of invasive fungal infection					
		or	0	paediatric haematologist or paediatric oncologist	ematologist, transplant physician, infectious disease specialist,
					of or guideline that has been endorsed by the Health New Zealand - Te s a greater than 10% risk of invasive fungal infection (IFI)

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				PATIENT:
Name	e:			Name:
Ward	:			NHI:
Posa	acon	azo	le	
Re-a	equis F	sment sites (tick b	by, or recommended by a haematologist or infectious disease specialist, or in accordance with a protocol or guideline that has been by the Health NZ Hospital. Patient has acute myeloid leukaemia Patient is planned to receive a stem cell transplant and is at high risk for aspergillus infection
	and	0	Patie	ent is to be treated with high dose remission induction therapy or re-induction therapy
Re-a	eiupe I	sment sites (Presc endor	t requ (tick b ribed sed b	by, or recommended by a haematologist or infectious disease specialist, or in accordance with a protocol or guideline that has been by the Health NZ Hospital. ent has previously received posaconazole prophylaxis during remission induction therapy Patient is to be treated with high dose remission re-induction therapy Patient is to be treated with high dose consolidation therapy Patient is receiving a high risk stem cell transplant
Re-a	ssess eiups F	sment sites (Presc NZ Ho	t requ (tick b ribed ospita	live fungal infection prophylaxis spired after 6 months boxes where appropriate) by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health al. patient is at risk of invasive fungal infection Posaconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist Prescribing posaconazole is in accordance with a protocol or guideline that has been endorsed by the Health New Zealand - Te Whatu Ora Hospital in the specific settings where there is a greater than 10% risk of invasive fungal infection (IFI)

I confirm that the above details are correct:

Cianad.	Data.	
Signeg	 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	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Posaconazole - continued			
CONTINUATION – Invasive fungal infection prophylaxis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by any relevant practitioner, or in a NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health		
The patient is at risk of invasive fungal infection O Posaconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialis paediatric haematologist or paediatric oncologist O Prescribing posaconazole is in accordance with a protocol or guideline that has been endorsed by the Health New Zea Whatu Ora Hospital in the specific settings where there is a greater than 10% risk of invasive fungal infection (IFI)			

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Flucytosine			
INITIATION			
Prerequisites (tick box where appropriate)			
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has		

Page 177

PRES	CRIE	BER			PATIENT:
Name	:				Name:
Ward:					NHI:
Casp	ofu	ngin			
	Э г	s ites (¹ ⊇rescr	ibed	oxes where appropriate) by, or recommended by a clinical microbiologist, haemato specialist, or in accordance with a protocol or guideline the	ologist, infectious disease specialist, oncologist, respiratory specialist or at has been endorsed by the Health NZ Hospital.
	O Proven or probable invasive fungal infection, to be prescribed under an established protocol		en or probable invasive fungal infection, to be prescribed u	under an established protocol	
		and	0	Possible invasive fungal infection A multidisciplinary team (including an infectious disease appropriate	physician or a clinical microbiologist) considers the treatment to be

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Clofazimine		
INITIATION		
Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a clinical microbiologist, dermato guideline that has been endorsed by the Health NZ Hospital.	ologist or infectious disease specialist, or in accordance with a protocol or	

Form RS1078 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 179

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
Dapsone		
INITIATION Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Cycloserine	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Isoniazid with rifampicin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, dermate or in accordance with a protocol or guideline that has been endorse	ologist, paediatrician, public health physician or internal medicine physician, d by the Health NZ Hospital.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pyrazinamide	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Rifampicin		
INITIATION		
Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a clinical microbiologist, dermatologist, internal medicine physician, paediatrician or public health physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

Page 184

PRES	CRIBER		PATIENT:
Name):		Name:
Ward			NHI:
Beda	aquiline		
Re-a	ATION – multi-drug ssessment required a equisites (tick boxes		
	O The perso	n has multi-drug resistant tuberculosis (MDR-TB)	
	O Ministry of Health's Tuberculosis Clinical Network has reviewed the individual case and recommends bedaquiline as part of the treatment regimen		

I confirm that the above details are correct:		
Signed:	Date:	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Isoniazid	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, dermate or in accordance with a protocol or guideline that has been endorse	ologist, paediatrician, public health physician or internal medicine physician, d by the Health NZ Hospital.

Form RS1086 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 186

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	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Rifabutin		
INITIATION		
Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a clinical microbiologist, gastroenterologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Ethambutol hydrochloride	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Para-aminosalicylic Acid	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

Form RS1084 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 189

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Protionamide	
INITIATION	
Prerequisites (tick box where appropriate)	
Prescribed by, or recommended by a clinical microbiologist, infection protocol or guideline that has been endorsed by the Health NZ Hosp	us disease specialist or respiratory specialist, or in accordance with a bital.

Form RS1088 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 190

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Albendazole	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Ivermectin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, dermatologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Artemether with lumefantrine	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

Page 193

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Artesunate	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

Page 194

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	PATIENT:
Name:	Name:
Ward:	NHI:
Atovaquone with proguanil hydrochloride	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Chloroquine phosphate	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, dermatologist, infectious disease specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Mefloquine hydrochloride		
INITIATION		
Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a clinical microbiologist, dermatologist, infectious disease specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pentamidine isethionate	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

Page 198

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Primaquine phosphate	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infect been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

Form RS1098 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 199

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pyrimethamine	
INITIATION Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist or maternal-foetal medicine specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Quinine dihydrochloride	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Sodium stibogluconate	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	tious disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Spiramycin	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a maternal-foetal medicine spec by the Health NZ Hospital.	ialist, or in accordance with a protocol or guideline that has been endorsed

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Nitazoxanide	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infecti been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Non-Nucleoside Reverse Transcriptase Inhibitors	
INITIATION – Confirmed HIV Prerequisites (tick box where appropriate)	
O Patient has confirmed HIV infection	
INITIATION – Prevention of maternal transmission Prerequisites (tick boxes where appropriate)	
O Prevention of maternal foetal transmission or O Treatment of the newborn for up to eight weeks	
INITIATION – Post-exposure prophylaxis following exposure to HIV Prerequisites (tick boxes where appropriate) Treatment course to be initiated within 72 hours post exposure and	ıre
Patient has had condomless anal intercourse or recept unknown or detectable viral load greater than 200 copi or Patient has shared intravenous injecting equipment with or Patient has had non-consensual intercourse and the corequired	
Note: Refer to local health pathways or the Australasian Society for HIV, Vira	al Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ashn
INITIATION – Percutaneous exposure Prerequisites (tick box where appropriate)	
O Patient has percutaneous exposure to blood known to be HIV posi-	tive

I confirm that the above details are correct:

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Zigneg.	i jate:	
Oigilica.	 Duic.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Nucleoside Reverse Transcriptase Inhibitors	
INITIATION – Confirmed HIV Prerequisites (tick box where appropriate) O Patient has confirmed HIV infection	
INITIATION – Prevention of maternal transmission Prerequisites (tick boxes where appropriate)	
O Prevention of maternal foetal transmission or O Treatment of the newborn for up to eight weeks	
INITIATION – Post-exposure prophylaxis following exposure to HIV Prerequisites (tick boxes where appropriate) Treatment course to be initiated within 72 hours post exposure and	re .
or Patient has shared intravenous injecting equipment with or Patient has had non-consensual intercourse and the cli required Patient has had condomless anal intercourse with a per	
	Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ashm
INITIATION – Percutaneous exposure Prerequisites (tick box where appropriate)	
O Patient has percutaneous exposure to blood known to be HIV positi	ve

0:	D - 1 - 1	
Zigneg.	i jate:	
Oigilica.	 Duic.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Protease Inhibitors	
INITIATION – Confirmed HIV Prerequisites (tick box where appropriate) O Patient has confirmed HIV infection	
INITIATION – Prevention of maternal transmission Prerequisites (tick boxes where appropriate)	
O Prevention of maternal foetal transmission or O Treatment of the newborn for up to eight weeks	
or O Patient has shared intravenous injecting equipment with	ve vaginal intercourse with a known HIV positive person with an us per ml
is unknown	rson from a high HIV prevalence country or risk group whose HIV status
Note: Heter to local health pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ashn
INITIATION – Percutaneous exposure Prerequisites (tick box where appropriate)	
O Patient has percutaneous exposure to blood known to be HIV position	ve

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Strand Transfer Inhibitors	
INITIATION – Confirmed HIV Prerequisites (tick box where appropriate) O Patient has confirmed HIV infection	
INITIATION – Prevention of maternal transmission Prerequisites (tick boxes where appropriate)	
O Prevention of maternal foetal transmission or O Treatment of the newborn for up to eight weeks	
INITIATION – Post-exposure prophylaxis following exposure to HIV Prerequisites (tick boxes where appropriate) Treatment course to be initiated within 72 hours post exposure and Patient has had condomless anal intercourse or receptive.	e ve vaginal intercourse with a known HIV positive person with an
or Patient has shared intravenous injecting equipment with or Patient has had non-consensual intercourse and the clir required or	s per ml
	Hepatitis and Sexual Health Medicine clinical guidelines for PEP (https://www.ashn
INITIATION – Percutaneous exposure Prerequisites (tick box where appropriate)	
O Patient has percutaneous exposure to blood known to be HIV positive	ve

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	PATIENT:
Name:	Name:
Ward:	NHI:

Ledipasvir with sofosbuvir

Note: Only for use in patients with approval by the Hepatitis C Treatment Panel (HepCTP). Applications will be considered by HepCTP at its regular meetings and approved subject to eligibility according to the Access Criteria (set out in Section B of the Pharmaceutical Schedule).

Form RS1108 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 209

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Cidofovir	
INITIATION Prerequisites (tick box where appropriate)	
Prescribed by, or recommended by a clinical microbiologist, infectious disease specialist, otolaryngologist or oral surgeon, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Foscarnet sodium	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ious disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Ganciclovir	
INITIATION	
Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a clinical microbiologist or infection been endorsed by the Health NZ Hospital.	ous disease specialist, or in accordance with a protocol or guideline that has

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward: NHI:		
Valganciclovir		
INITIATION – Transplant cytomegalovirus prophylaxis Re-assessment required after 3 months Prerequisites (tick box where appropriate) O Patient has undergone a solid organ transplant and requires valgan	ciclovir for CMV prophylaxis	
CONTINUATION – Transplant cytomegalovirus prophylaxis Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)		
CMV prophylaxis O Patient is to receive a maximum of 90 days of valgancion or		
Patient has received pulse methylprednisolone for acute prophylaxis and Patient is to receive a maximum of 90 days of valgancions.	e rejection and requires further valganciclovir therapy for CMV clovir prophylaxis following pulse methylprednisolone	
INITIATION – Lung transplant cytomegalovirus prophylaxis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)		
Patient has undergone a lung transplant O The donor was cytomegalovirus positive and the patien	t is cytomegalovirus negative	
The recipient is cytomegalovirus positive and Patient has a high risk of CMV disease		
CONTINUATION – Lung transplant cytomegalovirus prophylaxis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)		
Patient has undergone a lung re-transplant The donor was cytomegalovirus positive and the patien or The recipient is cytomegalovirus positive and Patient has a high risk of CMV disease	t is cytomegalovirus negative	
T alient has a might how of Olivi disease		

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Valganciclovir - continued	
INITIATION – Cytomegalovirus in immunocompromised patients Prerequisites (tick boxes where appropriate)	
O Patient is immunocompromised and	
O Patient has cytomegalovirus syndrome or tissue invasir	ve disease
O Patient has rapidly rising plasma CMV DNA in absence	of disease
O Patient has cytomegalovirus retinitis	

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	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Emtricitabine with tenofovir disoproxil				
INITIATION – Confirmed HIV Prerequisites (tick box where appropriate)				
O Patient has confirmed HIV infection				
INITIATION – Prevention of maternal transmission Prerequisites (tick boxes where appropriate)				
O Prevention of maternal foetal transmission O Treatment of the newborn for up to eight weeks				
INITIATION – Post-exposure prophylaxis following non-occupational exposure to HIV Prerequisites (tick boxes where appropriate)				
O Treatment course to be initiated within 72 hours post exposure and				
O Patient has had unprotected receptive anal intercourse with a known HIV positive person or				
O Patient has shared intravenous injecting equipment with	a known HIV positive person			
O Patient has had non-consensual intercourse and the clir required	nician considers that the risk assessment indicates prophylaxis is			
INITIATION – Percutaneous exposure Prerequisites (tick box where appropriate)				
O Patient has percutaneous exposure to blood known to be HIV position	ve			
INITIATION – Pre-exposure prophylaxis Re-assessment required after 24 months Prerequisites (tick boxes where appropriate)				
	toms of acute HIV infection and has been assessed for HIV seroconversion			
The Practitioner considers the patient is at elevated risk of HIV				
Note: Refer to local health pathways or the Australasian Society for HIV, Viral CONTINUATION – Pre-exposure prophylaxis Re-assessment required after 24 months Prerequisites (tick boxes where appropriate)	Hepatitis and Sexual Health Medicine clinical guidelines (https://ashm.org.au/HIV/F			
O Patient has tested HIV negative, does not have signs or symp	toms of acute HIV infection and has been assessed for HIV seroconversion			
O The Practitioner considers the patient is at elevated risk of HIV	/ exposure and use of PrEP is clinically appropriate			
Note: Refer to local health pathways or the Australasian Society for HIV, Viral	Hepatitis and Sexual Health Medicine clinical guidelines (https://ashm.org.au/HIV/F			

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER			PATIENT:			
Name:			Name:			
Ward:				NHI:		
Oseltamivir						
INITIATION Prerequisites (tick boxes where appropriate)			(tick boxes where appropriate)			
		0	Only for hospitalised patient with known or suspected influenz	a		
	or O	For prophylaxis of influenza in hospitalised patients as part of	a Health NZ Hospital approved infections control plan			

PRESCRIBER		NBER	PATIENT:				
Name:			Name:				
Ward:			NHI:				
Zanamivir - Powder for inhalation 5 mg							
INITIATION Prerequisites (tick boxes where appropriate)							
		Only for hospitalised patient with known or suspected influenza	a				
		O For prophylaxis of influenza in hospitalised patients as part of	a Health NZ Hospital approved infections control plan				

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
COVID-19 treatments			
INITIATION			
Prerequisites (tick box where appropriate)			
Only if patient meets access criteria (as per https://pharmac.govt.nz/covid-oral-antivirals). Note the supply of treatment is via Pharmac's approved distribution process. Refer to the Pharmac website for more information about this and stock availability			

Form RS1113 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 218

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	PATIENT:
Name:	Name:
Ward:	NHI:
Interferon gamma	
INITIATION Prerequisites (tick box where appropriate)	
O Patient has chronic granulomatous disease and requires interferon of	gamma

RS1827 - Pegylated interferon alfa-2a

Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior - INITIATION	
Chronic hepatitis C - genotype 1 infection - CONTINUATION	
- INITIATION	
Hepatitis B - INITIATION	
Myeloproliferative disorder or cutaneous T cell lymphoma - INITIATION	
Ocular surface squamous neoplasia - INITIATION	
Ocular surface squamous neoplasia - CONTINUATION	
Post-allogenic bone marrow transplant - INITIATION	

I confirm that the above details are correct:

Signed: Date:

PRESCRIBE	IBER PATIENT:	
Name:	Name:	
Ward:		
Pegylated	ed interferon alfa-2a	
	ON – Chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 posssment required after 48 weeks	st liver transplant
Prerequisite	isites (tick boxes where appropriate)	
or	O Patient has chronic hepatitis C, genotype 1, 4, 5 or 6 infection	
or	O Patient has chronic hepatitis C and is co-infected with HIV	
C	O Patient has chronic hepatitis C genotype 2 or 3 and has received a liver transplant	
treatment sin	onsider stopping treatment if there is absence of a virological response (defined as at least a 2-log reduction in at since this is predictive of treatment failure.	
	r reducing treatment to 24 weeks if serum HCV RNA level at Week 4 is undetectable by sensitive PCR assay (In CV RNA is less than 400,000IU/ml.	ess than 5010/ml) AND Baseline
CONTINUAT	UATION – Chronic hepatitis C - genotype 1 infection	
Re-assessme	ssment required after 48 weeks isites (tick boxes where appropriate)	
	Prescribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or guideline that has been endorsed by the Health NZ Hospital.	in accordance with a protocol or
and	O Patient has chronic hepatitis C, genotype 1	
and	O Patient has had previous treatment with pegylated interferon and ribavirin	
	O Patient has responder relapsed or	
	O Patient was a partial responder	
and	Patient is to be treated in combination with boceprevir	
INITIATION	ON – Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior	
Re-assessm	ssment required after 48 weeks isites (tick boxes where appropriate)	
	Prescribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or guideline that has been endorsed by the Health NZ Hospital.	in accordance with a protocol or
C	O Patient has chronic hepatitis C, genotype 1	
and and	O Patient has had previous treatment with pegylated interferon and ribavirin	
	O Patient has responder relapsed	
	or O Patient was a partial responder	
	O Patient received interferon treatment prior to 2004	
and	O Patient is to be treated in combination with boceprevir	

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	RESCRIBER PATIENT:		
Name:	ne:		
Ward:	NHI:		
Pegylated in	nterferon alfa-2a - continued		
INITIATION – C Re-assessment Prerequisites (Chronic hepatitis C - genotype 2 or 3 infection without co-infection not required after 6 months (tick box where appropriate) ent has chronic hepatitis C, genotype 2 or 3 infection	n with HIV	
Prerequisites (** Prescriguideliand and and and and and and	nt required after 48 weeks a (tick boxes where appropriate) cribed by, or recommended by a gastroenterologist, infectious disease eline that has been endorsed by the Health NZ Hospital. Patient has confirmed Hepatitis B infection (HBsAg positive for more Patient is Hepatitis B treatment-naive ALT > 2 times Upper Limit of Normal HBV DNA < 10 log10 IU/ml HBeAg positive	than 6 months)	
and and and and	Compensated liver disease No continuing alcohol abuse or intravenous drug use Not co-infected with HCV, HIV or HDV Neither ALT nor AST > 10 times upper limit of normal No history of hypersensitivity or contraindications to pegylated interfe	ron	
INITIATION – m	myeloproliferative disorder or cutaneous T cell lymphoma		
Re-assessment	nt required after 12 months (tick boxes where appropriate)		
or and	Patient has a cutaneous T cell lymphoma* O Patient has a myeloproliferative disorder*		
or	Treatment with anagrelide and busulfan is not clinically appropr Patient has a myeloproliferative disorder	iate	
and	O Patient is pregnant, planning pregnancy or lactating		

PRESCRIBER F	ATIENT:
Name:	ame:
Ward:	HI:
Pegylated interferon alfa-2a - continued	
CONTINUATION – myeloproliferative disorder or cutaneous T cell lymphon Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O No evidence of disease progression and The treatment remains appropriate and patient is benefitting from and O Patient has a cutaneous T cell lymphoma* or O Patient has a myeloproliferative disorder*	ent with anagrelide and busulfan remains clinically inappropriate
Note: Indications marked with * are unapproved indications	
INITIATION – ocular surface squamous neoplasia Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Prescribed by, or recommended by an ophthalmologist, or in accordan Hospital. and O Patient has ocular surface squamous neoplasia*	ce with a protocol or guideline that has been endorsed by the Health NZ
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 accordan Hospital. and The treatment remains appropriate and patient is benefitting from treat Note: Indications marked with * are unapproved indications	ce with a protocol or guideline that has been endorsed by the Health NZ
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 e CONTINUATION – post-allogenic bone marrow transplant Re-assessment required after 3 months	vidence of disease relapse
Prerequisites (tick box where appropriate) O 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:

Musculoskeletal System



PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Edrophonium chloride	
INITIATION	
Prerequisites (tick box where appropriate)	
O For the diagnosis of myasthenia gravis	

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Signed.	Date:	
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SCRIE	ER		PATIENT:
e:			
l:			NHI:
osun	nab		
			pporosis boxes where appropriate)
(•	patient has established osteoporosis
and		0	History of one significant osteoporotic fracture demonstrated radiologically, with a documented T-Score less than or equal to -2.5, that incorporates BMD measured using dual-energy x-ray absorptiometry (DEXA)
	or	0	History of one significant osteoporotic fracture, demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of logistical, technical or pathophysiological reasons
	or	0	History of two significant osteoporotic fractures demonstrated radiologically
	or	\bigcirc	Documented T-Score less than or equal to -3.0
		0	A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm that incorporates BMD measured using DEXA
and			
	or	0	Bisphosphonates are contraindicated because the patient's creatinine clearance or eGFR is less than 35 mL/min
	or	0	The patient has experienced at least two symptomatic new fractures or a BMD loss greater than 2% per year, after at least 12 months' continuous therapy with a funded antiresorptive agent
		0	Bisphosphonates result in intolerable side effects
	or	0	Intravenous bisphosphonates cannot be administered due to logistical or technical reasons
			rcalcaemia boxes where appropriate)
and	O	Patie	ent has hypercalcaemia of malignancy
and	\circ	Patie	ent has severe renal impairment

I confirm that the above details are correct:	
Cignod	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.

PRESCE	RIBER		PATIENT:
Name: .			Name:
Ward:			NHI:
Raloxif	ene		
INITIAT Prerequ		(tick boxes where appropriate)	
OI	0		adiologically and documented bone mineral density (BMD) greater than lue in young adults (i.e. T-Score less than or equal to -2.5) (see Notes)
	0		adiologically, and either the patient is elderly, or densitometry scanning pathophysiological reasons. It is unlikely that this provision would apply
OI OI	\circ	History of two significant osteoporotic fractures demonstrated	radiologically
01	\circ	Documented T-Score greater than or equal to -3.0 (see Notes)	
	0	A 10-year risk of hip fracture greater than or equal to 3%, calcular Garvan) which incorporates BMD measurements (see Notes)	ulated using a published risk assessment algorithm (e.g. FRAX or
OI		Patient has had a Special Authority approval for zoledronic aci approval for alendronate (Underlying cause - Osteoporosis) pr	d (Underlying cause - Osteoporosis) or has had a Special Authority ior to 1 February 2019

Note:

- a) BMD (including BMD used to derive T-Score) must be measured using dual-energy x-ray absorptiometry (DXA).
 Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable.
- b) Evidence suggests that patients aged 75 years and over who have a history of significant osteoporotic fracture demonstrated radiologically are very likely to have a T-Score less than or equal to -2.5 and, therefore, do not require BMD measurement for raloxifene funding.
- c) Osteoporotic fractures are the incident events for severe (established) osteoporosis, and can be defined using the WHO definitions of osteoporosis and fragility fracture. The WHO defines severe (established) osteoporosis as a T-score below -2.5 with one or more associated fragility fractures. Fragility fractures are fractures that occur as a result of mechanical forces that would not ordinarily cause fracture (minimal trauma). The WHO has quantified this as forces equivalent to a fall from a standing height or less.
- d) A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER			PATIENT:	
Name	ə:		Name:	
Ward	:		NHI:	
Teri	oaratide			
Re-a		nt required after 18 months (tick boxes where appropriate)		
	and	The patient has severe, established osteoporosis		
	0	The patient has a documented T-score less than or equal to -3	3.0 (see Notes)	
	and	The patient has had two or more fractures due to minimal trau	ıma	
	and	The patient has experienced at least one symptomatic new fra	acture after at least 12 months' continuous therapy with a funded	

Note:

- a) The bone mineral density (BMD) measurement used to derive the T-score must be made using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable
- b) Antiresorptive agents and their adequate doses for the purposes of this restriction are defined as: alendronate sodium tab 70 mg or tab 70 mg with colecalciferol 5,600 iu once weekly; raloxifene hydrochloride tab 60 mg once daily; zoledronic acid 5 mg per year. If an intolerance of a severity necessitating permanent treatment withdrawal develops during the use of one antiresorptive agent, an alternate antiresorptive agent must be trialled so that the patient achieves the minimum requirement of 12 months' continuous therapy.
- c) A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

I confirm that the above details are correct:	
Signed:	Date:

Page 228

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	PATIENT:
Name:	Name:
Ward:	NHI:
Rasburicase	
INITIATION Prerequisites (tick box where appropriate)	
O Prescribed by, or recommended by a haematologist, or in accordance Hospital.	ce with a protocol or guideline that has been endorsed by the Health NZ

PRESCRIBER			
		PATIENT:	
Name:		Name:	
Ward:		NHI:	
Febuxostat			
INITIATION – O Prerequisites	Gout (tick boxes where appropriate)		
and _	Patient has been diagnosed with gout		
or	O The patient has a serum urate level greater than 0.36 m and addition of probenecid at doses of up to 2 g per day	mol/l despite treatment with allopurinol at doses of at least 600 mg/day or maximum tolerated dose	
or		m allopurinol such that treatment discontinuation is required and serum robenecid at doses of up to 2 g per day or maximum tolerated dose	
	O The patient has renal impairment such that probenecid greater than 0.36 mmol/l despite optimal treatment with	is contraindicated or likely to be ineffective and serum urate remains allopurinol (see Note)	
O The patient has previously had an initial Special Authority approval for benzbromarone for treatment of gout.			
Re-assessmen Prerequisites Preso	Tumour lysis syndrome It required after 6 weeks (tick boxes where appropriate) cribed by, or recommended by a haematologist or oncologist, on NZ Hospital. Patient is scheduled to receive cancer therapy carrying an interpretation of the patient has a documented history of allopurinol intolerance	r in accordance with a protocol or guideline that has been endorsed by the ermediate or high risk of tumour lysis syndrome	
	DN – Tumour lysis syndrome It required after 6 weeks		
	(tick box where appropriate)		

PRESCRIBER				PATIENT:	
Name:	:			Name:	
Ward:				NHI:	
Suga	mm	nade	ex		
INITIATION Prerequisites (tick boxes where appropriate)					
O Patient requires reversal of profound neuromuscular blockade following rapid sequence induction that has been und rocuronium (i.e. suxamethonium is contraindicated or undesirable)					
	or	0	Severe neuromuscular degenerative disease where the use of	neuromuscular blockade is required	
	or	0		bated and requires a rapid reversal of anaesthesia and neuromuscular	
C	or	0	blockade The duration of the patient's surgery is unexpectedly short		
	or	0	Neostigmine or a neostigmine/anticholinergic combination is comorbid obesity or COPD)	ontraindicated (for example the patient has ischaemic heart disease,	
	or	0	Patient has a partial residual block after conventional reversal		

Form RS1592 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 231

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	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Etoricoxib			
INITIATION Prerequisites (tick box where appropriate)			
O For in-vivo investigation of allergy only			

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Capsaicin		
INITIATION		
Prerequisites (tick box where appropriate)		
O Patient has osteoarthritis that is not responsive to paracetamol and oral non-steroidal anti-inflammatories are contraindicated		

Nervous System



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	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Riluzole		
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a neurologist or respiratory specific by the Health NZ Hospital.	cialist, or in accordance with a protocol or guideline that has been endorsed	
The patient has amyotrophic lateral sclerosis with disease durand The patient has at least 60 percent of predicted forced vital call and The patient has not undergone a tracheostomy and The patient has not experienced respiratory failure and The patient is ambulatory or The patient is able to use upper limbs or The patient is able to swallow		
CONTINUATION Re-assessment required after 18 months Prerequisites (tick boxes where appropriate)		
The patient has not undergone a tracheostomy and The patient has not experienced respiratory failure and		
The patient is ambulatory The patient is able to use upper limbs or The patient is able to swallow		

I confirm that the above details are correct:

Signed: Date:

Form RS1763 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 235

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	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Sucrose			
INITIATION Prerequisites (tick box where appropriate)			
O For use in neonatal patients only			

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER			PATIENT:
Name:			Name:
Ward:			NHI:
Methoxyflurane			
INITIATION Prerequisites (tick boxes where appropriate)		(tick boxes where appropriate)	
	and	Patient is undergoing a painful procedure with an expected du	ration of less than one hour
		Only to be used under supervision by a medical practitioner or	r nurse who is trained in the use of methoxyflurane

Form RS1146 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 237

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	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Paracetamol			
INITIATION			
Prerequisites (tick box where appropriate)			
O Intravenous paracetamol is only to be used where other routes are unavailable or impractical, or where there is reduced absorption. The need for IV paracetamol must be re-assessed every 24 hours			

Form RS1145 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 238

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	PATIENT:
Name:	Name:
Ward:	NHI:
Capsaicin	
INITIATION Prerequisites (tick box where appropriate)	
O For post-herpetic neuralgia or diabetic peripheral neuropathy	

I confirm that the above details are correct:

Signed: Date:

PRESCRIB	BER	PATIENT:
Name:		Name:
Ward:		NHI:
Vigabatri	in	
	men	required after 15 months tick boxes where appropriate)
and	or or or	Patient has infantile spasms Patient has epilepsy and Patient has epilepsy Seizures are not adequately controlled with optimal treatment with other antiepilepsy agents or Seizures are controlled adequately but the patient has experienced unacceptable side effects from optimal treatment with other antiepilepsy agents Patient has tuberous sclerosis complex Patient is, or will be, receiving regular automated visual field testing (ideally before starting therapy and on a 6-monthly basis thereafter) It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields
CONTINU		
Prerequis	ites	tick boxes where appropriate)
and	\circ	The patient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality of life
	or	O Patient is receiving regular automated visual field testing (ideally every 6 months) on an ongoing basis for duration of treatment with vigabatrin
	or	O It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields

O'	D - 4
Signed.	Date.
OIGHICG:	

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 240

Schedule. For community funding, see the Special Authority Criteria.	
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Lacosamide	
INITIATION Re-assessment required after 15 months Prerequisites (tick boxes where appropriate)	
Patient has focal epilepsy and Seizures are not adequately controlled by, or patient has expe	erienced unacceptable side effects from, optimal treatment with all of the
Note: Those of childbearing potential are not required to trial phenytoin sodiu required to trial sodium valproate.	any two of carbamazepine, lamotrigine, and phenytoin sodium (see Note) Im, sodium valproate, or topiramate. Those who can father children are not
CONTINUATION Processulation (tigly box unbare engagerists)	
Prerequisites (tick box where appropriate)	
Patient has demonstrated a significant and sustained improvement starting lacosamide treatment	in seizure rate or severity and/or quality of life compared with that prior to

PRESCRIBI	ER	PATIENT:
Name:		Name:
Ward:		NHI:
Stiripento	ol .	
Prerequisit	ment required after 6 months tes (tick boxes where appropriate) rescribed by, or recommended by a paediatric neurologist, or in ac Z Hospital. Patient has confirmed diagnosis of Dravet syndrome	cordance with a protocol or guideline that has been endorsed by the Health
Note: Thos sodium valp		e or topiramate. Those who can father children are not required to trial
O PI	tes (tick box where appropriate)	cordance with a protocol or guideline that has been endorsed by the Health seizure frequency from baseline

I confirm that the above details are correct:

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PRESCRIBER		PATIENT:
Name:		Name:
Ward:		NHI:
Hyoscine h	ydrobromide - Patch 1.5 mg	
or or	patient cannot tolerate or does not adequately respond to oral Control of clozapine-induced hypersalivation where trials of at	

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Aprepitant		
INITIATION Prerequisites (tick box where appropriate)		
O Patient is undergoing highly emetogenic chemotherapy and/or anthracycline-based chemotherapy for the treatment of malignancy		

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Paliperidone	
or depot injection The patient has schizophrenia or other psychotic disord and The patient has been unable to adhere to treatment usi and	
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) The initiation of paliperidone depot injection has been associated w corresponding period of time prior to the initiation of an atypical anti	

I confirm that the above details are correc

C:	D-1	
Signed.	Date:	
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Use this checklist to determine if a patient meets the restrictions for funding in the Schedule. For community funding, see the Special Authority Criteria.	ne hospital setting. For more details, refer to Section H of the Pharmaceutical
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Paliperidone palmitate	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) The patient has schizophrenia and	
The patient has had an initial Special Authority approval for pa	aliperidone once-monthly depot injection
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) The initiation of paliperidone depot injection has been associated with corresponding period of time prior to the initiation of an atypical antiperior.	

I confirm that the above details are correct:

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Zigneg.	i jate:	
Oigilica.	 Duic.	

Form RS2018 January 2026

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 246

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	PATIENT:
Name:	Name:
Ward:	NHI:
Olanzapine	
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate)	
The initiation of olanzapine depot injection has been associated with corresponding period of time prior to the initiation of an atypical anti-	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Risperidone	
or Or The patient has schizophrenia or other psychotic disord and Or The patient has not been able to adhere to treatment us and	
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) The initiation of risperidone depot injection has been associated with corresponding period of time prior to the initiation of an atypical anticlement.	

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Signed.	Date:	
Oigilica.	 Duic.	

PRESCR	IBER	PATIENT:
Name:		
Ward:		NHI:
Aripipra	azole	
INITIATIO Prerequ		(tick boxes where appropriate)
	or	O The patient has had an initial Special Authority approval for risperidone depot injection or paliperidone depot injection or olanzapine depot injection
		The patient has schizophrenia or other psychotic disorder and The patient has received treatment with oral atypical antipsychotic agents but has been unable to adhere and The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in last 12 months
or		Patient has been unable to access olanzapine depot injection due to supply issues with olanzapine depot injection, or otherwise would have been initiated on olanzapine depot injection but has been unable to due to supply issues with olanzapine depot injection. (see Note below for the olanzapine Special Authority criteria for new olanzapine depot injection patients prior to 1 April 2024)
Note: Th	ne Olar	nzapine depot injection Special Authority criteria that apply to criterion 2 in this Aripiprazole Special Authority application are as follows:
• The p	atient	has had an initial Special Authority approval for paliperidone depot injection or risperidone depot injection; or
All of	the fol	lowing:
• Th	ne pati	ent has schizophrenia; and
• Th	ne pati	ent has tried but has not been able to adhere with treatment using oral atypical antipsychotic agents; and
	ne pation	ent has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last ths.

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.

PRESCR	IBER	PATIENT:
Name: .		Name:
Ward:		NHI:
Diazepa	am	
INITIATI Prerequ	ON ilsites (tick box where appropriate)	
0	Prescribed by, or recommended by a relevant specialist, or in accord Hospital.	dance with a protocol or guideline that has been endorsed by the Health NZ
and	Only for use in children where diazepam tablets are not appropriate	

I confirm that the above details are correct:

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Zigneg.	i jate:	
Oigilica.	 Duic.	

SCRIBER	PATIENT:
e:	Name:
:	NHI:
iple Scle	rosis
teriflunomi ssessment	ultiple Sclerosis - dimethyl fumarate, fingolimod, glatiramer acetate, interferon beta-1-alpha, interferon beta-1-beta, natalizu de required after 12 months ick boxes where appropriate)
O Prescri NZ Hos	bed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Hespital.
and	Diagnosis of multiple sclerosis (MS) meets the McDonald 2017 diagnostic criteria for MS and has been confirmed by a neurologist
and	Patient has an EDSS score between 0 – 6.0
and	Patient has had at least one significant attack of MS in the previous 12 months or two significant attacks in the past 24 months
	Each significant attack must be confirmed by the applying neurologist or general physician (the patient may not necessarily have been seen by them during the attack, but the neurologist/physician must be satisfied that the clinical features were characteristic) and
	Each significant attack is associated with characteristic new symptom(s)/sign(s) or substantially worsening of previously experienced symptoms(s)/sign(s)
	Each significant attack has lasted at least one week and has started at least one month after the onset of a previous attack (where relevant)
	Each significant attack can be distinguished from the effects of general fatigue; and is not associated with a fever (T> 37.5°C)
	Each significant attack is severe enough to change either the EDSS or at least one of the Kurtze Functional System scores by at least 1 point
	Each significant attack is a recurrent paroxysmal symptom of multiple sclerosis (tonic seizures/spasms, trigeminal neuralgia, Lhermitte's symptom)
and	Evidence of new inflammatory activity on an MRI scan within the past 24 months
	A sign of that new inflammatory activity on MRI scanning (in criterion 5 immediately above) is a gadolinium enhancing lesion
	A sign of that new inflammatory activity is a lesion showing diffusion restriction or
	O A sign of that new inflammatory is a T2 lesion with associated local swelling or
	A sign of that new inflammatory activity is a prominent T2 lesion that clearly is responsible for the clinical features of a recent attack that occurred within the last 2 years
	O A sign of that new inflammatory activity is new T2 lesions compared with a previous MRI scan
or O F	Patient has an active approval for ocrelizumab and does not have primary progressive MS
: Treatment	on two or more funded multiple sclerosis treatments simultaneously is not permitted.

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Multiple Sclerosis - continued	
CONTINUATION – Multiple Sclerosis - dimethyl fumarate, fingolimod, gla natalizumab and teriflunomide	ntiramer acetate, interferon beta-1-alpha, interferon beta-1-beta,
Prerequisites (tick box where appropriate)	
Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	ecordance with a protocol or guideline that has been endorsed by the Health
Patient has had an EDSS score of 0 to 6.0 (inclusive) with or without the patient has walked 100 metres or more with or without aids in the Note: Treatment on two or more funded multiple sclerosis treatments simultared.	

SCRIBER	PATIENT:	
):		
	NHI:	
iple Scler	osis	
	Iltiple Sclerosis - ocrelizumab	
	equired after 12 months ck boxes where appropriate)	
```		
✓ Prescri NZ Hos	ped by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by pital.	by the H
	Dispussion of multiple colours in (MC) make the MaDarald 2017, dispussion within for MC and been profitted by	
	Diagnosis of multiple sclerosis (MS) meets the McDonald 2017 diagnostic criteria for MS and has been confirmed by a neurologist	l
and (	Patient has an EDSS score between 0 – 6.0	
and		
and	Patient has had at least one significant attack of MS in the previous 12 months or two significant attacks in the past 24	months
	O Each significant attack must be confirmed by the applying neurologist or general physician (the patient may not	
	necessarily have been seen by them during the attack, but the neurologist/physician must be satisfied that the cli features were characteristic)	nical
	and  Each significant attack is associated with characteristic new symptom(s)/sign(s) or substantially worsening of pre	viouely
	experienced symptoms(s)/sign(s)	viousiy
	Each significant attack has lasted at least one week and has started at least one month after the onset of a previous	ous
	attack (where relevant) and	
	O Each significant attack can be distinguished from the effects of general fatigue; and is not associated with a fever 37.5°C)	(T>
	and	
	Each significant attack is severe enough to change either the EDSS or at least one of the Kurtze Functional System scores by at least 1 point	ul
	or  Corrections of the service of th	
	trigeminal neuralgia, Lhermitte's symptom)	
and		
and	Devidence of new inflammatory activity on an MRI scan within the past 24 months	
	A sign of that new inflammatory activity on MRI scanning (in criterion 5 immediately above) is a gadolinium enhal	ncing
	or lesion	
	O A sign of that new inflammatory activity is a lesion showing diffusion restriction or	
	O A sign of that new inflammatory is a T2 lesion with associated local swelling	
	O A sign of that new inflammatory activity is a prominent T2 lesion that clearly is responsible for the clinical features	s of a
	recent attack that occurred within the last 2 years or	
	A sign of that new inflammatory activity is new T2 lesions compared with a previous MRI scan	
or		
	atient has an active Special Authority approval for either dimethyl fumarate, fingolimod, glatiramer acetate, interferon beta-1 terferon beta-1-beta, natalizumab or teriflunomide	-alpha,
"	norm beta i beta, natalizumab or teriliunomiue	

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.

Schedule. For community funding, see the Special Authority Criteria.	
PRESCRIBER	PATIENT:
Name:	Name:
Ward: NHI:	
Multiple Sclerosis - continued	
CONTINUATION – Multiple Sclerosis - ocrelizumab Prerequisites (tick box where appropriate)	
NZ Hospital.	
INITIATION – Primary Progressive Multiple Sclerosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	ecordance with a protocol or guideline that has been endorsed by the Health
	neets the 2017 McDonald criteria and has been confirmed by a
Patient has an EDSS 2.0 (score equal to or greater than 2 on and Patient has no history of relapsing remitting multiple sclerosis	
NZ Hospital.	ecordance with a protocol or guideline that has been endorsed by the Health time in the last six months (ie patient has walked 20 metres with bilateral

I confirm that the above details are correct:

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

January 2026

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	PATIENT:
lame:	Name:
Vard:	NHI:
lelatonin	
guideline that has been endorsed by the Health NZ Hos  Patient has been diagnosed with persistent and di limited to, autism spectrum disorder or attention de  and  Behavioural and environmental approaches have and	atrician, neurologist or respiratory specialist, or in accordance with a protocol or pital.  istressing insomnia secondary to a neurodevelopmental disorder (including, but not eficit hyperactivity disorder)
O Patient is aged 18 years or under	
Patient is aged 18 years or under  CONTINUATION – insomnia secondary to neurodevelopmental Re-assessment required after 12 months  Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a psychiatrist, paedia guideline that has been endorsed by the Health NZ Hos	atrician, neurologist or respiratory specialist, or in accordance with a protocol or
Patient is aged 18 years or under  CONTINUATION – insomnia secondary to neurodevelopmental Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a psychiatrist, paediaguideline that has been endorsed by the Health NZ Host	atrician, neurologist or respiratory specialist, or in accordance with a protocol or
Patient is aged 18 years or under  CONTINUATION – insomnia secondary to neurodevelopmental Re-assessment required after 12 months  Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a psychiatrist, paedic guideline that has been endorsed by the Health NZ Hos and  Patient is aged 18 years or under and  Patient has demonstrated clinically meaningful beautiful processing the process of the process	atrician, neurologist or respiratory specialist, or in accordance with a protocol or
Patient is aged 18 years or under  CONTINUATION – insomnia secondary to neurodevelopmental Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a psychiatrist, paedia guideline that has been endorsed by the Health NZ Hos and  Patient is aged 18 years or under and  Patient has demonstrated clinically meaningful be and  Patient has had a trial of funded modified-release persistent and distressing insomnia	atrician, neurologist or respiratory specialist, or in accordance with a protocol or pital.
Patient is aged 18 years or under  CONTINUATION – insomnia secondary to neurodevelopmenta Re-assessment required after 12 months  Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a psychiatrist, paedia guideline that has been endorsed by the Health NZ Hos and  Patient is aged 18 years or under and  Patient has demonstrated clinically meaningful beand  Patient has had a trial of funded modified-release	atrician, neurologist or respiratory specialist, or in accordance with a protocol or pital.  nefit from funded modified-release melatonin (clinician determined)  melatonin discontinuation within the past 12 months and has had a recurrence of
Patient is aged 18 years or under  CONTINUATION – insomnia secondary to neurodevelopmental Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a psychiatrist, paedia guideline that has been endorsed by the Health NZ Hos and  Patient is aged 18 years or under and  Patient has demonstrated clinically meaningful be and  Patient has had a trial of funded modified-release persistent and distressing insomnia  Funded modified-release melatonin is to be given	atrician, neurologist or respiratory specialist, or in accordance with a protocol or pital.  nefit from funded modified-release melatonin (clinician determined)  melatonin discontinuation within the past 12 months and has had a recurrence of at doses no greater than 10 mg per day
Patient is aged 18 years or under  CONTINUATION – insomnia secondary to neurodevelopmental Re-assessment required after 12 months  Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a psychiatrist, paedic guideline that has been endorsed by the Health NZ Hos and  Patient is aged 18 years or under  Patient has demonstrated clinically meaningful be and  Patient has had a trial of funded modified-release persistent and distressing insomnia	atrician, neurologist or respiratory specialist, or in accordance with a protocol or pital.  nefit from funded modified-release melatonin (clinician determined)  melatonin discontinuation within the past 12 months and has had a recurrence of at doses no greater than 10 mg per day  e are contraindicated

I confirm that the above details are correct: Signed: ...... Date: .....

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Nusinersen	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
Patient has genetic documentation of homozygous SMN1 ge heterozygous mutation  and Patient is 18 years of age or under and	ne deletion, homozygous SMN1 point mutation, or compound
O Patient has experienced the defined signs and symptoms of SMA type I, II or IIIa prior to three years of age O Patient is pre-symptomatic and O Patient has three or less copies of SMN2	
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
while being treated with nusinersen	ne function since treatment initiation ust 16 hours per day), in the absence of a potentially reversible cause
O Nusinersen not to be administered in combination other SMA	disease modifying treatments or gene therapy

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Signeg	 Date	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Risdiplam	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
Patient has genetic documentation of homozygous SMN1 genetic documentation d	ne deletion, homozygous SMN1 point mutation, or compound ns of SMA type I, II or IIIa prior to three years of age
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  There has been demonstrated maintenance of motor mileston and Patient does not require invasive permanent ventilation (at lea while being treated with risdiplam and Risdiplam not to be administered in combination other SMA di	ast 16 hours per day), in the absence of a potentially reversible cause

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Signed.	Date:	
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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Modafinil	
INITIATION – Narcolepsy Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a neurologist or respiratory spe by the Health NZ Hospital.	cialist, or in accordance with a protocol or guideline that has been endorsed
The patient has a diagnosis of narcolepsy and has exc daily for three months or more	essive daytime sleepiness associated with narcolepsy occurring almost
	a mean sleep latency of less than or equal to 10 minutes and 2 or paralysis or hypnagogic hallucinations
An effective dose of a listed formulation of methy because of intolerable side effects  Methylphenidate and dexamphetamine are contri	Ilphenidate or dexamphetamine has been trialled and discontinued aindicated
O Patient meets the Hospital Restriction criteria for methy and O Patient is unable to access methylphenidate hydrochlo	
Note: Criterion 2 is to permit short-term funding to cover an out-of-stock of m	nethylphenidate hydrochloride.

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Signed.	Date:	
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PRESCRIBER	PA	ITIENT:
Name:	Na	ıme:
Nard:	NI	H:
isdexamfetamine di	imesilate	
INITIATION Prerequisites (tick boxes	where appropriate)	
Prescribed by, or Health NZ Hospi		accordance with a protocol or guideline that has been endorsed by the
or  O ADH and O Diag and  or O or O or O or O or O ar O ar O or O ar O a	Patient is taking a currently subsidised formulation of and has not received sufficient benefit or has experiently subsidised formulation of effective due to significant administration and/or treation. There is significant concern regarding the risk of diverse a significant concern regarding the risk of diverse which has not been effective due to significant concern regarding the risk of diverse a significant concern regarding the risk of diverse is si	dexamfetamine sulfate (immediate-release) which has not been ment adherence difficulties  rsion or abuse of immediate release dexamfetamine sulfate  methylphenidate hydrochloride (immediate-release or sustained not administration and/or treatment adherence difficulties  rsion or abuse of immediate release methylphenidate hydrochloride  red formulation of methylphenidate hydrochloride (extended-release)  sues with methylphenidate hydrochloride (extended-release)  r/lphenidate or dexamfetamine) are not appropriate

Scriedule. For community funding, see the Special Authority Criteria.		
PRESCRIBER PATIENT:		
Name:	Name:	
Ward:	NHI:	
Methylphenidate hydrochloride		
INITIATION – ADHD (immediate-release and sustained-release formulation in the prerequisites (tick box where appropriate)	ons)	
Prescribed by, or recommended by a paediatrician or psychiatrist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Patient has ADHD (Attention Deficit and Hyperactivity Disorder), diagnosed according to DSM-IV or ICD 10 criteria		
INITIATION – Narcolepsy (immediate-release and sustained-release form Prerequisites (tick box where appropriate)  O Prescribed by, or recommended by a neurologist or respiratory specified by the Health NZ Hospital.  and O Patient suffers from narcolepsy	cialist, or in accordance with a protocol or guideline that has been endorsed	
Patient has ADHD (Attention Deficit and Hyperactivity Disorder and  Patient has ADHD (Attention Deficit and Hyperactivity Disorder and  Patient is taking a currently listed formulation of methylp has not been effective due to significant administration and or	henidate hydrochloride (immediate-release or sustained-release) which	
INITIATION – Narcolepsy* (extended-release only)  Prerequisites (tick box where appropriate)  Prescribed by, or recommended by a neurologist or respiratory specific by the Health NZ Hospital.  and  Patient suffers from narcolepsy  Note: *narcolepsy is not a registered indication for Concerta, Ritalin LA or Me	cialist, or in accordance with a protocol or guideline that has been endorsed ethylphenidate Sandoz XR.	

I confirm that the above details are correct:	
Signed:	Date:

PATIENT:	
Name:	
NHI:	
r in accordance with a protocol or guideline that has been endorsed by the agnosed according to DSM-IV or ICD 10 criteria	
INITIATION – Narcolepsy Prerequisites (tick box where appropriate)  O Prescribed by, or recommended by a neurologist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  and O Patient suffers from narcolepsy	
1	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rivastigmine	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  The patient has been diagnosed with dementia and	
The patient is contraindicated to or has experienced intolerable	e side effects from donepezil tablets
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
The treatment remains appropriate  and The patient has demonstrated a significant and sustained ben	ofit from trootment
The patient has demonstrated a significant and sustained ben	Citt nom acament

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Naltrexone hydrochloride	
INITIATION – Alcohol dependence Prerequisites (tick boxes where appropriate)  O Patient is currently enrolled, or is planned to be enrolled, in a land O Naltrexone is to be prescribed by, or on the recommendation of	recognised comprehensive treatment programme for alcohol dependence of, a physician working in an Alcohol and Drug Service
INITIATION – Constipation Prerequisites (tick box where appropriate)	
O For the treatment of opioid-induced constipation	

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Signed.	Date:	
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PRES	CRI	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Nico	tine	)		
INITI. Prere			(tick boxes where appropriate)	
		0	For perioperative use in patients who have a 'nil by mouth' inst	truction
	or	0	For use within mental health inpatient units	
	or	0	Patient would be admitted to a mental health inpatient unit, but	t is unable to due to COVID-19 self-isolation requirement
	or	0	For acute use in agitated patients who are unable to leave the	hospital facilities

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	PATIENT:
Name:	
Ward:	NHI:
Varenicline	
INITIATION Prerequisites	(tick boxes where appropriate)
and and	Short-term therapy as an aid to achieving abstinence in a patient who has indicated that they are ready to cease smoking
and	The patient is part of, or is about to enrol in, a comprehensive support and counselling smoking cessation programme, which includes prescriber or nurse monitoring
or	O The patient has tried but failed to quit smoking after at least two separate trials of nicotine replacement therapy, at least one of which included the patient receiving comprehensive advice on the optimal use of nicotine replacement therapy
	O The patient has tried but failed to quit smoking using bupropion or nortriptyline
and and	The patient has not had a Special Authority for varenicline approved in the last 6 months
and _	Varenicline is not to be used in combination with other pharmacological smoking cessation treatments and the patient has agreed to this
and	The patient is not pregnant
O	The patient will not be prescribed more than 12 weeks' funded varenicline in a 12 month period

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Signed.	Date:	
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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Buprenorphine with naloxone	
INITIATION – Detoxification Prerequisites (tick boxes where appropriate)  O Patient is opioid dependent and O Patient is currently engaged with an opioid treatment service a and O Prescriber works in an opioid treatment service approved by the	
INITIATION – Maintenance treatment Prerequisites (tick boxes where appropriate)	
Patient is opioid dependent  and Patient will not be receiving methadone and Patient is currently enrolled in an opioid substitution treatment and Prescriber works in an opioid treatment service approved by the	

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Signed.	Date:	
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#### **Oncology Agents and Immunosuppressants**



Note: Indication marked with a * includes indications that are un (SLL).  INITIATION – Indolent, Low-grade lymphomas Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)  The patient has indolent low grade NHL requiring and Patient has ECOG performance status of 0-2 and  Patient is treatment naive  Bendamustine is to be administered  or  Patient is refractory to or has relapsed regimen  and  Bendamustine is to be administered  Bendamustine is to be administered	equiring treatment  um dose of 100 mg/m² on days 1 and 2 every 4 weeks for a maximum of 6 cycles approved. 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma
Bendamustine hydrochloride  INITIATION – CLL* Prerequisites (tick boxes where appropriate)  The patient has chronic lymphocytic leukaemia rand Patient has ECOG performance status 0-2 and Bendamustine is to be administered at a maximum location marked with a * includes indications that are un (SLL).  INITIATION – Indolent, Low-grade lymphomas Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)  The patient has indolent low grade NHL requiring and Patient has ECOG performance status of 0-2 and  Patient is treatment naive  and Bendamustine is to be administered  Or Patient is refractory to or has relapsed regimen  and Bendamustine is to be administered  Bendamustine is to be administered	equiring treatment  um dose of 100 mg/m² on days 1 and 2 every 4 weeks for a maximum of 6 cycles approved. 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma
INITIATION – CLL* Prerequisites (tick boxes where appropriate)  The patient has chronic lymphocytic leukaemia rand Patient has ECOG performance status 0-2 and Bendamustine is to be administered at a maximum. Note: Indication marked with a * includes indications that are un (SLL).  INITIATION – Indolent, Low-grade lymphomas Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)  The patient has indolent low grade NHL requiring and Patient has ECOG performance status of 0-2 and  Patient is treatment naive  Bendamustine is to be administered  Or Patient is refractory to or has relapse regimen  and Bendamustine is to be administered  Bendamustine is to be administered	um dose of 100 mg/m² on days 1 and 2 every 4 weeks for a maximum of 6 cycles approved. 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma
Prerequisites (tick boxes where appropriate)  The patient has chronic lymphocytic leukaemia rand Patient has ECOG performance status 0-2 and Bendamustine is to be administered at a maximum Note: Indication marked with a * includes indications that are un (SLL).  INITIATION – Indolent, Low-grade lymphomas Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)  The patient has indolent low grade NHL requiring and Patient has ECOG performance status of 0-2 and  Patient is treatment naive  Bendamustine is to be administered  Or  Patient is refractory to or has relapsed regimen  and Bendamustine is to be administered  Bendamustine is to be administered	um dose of 100 mg/m² on days 1 and 2 every 4 weeks for a maximum of 6 cycles approved. 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma
Patient has ECOG performance status 0-2  and Bendamustine is to be administered at a maximum.  Note: Indication marked with a * includes indications that are un (SLL).  INITIATION – Indolent, Low-grade lymphomas Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)  The patient has indolent low grade NHL requiring and Patient has ECOG performance status of 0-2  and  Patient is treatment naive  Bendamustine is to be administered  or  Patient is refractory to or has relapsed regimen  and Bendamustine is to be administered  Bendamustine is to be administered	um dose of 100 mg/m² on days 1 and 2 every 4 weeks for a maximum of 6 cycles approved. 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma
Re-assessment required after 9 months  Prerequisites (tick boxes where appropriate)  The patient has indolent low grade NHL requiring and Patient has ECOG performance status of 0-2 and  Patient is treatment naive  Bendamustine is to be administered  or  Patient is refractory to or has relapsed regimen  and Bendamustine is to be administered  Bendamustine is to be administered	g treatment
Patient is treatment naive  Bendamustine is to be administered  or  Patient is refractory to or has relapse regimen  and  Bendamustine is to be administered	
The patient has not received prior be and Bendamustine is to be administered CD20+) and Patient has had a rituximab treatmen	for a maximum of 6 cycles (in combination with rituximab when CD20+)  ed within 12 months of a rituximab containing combined chemo-immunotherapy  in combination with obinutuzumab for a maximum of 6 cycles  endamustine therapy  for a maximum of 6 cycles in relapsed patients (in combination with rituximab when

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBE	ER	PATIENT:
Name:		
Ward:		NHI:
Bendamu	stine hy	ydrochloride - continued
Re-assessm	nent requi	rdolent, Low-grade lymphomas red after 9 months oxes where appropriate)
	and	Patient is refractory to or has relapsed within 12 months of rituximab in combination with bendamustine  Bendamustine is to be administered in combination with obinutuzumab for a maximum of 6 cycles
or	O and	Patients have not received a bendamustine regimen within the last 12 months
	or	Bendamustine is to be administered for a maximum of 6 cycles in relapsed patients (in combination with rituximab when CD20+)  and  Patient has had a rituximab treatment-free interval of 12 months or more
		O Bendamustine is to be administered as a monotherapy for a maximum of 6 cycles in rituximab refractory patients
Note: 'indole	ent, low-g	grade lymphomas' includes follicular, mantle cell, marginal zone and lymphoplasmacytic/ Waldenström's macroglobulinaemia.
Re-assessm	nent requi	in's lymphoma* red after 6 months oxes where appropriate)
and	) Patier	nt has Hodgkin's lymphoma requiring treatment
and	) Patier	nt has a ECOG performance status of 0-2
	) Patier	nt has received one prior line of chemotherapy
and	) Patier	nt's disease relapsed or was refractory following prior chemotherapy
and		
	90 mg	amustine is to be administered in combination with gemcitabine and vinorelbine (BeGeV) at a maximum dose of no greater than g/m2 twice per cycle, for a maximum of four cycles

I confirm that the above details are correct:	

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

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Azacitidine	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
The individual has intermediate or high risk MDS based or The individual has chronic myelomonocytic leukaemia (recognised scoring system or 10%-29% marrow blasts The individual has acute myeloid leukaemia according that and The individual has an estimated life expectancy of at least 3 recognised.	(based on an intermediate or high risk score from an internationally without myeloproliferative disorder) to World Health Organisation (WHO) Classification
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate)  O No evidence of disease progression	

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	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Mercaptopurine		
INITIATION Re-assessment required after 12 months Prerequisites (tick box where appropriate)  O Prescribed by, or recommended by a paediatric haematologist or pabeen endorsed by the Health NZ Hospital.  and O The patient requires a total dose of less than one full 50 mg tablet p	nediatric oncologist, or in accordance with a protocol or guideline that has er day	
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate)		
O Prescribed by, or recommended by a paediatric haematologist or paediatric oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  and O The patient requires a total dose of less than one full 50 mg tablet per day		
The patient requires a total dose of less than one full 50 mg tablet p	or day	

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
	NIII.	
Venetoclax		
INITIATION – relapsed/refractory chronic lymphocytic leukaemia Re-assessment required after 7 months  Prerequisites (tick boxes where appropriate)		
Individual has chronic lymphocytic leukaemia requiring treatme	ent	
Individual has received at least one prior therapy for chronic ly	mphocytic leukaemia	
O Individual has not previously received funded venetoclax		
and  The individual's disease has relapsed		
Venetoclax to be used in combination with six 28-day cycles of venetoclax	f rituximab commencing after the 5-week dose titration schedule with	
and Individual has an ECOG performance status of 0-2		
That was an 2000 portonial to State of C2		
Re-assessment required after 6 months  Prerequisites (tick boxes where appropriate)  Treatment remains clinically appropriate and the individual is benefitting from and tolerating treatment and  Venetoclax is to be discontinued after a maximum of 24 months of treatment following the titration schedule unless earlier discontinuation is required due to disease progression or unacceptable toxicity		
INITIATION – previously untreated chronic lymphocytic leukaemia with 1 Re-assessment required after 6 months  Prerequisites (tick boxes where appropriate)	7p deletion or TP53 mutation*	
O Individual has previously untreated chronic lymphocytic leukae	emia	
There is documentation confirming that the individual has 17p	deletion by FISH testing or TP53 mutation by sequencing	
Individual has an ECOG performance status of 0-2		
CONTINUATION – previously untreated chronic lymphocytic leukaemia v Re-assessment required after 6 months  Prerequisites (tick box where appropriate)	vith 17p deletion or TP53 mutation*	
O No evidence of disease progression  Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymp  marked with * are unapproved indications	homa (SLL)* and B-cell prolymphocytic leukaemia (B-PLL)*. Indications	

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Sidned.	 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	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Venetoclax - continued			
INITIATION – previously untreated acute myeloid leukaemia Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
	net all remaining special authority criteria prior to commencing treatment		
	nemia (see note a), according to World Health Organization (WHO)		
Venetoclax not to be used in combination with standard	d intensive remission induction chemotherapy		
O Venetoclax to be used in combination with azacitidine	or low dose cytarabine		
CONTINUATION – previously untreated acute myeloid leukaemia Re-assessment required after 6 months  Prerequisites (tick box where appropriate)			
O No evidence of disease progression Note:			
a) 'Acute myeloid leukaemia' includes myeloid sarcoma*			
b) Indications marked with * are Unapproved indications	Indications marked with * are Unapproved indications		

I confirm that the above details are correct:

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

PRES	CRIB	ER			PATIENT:
Name	e:				Name:
Ward	:				. NHI:
Olap	arib				
Re-a	ssess <b>equis</b>	ment ites (	tick boxes v	fter 12 months where appropriate)	cordance with a protocol or guideline that has been endorsed by the Health NZ
	and ( and	$\overline{}$		Patient has received at least two lines** of previous Patient has platinum sensitive disease defined at the penultimate line** of platinum-based chemo	CA1 or BRCA2 gene mutation  e rement with platinum-based chemotherapy ial or complete response to the first-line platinum-based regimen  fous treatment with platinum-based chemotherapy as disease progression occurring at least 6 months after the last dose of
	and ( and ( and		Treatment t	Patient has not previously received funded olap will be commenced within 12 weeks of the patien to be administered as maintenance treatment not to be administered in combination with other	it's last dose of the immediately preceding platinum-based regimen

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Signed.	Date:	
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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	PATIENT:
Name:	Name:
Ward:	NHI:
Olaparib - continued	
CONTINUATION – Ovarian cancer Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a medical oncologist, or in accommended by a medical oncologist by a medical oncol	rdance with a protocol or guideline that has been endorsed by the Health NZ
O Treatment remains clinically appropriate and patient is benefi	tting from treatment
O No evidence of progressive disease or	
	patient would continue to benefit from treatment in the clinician's
and Treatment to be administered as maintenance treatment and	
Treatment not to be administered in combination with other cl	nemotherapy
	nent with platinum-based chemotherapy een informed and acknowledges that the funded treatment period of ne patient experiences a complete response to treatment and there is
O Patient has received at least two lines** of previous treat	atment with platinum-based chemotherapy

Note: *Note "high-grade serous" includes tumours with high-grade serous features or a high-grade serous component **A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments.

I confirm that the above details are correct:	
Signed:	Date:

PRESC	CRIB	ER			PATIENT:
Name:					Name:
Ward:					NHI:
Ibruti	nib				
Re-as	sessr	nent	required af	phocytic leukaemia (CLL) ter 6 months vhere appropriate)	
	(	)	Individual h	as chronic lymphocytic leukaemia (CLL) requiring t	therapy
	and ( and	C	Individual h	as not previously received funded ibrutinib	
	and	О —	Ibrutinib is t	o be used as monotherapy	
		or	and	There is documentation confirming that the individend individual has experienced intolerable side effects	
			and and	Individual has received at least one prior immunod Individual's CLL has relapsed Individual has experienced intolerable side effects	chemotherapy for CLL  with venetoclax in combination with rituximab regimen
		or	O Individ	dual's CLL is refractory to or has relapsed following	g a venetoclax regimen
Re-as	sessr <b>quisi</b>	ment <b>tes</b> (	required af	ter 12 months ere appropriate) inical disease progression	
				c leukaemia (CLL)' includes small lymphocytic lymphations marked with * are Unapproved indications.	noma (SLL) and B-cell prolymphocytic

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER		PATIENT:
Name:		Name:
Ward:		NHI:
Niraparib		
	nt required after 6 months s (tick boxes where appropriate)	
and and or and and and and and and and	Patient has advanced high-grade serous* epithelial ovarian, fall Patient has received at least one line** of treatment with plating Patient has experienced a partial or complete response to the Patient has not previously received funded treatment with a PATO Treatment will be commenced within 12 weeks of the patron Patient commenced treatment with niraparib prior to 1 Materials Treatment to be administered as maintenance treatment.	oreceding treatment with platinum-based chemotherapy RP inhibitor ient's last dose of the preceding platinum-based regimen ay 2024
	ON nt required after 6 months s (tick boxes where appropriate)	
and and and	No evidence of progressive disease  Treatment to be administered as maintenance treatment  Treatment not to be administered in combination with other che	emotherapy
OI	<ul> <li>Treatment with niraparib to cease after a total duration of</li> <li>Treatment with niraparib is being used in the second-line</li> </ul>	
Note: * "high	-grade serous" includes tumours with high-grade serous features	or a high-grade corous component

Note: * "high-grade serous" includes tumours with high-grade serous features or a high-grade serous component.
**A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen
and supportive treatments

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.

RESCRIBER	PATIENT:
ame:	Name:
/ard:	NHI:
enalidomide	
NITIATION – Plasma cell dyscrasia	
Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by any relevant practitioner, or in NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the Health
O Patient has plasma cell dyscrasia, not including Waldenströ	im macroglobulinaemia, requiring treatment
O Patient is not refractory to prior lenalidomide use	
NITIATION – Myelodysplastic syndrome Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by any relevant practitioner, or in NZ Hospital.	accordance with a protocol or guideline that has been endorsed by the Health
Patient has low or intermediate-1 risk myelodysplastic synd a deletion 5q cytogenetic abnormality and _	rome (based on IPSS or an IPSS-R score of less than 3.5) associated with
O Patient has transfusion-dependent anaemia	
CONTINUATION – Myelodysplastic syndrome Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
	accordance with a protocol or guideline that has been endorsed by the Health
O Patient has not needed a transfusion in the last 4 months and	
O No evidence of disease progression	

PRES	CRIBER	PATIENT:
Name	:	Name:
Ward:		NHI:
Pom	alidomide	
	ATION – Relapsed/refractory plasma cell dyscrasia ssessment required after 6 months	
	equisites (tick boxes where appropriate)	
( and	Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	coordance with a protocol or guideline that has been endorsed by the Health
	and	ncluding Waldenström macroglobulinaemia, requiring treatment
	O Patient has not received prior funded pomalidomide	
Re-a	TINUATION – Relapsed/refractory plasma cell dyscrasia ssessment required after 12 months equisites (tick box where appropriate)	
(	Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	cordance with a protocol or guideline that has been endorsed by the Health
and (	Patient has no evidence of disease progression	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
	NIII.
Temozolomide	
INITIATION – gliomas Re-assessment required after 12 months Prerequisites (tick box where appropriate)  Patient has a glioma	
CONTINUATION – gliomas Re-assessment required after 12 months Prerequisites (tick box where appropriate)  Or Treatment remains appropriate and patient is benefitting from treatment.	nent
INITIATION – Neuroendocrine tumours Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)	
Patient has been diagnosed with metastatic or unresectable wand  Temozolomide is to be given in combination with capecitabine and  Temozolomide is to be used in 28 day treatment cycles for a new per day  and  Temozolomide to be discontinued at disease progression	
CONTINUATION – Neuroendocrine tumours Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
No evidence of disease progression and  The treatment remains appropriate and the patient is benefitting	ng from treatment
INITIATION – ewing's sarcoma Re-assessment required after 9 months Prerequisites (tick box where appropriate)  O Patient has relapse or refractory Ewing's sarcoma	
CONTINUATION – ewing's sarcoma Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  No evidence of disease progression	
and  The treatment remains appropriate and the patient is benefitting	ng from treatment
Note: Indication marked with a * is an unapproved indication. Temozolomic relapsed high grade glioma.	de is not funded for the treatment of

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Thalidomide		
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  The patient has plasma cell dyscrasia, not including Waldenst or The patient has erythema nodosum leprosum	röm macroglobulinaemia, requiring treatment	
CONTINUATION Prerequisites (tick box where appropriate)  O Patient has obtained a response from treatment during the initial approval period Note: Prescription must be written by a registered prescriber in the thalidomide risk management programme operated by the supplier Maximum dose of 400 mg daily as monotherapy or in a combination therapy regimen		

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Signed.	Date:	
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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	PATIENT:
Name:	Name:
Ward:	NHI:
Bortezomib	
INITIATION – plasma cell dyscrasia Prerequisites (tick box where appropriate)	
O The patient has plasma cell dyscrasia, not including Waldenström m	nacroglobulinaemia, requiring treatment

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PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Pegaspargase		
INITIATION – Newly diagnosed ALL Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)		
The patient has newly diagnosed acute lymphoblastic leukaemia and Pegaspargase to be used with a contemporary intensive multi-agent chemotherapy treatment protocol		
INITIATION – Relapsed ALL Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)		
The patient has relapsed acute lymphoblastic leukaemia and Pegaspargase to be used with a contemporary intensive multi-	ragent chemotherapy treatment protocol	
INITIATION – Lymphoma Re-assessment required after 12 months Prerequisites (tick box where appropriate)  O Patient has lymphoma requiring L-asparaginase containing protocol	(e.g. SMILE)	

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Nilotinib	
Hospital.	ce with a protocol or guideline that has been endorsed by the Health NZ
Patient has a diagnosis of chronic myeloid leukaemia (CML) i	n blast crisis, high risk chronic phase, or in chronic phase
or  Patient has documented CML treatment failure* with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment limiting toxicity with a social patient has experienced treatment and the social patient has experienced treatment and the social patient has experienced treatment and the social patient has been also been as a social patient has experienced and the social	tyrosine kinase inhibitor (TKI) a tyrosine kinase inhibitor (TKI) precluding further treatment
and  Maximum nilotinib dose of 800 mg/day and  Subsidised for use as monotherapy only	
Note: *treatment failure as defined by Leukaemia Net Guidelines.	
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a haematologist, or in accordant Hospital. and	ce with a protocol or guideline that has been endorsed by the Health NZ
C Lack of treatment failure while on nilotinib as defined by Leuk and Nilotinib treatment remains appropriate and the patient is ben	
and  Maximum nilotinib dose of 800 mg/day and  Subsidised for use as monotherapy only	oning nom deadnent

I confirm that the above details are correct:		
Signed:	Date:	

PRES	SCRIB	BER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Rux	olitin	ib		
Re-a		men	t required after 12 months (tick boxes where appropriate)	
and		Presc Hospi		ce with a protocol or guideline that has been endorsed by the Health NZ
	and	0	The patient has primary myelofibrosis or post-polycythemia ve	era myelofibrosis or post-essential thrombocythemia myelofibrosis
		or	System (IPSS), Dynamic International Prognostic Scorin  A classification of risk of intermediate-1 myelofibre (IPSS), Dynamic International Prognostic Scoring and	osis according to either the International Prognostic Scoring System
	and	0	A maximum dose of 20 mg twice daily is to be given	
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)				
	and	$\overline{}$	The treatment remains appropriate and the patient is benefitin  A maximum dose of 20 mg twice daily is to be given	g from treatment

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Signed.	Date:	
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Page 285

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	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Alectinib		
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  O Patient has locally advanced, or metastatic, unresectable, non and O There is documentation confirming that the patient has an ALF and O Patient has an ECOG performance score of 0-2	n-small cell lung cancer  K tyrosine kinase gene rearrangement using an appropriate ALK test	
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
No evidence of progressive disease according to RECIST crite and The patient is benefitting from and tolerating treatment	ella	

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PRE	SCRIB	ER	PATIENT:
Nam	e:		
Ward	l:		NHI:
Palk	ocic	lib (lbra	ance)
Re-a		ment requ	uired after 6 months boxes where appropriate)
		and on and and and and	Patient has unresectable locally advanced or metastatic breast cancer  There is documentation confirming disease is hormone-receptor positive and HER2-negative  Patient has an ECOG performance score of 0-2  O Disease has relapsed or progressed during prior endocrine therapy  Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state  and O Patient has not received prior systemic treatment for metastatic disease  Treatment must be used in combination with an endocrine partner
	or	and and and	Patient has not received prior funded treatment with a CDK4/6 inhibitor  Patient has an active Special Authority approval for ribociclib  Patient has experienced a grade 3 or 4 adverse reaction to ribociclib that cannot be managed by dose reductions and requires treatment discontinuation  Treatment must be used in combination with an endocrine partner  There is no evidence of progressive disease since initiation of ribociclib
Re-a	assess	ites (tick	uired after 12 months boxes where appropriate)  Itment must be used in combination with an endocrine partner  re is no evidence of progressive disease since initiation of palbociclib

I confirm that the above details are correct:

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

PRES	CRIBER		PATIENT:
Name	:		Name:
Ward:			NHI:
Mido	staurin		
	ATION equisites	(tick boxes where appropriate)	
	and and	Patient has a diagnosis of acute myeloid leukaemia  Condition must be FMS tyrosine kinase 3 (FLT3) mutation pos	
	and and	Patient must not have received a prior line of intensive chemot Patient is to receive standard intensive chemotherapy in comb	
	$\mathbf{O}$	Midostaurin to be funded for a maximum of 4 cycles	

PRE	SCRIB	ER	PATIENT:
Nam	e:		
Ward	l:		NHI:
Ribo	ocicli	b	
Re-a		ment requ	ired after 6 months oxes where appropriate)
		and or and and or and	Patient has unresectable locally advanced or metastatic breast cancer  There is documentation confirming disease is hormone-receptor positive and HER2-negative  Patient has an ECOG performance score of 0-2  Disease has relapsed or progressed during prior endocrine therapy  Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state  Patient has not received prior systemic endocrine treatment for metastatic disease  Treatment to be used in combination with an endocrine partner  Patient has not received prior funded treatment with a CDK4/6 inhibitor
	or	and O and O	Patient has an active Special Authority approval for palbociclib  Patient has experienced a grade 3 or 4 adverse reaction to palbociclib that cannot be managed by dose reductions and requires treatment discontinuation  Treatment must be used in combination with an endocrine partner  There is no evidence of progressive disease since initiation of palbociclib
Re-a	assess	ites (tick b	ired after 12 months expressive appropriate)  ment must be used in combination with an endocrine partner expressive disease since initiation of ribociclib

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	PATIENT:
Name:	Name:
Ward:	NHI:
Lenvatinib	
INITIATION – thyroid cancer Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O Patient is currently on treatment with lenvatinib and met all re	emaining criteria prior to commencing treatment
The patient has locally advanced or metastatic different	ntiated thyroid cancer
O Patient must have symptomatic progressive dise	ase prior to treatment
Patient must progressive disease at critical anatocannot be achieved by other measures	omical sites with a high risk of morbidity or mortality where local control
and  O A lesion without iodine uptake in a RAI scan or O Receiving cumulative RAI greater than or equal to or O Experiencing disease progression after a RAI tree or O Experiencing disease progression after two RAI and O Patient has thyroid stimulating hormone (TSH) adequations.	treatments administered within 12 months of each other
Patient is not a candidate for radiotherapy with curative and Surgery is clinically inappropriate and Patient has an ECOG performance status of 0-2	intent
CONTINUATION – thyroid cancer Re-assessment required after 6 months Prerequisites (tick box where appropriate)  O There is no evidence of disease progression	

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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	PATIENT:
Name:	Name:
Ward:	NHI:
Lenvatinib - continued	
INITIATION – unresectable hepatocellular carcinoma Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Patient has unresectable hepatocellular carcinoma and Patient has preserved liver function (Childs-Pugh A) and Transarterial chemoembolisation (TACE) is unsuitable and Patient has an ECOG performance status of 0-2 and	
O Patient has not received prior systemic therapy for their or Patient has experienced treatment-limiting toxicity and No disease progression since initiation of atezoliz	from treatment with atezolizumab with bevacizumab
CONTINUATION – unresectable hepatocellular carcinoma Re-assessment required after 6 months Prerequisites (tick box where appropriate)  There is no evidence of disease progression	
INITIATION – renal cell carcinoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
The patient has metastatic renal cell carcinoma  The disease is of predominant clear-cell histology  and  The patient has documented disease progression follow  and  The patient has an ECOG performance status of 0-2  and  Lenvatinib is to be used in combination with everolimus	ing one previous line of treatment
Patient has received funded treatment with nivolumab for and Patient has experienced treatment limiting toxicity from the and Lenvatinib is to be used in combination with everolimus and There is no evidence of disease progression	or the second line treatment of metastatic renal cell carcinoma reatment with nivolumab
CONTINUATION – renal cell carcinoma Re-assessment required after 4 months Prerequisites (tick box where appropriate)  There is no evidence of disease progression	
I confirm that the above details are correct:	

Signed: Date:

I confirm that the above details are correct:

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

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

SCRIBER	PATIENT:
e:	
	NHI:
nertinib	
	NSCLC – first line nt required after 4 months
	(tick boxes where appropriate)
and	Patient has locally advanced or metastatic, incurable, non-squamous non-small cell lung cancer (NSCLC)
or	O Patient is treatment naïve
or	O Patient has received prior treatment in the adjuvant setting and/or while awaiting EGFR results
	The patient has discontinued gefitinib or erlotinib due to intolerance and
	O The cancer did not progress while on gefitinib or erlotinib
and	There is documentation confirming that the cancer expresses activating mutations of EGFR
and	Patient has an ECOG performance status 0-3
and	
assessmer requisites Resp	Baseline measurement of overall tumour burden is documented clinically and radiologically  ON – NSCLC – first line nt required after 6 months (tick box where appropriate)  conse to or stable disease with treatment in target lesions has been determined by comparable radiologic assessment following the most treatment period
NTINUATION – assessmer	DN – NSCLC – first line nt required after 6 months (tick box where appropriate)  ponse to or stable disease with treatment in target lesions has been determined by comparable radiologic assessment following the most treatment period  NSCLC – second line nt required after 4 months
ITINUATION – assessmer	DN – NSCLC – first line nt required after 6 months (tick box where appropriate)  ponse to or stable disease with treatment in target lesions has been determined by comparable radiologic assessment following the most treatment period  NSCLC – second line nt required after 4 months (tick boxes where appropriate)
ITINUATION – ISSESSMER	DN – NSCLC – first line nt required after 6 months (tick box where appropriate)  ponse to or stable disease with treatment in target lesions has been determined by comparable radiologic assessment following the most treatment period  NSCLC – second line nt required after 4 months
ITINUATION – Resprecent IATION – Issessmer equisites  and and	ON – NSCLC – first line nt required after 6 months (tick box where appropriate)  conse to or stable disease with treatment in target lesions has been determined by comparable radiologic assessment following the month treatment period  NSCLC – second line nt required after 4 months (tick boxes where appropriate)  Patient has locally advanced or metastatic, incurable, non-squamous non-small cell lung cancer (NSCLC)
TINUATION – assessmer requisites  IATION – assessmer requisites  and	ON – NSCLC – first line It required after 6 months (tick box where appropriate)  Donse to or stable disease with treatment in target lesions has been determined by comparable radiologic assessment following the most treatment period  NSCLC – second line Interequired after 4 months (tick boxes where appropriate)  Patient has locally advanced or metastatic, incurable, non-squamous non-small cell lung cancer (NSCLC)  Patient has an ECOG performance status 0-3
INTINUATION - Assessmer recent requisites  IATION - Assessmer requisites  and and and and and and	ON – NSCLC – first line Interceptive after 6 months (tick box where appropriate)  Interceptive after 6 months (tick box where appropriate)  Interceptive after 4 months (tick boxes where appropriate)  Patient has locally advanced or metastatic, incurable, non-squamous non-small cell lung cancer (NSCLC)  Patient has an ECOG performance status 0-3  The patient must have received previous treatment with erlotinib or gefitinib  There is documentation confirming that the cancer expresses T790M mutation of EGFR following progression on or after erlotinib or
INTINUATION - assessmer requisites  IATION - assessmer requisites  and and and	ON – NSCLC – first line Interpolate after 6 months (tick box where appropriate)  Sonse to or stable disease with treatment in target lesions has been determined by comparable radiologic assessment following the most treatment period  NSCLC – second line Interpolate after 4 months (tick boxes where appropriate)  Patient has locally advanced or metastatic, incurable, non-squamous non-small cell lung cancer (NSCLC)  Patient has an ECOG performance status 0-3  The patient must have received previous treatment with erlotinib or gefitinib  There is documentation confirming that the cancer expresses T790M mutation of EGFR following progression on or after erlotinib or gefitinib
ITINUATION – assessmer requisites  IATION – assessmer requisites  and and and and and and and	ON – NSCLC – first line Interculated after 6 months (tick box where appropriate) Interculated disease with treatment in target lesions has been determined by comparable radiologic assessment following the most treatment period  INSCLC – second line Interculated after 4 months (tick boxes where appropriate)  Patient has locally advanced or metastatic, incurable, non-squamous non-small cell lung cancer (NSCLC)  Patient has an ECOG performance status 0-3  The patient must have received previous treatment with erlotinib or gefitinib  There is documentation confirming that the cancer expresses T790M mutation of EGFR following progression on or after erlotinib or gefitinib  The treatment must be given as monotherapy
NTINUATION - Passessmer Passessme	ON – NSCLC – first line Intrequired after 6 months (tick box where appropriate) Intreatment period  NSCLC – second line Intrequired after 4 months (tick boxes where appropriate)  Patient has locally advanced or metastatic, incurable, non-squamous non-small cell lung cancer (NSCLC)  Patient has an ECOG performance status 0-3  The patient must have received previous treatment with erlotinib or gefitinib  There is documentation confirming that the cancer expresses T790M mutation of EGFR following progression on or after erlotinib or gefitinib  The treatment must be given as monotherapy  Baseline measurement of overall tumour burden is documented clinically and radiologically  ON – NSCLC – second line

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	PATIENT:
Name:	Name:
Ward:	NHI:
Axitinib	
Re-assessment required after 4 months  Prerequisites (tick boxes where appropriate)	
The patient has metastatic renal cell carcinoma and The disease is of predominant clear cell histology and The patient has documented disease progression following or and The patient has ECOG performance status of 0-2	ne previous line of treatment
CONTINUATION Re-assessment required after 4 months Prerequisites (tick box where appropriate)  O No evidence of disease progression.	

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Crizotinib	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O Individual has locally advanced or metastatic, unresectable, n	on-squamous non-small cell lung cancer
O The individual has not received entrectinib	
The individual has received treatment with entrect and The cancer did not progress while the individual v	tinib and has discontinued entrectinib due to intolerance  was on entrectinib
and  There is documentation confirming that the patient has a ROS and  Individual has ECOG performance score of 0-3 and	
O Baseline measurement of overall tumour burden is document	ed clinically and radiologically
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
Response to treatment has been determined by comparable rand  No evidence of disease progression	radiological assessment following the most recent treatment period

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Signed.	Date:	
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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Dabrafenib	
INITIATION – stage III or IV resected melanoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	ı - adjuvant
Prescribed by, or recommended by any NZ Hospital.	relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
O The individual has resected or	stage IIIB, IIIC, IIID or IV melanoma (excluding uveal) (see note a)
and	th dabrafenib is required
and The individual has not received pr and Treatment must be adjuvant to co	ior funded systemic treatment in the adjuvant setting for stage IIIB, IIIC, IIID or IV melanoma mplete surgical resection
and Treatment must be initiated within and The individual has a confirmed BF	13 weeks of surgical resection, unless delay is necessary due to post-surgery recovery (see note b)
and  Dabrafenib must be administered and	
O The individual has ECOG perform	ance score 0-2
Note:  a) Stage IIIB, IIIC, IIID or IV melanoma defined a	s per American Joint Committee on Cancer (AJCC) 8th Edition
	e surgical resection means 13 weeks after resection (primary or lymphadenectomy)

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Oigilica.	 Duic.	

PRE	SCRIE	BER	PATIENT:
Nam	e:		Name:
Ward	d:		NHI:
Dab	rafer	nib - cont	inued
COI Be-	NTINU	ATION – s	stage III or IV resected melanoma - adjuvant uired after 4 months
			poxes where appropriate)
and	1	Prescribed NZ Hospita	by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health al.
		and	No evidence of disease recurrence
		and	Dabrafenib must be administered in combination with trametinib
			Treatment to be discontinued at signs of disease recurrence or at completion of 12 months' total treatment course, including any systemic neoadjuvant treatment
	or		
		and	The individual has received adjuvant treatment with a BRAF/MEK inhibitor
		and	The individual has metastatic or unresectable melanoma (excluding uveal) stage III or IV
			The individual meets initiation criteria for dabrafenib for unresectable or metastatic melanoma
	or		
		and	The individual has received adjuvant treatment with a BRAF/MEK inhibitor
		O	The individual has received a BRAF/MEK inhibitor for unresectable or metastatic melanoma
		and	The individual meets continuation criteria for dabrafenib for unresectable or metastatic melanoma

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.

PRES	CRIB	ER	PATIENT:
Name	:		
Ward:			NHI:
Dabr	afen	ib -	continued
INITI Re-a	ATIOI ssess equis	N - u mentiites (Presculz He	Interesctable or metastatic melanoma It required after 4 months It tok boxes where appropriate)  ribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.  The individual has metastatic or unresectable melanoma (excluding uveal) stage III or IV  Baseline measurement of overall tumour burden is documented clinically and radiologically  The individual has ECOG performance score 0-2  The individual has confirmed BRAF mutation  Dabrafenib must be administered in combination with trametinib  The individual has been diagnosed in the metastatic or unresectable stage III or IV setting  The individual did not receive treatment in the adjuvant setting with a BRAF/MEK inhibitor  The individual did not experience disease recurrence while on treatment with that BRAF/MEK inhibitor  The individual did not experience disease recurrence within six months of completing adjuvant treatment with a BRAF/MEK inhibitor
Re-a Prero	ssess equis	mentites (	N – unresectable or metastatic melanoma trequired after 4 months (tick boxes where appropriate)  ribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.
and	and (	or or	O The individual's disease has had a complete response to treatment O The individual's disease has had a partial response to treatment O The individual has stable disease with treatment  Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent
			treatment period

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Trametinib	
INITIATION – stage III or IV resected melanoma - adjuvant Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
	ccordance with a protocol or guideline that has been endorsed by the Health
O The individual has resected stage IIIB, IIIC, IIID or IV m	elanoma (excluding uveal) (see note a)
The individual has received neoadjuvant treatment and Adjuvant treatment with trametinib is required	nt with a PD-1/PD-L1 inhibitor
and	ent in the adjuvant setting for stage IIIB, IIIC, IIID or IV melanoma
Treatment must be adjuvant to complete surgical resection and Treatment must be initiated within 13 weeks of surgical resect and	tion, unless delay is necessary due to post-surgery recovery (see note b)
The individual has a confirmed BRAF mutation and	
Trametinib must be administered in combination with dabrafer	nib
The individual has ECOG performance score 0-2	
Note:	
a) Stage IIIB, IIIC, IIID or IV melanoma defined as per American Joint Comm	nittee on Cancer (AJCC) 8th Edition
b) Initiating treatment within 13 weeks of complete surgical resection means	13 weeks after resection (primary or lymphadenectomy)

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Signed.	Date:	
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PRES	SCRIB	BER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Tran	netin	i <b>b</b> - conti	nued	
Re-a	assess	ment requ	tage III or IV resected melanoma - adjuvant ired after 4 months	
and	О б	,		cordance with a protocol or guideline that has been endorsed by the Health
		and and	No evidence of disease recurrence  Trametinib must be administered in combination with data  Treatment to be discontinued at signs of disease recurre any systemic neoadjuvant treatment	brafenib ence or at completion of 12 months' total treatment course, including
	or	and and	The individual has received adjuvant treatment with a Br The individual has metastatic or unresectable melanoma The individual meets initiation criteria for trametinib for u	a (excluding uveal) stage III or IV
	or	and and	The individual has received adjuvant treatment with a BF The individual has received a BRAF/MEK inhibitor for ur The individual meets continuation criteria for trametinib f	nresectable or metastatic melanoma

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Signed.	Date:	
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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	PATIENT:
Name:	Name:
Ward:	NHI:
Trametinib - continued	
INITIATION – unresectable or metastatic melanoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by any relevant practitioner, or in a NZ Hospital.  and  The individual has metastatic or unresectable melanoma (excland  Baseline measurement of overall tumour burden is document and  The individual has ECOG performance score 0-2 and  The individual has confirmed BRAF mutation and  Trametinib must be administered in combination with dabrafer and  The individual has been diagnosed in the metastatic or	ed clinically and radiologically
Or The individual did not receive treatment in the adjuvant or  Or The individual received treatment in the adjuvant and Or The individual did not experience disease recurre and	setting with a BRAF/MEK inhibitor
CONTINUATION – unresectable or metastatic melanoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)  Orescribed by, or recommended by any relevant practitioner, or in an NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health
The individual's disease has had a complete response to to The individual has stable disease with treatment	
Response to treatment in target lesions has been determined treatment period	by comparable radiologic assessment following the most recent

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	PAT	TENT:	
Name:	Nar	ne:	
Ward:	NH	:	
Entrectinib			
INITIATION Re-assessment required after Prerequisites (tick boxes whe			
Frerequisites (tick boxes whe	те арргорнате)		
O Individual has	locally advanced or metastatic, unresectable, non-sc	juamous non-small cell lung cancer	
or The indiv	vidual has not received crizotinib		
	ne individual has received an initial Special Authority olerance	approval for crizotinib and has discontinued crizotinib due to	
	ne cancer did not progress while the individual was or	n crizotinib	
and There is docum	mentation confirming that the patient has a ROS1 re-	arrangement using an appropriate ROS1 test	
_	ECOG performance score of 0-3		
O Baseline meas	Baseline measurement of overall tumour burden is documented clinically and radiologicallyy		
CONTINUATION Re-assessment required after Prerequisites (tick boxes whe			
	reatment has been determined by comparable radiol	ogical assessment following the most recent treatment period	
O No evidence of	f disease progression		

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PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Dasatinib			
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Or Prescribed by, or recommended by a haematologist or any relevant with a protocol or guideline that has been endorsed by the Health Name	practitioner on the recommendation of a haematologist, or in accordance Z Hospital.		
or	O The patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis or accelerated phase O The patient has a diagnosis of Philadelphia chromosome-positive acute lymphoid leukaemia (Ph+ ALL)		
The patient has a diagnosis of CML in chronic phase and  Patient has documented treatment failure* with im or Patient has experienced treatment-limiting toxicity or Patient has high-risk chronic-phase CML defined I	with imatinib precluding further treatment with imatinib		
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a haematologist or any relevant with a protocol or guideline that has been endorsed by the Health Name	practitioner on the recommendation of a haematologist , or in accordance Z Hospital.		
Lack of treatment failure while on dasatinib*  O Dasatinib treatment remains appropriate and the patient is ber	nefiting from treatment		
Note: *treatment failure for CML as defined by Leukaemia Net Guidelines.			

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Erlotinib	
INITIATION Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)  Patient has locally advanced or metastatic, unresectable, nonand There is documentation confirming that the disease expresses and  Patient is treatment naive  Or Patient has received prior treatment in the adjuvant setting The patient has discontinued osimertinib or getitin and The cancer did not progress while on osimertinib or	activating mutations of EGFR  Ing and/or while awaiting EGFR results  ib due to intolerance
CONTINUATION Re-assessment required after 6 months Prerequisites (tick box where appropriate)  Radiological assessment (preferably including CT scan) indicates NS	SCLC has not progressed

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I confirm that the above details are correct:

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

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Sunitinib	
INITIATION – RCC Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
The patient has metastatic renal cell carcinoma  The patient has not previously received funded sunitinib	
CONTINUATION – RCC Re-assessment required after 4 months Prerequisites (tick box where appropriate)  O No evidence of disease progression	
INITIATION – GIST Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)	
The patient has unresectable or metastatic malignant gastroin and  The patient's disease has progressed following treatment or On the patient has documented treatment-limiting intolerance.	nt with imatinib
CONTINUATION – GIST Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
The patient has responded to treatment or has stable disease a follows:	s determined by Choi's modified CT response evaluation criteria as
The patient has had a complete response (disappearance)  The patient has had a partial response (a decrease in single (HU) of 15% or more on CT and no new lesions and no	ze of 10% or more or decrease in tumour density in Hounsfield Units obvious progression of non-measurable disease) ne two above) and does not have progressive disease and no
The treatment remains appropriate and the patient is benefiting	g from treatment
CONTINUATION – GIST pandemic circumstances Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
The patient has unresectable or metastatic malignant gastroin and The patient is clinically benefiting from treatment and continue and Sunitinib is to be discontinued at progression and	
The regular renewal requirements cannot be met due to COVI	D-19 constraints on the health sector

Page 304

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	PATIENT:		
Name:	Name:		
Ward:	NHI:		

Sunitinib - continued

Note: GIST - It is recommended that response to treatment be assessed using Choi's modified CT response evaluation criteria (J Clin Oncol, 2007, 25:1753-1759). Progressive disease is defined as either: an increase in tumour size of 10% or more and not meeting criteria of partial response (PR) by tumour density (HU) on CT; or: new lesions, or new intratumoral nodules, or increase in the size of the existing intratumoral nodules.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Lapatinib	
INITIATION Prerequisites (tick box where appropriate)  Or For continuation use only	
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
The patient has metastatic breast cancer expressing HER-2 II  and  The cancer has not progressed at any time point during the prand  Lapatinib not to be given in combination with trastuzumab  and  Lapatinib to be discontinued at disease progression	

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PRESCRIBER	PATIENT:
Name:	
Ward:	NHI:
Pazopanib	
Prerequisites	ont required after 3 months (tick boxes where appropriate)  O The patient has metastatic renal cell carcinoma of predominantly clear cell histology
ai	The patient is treatment naive  Or  The patient has only received prior cytokine treatment
	The patient has an ECOG performance score of 0-2 and The patient has intermediate or poor prognosis defined as:
	Lactate dehydrogenase level > 1.5 times upper limit of normal  Or  Haemoglobin level < lower limit of normal  Or  Corrected serum calcium level > 10 mg/dL (2.5 mmol/L)  Or  Interval of < 1 year from original diagnosis to the start of systemic therapy  Or  Karnofsky performance score of less than or equal to 70  Or  2 or more sites of organ metastasis
	The patient has metastatic renal cell carcinoma  The patient has discontinued sunitinib within 3 months of starting treatment due to intolerance  The cancer did not progress whilst on sunitinib  Pazopanib to be used for a maximum of 3 months
Prerequisites	ON Int required after 3 months Is (tick box where appropriate)  evidence of disease progression

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Gefitinib	
INITIATION Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
O Patient has locally advanced, or metastatic, unresectable, nor and	n-squamous Non Small Cell Lung Cancer (NSCLC)
Patient is treatment naive  Patient has received prior treatment in the adjuvant settion  The patient has discontinued osimertinib or erlotin and  The cancer did not progress whilst on osimertinib	hib due to intolerance
There is documentation confirming that disease expresses ac	tivating mutations of EGFR
CONTINUATION Re-assessment required after 6 months Prerequisites (tick box where appropriate)  O Radiological assessment (preferably including CT scan) indicates N	SCLC has not progressed

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Signed.	Date:	
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PRES	SCRIE	BER			PATIENT:
Name	ə:				Name:
Ward	:				NHI:
Dexi	razo	xan	9		
	O 1	Preso	Patie Base great	or guideline that has been endorsed by the Health NZ Host and is to receive treatment with high dose anthracycline gived on current treatment plan, patient's cumulative lifetime of the azoxane to be administered only whilst on anthracycline to the treatment to be used as a cardioprotectant for a child or	en with curative intent  dose of anthracycline will exceed 250mg/m2 doxorubicin equivalent or  reatment  young adult
			$\bigcirc$	Treatment to be used as a cardioprotectant for secondar	y malignancy

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Abiraterone acetate	
been endorsed by the Health NZ Hospital.	oncologist or urologist, or in accordance with a protocol or guideline that has
Patient has prostate cancer and Patient has metastases and Patient's disease is castration resistant and	
Patient is symptomatic  and Patient has disease progression (rising serum PS and Patient has ECOG performance score of 0-1  and Patient has not had prior treatment with taxane ch  or  Patient's disease has progressed following prior ch and Patient has ECOG performance score of 0-2 and Patient has not had prior treatment with abirateror	hemotherapy containing a taxane
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Or Prescribed by a recommended by a medical encologist radiation of	proclogist or unalogist, or in accordance with a protocol or guideline that has
been endorsed by the Health NZ Hospital.	encologist or urologist, or in accordance with a protocol or guideline that has
Significant decrease in serum PSA from baseline and _	
O No evidence of clinical disease progression and	
O No initiation of taxane chemotherapy with abiraterone and	
The treatment remains appropriate and the patient is benefiting	ng from treatment

I confirm that the above details are correct:

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

PRES	CRIBER	l .	PATIENT:
Name	:		Name:
Ward:			NHI:
Abira	ateron	e acetate - continued	
Re-a	ssessme	ON – pandemic circumstances ent required after 6 months s (tick boxes where appropriate)	
	and	The patient is clinically benefiting from treatment and continue	d treatment remains appropriate
		Abiraterone acetate to be discontinued at progression	
	and	No initiation of taxane chemotherapy with abiraterone	
	and	The regular renewal requirements cannot be met due to COVI	D-19 constraints on the health sector

PRES	SCRIBER	PATIENT:
Name	э:	Name:
Ward	:	NHI:
Fulv	estrant	
Re-a	IATION assessment required after 6 months equisites (tick boxes where appropriate)  Prescribed by, or recommended by a medical oncologist, or in accordance to the properties.	rdance with a protocol or guideline that has been endorsed by the Health NZ
and	O Patient has oestrogen-receptor positive locally advanced or m	an aromatase inhibitor or tamoxifen for their locally advanced or
Re-a	ITINUATION assessment required after 6 months equisites (tick boxes where appropriate)  Prescribed by, or recommended by a medical oncologist, or in according to the properties of the properti	rdance with a protocol or guideline that has been endorsed by the Health NZ
	Treatment remains appropriate and patient is benefitting from and Treatment to be given at a dose of 500 mg monthly and No evidence of disease progression	treatment

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I confirm that the above details are correct:

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

Schedule. For community funding, see the Special Authority Criteria	
PRESCRIBER	PATIENT:
Name:	
Ward:	NHI:
Long-acting Somatostatin Analogues	
INITIATION – Malignant bowel obstruction Prerequisites (tick boxes where appropriate)	
The patient has nausea* and vomiting* due to maliq	gnant bowel obstruction*
	arinic agents, corticosteroids and analgesics for at least 48 hours has not been
O Treatment to be given for up to 4 weeks	
Note: Indications marked with * are unapproved indications	
INITIATION – acromegaly Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)	
The patient has acromegaly	
O Treatment with surgery and radiotherapy is no	ot suitable or was unsuccessful
O Treatment is for an interim period while await	ing the beneficial effects of radiotherapy
Treatment with a dopamine agonist has been unsuc	ccessful
CONTINUATION – acromegaly Prerequisites (tick box where appropriate)	
	ed if IGF1 levels have no decreased 3 months after treatment. In patients treated r 1 month, for assessment of remission. Treatment should be stopped where there is

ESCRIBER	PATIENT:
ne:	Name:
d:	NHI:
ng-acting Somatostatin Analogues - conti	nued
TIATION – Other indications erequisites (tick boxes where appropriate)	
	ts who are seriously ill in order to improve their clinical state prior to definitive surgery
Gastrinoma	
O Surgery has been unsuccess	sful
O Patient has metastatic diseas	se after treatment with H2 antagonist or proton pump inhibitors has been unsuccessful
or Insulinomas	
and O Surgery is contraindicated or has n	not been successful
or O For pre-operative control of hypoglycaem	nia and for maintenance therapy
	tissue pathology and/or urinary 5HIAA analysis)
O Disabling symptoms not controlled	by maximal medical therapy
TIATION – pre-operative acromegaly	
-assessment required after 12 months -requisites (tick boxes where appropriate)	
Patient has acromegaly	
O Patient has a large pituitary tumour, grea	ter than 10 mm at its widest
O Patient is scheduled to undergo pituitary	surgery in the next six months
te: Indications marked with * are unapproved indication te: The use of a long-acting somatostatin analogue in ded under Special Authority	ons patients with fistulae, oesophageal varices, miscellaneous diarrhoea and hypotension will not be
	<u> </u>

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PRES	CRIBER		PATIENT:
Name	e:		Name:
Ward	:		NHI:
Amiı	nolevuli	nic acid hydrochloride	
		high grade malignant glioma (tick boxes where appropriate)	
	O	Patient has newly diagnosed, untreated, glioblastoma multiform	me
	and	Treatment to be used as adjuvant to fluorescence-guided rese	ection
	and	Patient's tumour is amenable to complete resection	

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Signed.	Date:	
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Page 315

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	PATIENT:
Name:	Name:
Ward:	NHI:
Tacrolimus	
INITIATION – organ transplant recipients Prerequisites (tick boxes where appropriate)  Or For use in organ transplant recipients or Or The individual is receiving induction therapy for an organ transplant recipients	plant
INITIATION – non-transplant indications* Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by any specialist, or in accordance Hospital.	with a protocol or guideline that has been endorsed by the Health NZ
Patient requires long-term systemic immunosuppression and	t because of unacceptable side effects or inadequate clinical response
Note: Indications marked with * are unapproved indications	

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### RS2062 - Etanercept

Arthritis - rheumatoid - INITIATION	319
Arthritis - rheumatoid - CONTINUATION	319
Adult-onset Still's disease - INITIATION	325
Adult-onset Still's disease - CONTINUATION	325
Ankylosing spondylitis - INITIATION	320
Ankylosing spondylitis - CONTINUATION	321
Oligoarticular course juvenile idiopathic arthritis - INITIATION	
Oligoarticular course juvenile idiopathic arthritis - CONTINUATION	318
Polyarticular course juvenile idiopathic arthritis - INITIATION	317
Polyarticular course juvenile idiopathic arthritis - CONTINUATION	317
Psoriatic arthritis - INITIATION	321
Psoriatic arthritis - CONTINUATION	322
Pyoderma gangrenosum - INITIATION	324
Pyoderma gangrenosum - CONTINUATION	325
Severe chronic plaque psoriasis - CONTINUATION	324
Severe chronic plaque psoriasis, prior TNF use - INITIATION	322
Severe chronic plaque psoriasis, treatment-naive - INITIATION	323
Undifferentiated spondyloarthritis - INITIATION	326
Undifferentiated spondyloarthritis - CONTINUATION	326

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.

PRES	SCRIB	BER PATIENT:		
Name	e:			
Ward	:			NHI:
Etan	erce	pt		
Re-a	ssess <b>equis</b>	ment ites ( Presc	requ tick b	ticular course juvenile idiopathic arthritis ired after 6 months oxes where appropriate)  by, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been endorsed th NZ Hospital.
		and	O I	The patient has had an initial Special Authority approval for adalimumab for polyarticular course juvenile idiopathic arthritis (JIA)
			or	O The patient has experienced intolerable side effects from adalimumab  The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for polyarticular course JIA
	or	and	0	To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Patient has had polyarticular course JIA for 6 months duration or longer  At least 5 active joints and at least 3 joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose)  Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the maximum tolerated dose)  Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate
Re-a	ssess	ment	requ	olyarticular course juvenile idiopathic arthritis ired after 6 months oxes where appropriate)
and				by, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been endorsed th NZ Hospital.
	Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity intolerance			
physician's global assessment from baseline  or			On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and	

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PRES	CRIB	RIBER PATIENT:				
Name	e:					
Ward	:			NHI:		
Etan	erce	pt -	conti	nued		
Re-a	ssess <b>equis</b>	ment ites ( Presci	requitick b	rticular course juvenile idiopathic arthritis ired after 6 months oxes where appropriate)  by, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been endorsed th NZ Hospital.		
		and		The patient has had an initial Special Authority approval for adalimumab for oligoarticular course juvenile idiopathic arthritis (JIA)		
			or	The patient has experienced intolerable side effects from adalimumab  The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for oligoarticular course JIA		
	or	and	$\circ$	To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Patient has had oligoarticular course JIA for 6 months duration or longer  O At least 2 active joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose)  O Moderate or high disease activity (cJADAS10 score greater than 1.5) with poor prognostic features after a 3-month trial of methotrexate (at the maximum tolerated dose)  O High disease activity (cJADAS10 score greater than 4) after a 6-month trial of methotrexate		
Re-a	ssess <b>equis</b>	ment i <b>tes</b> ( Presci	requitick b	ligoarticular course juvenile idiopathic arthritis ired after 6 months oxes where appropriate) by, or recommended by a rheumatologist or named specialist, or in accordance with a protocol or guideline that has been endorsed th NZ Hospital.		
	and	0	Subs	idised as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance		
		or	0	Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baselinee  On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline		

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I confirm that the above details are correct:

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PRESCRIBER				PATIENT:
Name: .				
Ward:				NHI:
Etaner	сер	<b>t</b> - cor	ntinuec	1
INITIAT	ION	– Arth	ritis -	rheumatoid after 6 months
Prerequ	uisite	es (tick	boxes	where appropriate)
and		escribe spital.	d by, c	or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		and	The	patient has had an initial Special Authority approval for adalimumab for rheumatoid arthritis
		C	or O	The patient has experienced intolerable side effects
			0	The patient has received insufficient benefit to meet the renewal criteria for rheumatoid arthritis
OI	r			
		and		ent has had rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic citrullinated peptide (CCP) body positive) for six months duration or longer
		and		atment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity intolerance
		and _	Pati	ent has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated)
		C		ent has tried and not responded to at least three months of methotrexate in combination with sulfasalazine and hydroxychloroquin shate at maximum tolerated doses (unless contraindicated)
	ľ	and	0	Patient has tried and not responded to at least three months of methotrexate in combination with the maximum tolerated dose of ciclosporin
		C	or O	Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide alone or in combination with methotrexate
	1	and _		
			0	Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen joints
		C		Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip
Re-asse	essm	ent rec	uired	itis - rheumatoid after 2 years where appropriate)
		escribe Hospi		or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
and	nd		atmen leranc	t is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or e
		Or O		owing initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant conse to treatment in the opinion of the physician
		. C		subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count from eline and a clinically significant response to treatment in the opinion of the physician
aı	and  Etanercept to be administered at doses no greater than 50 mg every 7 days			

RESCRII	BER		PATIENT:
ame:			Name:
ard:			NHI:
anerce	<b>ept</b> - conti	inued	
e-asses rerequis	sment requ	osing spondylitis nired after 6 months ooxes where appropri by, or recommended	iate) d by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
	and	The patient has had	d an initial Special Authority approval for adalimumab for ankylosing spondylitis
	or	·	as experienced intolerable side effects from adalimumab
			as received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for condylitis
or			
	and or and	Patient has low bace Patient has bilateral Patient's ankylosing drugs (NSAIDs), in exercise regimen for  Patient has lir Bath Ankylosi 4 cm and lum  Patient has lir gender (see N	Is pain and stiffness that is relieved by exercise but not by rest Is sacroillitis demonstrated by plain radiographs, CT or MRI scan Is spondylitis has not responded adequately to treatment with two or more non-steroidal anti-inflammatory combination with anti-ulcer therapy if indicated, while patient was undergoing at least 3 months of a regular or ankylosing spondylitis  mitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by the following ing Spondylitis Metrology Index (BASMI) measures: a modified Schober's test of less than or equal to abar side flexion measurement of less than or equal to 10 cm (mean of left and right)  mitation of chest expansion by at least 2.5 cm below the average normal values corrected for age and Notes)  condylitis Disease Activity Index (BASDAI) of at least 6 on a 0-10 scale
easure	must be no	more than 1 month	rmined at the completion of the 3 month exercise trial, but prior to ceasing NSAID treatment. The BASDAI old at the time of starting treatment.
erage r	normal ches <b>Age</b>	· ·	ed for age and gender: Female
	18-2		5.5 cm
	25-3		5.5 cm
	35-4		4.5 cm
	45-5		5.0 cm
	55-6		4.0 cm
	65-7		4.0 cm
			*** ****

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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.

PRESCF	RIBER	PATIENT:		
Name: .		Name:		
Ward: NHI:				
Etaner	cept -	continued		
Re-asse	essment uisites (	I – ankylosing spondylitis required after 6 months ck boxes where appropriate) bed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ al.		
ar		following 12 weeks' initial treatment and for subsequent renewals, treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point scale, or an improvement in BASDAI of 50%, whichever is less on the patient has benefited from treatment and that continued treatment is appropriate transcept to be administered at doses no greater than 50 mg every 7 days		
Re-asse	essment uisites (	coriatic arthritis required after 6 months ck boxes where appropriate) bed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ al.		
	and	The patient has had an initial Special Authority approval for adalimumab or secukinumab for psoriatic arthritis  The patient has experienced intolerable side effects from adalimumab or secukinumab  The patient has received insufficient benefit from adalimumab or secukinumab to meet the renewal criteria for adalimumab or secukinumab for psoriatic arthritis		
or	and and and	Patient has had severe active psoriatic arthritis for six months duration or longer  Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose  Patient has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day or leflunomide at a dose of up to 20 mg daily (or maximum tolerated doses)  Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen, tender joints  Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip  Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application  Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour  ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months		

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.

PRES	CRIBE	?		PATIENT:
Name	e:			Name:
Ward:	:			NHI:
Etan	ercep	- con	tinued	
Re-a	ssessm	ent requ	osoriatic arthritis uired after 6 months boxes where appropriate)	
and		scribec pital.	by, or recommended by a rheumatologist, or in accordan	ce with a protocol or guideline that has been endorsed by the Health NZ
		° 0	clinically significant response to treatment in the opinion	rovement in active joint count from baseline and a clinically significant
	and	Etan	ercept to be administered at doses no greater than 50 mg	every 7 days
Re-a	ssessm	ent requ	e chronic plaque psoriasis, prior TNF use uired after 4 months boxes where appropriate)	
( and		scribed spital.	by, or recommended by a dermatologist, or in accordance	e with a protocol or guideline that has been endorsed by the Health NZ
	and	The	patient has had an initial Special Authority approval for ad	alimumab for severe chronic plaque psoriasis
		0	The patient has experienced intolerable side effects from	n adalimumab
		' O	The patient has received insufficient benefit from adalim plaque psoriasis	umab to meet the renewal criteria for adalimumab for severe chronic
	and	Patie	ent must be reassessed for continuation after 3 doses	

C:	D-1	
Signed.	Date:	
Oigilica.	 Daic.	

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.

RESCRIBER		PATIENT:
ıme:		Name:
ard:		NHI:
anercept	- continued	
	severe chronic plaque psoriasis, treatment-naive	
	nt required after 4 months (tick boxes where appropriate)	
O Pres Hosp		cordance with a protocol or guideline that has been endorsed by the Health NZ
Ot	10, where lesions have been present for at least	psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 6 months from the time of initial diagnosis
Or	been present for at least 6 months from the time	ne face, or palm of a hand or sole of a foot, where the plaque or plaques have of initial diagnosis
	O Patient has severe chronic localised genital or fle	exural plaque psoriasis where the plaques or lesions have been present for at and with a Dermatology Life Quality Index (DLQI) score greater than 10
and		e Note) to, or has experienced intolerable side effects from, at least three of the dicated): phototherapy, methotrexate, ciclosporin, or acitretin
0		ex (DLQI) assessment has been completed for at least the most recent prior urses), preferably while still on treatment but no longer than 1 month following
and	The most recent PASI or DLQI assessment is no more	than 1 month old at the time of initiation
hile still on tr ce, hand, for evere, and fo	eatment but no longer than 1 month following cessation ot, genital or flexural areas at least 2 of the 3 PASI symp	ronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably of the most recent prior treatment; for severe chronic plaque psoriasis of the otom subscores for erythema, thickness and scaling are rated as severe or very affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed cessation of the most recent prior treatment.

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	?	PATIENT:		
Name:				
Ward:		NHI:		
Etanercept	- continu	ued		
		vere chronic plaque psoriasis ed after 6 months		
Prerequisites	s (tick bo	xes where appropriate)		
	and	O Patient had "whole body" severe chronic plaque psoriasis at the start of treatment		
	and	Following each prior etanercept treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-etanercept treatment baseline value		
		Following each prior etanercept treatment course the patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, when compared with the pre-treatment baseline value		
0	r and	O Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment		
		Following each prior etanercept treatment course the patient has a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values		
		Following each prior etanercept treatment course the patient has a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-etanercept treatment baseline value		
О	r			
	and	O Patient had severe chronic localised genital or flexural plaque psoriasis at the start of treatment		
		The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value		
		O Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing etanercept		
and	Etaner	cept to be administered at doses no greater than 50 mg every 7 days		
		ma gangrenosum xes where appropriate)		
	O Prescribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
and	Patient	t has pyoderma gangrenosum*		
and		t has received three months of conventional therapy including a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin, oprine, or methotrexate) and not received an adequate response		
and	A maxi	imum of 8 doses		
Note: Indicati	ions mark	ked with * are unapproved indications.		

I confirm that the above details are correct:

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

PRES	CRIB	ER		PATIENT:	
Name	):			Name:	
Ward: NHI:					
Etan	erce	pt -	conti	inued	
	e <b>quis</b> i	rescr lospit	ick bibed al. Patie	byoderma gangrenosum boxes where appropriate) by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ent has shown clinical improvement ent continues to require treatment eximum of 8 doses	
Re-a	ssess <b>equis</b> i	ment i <b>tes</b> (t	requ ick b ibed	onset Still's disease irred after 6 months oxes where appropriate) by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
	or	and	or	O The patient has had an initial Special Authority approval for etanercept for adult-onset Still's disease (AOSD) O The patient has been started on tocilizumab for AOSD in a Health NZ Hospital O The patient has experienced intolerable side effects from etanercept and/or tocilizumab O The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or tocilizumab such that they do not meet the renewal criteria for AOSD	
	or	and	0	Patient diagnosed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430)  Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-steroidal antiinflammatory drugs (NSAIDs) and methotrexate  Patient has persistent symptoms of disabling poorly controlled and active disease	
CONTINUATION – adult-onset Still's disease Re-assessment required after 6 months Prerequisites (tick box where appropriate)				ired after 6 months	
and (	<b>⊢</b>	lospit	al.	by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ thas a sustained improvement in inflammatory markers and functional status	

I confirm that the above details are correct:

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

SCRIB	BER		PATIENT:
ie:			
d:			NHI:
nerce	pt -	conti	inued
TIATIOI assess requis	N - usmentiites	ribed ital.  Patie wrist,  Patie maxii	erentiated spondyloarthritis irred after 6 months oxes where appropriate)  by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ  ent has undifferentiated peripheral spondyloarthritis* with active peripheral joint arthritis in at least four joints from the following: a elbow, knee, ankle, and either shoulder or hip  ent has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a mum tolerated dose  ent has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day (or maximum tolerated
and (and	O or		Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application  Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour measured no more than one month prior to the date of this application  ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months
e: Indi	catio	ns ma	arked with * are unapproved indications.
assess	men	t requ	Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with etanercept treatment
and	or	О О	Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician  The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior etanercept treatment in the opinion of the treating physician
	and  Etanercept to be administered at doses no greater than 50 mg dose every 7 days		

I confirm that the above details are correct:

Signed: Date:

PRES	CRIBE	ER .	PATIENT:		
Name	e:		Name:		
Ward	:		NHI:		
Beva	acizur	mab			
		- ocular conditions tes (tick boxes where appropriate)			
		Ocular neovascularisation			
	or	O Exudative ocular angiopathy			

Name:
NHI:
er than wet AMD  or severe posterior uveitis following treatment with bevacizumab  ry despite three intraocular injections of bevacizumab four weeks  treated eye
treatment of wAMD and was found to be intolerant within 3 months
ore d eye

I confirm that the above details are correct:

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

#### RS2124 - Infliximab

Crohn's disease (adults) - INITIATION	
Crohn's disease (adults) - CONTINUATION	334
Crohn's disease (children) - INITIATION	
Crohn's disease (children) - CONTINUATION	
Graft vs host disease - INITIATION	
Inflammatory bowel arthritis (axial) - INITIATION	340
Inflammatory bowel arthritis (axial) - CONTINUATION	340
Inflammatory bowel arthritis (peripheral) - INITIATION	341
Inflammatory bowel arthritis (peripheral) - CONTINUATION	341
Pulmonary sarcoidosis - INITIATION	333
Acute fulminant ulcerative colitis - INITIATION	336
Ankylosing spondylitis - INITIATION	330
Ankylosing spondylitis - CONTINUATION	331
Chronic ocular inflammation - INITIATION	
Chronic ocular inflammation - CONTINUATION	
Fistulising Crohn's disease - INITIATION	335
Fistulising Crohn's disease - CONTINUATION	335
Fulminant ulcerative colitis - CONTINUATION	
Immune checkpoint inhibitor toxicity in malignancy* - INITIATION	341
Immune checkpoint inhibitor toxicity in malignancy* - CONTINUATION	
Neurosarcoidosis - INITIATION	338
Neurosarcoidosis - CONTINUATION	
Plaque psoriasis - INITIATION	
Plague psoriasis - CONTINUATION	338
Psoriatic arthritis - INITIATION	331
Psoriatic arthritis - CONTINUATION	
Pyoderma gangrenosum - INITIATION	
Pyoderma gangrenosum - CONTINUATION	340
Pyoderma gangrenosum - CONTINUATION	330
Rheumatoid arthritis - CONTINUATION	
Severe Behcet's disease - INITIATION	
Severe Behcet's disease - CONTINUATION	
Severe ocular inflammation - INITIATION	332
Severe ocular inflammation - CONTINUATION	
Ulcerative colitis - INITIATION	
Ulcerative colitis - CONTINUATION	
Olderative collis - OOM HOMHON	337

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.

PRES	CRI	BER			PATIENT:				
Name	:				Name:				
Ward:					NHI:				
Inflix	nfliximab								
				vs host disease					
Prer	`			box where appropriate)					
	<i></i>	Patie	nt has	s steroid-refractory acute graft vs. host disease of the gut					
				natoid arthritis uired after 4 months					
Prer	qui	sites	(tick b	boxes where appropriate)					
and		Preso Hosp		d by, or recommended by a rheumatologist, or in accordar	nce with a protocol or guideline that has been endorsed by the Health NZ				
	and	$C_{k}$	The	patient has had an initial Special Authority approval for ac	dalimumab and/or etanercept for rheumatoid arthritis				
		or	0	The patient has experienced intolerable side effects from	m a reasonable trial of adalimumab and/or etanercept				
			0	Following at least a four month trial of adalimumab and/adalimumab and/or etanercept	or etanercept, the patient did not meet the renewal criteria for				
	and	O		atment is to be used as an adjunct to methotrexate therapy erance	or monotherapy where use of methotrexate is limited by toxicity or				
Prer		sites	tick b	uired after 6 months boxes where appropriate) d by, or recommended by a rheumatologist, or in accordar	nce with a protocol or guideline that has been endorsed by the Health NZ				
and	and			atment is to be used as an adjunct to methotrexate therapy erance	or monotherapy where use of methotrexate is limited by toxicity or				
		or	0	Following 3 to 4 months' initial treatment, the patient had clinically significant response to treatment in the opinion	as at least a 50% decrease in active joint count from baseline and a of the physician				
			0	The patient demonstrates at least a continuing 30% impresponse to treatment in the opinion of the physician	provement in active joint count from baseline and a clinically significant				
	and	O	Inflix	kimab to be administered at doses no greater than 3 mg/k	g every 8 weeks				
INITIATION – ankylosing spondylitis Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)  Or Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.									
and	and	O	The	patient has had an initial Special Authority approval for ac	dalimumab and/or etanercept for ankylosing spondylitis				
			0	The patient has experienced intolerable side effects from	m a reasonable trial of adalimumab and/or etanercept				
		or	0	Following 12 weeks of adalimumab and/or etanercept transformed and/or etanercept for ankylosing spondylitis	reatment, the patient did not meet the renewal criteria for adalimumab				

I confirm that the above details are correct:

Cianad.	Data.	
Signeg	 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.

PRESC	RIBER	PATIENT:		
Name:		Name:		
Ward:		NHI:		
Inflixi	mab - continued			
Re-ass	NUATION – ankylosing spondylitis sessment required after 6 months juisites (tick boxes where appropriate)			
and	Prescribed by, or recommended by a rheumatologist, or in accordar Hospital.	nce with a protocol or guideline that has been endorsed by the Health NZ		
•	Following 12 weeks of infliximab treatment, BASDAI has impror by 50%, whichever is less  Physician considers that the patient has benefited from treatment  Infliximab to be administered at doses no greater than 5 mg/k			
Re-ass	TION – psoriatic arthritis dessment required after 4 months quisites (tick boxes where appropriate)  Prescribed by, or recommended by a rheumatologist, or in accordant Hospital.	nce with a protocol or guideline that has been endorsed by the Health NZ		
and	The patient has experienced intolerable side effects from	dalimumab and/or etanercept and/or secukinumab for psoriatic arthritis  m a reasonable trial of adalimumab and/or etanercept and/or secukinumab o and/or etanercept and/or secukinumab, the patient did not meet the or secukinumab for psoriatic arthritis.		
CONTINUATION – psoriatic arthritis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
	or clinically significant response to treatment in the opinion	provement in active joint count from baseline and a clinically significant		
	O Infliximab to be administered at doses no greater than 5 mg/k	g every 8 weeks		

PRESCR	IBER			PATIENT:	
Name:				Name:	
Ward:				NHI:	
nflixim	ab -	continued	d		
Re-asse	ssmen	t required (tick boxe	cular inflammation d after 4 months es where appropriate) ne patient has had an initial Special Author	rity approval for adalimumab for severe ocular inflammation	
	an	or	The patient has experienced intolerab  The patient has received insufficient b ocular inflammation	ple side effects from adalimumab benefit from adalimumab to meet the renewal criteria for adalimumab for severe	
or	and		ineffective at controlling symptoms  Patient developed new inflammatory s	r inflammation requiring rapid control ravenous methylprednisolone) followed by high dose oral steroids has proven symptoms while receiving high dose steroids atment with high dose oral steroids and other immunosuppressants has proven	
Re-asse	CONTINUATION – severe ocular inflammation Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)				
or	0	Following Nomeno uveitic co	elature (SUN) criteria < ½+ anterior chamb ystoid macular oedema)	tient has had a sustained reduction in inflammation (Standardisation of Uveitis ter or vitreous cells, absence of active vitreous or retinal lesions, or resolution of tient has a sustained steroid sparing effect, allowing reduction in prednisone to	
		thdrawal		ths of stability, unless the patient is deemed to have extremely high risk of irreversible	

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.

PRESCRIB	BER	PATIENT:
Name:		
Ward:		NHI:
nfliximal	<b>b</b> - cor	tinued
Re-assess	ment re	onic ocular inflammation equired after 4 months k boxes where appropriate)
	and	The patient has had an initial Special Authority approval for adalimumab for chronic ocular inflammation
		O The patient has experienced intolerable side effects from adalimumab or
		O The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for chronic ocular inflammation
or		
	and	Patient has severe uveitis uncontrolled with treatment of steroids and other immunosuppressants with a severe risk of vision loss
		O Patient is 18 years or older and treatment with at least two other immunomodulatory agents has proven ineffective or
		O Patient is under 18 years and treatment with methotrexate has proven ineffective or is not tolerated at therapeutic dose or
		Patient is under 8 years and treatment with steroids or methotrexate has proven ineffective or is not tolerated at a therapeutic dose; or disease requires control to prevent irreversible vision loss prior to achieving a therapeutic dose of methotrexate
Re-assess	ment re	- chronic ocular inflammation quired after 12 months k boxes where appropriate)
or (	От	e patient has had a good clinical response following 3 initial doses
(	No	llowing each 12-month treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis menclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of eitic cystoid macular oedema)
or (	O Fo	llowing each 12-month treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to 10mg daily, or steroid drops less than twice daily if under 18 years old
		rawal should be considered after every 24 months of stability, unless the patient is deemed to have extremely high risk of irreversible mab is withdrawn.
		monary sarcoidosis k boxes where appropriate)
and	ОРа	tient has life-threatening pulmonary sarcoidosis that is refractory to other treatments
and (	O Tr	eatment is to be prescribed by, or has been recommended by, a physician with expertise in the treatment of pulmonary sarcoidosis

I confirm that the above details are correct:

Signed: Date:

I confirm that the above details are correct:

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER PATIENT:					
Name					
Ward: NHI:					
Inflix	kima	ıb -	contin	ued	
Re-a	sses equi:	smen sites	t requ (tick b	's disease (adults) ired after 6 months ioxes where appropriate)	
and			ospita	by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health I.	
	and	0	Patie	nt has active Crohn's disease	
		or	0	Patient has a CDAI score of greater than or equal to 300, or HBI score of greater than or equal to 10	
		or	0	Patient has extensive small intestine disease affecting more than 50 cm of the small intestine	
		or	0	Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection	
			$\cup$	Patient has an ileostomy or colostomy, and has intestinal inflammation	
	and	0		nt has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators corticosteroids	
	equis	Preso NZ H or or	(tick beribed ospital)  O  Inflixition to the content of the conte	by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health II.  CDAI score has reduced by 100 points from the CDAI score, or HBI score has reduced by 3 points, from when the patient was initiated on infliximab  CDAI score is 150 or less, or HBI is 4 or less  The patient has demonstrated an adequate response to treatment but CDAI score and/or HBI score cannot be assessed  mab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen s after completing the last re-induction cycle	
Re-a	sses	smen	t requ	's disease (children) ired after 6 months oxes where appropriate)	
and			cribed ospita	by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health II.	
	and	O	Paed	iatric patient has active Crohn's disease	
		or	O O	Patient has a PCDAI score of greater than or equal to 30  Patient has extensive small intestine disease	
	and	0		nt has tried but experienced an inadequate response to, or intolerable side effects from, prior therapy with immunomodulators corticosteroids	

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.

PRES	CRII	BER		PATIENT:		
Name	:			Name:		
Ward:						
Inflix	ima	ıb -	contin	ued		
Re-a	sses equi:	smen sites Preso	t requ (tick b	crohn's disease (children) ired after 2 years oxes where appropriate) by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health I.  PCDAI score has reduced by 10 points from the PCDAI score when the patient was initiated on infliximab  PCDAI score is 15 or less		
	and	0	up to	The patient has demonstrated an adequate response to treatment but PCDAI score cannot be assessed  mab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen s after completing the last re-induction cycle		
INITIATION – fistulising Crohn's disease Re-assessment required after 6 months  Prerequisites (tick boxes where appropriate)  Or Prescribed by, or recommended by a gastroenterologist, or in accordance with a protocol or guideline that has been endors Hospital.  and  Or Patient has confirmed Crohn's disease  and  Or Patient has one or more complex externally draining enterocutaneous fistula(e)			ired after 6 months oxes where appropriate)  by, or recommended by a gastroenterologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ  int has confirmed Crohn's disease			
		or	0	Patient has one or more rectovaginal fistula(e)  Patient has complete peri-anal fistula		
CONTINUATION – fistulising Crohn's disease Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the NZ Hospital.						
and	and	or I	up to	The number of open draining fistulae have decreased from baseline by at least 50%  There has been a marked reduction in drainage of all fistula(e) from baseline (in the case of adult patients, as demonstrated by a reduction in the Fistula Assessment score), together with less induration and patient reported pain  mab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen s after completing the last re-induction cycle		

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Infliximab - continued	
INITIATION – acute fulminant ulcerative colitis Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a gastroenterologist, or in according Hospital.	dance with a protocol or guideline that has been endorsed by the Health NZ
Patient has acute, fulminant ulcerative colitis  and  Treatment with intravenous or high dose oral corticosteroids has	as not been successful
CONTINUATION – fulminant ulcerative colitis Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	cordance with a protocol or guideline that has been endorsed by the Health
Where maintenance treatment is considered appropriate, inflix reassessed every 6 months  and  Infliximab to be administered at doses up to 5 mg/kg every 8 v	weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for ment for re-induction. Another re-induction may be considered sixteen
INITIATION – ulcerative colitis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	cordance with a protocol or guideline that has been endorsed by the Health
Patient has active ulcerative colitis  O Patients SCCAI is greater than or equal to 4  Or Patients PUCAI score is greater than or equal to 20  and O Patient has experienced an inadequate response to, or intoleral systemic corticosteroids	able side effects from, prior therapy with immunomodulators and

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.

PRES	SCRII	BER		PATIENT:
Name	e:			
Ward	:			NHI:
Inflix	kima	<b>ab</b> - c	ontini	ued
Re-a	equis	sment sites (	requi tick b	Icerative colitis ired after 2 years oxes where appropriate)
and		NZ Ho		by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health I.
		or	0	The SCCAI score has reduced by 2 points or more from the SCCAI score when the patient was initiated on infliximab
			$\bigcup$	The PUCAI score has reduced by 30 points or more from the PUCAI score when the patient was initiated on infliximab
	and	0	up to	mab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen s after completing the last re-induction cycle
Re-a	issesi equis	sment sites (	requitick b	e psoriasis irred after 3 doses oxes where appropriate) by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		and	O	Patient has had an initial Special Authority approval for adalimumab, etanercept or secukinumab for severe chronic plaque psoriasis  O Patient has experienced intolerable side effects from adalimumab, etanercept or secukinumab  Patient has received insufficient benefit from adalimumab, etanercept or secukinumab to meet the renewal criteria for adalimumab, etanercept or secukinumab for severe chronic plaque psoriasis
	or			
		and	or or	Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis  Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis  Patient has severe chronic localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and with a Dermatology Life Quality Index (DLQI) score greater than 10  Patient has tried, but had an inadequate response (see Note) to, or has experienced intolerable side effects from, at least three of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, cyclosporin, or actiretin
		and	0	A PASI assessment has been completed for at least the most recent prior treatment course (but preferably all prior treatment courses), preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course  The most recent PASI assessment is no more than 1 month old at the time of initiation
while face, seve	e still , hand re, ar	on tread, foot not for t	atmer geni the fa	sponse" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably it but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the tall or flexural areas at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very ce, palm of a hand or sole of a foot the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed on treatment but no longer than 1 month following cessation of the most recent prior treatment.

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.

PRESCRIBE	ER	PATIENT:
Name:		
Ward:		NHI:
Infliximab	- con	tinued
Re-assessn	nent re	- plaque psoriasis quired after 3 doses k boxes where appropriate)
	or	Patient had "whole body" severe chronic plaque psoriasis at the start of treatment  Following each prior infliximab treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-infliximab treatment baseline value  Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment  Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment  Following each prior infliximab treatment course the patient has a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values  Following each prior infliximab treatment course the patient has a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-infliximab treatment baseline value  Patient had severe chronic localised genital or flexural plaque psoriasis at the start of treatment  Or The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value  Or Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing infliximab
and	) Inf	liximab to be administered at doses no greater than 5 mg/kg every 8 weeks
Re-assessn Prerequisit	nent re t <b>es</b> (tic	rosarcoidosis equired after 18 months k boxes where appropriate)  ed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and and and	) Pa	opsy consistent with diagnosis of neurosarcoidosis  Itient has CNS involvement  Itient has steroid-refractory disease  IV cyclophosphamide has been tried  Treatment with IV cyclophosphamide is clinically inappropriate

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Infliximab - continued	
CONTINUATION – neurosarcoidosis Re-assessment required after 18 months Prerequisites (tick boxes where appropriate)	t be clinically appropriate
INITIATION – severe Behcet's disease Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
or  The patient has severe gastrointestinal, rheumatologic two or more treatment appropriate for the particular symptom(s)	culitic symptoms and has not responded adequately to one or more (see Notes) and/or mucocutaneous symptoms and has not responded adequately to
The patient is experiencing significant loss of quality of life	
Note:	
<ul> <li>a) Behcet's disease diagnosed according to the International Study Group for measured using an appropriate quality of life scale such as that published</li> </ul>	
<ul> <li>Treatments appropriate for the particular symptoms are those that are con- intravenous/oral steroids and other immunosuppressants for ocular symp- mucocutaneous symptoms; and colchicine, steroids and methotrexate for</li> </ul>	toms; azathioprine, steroids, thalidomide, interferon alpha and ciclosporin for
CONTINUATION – severe Behcet's disease Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O Patient has had a good clinical response to initial treatment v	vith measurably improved quality of life
O Infliximab to be administered at doses no greater than 5 mg/l	kg every 8 weeks

I confirm that the above details are correct:

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Infliximab - continued	
INITIATION – pyoderma gangrenosum Prerequisites (tick boxes where appropriate)	
	te with a protocol or guideline that has been endorsed by the Health NZ
	luding a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin,
azathioprine, or methotrexate) and not received an adequate and  A maximum of 8 doses	response
Note: Indications marked with * are unapproved indications.	
CONTINUATION – pyoderma gangrenosum  Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a dermatologist, or in accordance Hospital.	ee with a protocol or guideline that has been endorsed by the Health NZ
Patient has shown clinical improvement and Patient continues to require treatment and A maximum of 8 doses	
INITIATION – Inflammatory bowel arthritis (axial) Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
O Patient has a diagnosis of active ulcerative colitis or active Cro	phn's disease
Patient has had axial inflammatory pain for six months or more and	е
O Patient is unable to take NSAIDs	
Patient has unequivocal sacroiliitis demonstrated by radiologic	
by a physiotherapist  and	eatment consisting of at least 3 months of an exercise regime supervised
O Patient has a BASDAI of at least 6 on a 0-10 scale completed pharmacological treatment	d after the 3 month exercise trial, but prior to ceasing any previous
CONTINUATION – Inflammatory bowel arthritis (axial) Re-assessment required after 2 years Prerequisites (tick box where appropriate)	
O Where treatment has resulted in an improvement in BASDAI of 4 or improvement in BASDAI of 50%, whichever is less	more points from pre-treatment baseline on a 10-point scale, or an

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PRES	ESCRIBER PATIENT:			
Name	ıme: Name:			
Ward:	ard:NHI:			
Inflix	imab	- continued		
Re-a	ssessm	Inflammatory bowel arthritis (peripheral) ent required after 6 months s (tick boxes where appropriate)		
	Patient has a diagnosis of active ulcerative colitis or active Crohn's disease  Patient has active arthritis in at least four joints from the following: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, sternoclavicular  Patient has tried and not experienced a response to at least three months of methotrexate or azathioprine at a maximum tolerated dose (unless contraindicated)  Patient has tried and not experienced a response to at least three months of sulfasalazine at a maximum tolerated dose (unless contraindicated)  Patient has a CRP level greater than 15 mg/L measured no more than one month prior to the date of this application  Or Patient has an ESR greater than 25 mm per hour measured no more than one month prior to the date of this application  ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months			
Re-a	ssessm	ION – Inflammatory bowel arthritis (peripheral) ent required after 2 years s (tick boxes where appropriate)		
	or C	significant response to treatment in the opinion of the physician	10% decrease in active joint count from baseline and a clinically in the in active joint count from baseline in the opinion of the treating	
Re-a	INITIATION – immune checkpoint inhibitor toxicity in malignancy* Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)  Orecommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
and	and and	The individual requires treatment for moderate to severe autoir malignancy  The individual has received insufficient benefit from use of cord infliximab is to be administered at up to 5mg/kg for up to four contents.		

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Infliximab - continued	
CONTINUATION – immune checkpoint inhibitor toxicity in malignancy* Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by any relevant practitioner, or in an NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health
The individual has shown clinical improvement and ongoing trand Infliximab is to be administered at up to 5mg/kg for up to a total	
Note: Indications marked with * are unapproved indications.	

#### RS2125 - Tocilizumab

Rheumatoid Arthritis - INITIATION	346
Rheumatoid Arthritis - CONTINUATION	
Rheumatoid Arthritis (patients previously treated with adalimumab or etanercept) - INITIATION	345
Adult-onset Still's disease - INITIATION	
Adult-onset Still's disease - CONTINUATION	349
Cytokine release syndrome - INITIATION	
Idiopathic multicentric Castleman's disease - INITIATION	
Idiopathic multicentric Castleman's disease - CONTINUATION	
Immune checkpoint inhibitor toxicity in malignancy* - INITIATION	
Immune checkpoint inhibitor toxicity in malignancy* - CONTINUATION	
Moderate to severe COVID-19 - INITIATION	348
Polyarticular juvenile idiopathic arthritis - INITIATION	347
Polyarticular juvenile idiopathic arthritis - CONTINUATION	349
Previous use - INITIATION	
Systemic juvenile idiopathic arthritis - INITIATION	346
Systemic juvenile idiopathic arthritis - CONTINUATION	348

PRE	SCRII	BER	PATIENT:
Nam	e:		
Ward	l:		NHI:
Toci	lizur	mab	
Re-a	asses	sment requ	The patient has developed grade 3 or 4 cytokine release syndrome associated with the administration of blinatumomab for the treatment of acute lymphoblastic leukaemia  Tocilizumab is to be administered at doses no greater than 8 mg/kg IV for a maximum of 3 doses (if less than 30kg, maximum of 12 mg/kg)  The patient is enrolled in the Malaghan Institute of Medical Research ENABLE trial programme  The patient has developed CRS or Immune Effector Cell-Associated Neurotoxicity Syndrome (ICANS) following CAR T-Cell therapy for the treatment of relapsed or refractory B-cell non-Hodgkin lymphoma  Tocilizumab is to be administered according to the consensus guidelines for CRS or ICANS for CAR T-cell therapy at doses no greater than 8 mg/kg IV for a maximum of 3 doses
Re-a	asses: requis	Prescribed NZ Hospita	uired after 6 months boxes where appropriate)  by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health

I confirm that the above details are correct:	
Signed:	Date:

PRES	SCRIB	BER		PATIENT:
Name	e:			
Ward	:			NHI:
Toci	lizun	nab	- con	tinued
				natoid Arthritis (patients previously treated with adalimumab or etanercept) ired after 6 months
				oxes where appropriate)
and				by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
	and	$\circ$	The p	patient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis
		or	O	The patient has experienced intolerable side effects from adalimumab and/or etanercept
			0	The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or etanercept such that they do not meet the renewal criteria for rheumatoid arthritis
	and			
		or	$\circ$	The patient is seronegative for both anti-cyclic citrullinated peptide (CCP) antibodies and rheumatoid factor
			an	The patient has been started on rituximab for rheumatoid arthritis in a Health NZ Hospital
				Or The patient has experienced intolerable side effects from rituximab Or At four months following the initial course of rituximab the patient has received insufficient benefit such that they do not meet the renewal criteria for rheumatoid arthritis

I confirm that the above details are corre
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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.

PRES	SCRIE	BER			PATIENT:		
Name	ame: Name:			Name:			
Vard	rd:NHI:						
oci	lizur	nab	- cor	ntinued			
Re-a	sses	smen	requ	matoid Arthritis uired after 6 months poxes where appropriate)			
O Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or protocol or guideline that has been endorsed by the Health NZ Hospital.				on the recommendation of a rheumatologist, or in accordance with a ital.			
	and			Patient has had severe and active erosive rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic citrullinated peptide (CCP) antibody positive) for six months duration or longer			
	and	$\circ$	Tocili	izumab is to be used as monotherapy			
		or	0	Treatment with methotrexate is contraindicated			
			O Patient has tried and did not tolerate oral and/or parenteral methotrexate				
	and	or	0	Patient has tried and not responded to at least three more combination with another agent	nths therapy at the maximum tolerated dose of ciclosporin alone or in		
			0	Patient has tried and not responded to at least three more combination with another agent	nths therapy at the maximum tolerated dose of leflunomide alone or in		
	and		$\overline{}$				
		or	Ō	Patient has persistent symptoms of poorly controlled and	d active disease in at least 20 active, swollen, tender joints		
			0	Patient has persistent symptoms of poorly controlled and elbow, knee, ankle, and either shoulder or hip	d active disease in at least four active joints from the following: wrist,		
	and						
	or		$\bigcirc$	Patient has a C-reactive protein level greater than 15 mapplication	g/L measured no more than one month prior to the date of this		
			0	C-reactive protein levels not measured as patient is curreday and has done so for more than three months	ently receiving prednisone therapy at a dose of greater than 5 mg per		
_							
Re-a	sses	smen	requ	mic juvenile idiopathic arthritis uired after 6 months			
	С	Presc	ribed	by, or recommended by a rheumatologist or Practitioner of guideline that has been endorsed by the Health NZ Hosp	on the recommendation of a rheumatologist, or in accordance with a ital.		
and	and	0	Patie	ent diagnosed with systemic juvenile idiopathic arthritis			
	and	0		ent has tried and not responded to a reasonable trial of all lotrexate; non-steroidal anti-inflammatory drugs (NSAIDs):	of the following, either alone or in combination: oral or parenteral and systemic corticosteroids		

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PRESCRIBER			PATIENT:
Name:			Name:
Vard:NHI:			
ocilizu	mab .	- con	ntinued
INITIATION Re-asses	ON – ad ssment sites (t	lult-d requick b	onset Still's disease ired after 6 months oxes where appropriate)  by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
and	and	or	The patient has had an initial Special Authority approval for adalimumab and/or etanercept for adult-onset Still's disease (AOSD)  The patient has been started on tocilizumab for AOSD in a Health NZ Hospital  The patient has experienced intolerable side effects from adalimumab and/or etanercept  The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or etanercept such that they do not meet the renewal criteria for AOSD
Patient has tried and not responded to at least 6 mon antiinflammatory drugs (NSAIDs) and methotrexate			Patient diagnosed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430)  Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-steroidal antiinflammatory drugs (NSAIDs) and methotrexate  Patient has persistent symptoms of disabling poorly controlled and active disease
Re-asses	sment sites (t Prescri	requick b	rticular juvenile idiopathic arthritis ired after 4 months poxes where appropriate)  by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
or	and and and		The patient has had an initial Special Authority approval for both etanercept and adalimumab for polyarticular course juvenile idiopathic arthritis (JIA)  The patient has experienced intolerable side effects, or has received insufficient benefit from, both etanercept and adalimumab  Treatment with a tumour necrosis factor alpha inhibitor is contraindicated  Patient has had polyarticular course JIA for 6 months duration or longer  To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Of At least 5 active joints and at least 3 joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose)  Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the maximum tolerated dose)
		or	O Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate

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PATIENT:		
Name:		
ard:NHI:		
c Castleman's disease ns opriate)  ded by a haematologist, rheumatologist or Practitioner on the recommendation of a haematologist or rheumatologist, ocol or guideline that has been endorsed by the Health NZ Hospital.  IV-8 negative idiopathic multicentric Castleman's disease equate trial of corticosteroids has proven ineffective		
ninistered at doses no greater than 8 mg/kg IV every 3-4 weeks		
opriate)  (or probable) COVID-19  ( 92% on room air, or requiring supplemental oxygen junct systemic corticosteroids, or systemic corticosteroids are contraindicated dministered at doses no greater than 8mg/kg IV for a maximum of one dose se administered in combination with barcitinib		
CONTINUATION – Rheumatoid Arthritis Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
nitial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically be treatment in the opinion of the physician lications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and response to treatment in the opinion of the physician		
e idiopathic arthritis as opriate)  ded by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a sepan endorsed by the Health NZ Hospital.  ACR Pedi 30) response from baseline  dications, the patient demonstrates at least a continuing ACR Pedi 30 response from baseline		
nitial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically of treatment in the opinion of the physician dications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and response to treatment in the opinion of the physician decided by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a speen endorsed by the Health NZ Hospital.  ACR Pedi 30) response from baseline		

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	PATIENT:			
Name:	Name:			
Vard:NHI:				
Tocilizumab - continued				
CONTINUATION – adult-onset Still's disease Re-assessment required after 6 months Prerequisites (tick box where appropriate)  Prescribed by, or recommended by a rheumatologist or Practitioner of protocol or guideline that has been endorsed by the Health NZ Hosp and  The patient has a sustained improvement in inflammatory markers and	ital.			
CONTINUATION – polyarticular juvenile idiopathic arthritis Re-assessment required after 6 months  Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a rheumatologist or Practitioner of	on the recommendation of a rheumatologist, or in accordance with a			
intolerance  Following 3 to 4 months' initial treatment, the patient has physician's global assessment from baseline  or	or monotherapy where use of methotrexate is limited by toxicity or at least a 50% decrease in active joint count and an improvement in at least a continuing 30% improvement in active joint count and			
CONTINUATION – idiopathic multicentric Castleman's disease Re-assessment required after 12 months Prerequisites (tick box where appropriate)  O Prescribed by, or recommended by a haematologist, rheumatologist or Practitioner on the recommendation of a haematologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  and  The treatment remains appropriate and the patient has a sustained improvement in inflammatory markers and functional status				
INITIATION – immune checkpoint inhibitor toxicity in malignancy* Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	cordance with a protocol or guideline that has been endorsed by the Health			

I confirm that the above details are correct:

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

Page 350

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Tocilizumab - continued		
CONTINUATION – immune checkpoint inhibitor toxicity in malignancy* Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)		
Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	ecordance with a protocol or guideline that has been endorsed by the Health	
O The individual has shown clinical improvement and ongoing treatment is required		
Tocilizumab is to be administered at a maximum dose of 8 mg	/kg fortnightly	
Note: Indications marked with * are unapproved indications.		

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Omalizumab	
endorsed by the Health NZ Hospital.  Patient must be aged 6 years or older and Patient has a diagnosis of severe asthma and Past or current evidence of atopy, documented by skin prick te and Total serum human immunoglobulin E (IgE) between 76 IU/ml and Proven adherence with optimal inhaled therapy including high fluticasone propionate 1,000 mcg per day or equivalent), plus eformoterol 12 mcg bd) for at least 12 months, unless contrain and Patient has received courses of systemic corticosteroids contraindicated or not tolerated Patient has had at least 4 exacerbations needing system defined as either documented use of oral corticosteroids and Patient has an Asthma Control Test (ACT) score of 10 or less and	dose inhaled corticosteroid (budesonide 1,600 mcg per day or long-acting beta-2 agonist therapy (at least salmeterol 50 mcg bd or indicated or not tolerated sequivalent to at least 28 days treatment in the past 12 months, unless inic corticosteroids in the previous 12 months, where an exacerbation is a for at least 3 days or parenteral steroids
NZ Hospital.	ordance with a protocol or guideline that has been endorsed by the Health
An increase in the Asthma Control Test (ACT) score of at lease and  A reduction in the maintenance oral corticosteroid dose or nur	

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PRESCRIB	ER	PATIENT:
Name:		Name:
Ward:		NHI:
Omalizun	nab - continued	
Prerequisi	N – severe chronic spontaneous urticaria ment required after 6 months ites (tick boxes where appropriate) rescribed by, or recommended by a clinical immunologist or derm ndorsed by the Health NZ Hospital.	natologist, or in accordance with a protocol or guideline that has been
(and	Patient must be aged 12 years or older	
	Patient is symptomatic with Urticaria Activity Sco	
and		
	O Patient has been taking high dose antihistamines (e.g. 6 weeks	4 times standard dose) and ciclosporin (> 3 mg/kg day) for at least
	Patient has been taking high dose antihistamines (e.g. (> 20 mg prednisone per day for at least 5 days) in the	4 times standard dose) and at least 3 courses of systemic corticosteroids previous 6 months
	O Patient has developed significant adverse effects whils	et on corticosteroids or ciclosporin
and	O Treatment to be stopped if inadequate response* follow or	ving 4 doses
	O Complete response* to 6 doses of omalizumab	
Prerequisi	ATION – severe chronic spontaneous urticaria ment required after 6 months ites (tick boxes where appropriate) rescribed by, or recommended by a clinical immunologist or derm ndorsed by the Health NZ Hospital.	natologist, or in accordance with a protocol or guideline that has been
or	Patient has previously had a complete response* to 6 doses	
	Patient has previously had a complete response* to 6 of and Patient has relapsed after cessation of omalizumab the	
of less than	n 4 from baseline. Patient is to be reassessed for response after a and DLQI less than or equal to 5; or UCT of 16. Relapse of chron	UAS7 and DLQI score, or an increase in Urticaria Control Test (UCT) score 4 doses of omalizumab. Complete response is defined as UAS7 less than or ic urticaria on stopping prednisone/ciclosporin does not justify the funding of

I confirm that the above details are correct:

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PRESC	RIBER	PATIENT:
Name:		Name:
Ward: .		NHI:
Siltuxi	mab	
Prereq and a	essment required after 6 months uisites (tick boxes where appropriate)	ineffective
Re-ass	essment required after 12 months uisites (tick box where appropriate)  Prescribed by, or recommended by a haematologist or rheumatologist the Health NZ Hospital.  The treatment remains appropriate and the patient has sustained im	ist, or in accordance with a protocol or guideline that has been endorsed by

I confirm that the above details are correct:

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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.

PATIENT:
Name:
NHI:
nab
nt required after 6 months s (tick boxes where appropriate)  The patient has progressive Binet stage A, B or C CD20+ chronic lymphocytic leukaemia requiring treatment  The patient is obinutuzumab treatment naive
The patient is not eligible for full dose FCR due to comorbidities with a score > 6 on the Cumulative Illness Rating Scale (CIRS) or reduced renal function (creatinine clearance < 70mL/min)  Patient has adequate neutrophil and platelet counts* unless the cytopenias are a consequence of marrow infiltration by CLL  Patient has good performance status  Obinutuzumab to be administered at a maximum cumulative dose of 8,000 mg and in combination with chlorambucil for a maximum of 6 cycles
ment in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL disease eigher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2. or equal to 1.5 × 10 ⁹ /L and platelets greater than or equal to 75 × 10 ⁹ /L  follicular / marginal zone lymphoma after 9 months (citick boxes where appropriate)
Patient has follicular lymphoma Patient has marginal zone lymphoma  Patient is refractory to or has relapsed within 12 months of a rituximab containing combined chemo-immunotherapy regimen*  Patient has an ECOG performance status of 0-2  Patient has been previously treated with no more than four chemotherapy regimens  Obinutuzumab to be administered at a maximum dose of 1000 mg for a maximum of 6 cycles in combination with chemotherapy*
es unapproved indications
ON – follicular / marginal zone lymphoma nt required after 24 months

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.

PRESCR	IBER	R PATIENT:	
Name: .		Name:	
Ward:		NHI:	
Pertuzu	ımab	ab	
	ssmer	nent required after 12 months es (tick boxes where appropriate)	
an	O	The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (	including FISH or other current technology)
	or	O Patient is chemotherapy treatment naive O Patient has not received prior treatment for their metastatic disease and	has had a treatment free interval of at least 12 months
ar ar ar		Detween prior (neo)adjuvant chemotherapy treatment and diagnosis of the patient has good performance status (ECOG grade 0-1)  Pertuzumab to be administered in combination with trastuzumab  Pertuzumab maximum first dose of 840 mg, followed by maximum of 420 mg  Pertuzumab to be discontinued at disease progression	
	ssmer	rion nent required after 12 months es (tick boxes where appropriate)	
		The patient has metastatic breast cancer expressing HER-2 IHC 3+ or I and The cancer has not progressed at any time point during the previous 12	
or		Patient has previously discontinued treatment with pertuzumab and tras disease progression  And Patient has signs of disease progression	stuzumab for reasons other than severe toxicity or
	an	Disease has not progressed during previous treatment with pertuzumat	and trastuzumab

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

	community funding, see the Special Authority Criteria.	
PRESCRIBER		PATIENT:
Name:		Name:
Ward:		NHI:
Cetuximab		
	head and neck cancer, locally advanced (tick boxes where appropriate)	
and	Patient has locally advanced, non-metastatic, squamous cell of Cisplatin is contraindicated or has resulted in intolerable side	
and and	Patient has an ECOG performance score of 0-2  To be administered in combination with radiation therapy	ellects
Re-assessmer	Patient has metastatic colorectal cancer located on the left side.  There is documentation confirming disease is RAS and BRAF.  Patient has an ECOG performance score of 0-2.  Patient has not received prior funded treatment with cetuxima.  Cetuximab is to be used in combination with chemother.  Chemotherapy is determined to not be in the best interest.	b apy
Re-assessmer Prerequisites  No e	ON – colorectal cancer, metastatic nt required after 6 months (tick box where appropriate) vidence of disease progression ed colorectal cancer comprises of the distal one-third of the tran	nsverse colon, the splenic flexure, the descending colon, the sigmoid colon,

I confirm that the above details are correct:

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I confirm that the above details are correct:

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PRESCRIBER	PATIENT:
Name:	
Ward:	NHI:
Aflibercept	
Re-assessme	Wet Age Related Macular Degeneration ent required after 3 months s (tick boxes where appropriate)
a	O Wet age-related macular degeneration (wet AMD) or O Polypoidal choroidal vasculopathy O Choroidal neovascular membrane from causes other than wet AMD  or O The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab  or O There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart  There is no structural damage to the central fovea of the treated eye  Patient has not previously been treated with ranibizumab or faricimab for longer than 3 months  O Patient has current approval to use ranibizumab or faricimab for treatment of wAMD and was found to be intolerant within 3 months  Patient has previously* (*before June 2018) received treatment with ranibizumab for wAMD and disease was stable while on treatment
Re-assessme	ON – Wet Age Related Macular Degeneration ent required after 12 months s (tick boxes where appropriate)
and and	Documented benefit must be demonstrated to continue  Patient's vision is 6/36 or better on the Snellen visual acuity score  There is no structural damage to the central fovea of the treated eye
Re-assessme	Diabetic Macular Oedema ent required after 4 months s (tick boxes where appropriate)
O	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
and	Patient has not previously been treated with faricimab for longer than 3 months

PRESCRI	BER	PATIENT:
Name:		Name:
Ward:		NHI:
Afliberc	ept - continued	
Re-asses	JATION – Diabetic Macular Oedema sment required after 12 months sites (tick boxes where appropriate)	
and	There is structural improvement on OCT scan (with reduction Patient's vision is 6/36 or better on the Snellen visual acuity s	

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.

PRES	CRIE	BER	PATIENT:
Name	):		Name:
Ward:	:		NHI:
Secu	ıkin	uma	ab
Re-a	sses	smen	severe chronic plaque psoriasis, second-line biologic nt required after 4 months (tick boxes where appropriate)
( and		Preso Hosp	cribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.
	and	0	The patient has had an initial Special Authority approval for adalimumab or etanercept, or has trialled infliximab in a Health NZ Hospital, for severe chronic plaque psoriasis
	unu	or	The patient has experienced intolerable side effects from adalimumab, etanercept or infliximab     The patient has received insufficient benefit from adalimumab, etanercept or infliximab
	and	0	A Psoriasis Area and Severity Index (PASI) assessment or Dermatology Quality of Life Index (DLQI) assessment has been completed for at least the most recent prior treatment course, preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course
	and	O	The most recent PASI or DQLI assessment is no more than 1 month old at the time of application
Re-a	ssess equis	smen sites	DN – severe chronic plaque psoriasis, second-line biologic nt required after 6 months (tick boxes where appropriate) cribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
and		or	O Patient's PASI score has reduced by 75% or more (PASI 75) as compared to baseline PASI prior to commencing secukinumab O Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing secukinumab
	and	0	Secukinumab to be administered at a maximum dose of 300 mg monthly

I confirm that the above details are correct:

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

ie.		Name:
		Name.
d:		NHI:
ukinuma	ab - continued	
TIATION – s assessmen erequisites	severe chronic plaque psoriasis, first-line biolog trequired after 4 months (tick boxes where appropriate)	
Preso Hosp		n accordance with a protocol or guideline that has been endorsed by the Health NZ
or	10, where lesions have been present for at I	que psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than east 6 months from the time of initial diagnosis
or	been present for at least 6 months from the	of the face, or palm of a hand or sole of a foot, where the plaque or plaques have time of initial diagnosis
		or flexural plaque psoriasis where the plaques or lesions have been present for at osis, and with a Dermatology Life Quality Index (DLQI) score greater than 10
and		(see Note) to, or has experienced intolerable side effects from, at least three of the traindicated): phototherapy, methotrexate, ciclosporin, or acitretin
		e Index (DLQI) assessment has been completed for at least the most recent prior
and		nt but no longer than 1 month following cessation of each prior treatment course
0	The most recent PASI or DQLI assessment is no	more than 1 month old at the time of application
e: A treatm riasis, a PA ent prior treat erythema, the e of the face	The most recent PASI or DQLI assessment is no ment course is defined as a minimum of 12 weeks on a score of greater than 10, as assessed preferably eatment; for severe chronic plaque psoriasis of the fathickness and scaling are rated as severe or very second to the score of the second to the score of the second to the score of the second to the secon	f treatment. "Inadequate response" is defined as: for whole body severe chronic play while still on treatment but no longer than 1 month following cessation of the most ace, hand, foot, genital or flexural areas, at least 2 of the 3 PASI symptom sub score evere, and for the face, palm of a hand or sole of a foot the skin area affected is 30%
e: A treatm riasis, a PA ent prior treaterythema, the e of the fact at recent pri	The most recent PASI or DQLI assessment is no ment course is defined as a minimum of 12 weeks on a score of greater than 10, as assessed preferably eatment; for severe chronic plaque psoriasis of the fathickness and scaling are rated as severe or very see, palm of a hand or sole of a foot, as assessed professional professional part of the fathickness and scaling are rated as severe or very see, palm of a hand or sole of a foot, as assessed professional pro	f treatment. "Inadequate response" is defined as: for whole body severe chronic play while still on treatment but no longer than 1 month following cessation of the most ace, hand, foot, genital or flexural areas, at least 2 of the 3 PASI symptom sub score evere, and for the face, palm of a hand or sole of a foot the skin area affected is 30% eferably while still on treatment but no longer than 1 month following cessation of the
e: A treatm riasis, a PA ent prior treaterythema, the e of the fact st recent pri	The most recent PASI or DQLI assessment is no report of the property of the most recent page as a minimum of 12 weeks of the score of greater than 10, as assessed preferably eatment; for severe chronic plaque psoriasis of the factoristic property of the page and scaling are rated as severe or very see, palm of a hand or sole of a foot, as assessed preferably of the property of th	f treatment. "Inadequate response" is defined as: for whole body severe chronic play while still on treatment but no longer than 1 month following cessation of the most ace, hand, foot, genital or flexural areas, at least 2 of the 3 PASI symptom sub score evere, and for the face, palm of a hand or sole of a foot the skin area affected is 30% eferably while still on treatment but no longer than 1 month following cessation of the biologic
e: A treatm riasis, a PA ent prior treaterythema, the e of the fact at recent pri	The most recent PASI or DQLI assessment is no report of the property of the most recent page as a minimum of 12 weeks of the score of greater than 10, as assessed preferably eatment; for severe chronic plaque psoriasis of the factoristic property of the page and scaling are rated as severe or very see, palm of a hand or sole of a foot, as assessed preferably of the property of th	f treatment. "Inadequate response" is defined as: for whole body severe chronic play while still on treatment but no longer than 1 month following cessation of the most ace, hand, foot, genital or flexural areas, at least 2 of the 3 PASI symptom sub score evere, and for the face, palm of a hand or sole of a foot the skin area affected is 30% eferably while still on treatment but no longer than 1 month following cessation of the
e: A treatm riasis, a PA ent prior treat erythema, the e of the fact t recent pri	The most recent PASI or DQLI assessment is no report of the following course is defined as a minimum of 12 weeks of the following course of greater than 10, as assessed preferably eatment; for severe chronic plaque psoriasis of the following course is and scaling are rated as severe or very seaso, palm of a hand or sole of a foot, as assessed preferably in treatment.  DN – severe chronic plaque psoriasis, first-line in the required after 6 months (tick boxes where appropriate)  Patient's PASI score has reduced by Tasecukinumab	f treatment. "Inadequate response" is defined as: for whole body severe chronic play while still on treatment but no longer than 1 month following cessation of the most ace, hand, foot, genital or flexural areas, at least 2 of the 3 PASI symptom sub score evere, and for the face, palm of a hand or sole of a foot the skin area affected is 30% eferably while still on treatment but no longer than 1 month following cessation of the biologic
e: A treatm riasis, a PA ent prior treat erythema, the e of the fact t recent pri	The most recent PASI or DQLI assessment is no recent course is defined as a minimum of 12 weeks or associated associated as a minimum of 12 weeks or associated assoc	f treatment. "Inadequate response" is defined as: for whole body severe chronic play while still on treatment but no longer than 1 month following cessation of the most ace, hand, foot, genital or flexural areas, at least 2 of the 3 PASI symptom sub score evere, and for the face, palm of a hand or sole of a foot the skin area affected is 30% eferably while still on treatment but no longer than 1 month following cessation of the piologic  75% or more (PASI 75) as compared to baseline PASI prior to commencing  Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior
e: A treatmriasis, a PA ant prior treatry thema, the of the fact trecent prior treatry thema.	The most recent PASI or DQLI assessment is no recent course is defined as a minimum of 12 weeks or associated associated as a minimum of 12 weeks or associated assoc	f treatment. "Inadequate response" is defined as: for whole body severe chronic play while still on treatment but no longer than 1 month following cessation of the most ace, hand, foot, genital or flexural areas, at least 2 of the 3 PASI symptom sub score evere, and for the face, palm of a hand or sole of a foot the skin area affected is 30% eferably while still on treatment but no longer than 1 month following cessation of the poliologic
e: A treatmriasis, a PA ent prior treatrythema, the of the fact recent prior treatrythema. The end of the fact recent prior treatry the end of the end o	The most recent PASI or DQLI assessment is no recent course is defined as a minimum of 12 weeks or a score of greater than 10, as assessed preferably eatment; for severe chronic plaque psoriasis of the factorises and scaling are rated as severe or very see, palm of a hand or sole of a foot, as assessed preferably in treatment.  DN – severe chronic plaque psoriasis, first-line in the required after 6 months (tick boxes where appropriate)  Patient's PASI score has reduced by a secukinumab  Patient has a Dermatology Quality of to commencing secukinumab  Patient had severe chronic localised of and  The patient has experienced a recompared to the pre-treatment is	f treatment. "Inadequate response" is defined as: for whole body severe chronic play while still on treatment but no longer than 1 month following cessation of the most ace, hand, foot, genital or flexural areas, at least 2 of the 3 PASI symptom sub score evere, and for the face, palm of a hand or sole of a foot the skin area affected is 30% eferably while still on treatment but no longer than 1 month following cessation of the piologic  75% or more (PASI 75) as compared to baseline PASI prior to commencing  Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior genital or flexural plaque psoriasis at the start of treatment
e: A treatmriasis, a PA ent prior treatrythema, the of the fact recent prior treatrythema. The end of the fact recent prior treatry the end of the end o	The most recent PASI or DQLI assessment is no recent course is defined as a minimum of 12 weeks or a score of greater than 10, as assessed preferably eatment; for severe chronic plaque psoriasis of the factorises and scaling are rated as severe or very see, palm of a hand or sole of a foot, as assessed preferably in treatment.  ON – severe chronic plaque psoriasis, first-line in the required after 6 months (tick boxes where appropriate)  On Patient's PASI score has reduced by a secukinumab  Patient has a Dermatology Quality of to commencing secukinumab  On Patient has a Dermatology Quality of the commencing secukinumab  On The patient has experienced a recompared to the pre-treatment in the pr	f treatment. "Inadequate response" is defined as: for whole body severe chronic platy while still on treatment but no longer than 1 month following cessation of the most ace, hand, foot, genital or flexural areas, at least 2 of the 3 PASI symptom sub score evere, and for the face, palm of a hand or sole of a foot the skin area affected is 30% eferably while still on treatment but no longer than 1 month following cessation of the policies.  To work or more (PASI 75) as compared to baseline PASI prior to commencing. Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior denital or flexural plaque psoriasis at the start of treatment.  The eduction of 75% or more in the skin area affected, or sustained at this level, as baseline value.  It work of the most area of the most area of the most area of the most area. The most area of the most area of the most area of the most area. The most area of the most area of the most area of the most area of the most area. The most area of the most area of the most area of the most area of the most area. The most area of the most area of the most area of the most area of the most area. The most area of the most area of the most area of the most area of the most area. The most area of the most area. The most area of the mos
e: A treatm riasis, a PA ent prior treaterythema, the e of the factst recent prior NTINUATIC assessmen requisites	The most recent PASI or DQLI assessment is no recent course is defined as a minimum of 12 weeks or association of greater than 10, as assessed preferably eathern; for severe chronic plaque psoriasis of the fishickness and scaling are rated as severe or very sea, palm of a hand or sole of a foot, as assessed preior treatment.  DN – severe chronic plaque psoriasis, first-line in the required after 6 months (tick boxes where appropriate)  O Patient's PASI score has reduced by a secukinumab  Patient has a Dermatology Quality of to commencing secukinumab  O Patient had severe chronic localised grand  O The patient has experienced a recompared to the pre-treatment is or  O Patient has a Dermatology Quality Or	f treatment. "Inadequate response" is defined as: for whole body severe chronic play while still on treatment but no longer than 1 month following cessation of the most ace, hand, foot, genital or flexural areas, at least 2 of the 3 PASI symptom sub score evere, and for the face, palm of a hand or sole of a foot the skin area affected is 30% eferably while still on treatment but no longer than 1 month following cessation of the policies.  To or more (PASI 75) as compared to baseline PASI prior to commencing. Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior denital or flexural plaque psoriasis at the start of treatment.  The eduction of 75% or more in the skin area affected, or sustained at this level, as baseline value.  It is possible to the most accompared to baseline DLQI improvement of 5 or more, as compared to baseline DLQI.

PRES	CRIBER		PATIENT:
Name	e:		Name:
Ward:	·		NHI:
Secu	ıkinuma	b - continued	
		ankylosing spondylitis, second-line biologic trequired after 3 months	
Prere	equisites	(tick boxes where appropriate)	
( and	O Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
	and	The patient has had an initial Special Authority approval for ad	lalimumab and/or etanercept for ankylosing spondylitis
O The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept or		n a reasonable trial of adalimumab and/or etanercept	
		O Following 12 weeks of adalimumab and/or etanercept transport and/or etanercept for ankylosing spondylitis	eatment, the patient did not meet the renewal criteria for adalimumab
CONTINUATION – ankylosing spondylitis, second-line biologic Re-assessment required after 6 months  Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health N. Hospital.  O Following 12 weeks initial treatment of secukinumab treatment, BASDAI has improved by 4 or more points from pre-secukinumab			
	and on and	baseline on a 10 point scale, or by 50%, whichever is less  Physician considers that the patient has benefitted from treatm  Secukinumab to be administered at doses no greater than 300	

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			PATIENT:		
Name	e:				
Ward	:			NHI:	
Secu	ıkinı	ımal	<b>)</b> - c	tinued	
Re-a	equis	ment ites (1	requ ick b	arthritis d after 6 months es where appropriate) , or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health N	IZ
and		Hospit			
		and	0	atient has had an initial Special Authority approval for adalimumab, etanercept or infliximab for psoriatic arthritis	
			or	Patient has experienced intolerable side effects from adalimumab, etanercept or infliximab	
				Patient has received insufficient benefit from adalimumab, etanercept or infliximab to meet the renewal criteria for adalimumab, etanercept or infliximab for psoriatic arthritis	
	or				
		and	$\circ$	atient has had severe active psoriatic arthritis for six months duration or longer	
		_	0	atient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg eekly or a maximum tolerated dose	
		and	0	atient has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day or leflunomide at dose of up to 20 mg daily (or maximum tolerated doses)	:
			or	Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen, tender joints	
				Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip	
		and		Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application	
			or	Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour	
			Ů.	ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months	
Re-a	ssess	ment	requ	riatic arthritis d after 6 months es where appropriate)	
(					17
and		Hospit		, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health N	IZ
		or	0	ollowing 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a inically significant response to treatment in the opinion of the physician	
			0	ne patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant sponse to prior secukinumab treatment in the opinion of the treating physician	
and O Secukinumab to be administered at doses no greater than 300 mg monthly		umab to be administered at doses no greater than 300 mg monthly			

I confirm that the above details are correct:

RESCRIBER	PATIENT:
ame:	
ard:	NHI:
astuzuma	b emtansine
	early breast cancer (tick boxes where appropriate)
	Patient has early breast cancer expressing HER2 IHC3+ or ISH+  Documentation of pathological invasive residual disease in the breast and/or axiliary lymph nodes following completion of surgery  Patient has completed systemic neoadjuvant therapy with trastuzumab and chemotherapy prior to surgery  Disease has not progressed during neoadjuvant therapy  Patient has left ventricular ejection fraction of 45% or greater  Adjuvant treatment with trastuzumab emtansine to be commenced within 12 weeks of surgery  Trastuzumab emtansine to be discontinued at disease progression  Total adjuvant treatment duration must not exceed 42 weeks (14 cycles)
	(tick boxes where appropriate)  Patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
and and	Patient has previously received trastuzumab and chemotherapy, separately or in combination
or	O The patient has received prior therapy for metastatic disease* O The patient developed disease recurrence during, or within six months of completing adjuvant therapy*
and and	Patient has a good performance status (ECOG 0-1)
or	O Patient does not have symptomatic brain metastases O Patient has brain metastases and has received prior local CNS therapy
and	O Patient has not received prior funded trastuzumab emtansine or trastuzumab deruxtecan treatment  O Patient has discontinued trastuzumab deruxtecan due to intolerance and O The cancer did not progress while on trastuzumab deruxtecan

I confirm that the above details are correct:

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Trastuzumab emtansine - continued			
CONTINUATION – metastatic breast cancer Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab emtansine and			
O Treatment to be discontinued at disease progression  Note: *Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy, biological drugs, or endocrine therapy.			

#### RS2133 - Rituximab

ABO-incompatible organ transplant - INITIATION	
ANCA associated vasculitis - INITIATION	
ANCA associated vasculitis - CONTINUATION	372
Antibody-mediated organ transplant rejection - INITIATION	
B-cell acute lymphoblastic leukaemia/lymphoma* - INITIATION	380
CD20+ low grade or follicular B-cell NHL - INITIATION	
CD20+ low grade or follicular B-cell NHL - CONTINUATION	
Chronic lymphocytic leukaemia - INITIATION	368
Chronic lymphocytic leukaemia - CONTINUATION	369
Membranous nephropathy - INITIATION	379
Membranous nephropathy - CONTINUATION	379
Neuromyelitis Optica Spectrum Disorder (NMOSD) - INITIATION	3/5
Neuromyelitis Optica Spectrum Disorder (NMOSD) - CONTINUATION	3/5
Severe Refractory Myasthenia Gravis - INITIATION	3/6
Severe Refractory Myasthenia Gravis - CONTINUATION	3/6
Severe antisynthetase syndrome - INITIATION	3/6
Severe antisynthetase syndrome - CONTINUATION	3//
Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRNS) - II	NITIATION
374	NITINILIATION
Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRNS) - CO	NTINUATION
374	074
Steroid resistant nephrotic syndrome (SRNS) - INITIATION	374
Steroid resistant nephrotic syndrome (SRNS) - CONTINUATION	
Aggressive CD20 positive NHL - INITIATION	
Aggressive CD20 positive NHL - CONTINUATION	368
Anti-NMDA receptor autoimmune encephalitis - INTTATION  Anti-NMDA receptor autoimmune encephalitis - CONTINUATION	3/8
Desensitisation prior to transplant - INITIATION	300
Graft versus host disease - INITIATION	300
Haemophilia with inhibitors - INITIATION	
Haemophilia with inhibitors - CONTINUATION	300
Immune thrombocytopenic purpura (ITP) - INITIATION	270
Immune thrombocytopenic purpura (TP) - IMMATION	271
Immunoglobulin G4-related disease (IgG4-RD*) - INITIATION	3/1
Immunoglobulin G4-related disease (IgG4-RD*) - INTIATION	301
Indolent, low-grade lymphomas or hairy cell leukaemia* - INITIATION	361
Indolent, low-grade lymphomas or hairy cell leukaemia* - CONTINUATION	307
Pemiphigus* - INITIATION	200
Pemiphigus* - CONTINUATION	
Post-transplant - INITIATION	266
Post-transplant - CONTINUATION Post-transplant - CONTINUATION	366
Pure red cell aplasia (PRCA) - INITIATION	272
Pure red cell aplasia (PRCA) - CONTINUATION	272
Severe chronic inflammatory demyelinating polyneuropathy - INITIATION	377
Severe chronic inflammatory demyelinating polyneuropathy - CONTINUATION	377
Severe cold haemagglutinin disease (CHAD) - INITIATION	360
Severe cold haemagglutinin disease (CHAD) - INTINATION Severe cold haemagglutinin disease (CHAD) - CONTINUATION	360
Thrombotic thrombocytopenic purpura (TTP) - INITIATION	271
Thrombotic thrombocytopenic purpura (TTP) - INTINATION	
Treatment refractory systemic lupus erythematosus (SLE) - INITIATION	
Treatment refractory systemic lupus erythematosus (SLE) - INTIATION	درد
Warm autoimmune haemolytic anaemia (warm AIHA) - INITIATION	370
Warm autoimmune haemolytic anaemia (warm AIHA) - INTIATION	370
warm autoimmune naemolytic anaemia (warm Ama) - Continuation	

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Rituximab (Riximyo)		
INITIATION – haemophilia with inhibitors Prerequisites (tick boxes where appropriate)		
Prescribed by, or recommended by a haematologist, or in accordant Hospital.	ce with a protocol or guideline that has been endorsed by the Health NZ	
O Patient has mild congenital haemophilia complicated by inhibi	tors	
O Patient has severe congenital haemophilia complicated by inhor	ibitors and has failed immune tolerance therapy	
O Patient has acquired haemophilia		
CONTINUATION – haemophilia with inhibitors  Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by t		
Hospital.		
Patient was previously treated with rituximab for haemophilia and		
An initial response lasting at least 12 months was demonstrat and Patient now requires repeat treatment	ed	
INITIATION – post-transplant Prerequisites (tick boxes where appropriate)		
The patient has B-cell post-transplant lymphoproliferative disc and	rder*	
O To be used for a maximum of 8 treatment cycles		
Note: Indications marked with * are unapproved indications.		
CONTINUATION – post-transplant Prerequisites (tick boxes where appropriate)		
The patient has had a rituximab treatment-free interval of 12 r	nonths or more	
The patient has B-cell post-transplant lymphoproliferative disc	order*	
To be used for no more than 6 treatment cycles		
Note: Indications marked with * are unapproved indications.		

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER		PATIENT:			
Name:		Name:			
Ward:		NHI:			
Rituximab (Rix	imyo) - continued				
Re-assessment r	INITIATION – indolent, low-grade lymphomas or hairy cell leukaemia* Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)				
or (	The patient has indolent low grade NHL or hairy cell lead.  To be used for a maximum of 6 treatment cycles	skaemia* with relapsed disease following prior chemotherapy			
and	The patient has indolent, low grade lymphoma or hairy  To be used for a maximum of 6 treatment cycles	cell leukaemia* requiring first-line systemic chemotherapy			
	ow-grade lymphomas' includes follicular, mantle, marginal zo cell leukaemia' also includes hairy cell leukaemia variant.	one and lymphoplasmacytic/Waldenstrom macroglobulinaemia. *Unapproved			
Re-assessment r	indolent, low-grade lymphomas or hairy cell leukaem equired after 12 months ck boxes where appropriate)	ia*			
and T	he patient has had a rituximab treatment-free interval of 12 n he patient has indolent, low-grade NHL or hairy cell leukaen to be used for no more than 6 treatment cycles				
	ow-grade lymphomas' includes follicular, mantle, marginal zo cell leukaemia' also includes hairy cell leukaemia variant.	one and lymphoplasmacytic/Waldenstrom macroglobulinaemia. *Unapproved			
_	gressive CD20 positive NHL ck boxes where appropriate)				
and (and	The patient has treatment naive aggressive CD20 posit  To be used with a multi-agent chemotherapy regimen g  To be used for a maximum of 8 treatment cycles				
or (and	The patient has aggressive CD20 positive NHL with relation To be used for a maximum of 6 treatment cycles	apsed disease following prior chemotherapy			
Note: 'Aggressive	e CD20 positive NHL' includes large B-cell lymphoma and Bu	urkitt's lymphoma/leukaemia.			

I confirm that the above details are correct:

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.

ESCRIBER	PATIENT:
ne:	Name:
rd:	NHI:
uximab (F	Riximyo) - continued
	ON – aggressive CD20 positive NHL (tick boxes where appropriate)
and and	The patient has had a rituximab treatment-free interval of 12 months or more  The patient has relapsed refractory/aggressive CD20 positive NHL
and	To be used with a multi-agent chemotherapy regimen given with curative intent  To be used for a maximum of 4 treatment cycles
te: 'Aggress	sive CD20 positive NHL' includes large B-cell lymphoma and Burkitt's lymphoma/leukaemia.
-assessmer	Chronic lymphocytic leukaemia  tt required after 12 months (tick boxes where appropriate)
and	The patient has progressive Binet stage A, B or C chronic lymphocytic leukaemia (CLL) requiring treatment
or	O The patient is rituximab treatment naive
	Or The patient is chemotherapy treatment naive
	The patient's disease has relapsed following no more than three prior lines of chemotherapy treatment  The patient has had a treatment-free interval of 12 months or more if previously treated with fludarabine and cyclophosphamide chemotherapy
or	O The patient's disease has relapsed and rituximab treatment is to be used in combination with funded venetoclax
and	The patient has good performance status
or	O The patient does not have chromosome 17p deletion CLL
and	O Rituximab treatment is to be used in combination with funded venetoclax for relapsed/refractory chronic lymphocytic leukaemia
and	Rituximab to be administered in combination with fludarabine and cyclophosphamide, bendamustine or venetoclax for a maximum of 6 treatment cycles
	It is planned that the patient receives full dose fludarabine and cyclophosphamide (orally or dose equivalent intravenous administration), bendamustine or venetoclax
indard thera nporarily del	lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma. A line of chemotherapy treatment is considered to comprise a know peutic chemotherapy regimen and supportive treatments. 'Good performance status' means ECOG score of 0-1, however, in patients oilitated by their CLL disease symptoms a higher ECOG (2 or 3) is acceptable where treatment with rituximab is expected to improve improve ECOG score to < 2.

I confirm that the above details are correct:

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rituximab (Riximyo) - continued	
CONTINUATION – Chronic lymphocytic leukaemia Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
Troisquistics (not solves imore appropriate)	
O The patient's disease has relapsed and rituximab treat	ment is to be used in combination with funded venetoclax
The patient's disease has relapsed following no and	more than one prior line of treatment with rituximab for CLL
The patient has had an interval of 36 months or	more since commencement of initial rituximab treatment
The patient does not have chromosome 17p dele	etion CLL
It is planned that the patient receives full dose flu administration) or bendamustin	idarabine and cyclophosphamide (orally or dose equivalent intravenous
and  Rituximab to be administered in combination with fludarabine	e and cyclophosphamide, bendamustine or venetoclax for a maximum of
6 treatment cycles	
Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymstandard therapeutic chemotherapy regimen and supportive treatments.	phoma. A line of chemotherapy treatment is considered to comprise a known
INITIATION – severe cold haemagglutinin disease (CHAD) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a haematologist, or in accordant Hospital.	nce with a protocol or guideline that has been endorsed by the Health NZ
O Patient has cold haemagglutinin disease*	
O Patient has severe disease which is characterized by symptoms	matic anaemia, transfusion dependence or disabling circulatory
The total rituximab dose used would not exceed the equivale	nt of 375 mg/m2 of body surface area per week for a total of 4 weeks
Note: Indications marked with * are unapproved indications.	
CONTINUATION – severe cold haemagglutinin disease (CHAD) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)	
Hospital.	nce with a protocol or guideline that has been endorsed by the Health NZ
Previous treatment with lower doses of rituximab (100 mg words) doses (375 mg/m² weekly for 4 weeks) is now planned or	eekly for 4 weeks) have proven ineffective and treatment with higher
O Patient was previously treated with rituximab for severe	e cold haemagglutinin disease*
An initial response lasting at least 12 months was dem	onstrated
O Patient now requires repeat treatment	
Note: Indications marked with * are unapproved indications.	

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.

RESCRIE	BER		PATIENT:	
Name:			Name:	
/ard:			NHI:	
ituxima	ab (R	liximy	yo) - continued	
			autoimmune haemolytic anaemia (warm AIHA) uired after 8 weeks	
			boxes where appropriate)	
	Presc Hospi		by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
and		Patie	ent has warm autoimmune haemolytic anaemia*	
and		One > 5 n	of the following treatments has been ineffective: steroids (including if patient requires ongoing steroids at doses equivalent to mg prednisone daily), cytotoxic agents (e.g. cyclophosphamide monotherapy or in combination), intravenous immunoglobulin	
	$\circ$	The t	total rituximab dose used would not exceed the equivalent of 375 mg/m2 of body surface area per week for a total of 4 weeks	
Note: Indi	icatio	ns ma	arked with * are unapproved indications.	
Re-assess	smen	t requ	warm autoimmune haemolytic anaemia (warm AIHA) uired after 8 weeks boxes where appropriate)	
	Preso Hospi		by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
or	O	Previ dose	rious treatment with lower doses of rituximab (100 mg weekly for 4 weeks) have proven ineffective and treatment with higher es (375 mg/m² weekly for 4 weeks) is now planned	
	and		Patient was previously treated with rituximab for warm autoimmune haemolytic anaemia*	
	and		An initial response lasting at least 12 months was demonstrated  Patient now requires repeat treatment	
Note: Indi	icatio	ns ma	arked with * are unapproved indications.	
Re-assess Prerequis	sment sites Presc	t requ (tick b cribed	Ine thrombocytopenic purpura (ITP) Luired after 8 weeks boxes where appropriate) If by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
and	Hospi	ııaı.		
	or	0	Patient has immune thrombocytopenic purpura* with a platelet count of less than or equal to 20,000 platelets per microlitre	
		0	Patient has immune thrombocytopenic purpura* with a platelet count of 20,000 to 30,000 platelets per microlitre and significant mucocutaneous bleeding	
and	or	0	Treatment with steroids and splenectomy have been ineffective	
		$\circ$	Treatment with steroids has been ineffective and splenectomy is an absolute contraindication	
	or	0	Other treatments including steroids have been ineffective and patient is being prepared for elective surgery (e.g. splenectomy)	
and		The t	total rituximab dose used would not exceed the equivalent of 375 mg/m2 of body surface area per week for a total of 4 weeks	
		Note: Indications marked with * are unapproved indications.		

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.

PRES	CRII	BER PATIENT:		
Name	:			
Ward:		NHI:		
Ritu	cima	ab (Riximyo) - continued		
Re-a	CONTINUATION – immune thrombocytopenic purpura (ITP) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)			
( and		Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
	or	O Previous treatment with lower doses of rituximab (100 mg weekly for 4 weeks) have proven ineffective and treatment with higher doses (375 mg/m² weekly for 4 weeks) is now planned		
		Patient was previously treated with rituximab for immune thrombocytopenic purpura*  An initial response lasting at least 12 months was demonstrated and Patient now requires repeat treatment		
Note	Ind	ications marked with * are unapproved indications.		
Re-a Prere	and	Sites (tick boxes where appropriate)  Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  The total rituximab dose used would not exceed the equivalent of 375 mg/m2 of body surface area per week for a total of 4 weeks  Patient has thrombotic thrombocytopenic purpura* and has experienced progression of clinical symptoms or persistent thrombocytopenia despite plasma exchange  Patient has acute idiopathic thrombotic thrombocytopenic purpura* with neurological or cardiovascular pathology ications marked with * are unapproved indications.		
Re-a	ssess equis	DATION – thrombotic thrombocytopenic purpura (TTP) sment required after 8 weeks sites (tick boxes where appropriate)  Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.		
	and and	O An initial response lasting at least 12 months was demonstrated O Patient now requires repeat treatment		
Note	Ind	ications marked with * are unapproved indications.		

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Signed.	Date.
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I confirm that the above details are correct:

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Rituximab (Riximyo) - continued		
INITIATION – pure red cell aplasia (PRCA) Re-assessment required after 6 weeks Prerequisites (tick box where appropriate)  Prescribed by, or recommended by a haematologist, or in accordance Hospital.  and Patient has autoimmune pure red cell aplasia* associated with a den Note: Indications marked with * are unapproved indications.	e with a protocol or guideline that has been endorsed by the Health NZ nonstrable B-cell lymphoproliferative disorder	
CONTINUATION – pure red cell aplasia (PRCA) Re-assessment required after 6 weeks Prerequisites (tick box where appropriate)  O Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  and O Patient was previously treated with rituximab for pure red cell aplasia* associated with a demonstrable B-cell lymphoproliferative disorder and demonstrated an initial response lasting at least 12 months  Note: Indications marked with * are unapproved indications.		
or disease after at least 3 months	clophosphamide has failed to achieve significant improvement of osphamide > 15 g or a further repeat 3 month induction course of 5 g	
CONTINUATION – ANCA associated vasculitis Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)  Patient has been diagnosed with ANCA associated vasculitis* and Patient has previously responded to treatment with rituximab beand The total rituximab dose would not exceed the equivalent of 37		
Note: Indications marked with * are unapproved indications.	<u> </u>	

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Rituximab (Riximyo) - continued		
INITIATION – treatment refractory systemic lupus erythematosus (SLE)  Prerequisites (tick boxes where appropriate)		
and	t 6 months with maximal tolerated doses of azathioprine, mycophenolate	
Note: Indications marked with * are unapproved indications.		
CONTINUATION – treatment refractory systemic lupus erythematosus (SLE)  Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a rheumatologist or nephrologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  and  O Patient's SLE* achieved at least a partial response to the previous round of prior rituximab treatment		
The disease has subsequently relapsed and		
O Maximum of two 1000 mg infusions of rituximab		
Note: Indications marked with * are unapproved indications.		
INITIATION – Antibody-mediated organ transplant rejection Prerequisites (tick box where appropriate)  O Patient has been diagnosed with antibody-mediated organ transplant rejection* Note: Indications marked with * are unapproved indications.		
INITIATION – ABO-incompatible organ transplant Prerequisites (tick box where appropriate)		
O Patient is to undergo an ABO-incompatible solid organ transplant* Note: Indications marked with * are unapproved indications.		

I confirm that the above details are correct:	
Signed:	Date:

I confirm that the above details are correct:

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rituximab (Riximyo) - continued	
INITIATION – Steroid dependent nephrotic syndrome (SDNS) or frequence Re-assessment required after 8 weeks  Prerequisites (tick boxes where appropriate)	uently relapsing nephrotic syndrome (FRNS)
	ance with a protocol or guideline that has been endorsed by the Health NZ
Treatment with steroids for at least a period of 3 months h	as been ineffective or associated with evidence of steroid toxicity
Treatment with ciclosporin for at least a period of 3 months and  Treatment with mycophenolate for at least a period of 3 m	s has been ineffective and/or discontinued due to unacceptable side effects onths with no reduction in disease relapses
and	alent of 375 mg/m ² of body surface area per week for a total of 4 weeks
Note: Indications marked with a * are unapproved indications.	
CONTINUATION – Steroid dependent nephrotic syndrome (SDNS) or Re-assessment required after 8 weeks  Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a nephrologist, or in accordate Hospital.	ance with a protocol or guideline that has been endorsed by the Health NZ
relapsed and the patient now requires repeat treatment and	as demonstrated sustained response for > 6 months, but the condition has alent of 375 mg/m² of body surface area per week for a total of 4 weeks
Note: Indications marked with a * are unapproved indications.	
INITIATION – Steroid resistant nephrotic syndrome (SRNS) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a nephrologist, or in accordance Hospital.	ance with a protocol or guideline that has been endorsed by the Health NZ
Patient is a child with SRNS* where treatment with steroid and  Treatment with tacrolimus for at least 3 months has been and  Genetic causes of nephrotic syndrome have been exclude and	
Note: Indications marked with a * are unapproved indications.	and por moon or a configuration of the configuratio

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PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Rituximab (Riximyo) - continued		
CONTINUATION – Steroid resistant nephrotic syndrome (SRNS) Re-assessment required after 8 weeks Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a nephrologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  and  Patient who was previously treated with rituximab for nephrotic syndrome* and  Treatment with rituximab was previously successful and has demonstrated sustained response for greater than 6 months, but the condition has relapsed and the patient now requires repeat treatment and  The total rituximab dose used would not exceed the equivalent of 375 mg/m² of body surface area per week for a total of 4 weeks		
weekly for four weeks	of NMOSD (rapidly progressing symptoms and clinical investigations	
The patient is receiving treatment with mycopheno and The patients is receiving treatment with corticoster		
CONTINUATION – Neuromyelitis Optica Spectrum Disorder (NMOSD) Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)		
One of the following dose regimens is to be used: 2 doses of weekly for four weeks  and  The patients has responded to the most recent course of rituxiand	1,000 mg rituximab administered fortnightly, or 4 doses of 375 mg/m2 administere	
O The patient has not received rituximab in the previous 6 month		

I confirm that the above details are correct:

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	. NHI:	
Rituximab (Riximyo) - continued		
	e with a protocol or guideline that has been endorsed by the Health NZ	
Hospital.  One of the following dose regimens is to be used: 375 mg/r weekly for four weeks, or two 1,000 mg doses given two we	m2 of body surface area per week for a total of four weeks, or 500 mg once	
Treatment with corticosteroids and at least one other ineffective  Or  Treatment with at least one other immunosuppressed.	mmunosuppressant for at least a period of 12 months has been	
CONTINUATION – Severe Refractory Myasthenia Gravis Re-assessment required after 2 years		
Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ  n2 of body surface area per week for a total of four weeks, or 500 mg once eks apart	
An initial response lasting at least 12 months was demonstr		
or least 12 months	osteroids and at least one other immunosuppressant for a period of at	
least 12 months	espite treatment with at least one immunosuppressant for a period of at  months and have been discontinued due to unacceptable side effects	
INITIATION – Severe antisynthetase syndrome Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)		
Patient has confirmed antisynthetase syndrome and Patient has severe, immediately life or organ threatening dis	ease, including interstitial lung disease	
or  Treatment with at least 3 immunosuppressants (oral sazathioprine) has not be effective at controlling active  Rapid treatment is required due to life threatening cor		
Maximum of four 1,000 mg infusions of rituximab		

PRESCRIBER	PATIENT:	
Name:		
Ward:	NHI:	
Rituximab (Riximy	ro) - continued	
Re-assessment requ	Severe antisynthetase syndrome uired after 12 months coxes where appropriate)	
and Strer	ent's disease has responded to the previous rituximab treatment with demonstrated improvement in inflammatory markers, muscle agth and pulmonary function patient has not received rituximab in the previous 6 months finum of two cycles of 2 × 1,000 mg infusions of rituximab given two weeks apart	
	versus host disease poxes where appropriate)	
and Trea conti	thent has refractory graft versus host disease following transplant tment with at least 3 immunosuppressants (oral steroids, ciclosporin, tacrolimus, mycophenolate, sirolimus) has not be effective at rolling active disease total rituximab dose used would not exceed the equivalent of 375 mg/m² of body surface area per week for a total of 4 weeks	
Prescribed Hospital.	boxes where appropriate)  I by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ	
and ar	Treatment with steroids and intravenous immunoglobulin and/or plasma exchange has not been effective at controlling active disease  At least one other immunosuppressant (cyclophosphamide, ciclosporin, tacrolimus, mycophenolate) has not been effective at controlling active disease  Rapid treatment is required due to life threatening complications	
	of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once kly for four weeks, or two 1,000 mg doses given two weeks apart	
CONTINUATION – severe chronic inflammatory demyelinating polyneuropathy Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
and com	ent's disease has responded to the previous rituximab treatment with demonstrated improvement in neurological function pared to baseline patient has not received rituximab in the previous 6 months	
	of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once kly for four weeks, or two 1,000 mg doses given two weeks apart	

I confirm that the above details are correct:

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	PATIENT:	
Name:		
Ward:	NHI:	
Rituximab (Riximyo) - continued		
Hospital.		
and active disear and At least one effective at or Rapid treatment is	e other immunosuppressant (cyclophosphamide, ciclosporin, tacrolimus, mycophenolate) has not been controlling active disease s required due to life threatening complications	
One of the following dose regimens is to be used: 375 mg/m2 of body surface area per week for a total of four weeks, or 500 mg once weekly for four weeks, or two 1,000 mg doses given two weeks apart  CONTINUATION – anti-NMDA receptor autoimmune encephalitis		
Hospital.  Patient's disease has read  The patient has not receand  The patient has experie and  One of the following dos		
INITIATION – CD20+ low grade or foll Re-assessment required after 9 months Prerequisites (tick boxes where appropri		
or  To be used for a r  The patient has C	ED20+ low grade or follicular B-cell NHL with relapsed disease following prior chemotherapy maximum of 6 treatment cycles  ED20+ low grade or follicular B-cell NHL requiring first-line systemic chemotherapy maximum of 6 treatment cycles	

I confirm that the above details are correct:

I confirm that the above details are correct:

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER		PATIENT:
Name:		Name:
Ward:		NHI:
<b>Rituximab</b> (Riz	ximyo) - continued	
CONTINUATION Re-assessment Prerequisites (t	N – CD20+ low grade or follicular B-cell NHL required after 24 months tick boxes where appropriate)  Rituximab is to be used for maintenance in CD20+ low grade of chemotherapy  Patient is intended to receive rituximab maintenance therapy for	or follicular B-cell NHL following induction with first-line systemic or 2 years at a dose of 375 mg/m2 every 8 weeks (maximum of
INITIATION – Mo	embranous nephropathy required after 6 weeks tick boxes where appropriate)	
and	measures (see Note)	
Prerequisites (t	N – Membranous nephropathy required after 6 weeks tick boxes where appropriate) Patient was previously treated with rituximab for membranous	nephropathy*
or (	treatment  Patient achieved partial response to treatment and requi	the condition has relapsed, and the patient now requires repeat ires repeat treatment (see Note)  t of 375 mg/m2 of body surface area per week for a total of 4 weeks
Note:  a) Indications m b) High risk of p c) Conservative dyslipidaemia	narked with * are unapproved indications.  progression to end-stage kidney disease defined as > 5g/day per measures include renin-angiotensin system blockade, blooda, and anticoagulation agents unless contraindicated or the page	proteinuria.  pressure management, dietary sodium and protein restriction, treatment of

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	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Rituximab (Riximyo) - continued		
INITIATION – B-cell acute lymphoblastic leukaemia/lymphoma* Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)		
Patient has newly diagnosed B-cell acute lymphoblastic leukae and Treatment must be in combination with an intensive chemothe and The total rituximab dose would not exceed the equivalent of 37	rapy protocol with curative intent	
Note: Indications marked with * are unapproved indications.		
INITIATION – desensitisation prior to transplant Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)		
Patient requires desensitisation prior to mismatched allogenic stem cell transplant*  Patient would receive no more than two doses at 375 mg/m2 of body-surface area  Note: Indications marked with * are unapproved indications.		
INITIATION – pemiphigus* Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a dermatologist or relevant specific by the Health NZ Hospital.  and	ialist, or in accordance with a protocol or guideline that has been endorsed	
Patient has severe rapidly progressive pemphigus  Is used in combination with systemic corticosteroids (20  and  Skin involvement is at least 5% body surface area  or  Significant mucosal involvement (10 or more muco  or  Involvement of two or more mucosal sites  or  Patient has pemphigus  and		

I confirm that the above details are correct:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rituximab (Riximyo) - continued	
CONTINUATION – pemiphigus* Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a dermatologist or relevant speciby the Health NZ Hospital.  and	ialist, or in accordance with a protocol or guideline that has been endorsed
Patient has experienced adequate clinical benefit from rituximal ulceration and reduction in corticosteroid requirement  and Patient has not received rituximab in the previous 6 months  Note: Indications marked with * are unapproved indications.	ab treatment, with improvement in symptoms and healing of skin
INITIATION – immunoglobulin G4-related disease (IgG4-RD*) Re-assessment required after 6 weeks Prerequisites (tick boxes where appropriate)	
or lowering corticosteroid dose below 5 mg per day (predn	anti-rheumatic drugs is contraindicated or associated with evidence of
Note: Indications marked with * are unapproved indications.	
CONTINUATION – immunoglobulin G4-related disease (IgG4-RD*) Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
Treatment with rituximab for IgG4-RD* was previously st but the condition has relapsed  Patient is receiving maintenance treatment for IgG4-RD*  and  Rituximab re-treatment not to be given within 6 months of prevand  Maximum of two 1000 mg infusions of rituximab given two were	vious course of treatment
Note: Indications marked with * are unapproved indications.	ens apail
Troto. Indications marked with are unapproved indications.	

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Mepolizumab	
INITIATION – Severe eosinophilic asthma Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a respiratory physician or clinical endorsed by the Health NZ Hospital.  and  Patient must be aged 12 years or older and  Patient must have a diagnosis of severe eosinophilic asthmate and  Conditions that mimic asthmateg. vocal cord dysfunction, certain and  Patient has a blood eosinophil count of greater than 0.5 × 10° and  Patient must be adherent to optimised asthmatherapy includity of fluticasone propionate) plus long acting beta-2 agonist, or a therapy regimen, unless contraindicated or not tolerated  Patient has had at least 4 exacerbations needing system defined as either documented use of oral corticosteroids of a and  Treatment is not to be used in combination with subsidised be and  Patient has an Asthma Control Test (ACT) score of 10 or less	ng inhaled corticosteroids (equivalent to at least 1000 mcg per day budesonide/formoterol as part of the single maintenance and reliever mic corticosteroids in the previous 12 months, where an exacerbation is at least 3 days or parenteral corticosteroids at least the equivalent of 10 mg per day over the previous 3 months enralizumab  Baseline measurements of the patient's asthma control using the ACT ication, and again at around 52 weeks after the first dose to assess
Patient was refractory or intolerant to previous an and Patient was not eligible to continue treatment with 12 months of commencing treatment	ti-IL5 biological therapy  previous anti-IL5 biological therapy and discontinued within
CONTINUATION – Severe eosinophilic asthma Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a respiratory physician or clinical endorsed by the Health NZ Hospital.	al immunologist, or in accordance with a protocol or guideline that has been
An increase in the Asthma Control Test (ACT) score of at least and  O Exacerbations have been reduced from baseline by 50% or	

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Mepolizumab - continued	
INITIATION – eosinophilic granulomatosis with polyangiitis Re-assessment required after 12 months	
Prerequisites (tick boxes where appropriate)	
The patient has eosinophilic granulomatosis with polyangiitis and The patient has trialled and not received adequate benefit fron contraindicated to all): azathioprine, cyclophosphamide, leflun	
The patient has trialled prednisone for a minimum of three 7.5 mg per day  Corticosteroids are contraindicated	ee months and is unable to maintain disease control at doses below
CONTINUATION – eosinophilic granulomatosis with polyangiitis Re-assessment required after 12 months Prerequisites (tick box where appropriate)  O Patient has no evidence of clinical disease progression	

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#### RS2140 - Adalimumab (Amgevita)

Arthritis - oligoarticular course juvenile idiopathic - INITIATION	393
Arthritis - oligoarticular course juvenile idiopathic - CONTINUATION	393
Arthritis - polyarticular course juvenile idiopathic - INITIATION	394
Arthritis - polyarticular course juvenile idiopathic - CONTINUATION	394
Arthritis - psoriatic - INITIATION	
Arthritis - psoriatic - CONTINUATION	395
Arthritis - rheumatoid - INITIATION	396
Arthritis - rheumatoid - CONTINUATION	
Behcet's disease - severe - INITIATION	385
Crohn's disease - adults - INITIATION	388
Crohn's disease - adults - CONTINUATION	388
Crohn's disease - children - INITIATION	388
Crohn's disease - children - CONTINUATION	389
Crohn's disease - fistulising - INITIATION	389
Crohn's disease - fistulising - CONTINUATION	389
Hidradenitis suppurativa - INITIATION	385
Hidradenitis suppurativa - CONTINUATION	385
Ocular inflammation - chronic - INITIATION	390
Ocular inflammation - chronic - CONTINUATION	
Ocular inflammation - severe - INITIATION	391
Ocular inflammation - severe - CONTINUATION	391
Plaque psoriasis - severe chronic - INITIATION	386
Plaque psoriasis - severe chronic - CONTINUATION	387
Still's disease - adult-onset (AOSD) - INITIATION	397
Ankylosing spondylitis - INITIATION	392
Ankylosing spondylitis - CONTINUATION	392
Inflammatory bowel arthritis – axial - INITIATION	398
Inflammatory bowel arthritis – axial - CONTINUATION	399
Inflammatory bowel arthritis – peripheral - INITIATION	399
Inflammatory bowel arthritis – peripheral - CONTINUATION	399
Pyoderma gangrenosum - INITIATION	387
Ulcerative colitis - INITIATION	
Ulcerative colitis - CONTINUATION	
Undifferentiated spondyloarthiritis - INITIATION	398
Undifferentiated spondyloarthiritis - CONTINUATION	398

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.

PRES	CRI	BER			PATIENT:
Name:					Name:
Ward:					NHI:
Adal	imı	ımal	A) (Ar	mgevita)	
				et's disease - severe boxes where appropriate)	
( and	С		cribed ospita		cordance with a protocol or guideline that has been endorsed by the Health
	and	O	The	patient has severe Behcet's disease* that is significantly in	mpacting the patient's quality of life
		or	0	The patient has severe ocular, neurological, and/or vasc treatment(s) appropriate for the particular symptom(s)	sullitic symptoms and has not responded adequately to one or more
			0	The patient has severe gastrointestinal, rheumatological to two or more treatments appropriate for the particular s	and/or mucocutaneous symptoms and has not responded adequately symptom(s)
Note	: Inc	dicatio	ns ma	arked with * are unapproved indications.	
		President Hosp	Patie	ent has hidradenitis suppurativa Hurley Stage II or Hurley	a 90 day trial of systemic antibiotics or patient has demonstrated
Re-a	sses	ssmer sites Pres	t requ (tick t		ecordance with a protocol or guideline that has been endorsed by the Health
	and			patient has a reduction in active lesions (e.g. inflammator patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a DLQI improvement of 4 or more from baseling patient has a	ry nodules, abscesses, draining fistulae) of 25% or more from baseline ne
			4		

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.

PRES	CRIB	ER			PATIENT:
Name	:				
Ward:					NHI:
Adal	imur	nab	(An	ngev	ita) - continued
Re-a	ssess	ment ı	equ	ired a	riasis - severe chronic fter 4 months where appropriate)
(and		Prescri Hospita		by, or	recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		and	C	Patie	ent has had an initial Special Authority approval for etanercept for severe chronic plaque psoriasis
			or	0	Patient has experienced intolerable side effects  Patient has received insufficient benefit to meet the renewal criteria for etanercept for severe chronic plaque psoriasis
	or		_		
			or or	0	Patient has "whole body" severe chronic plaque psoriasis with a (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis  Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis  Patient has severe chronic localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and with a Dermatology Life Quality Index (DLQI) score greater
		and ( and	_ Э Э	follov	than 10  In that tried, but had an inadequate response to, or has experienced intolerable side effects from, at least three of the ving (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin  SI assessment or (DLQI) assessment has been completed for at least the most recent prior treatment course but no
					er than 1 month following cessation of each prior treatment course and is no more than 1 month old at the time of cation

PRES	CRIB	ER		PATIENT:
Name	:			Name:
Ward:				NHI:
Adali	imur	mab (	Αmg	gevita) - continued
Re-as	ssess	ment re	quire	que psoriasis - severe chronic d after 2 years res where appropriate)
		and	) P	The patient has experienced a 75% or more reduction in PASI score, or is sustained at this level, when compared with the pre-treatment baseline value  The patient has a DLQI improvement of 5 or more, when compared with the pre-treatment baseline value
	or	and	) _P	ratient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment
			or (	The patient has experienced a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values  The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value
	or	and	) _P	ratient had severe chronic localised genital or flexural plaque psoriasis at the start of treatment
			or	The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value
			(	Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing adalimumab
				na gangrenosum res where appropriate)
and		Hospital		r, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
	and (	О Ра	ıtient	has pyoderma gangrenosum*  has received three months of conventional therapy including a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin, prine, or methotrexate) and not received an adequate response
Note:	India	cations	mark	ed with * are unapproved indications.

I confirm that the above details are correct:

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.

PRES	CRIE	BER	PATIENT:
Name	:		
Ward:			NHI:
Adal	imu	mak	o (Amgevita) - continued
Re-a	ssess equis	smen sites Preso	Crohn's disease - adults It required after 6 months (tick boxes where appropriate)  cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.
	and		Patient has severe active Crohn's disease  O Patient has a CDAI score of greater than or equal to 300 or HBI score of greater than or equal to 10
		or or	O Patient has extensive small intestine disease affecting more than 50 cm of the small intestine
		or	O Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection O Patient has an ileostomy or colostomy and has intestinal inflammation
	and	0	Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators and corticosteroids
Re-a	ssess siupe	smen sites Preso	ON – Crohn's disease - adults It required after 2 years (tick boxes where appropriate)  cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.  CDAI score has reduced by 100 points from the CDAI score, or HBI score has reduced 3 points, from when the patient was initiated on adalimumab  CDAI score is 150 or less, or HBI is 4 or less  The patient has demonstrated an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed
Re-a	ssess equis	smen sites Preso	Crohn's disease - children It required after 6 months (tick boxes where appropriate)  cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.
and	and	O	Paediatric patient has active Crohn's disease  O Patient has a PCDAI score of greater than or equal to 30
	and	or O	O Patient has extensive small intestine disease  Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators and corticosteroids

I confirm that the above details are correct:

Signed: Date:

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PRES	CRI	BER		PATIENT:	
Name	:			Name:	
Ward				NHI:	
Adal	imı	ımak	o (Amgevita) - continued		
Re-a	sses	smen	N – Crohn's disease - children t required after 2 years (tick boxes where appropriate)		
Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the He NZ Hospital.					
and	or	0	PCDAI score has reduced by 10 points from the PCDAI score	when the patient was initiated on adalimumab	
	or	$\bigcirc$	PCDAI score is 15 or less		
		0	The patient has demonstrated an adequate response to treatment of the patient has demonstrated an adequate response to treatment of the patient has demonstrated an adequate response to treatment of the patient has demonstrated an adequate response to treatment of the patient has demonstrated an adequate response to treatment of the patient has demonstrated an adequate response to the patient has demonstrated and the p	nent but PCDAI score cannot be assessed	
Re-a	sses	Preson NZ H	Crohn's disease - fistulising t required after 6 months (tick boxes where appropriate)  cribed by, or recommended by any relevant practitioner, or in accospital.  Patient has confirmed Crohn's disease  O Patient has one or more complex externally draining enters O Patient has one or more rectovaginal fistula(e)  O Patient has complex peri-anal fistula  A Baseline Fistula Assessment has been completed and is no		
Re-a	sses	smen <b>sites</b> Presc	ON – Crohn's disease - fistulising t required after 2 years (tick boxes where appropriate) cribed by, or recommended by any relevant practitioner, or in accospital.  The number of open draining fistulae have decreased from base	cordance with a protocol or guideline that has been endorsed by the Health seline by at least 50%	
		O 	There has been a marked reduction in drainage of all fistula(e) score, together with less induration and patient-reported pain	from baseline as demonstrated by a reduction in the Fistula Assessment	

PRES	SCRI	BER	PATIENT:
Name	e:		Name:
Ward	:		NHI:
Adal	limu	ımab	(Amgevita) - continued
Re-a	asses	ssment sites (	Ocular inflammation - chronic required after 4 months (tick boxes where appropriate) ribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
and	_	NZ Ho	
	or	O .	The patient has had an initial Special Authority approval for infliximab for chronic ocular inflammation
	OI.	and	Patient has severe uveitis uncontrolled with treatment of steroids and other immunosuppressants with a severe risk of vision loss
			Patient is 18 years or older and treatment with at least two other immunomodulatory agents has proven ineffective  Patient is under 18 years and treatment with methotrexate has proven ineffective or is not tolerated at a therapeutic dose  Patient is under 8 years and treatment with steroids or methotrexate has proven ineffective or is not tolerated at a therapeutic dose; or disease requires control to prevent irreversible vision loss prior to achieving a therapeutic dose of methotrexate
Re-a	equi	ssment sites (	N – Ocular inflammation - chronic required after 2 years tick boxes where appropriate)  ribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.
anu		O .	The patient has had a good clinical response following 12 weeks' initial treatment
	or		Following each 2 year treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)
	31		Following each 2 year treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old

I confirm that the above details are correct:	
Signed:	Date:

PRES	CRI	BER	PATIENT:
Name	):		Name:
Ward:	:		NHI:
Adal	imu	ımab	(Amgevita) - continued
INITI Re-a	ATIC sses equi	ON - Cosment sites ( Presc NZ Ho	Ocular inflammation - severe required after 4 months (tick boxes where appropriate)  ribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.  Patient has had an initial Special Authority approval for infliximab for severe ocular inflammation
		anc	Patient has severe, vision-threatening ocular inflammation requiring rapid control  Treatment with high-dose steroids (intravenous methylprednisolone) followed by high dose oral steroids has proven ineffective at controlling symptoms  Patient developed new inflammatory symptoms while receiving high dose steroids  Patient is aged under 8 years and treatment with high dose oral steroids and other immunosuppressants has proven ineffective at controlling symptoms
Re-a	sses equi	ssment sites ( Presc	N – Ocular inflammation - severe required after 2 years (tick boxes where appropriate)  ribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.
und	or or	0	The patient has had a good clinical response following 3 initial doses  Following each 2 year treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)
			Following each 2 year treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old

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.

PRESCR	IBER		PATIENT:
Name:			Name:
Ward:			NHI:
Adalim	umab	(An	evita) - continued
INITIATI Re-asse	ON – ar ssment isites (i Prescr Hospit	or	Ing spondylitis It defers a months It is where appropriate) It is where appropriate and initial special Authority approval for etanercept for ankylosing spondylitis  The patient has experienced intolerable side effects  The patient has received insufficient benefit to meet the renewal criteria for ankylosing spondylitis  The patient has received insufficient benefit to meet the renewal criteria for ankylosing spondylitis  attent has a confirmed diagnosis of ankylosing spondylitis for more than six months  attent has low back pain and stiffness that is relieved by exercise but not by rest  attent has bilateral sacroilitits demonstrated by radiology imaging  attent has not responded adequately to treatment with two or more NSAIDs, while patient was undergoing at least 3 months of
	and	or	Patient has limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by the following BASMI measures: a modified Schober's test of less than or equal to 4 cm and lumbar side flexion measurement of less than or equal to 10 cm (mean of left and right)  Patient has limitation of chest expansion by at least 2.5 cm below the average normal values corrected for age and gender  BASDAI of at least 6 on a 0-10 scale completed after the 3 month exercise trial, but prior to ceasing any previous narmacological treatment and is no more than 1 month old at the time of application
CONTIN	LIATIO		
Re-asse	ssment isites (i Prescr NZ Ho For ap	requitick bribed spita	ylosing spondylitis d after 2 years where appropriate) , or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health his where treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point hiprovement in BASDAI of 50%, whichever is less

0:	D - 1 - 1	

PRE	SCRI	RIBER	ATIENT:
Nam	e:		lame:
Ward	l:	N	IHI:
Ada	limu	umab (Amgevita) - continued	
INIT Re-a	IATIC asses requi	ION – Arthritis - oligoarticular course juvenile idiopathic essment required after 6 months uisites (tick boxes where appropriate)  Prescribed by, or recommended by a named specialist or rheumatolog by the Health NZ Hospital.  The patient has had an initial Special Authority approval for and  Patient has experienced intolerable side effects or  Patient has received insufficient benefit to meet the received and  Patient has had oligoarticular course JIA for 6 months dura and  At least 2 active joints with limited range of motion, present and maximum tolerated dose)	therapy where use of methotrexate is limited by toxicity or intolerance
		of methotrexate (at the maximum tolerated dose)	
Re-a	asses equi	NUATION – Arthritis - oligoarticular course juvenile idiopathic essment required after 2 years uisites (tick boxes where appropriate)  Prescribed by, or recommended by any relevant practitioner, or in acconditional NZ Hospital.	ordance with a protocol or guideline that has been endorsed by the Health
	or		se in active joint count and an improvement in physician's global a continuing 30% improvement in active joint count and continued

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.

PRES	PRESCRIBER PATIENT:						
Name	e:					Name:	
Ward	:					NHI:	
Adal	imu	ımab	(Ar	ng	evi	rita) - continued	
Re-a	sses	sites (	requitick b	ired Oxe by,	d af es v	olyarticular course juvenile idiopathic fter 6 months where appropriate) recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed Hospital.	
		and	O	Pa	ıtier	ent has had an initial Special Authority approval for etanercept for polyarticular course juvenile idiopathic arthritis (JIA)	
			or		)	Patient has experienced intolerable side effects  Patient has received insufficient benefit to meet the renewal criteria for polyarticular course JIA	
	or	and	0		atier	e used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance ent has had polyarticular course JIA for 6 months duration or longer  At least 5 active joints and at least 3 joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose)	
			or		)	Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the maximum tolerated dose)  Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate	
Re-a	sses	sment	requ	ire	d af	is - polyarticular course juvenile idiopathic fter 2 years where appropriate)	
and	С	Presc NZ Ho			or	recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health	
	or	0				nitial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global not from baseline	
						uent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued ent in physician's global assessment from baseline	

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PRES	SCRIE	BER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Adal	imu	mab	(An	ngevita) - continued
Re-a	ssess equis	sment sites (t	requ ick b ibed	tis - psoriatic ired after 6 months boxes where appropriate) by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		and	$\mathcal{O}$	Patient has had an initial Special Authority approval for etanercept or secukinumab for psoriatic arthritis
			or	O Patient has experienced intolerable side effects O Patient has received insufficient benefit to meet the renewal criteria for psoriatic arthritis
	or		_	
		and	$\bigcirc$	Patient has had active psoriatic arthritis for six months duration or longer
		and	$\bigcirc$	Patient has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated)
		and	0	Patient has tried and not responded to at least three months of sulfasalazine or leflunomide at maximum tolerated doses (unless contraindicated)
		ana		O Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen joints
			or	O Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip
		and		
			or	Patient has CRP level greater than 15 mg/L measured no more than one month prior to the date of this application
			or	Patient has an elevated ESR greater than 25 mm per hour
				ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months
Re-a	ssess	sment	requ	Arthritis - psoriatic ired after 2 years
Prer	·	,		poxes where appropriate)
and		Prescr NZ Ho		by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health al.
anu	or			wing initial treatment, the patient has at least a 50% decrease in swollen joint count from baseline and a clinically significant onse in the opinion of the physician
				ent demonstrates at least a continuing 30% improvement in swollen joint count from baseline and a clinically significant response e opinion of the treating physician

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.

	RIBEF	1		PATIENT:
Name: .				Name:
Vard:				NHI:
Adalim	numa	ab (Ar	ngevita) - co	ontinued
Re-asse	essme uisite Pre	ent requ <b>s</b> (tick b scribed	tis - rheumato nired after 6 mono coxes where ap	nths
and	Hos	spital.		
	а	O	The patient ha	as had an initial Special Authority approval for etanercept for rheumatoid arthritis
		or		ient has experienced intolerable side effects
			O The pati	ient has received insufficient benefit from etanercept to meet the renewal criteria for rheumatoid arthritis
OI	r			
	а		antibody posit	ad rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic citrullinated peptide (CCP) ive) for six months duration or longer  b be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity
		nd ond		ed and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated)
	а	O nd		ed and not responded to at least three months of methotrexate in combination with sulfasalazine and hydroxychloroquii aximum tolerated doses (unless contraindicated)
		or	dose of	has tried and not responded to at least three months of methotrexate in combination with the maximum tolerated ciclosporin (unless contraindicated)
			O Patient I	has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomid contraindicated) alone or in combination with methotrexate
	а	nd		has persistent symptoms of poorly controlled and active disease in at least 15 swollen joints
		or	O Patient I	has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, tnee, ankle, and either shoulder or hip
Re-asse	essme uisite	ent requ s (tick b	Arthritis - rheur hired after 2 year poxes where ap	urs
and _		Hospita	al.	
OI	r ~			tment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant in the opinion of the physician
	$\circ$			oplications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and it response to treatment in the opinion of the physician

I confirm that the above details are correct:

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.

PRESCRIBE		BER		PATIENT:
Name	:			
Ward:				NHI:
Adal	imu	ımab (	Am	gevita) - continued
				lisease - adult-onset (AOSD)  oxes where appropriate)
( and		Prescrib Hospita		by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ
		and	)	The patient has had an initial Special Authority approval for etanercept and/or tocilizumab for (AOSD)
			or	O Patient has experienced intolerable side effects from etanercept and/or tocilizumab
				O Patient has received insufficient benefit from at least a three-month trial of etanercept and/or tocilizumab
	or	and	)	Patient diagnosed with AOSD according to the Yamaguchi criteria
		and		Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, NSAIDs and methotrexate
			)	Patient has persistent symptoms of disabling poorly controlled and active disease
( and	C	Prescrib NZ Hos	ed I pital	
	and		atier	t has active ulcerative colitis
		or	)	Patient's SCCAI score is greater than or equal to 4
			)	Patient's PUCAI score is greater than or equal to 20
	and	O Pa		It has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators ystemic corticosteroids
		$\sim$	urge	ry (or further surgery) is considered to be clinically inappropriate
Re-assessm Prerequisite		sment re sites (tid	equi ck bo ed l	cerative colitis red after 2 years exposes where appropriate)  by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
	or	От	ne S	CCAI score has reduced by 2 points or more from the SCCAI score when the patient was initiated on biologic therapy
		От	ne P	UCAI score has reduced by 10 points or more from the PUCAI score when the patient was initiated on biologic therapy

I confirm that the above details are correct:

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

I confirm that the above details are correct:

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER			PATIENT:					
Name:								
Ward	:		NHI:					
Adal	imu	mal	(Amgevita) - continued					
INITIATION – undifferentiated spondyloarthiritis Re-assessment required after 6 months  Prerequisites (tick boxes where appropriate)								
and		Preso Hosp	cribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.					
	and		Patient has undifferentiated peripheral spondyloarthritis* with active peripheral joint arthritis in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip					
	and	0	Patient has tried and not responded to at least three months of each of methotrexate, sulphasalazine and leflunomide, at maximum tolerated doses (unless contraindicated)					
		or	O Patient has a CRP level greater than 15 mg/L measured no more than one month prior to the date of this application					
		or	Patient has an ESR greater than 25 mm per hour measured no more than one month prior to the date of this application					
			O ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months					
Note	: Ind	icatio	ns marked with * are unapproved indications.					
	equi:	<b>sites</b> Preso	trequired after 2 years (tick boxes where appropriate)  cribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health ospital.  Following initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician  The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response in the opinion of the treating physician					
INITIATION – inflammatory bowel arthritis – axial Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)								
and		Preso Hosp	cribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.					
unu	and	0	Patient has a diagnosis of active ulcerative colitis or active Crohn's disease					
	and	0	Patient has axial inflammatory pain for six months or more  Patient is unable to take NSAIDs					
	and	0	Patient has unequivocal sacroiliitis demonstrated by radiological imaging or MRI					
	and	$\circ$	Patient has not responded adequately to prior treatment consisting of at least 3 months of an exercise regime supervised by a physiotherapist					
	3.10	O	A BASDAI of at least 6 on a 0-10 scale completed after the 3 month exercise trial, but prior to ceasing any previous pharmacological treatment					

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.

PRES	CRIBER PATIENT:				
Name					
Ward	NHI:				
Ada	mumab (Amgevita) - continued				
	TINUATION – inflammatory bowel arthritis – axial seessment required after 2 years				
	equisites (tick box where appropriate)				
O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been end NZ Hospital.					
and	Where treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point scale, or an improvement in BASDAI of 50%, whichever is less				
Re-a	ATION – inflammatory bowel arthritis – peripheral seessment required after 6 months equisites (tick boxes where appropriate)				
and	Prescribed by, or recommended by a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
	O Patient has a diagnosis of active ulcerative colitis or active Crohn's disease and				
	Patient has active arthritis in at least four joints from the following: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, sternoclavicular				
	Patient has tried and not experienced a response to at least three months of methotrexate, or azathioprine at a maximum tolerated dose (unless contraindicated)  and				
	Patient has tried and not experienced a response to at least three months of sulphasalazine at a maximum tolerated dose (unless contraindicated)  and				
	O Patient has a CRP level greater than 15 mg/L measured no more than one month prior to the date of this application or				
	O Patient has an ESR greater than 25 mm per hour				
	ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months				
Re-a	CONTINUATION – inflammatory bowel arthritis – peripheral Re-assessment required after 2 years  Prerequisites (tick boxes where appropriate)				
and	Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
	Following initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician				
	O Patient demonstrates at least a continuing 30% improvement in active joint count from baseline in the opinion of the treating physician				

I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Palivizumab	
support (see Note A) in the community  Child has haemodynamically significant and  Child has unoperated simple cong B)  Or Child has unoperated or surgically or Child has severe pulmonary hyperor Child has moderate or severe left  Or Child has severe combined immune deficiency transplant	neuromuscular disease that requires ongoing ventilatory/respiratory heart disease genital heart disease with significant left to right shunt (see Note y palliated complex congenital heart disease

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RESCRIBER		PATIENT:
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alivizumak	• cont	tinued
	nt requir	red after 6 months  oxes where appropriate)
and and	O Child was born in the last 24 months	
or	ı	Child has severe lung, airway, neurological or neuromuscular disease that requires ongoing ventilatory/respiratory support (see Note A) in the community  Child has haemodynamically significant heart disease
	and	Child has unoperated simple congenital heart disease with significant left to right shunt (see Note B)  Child has unoperated or surgically palliated complex congenital heart disease  Child has severe pulmonary hypertension (see Note C)  Child has moderate or severe left ventricular (LV) failure (see Note D)
or	$\frac{\circ}{\circ}$	Child has severe combined immune deficiency, confirmed by an immunologist, but has not received a stem cell transplant  Child has inborn errors of immunity (see Note E) that increase susceptibility to life-threatening viral respiratory infections, confirmed by an immunologist

#### Note:

- a) Ventilatory/respiratory support includes those on home oxygen, CPAP/VPAP and those with tracheostomies in situ managed at home
- b) Child requires/will require heart failure medication, and/or child has significant pulmonary hypertension, and/or infant will require surgical palliation/definitive repair within the next 3 months
- c) Mean pulmonary artery pressure more than 25 mmHg
- d) LV Ejection Fraction less than 40%
- e) Inborn errors of immunity include, but are not limited to, IFNAR deficiencies

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:
Name:	
Ward:	NHI:
Gemtuzuma	b ozogamicin
INITIATION Prerequisites	(tick boxes where appropriate)
and and	Patient has not received prior chemotherapy for this condition  Patient has de novo CD33-positive acute myeloid leukaemia  Patient does not have acute promyelocytic leukaemia
and and	Gemtuzumab ozogamicin will be used in combination with standard anthracycline and cytarabine (AraC)  Patient is being treated with curative intent
and and	Patient's disease risk has been assessed by cytogenetic testing to be good or intermediate  Patient must be considered eligible for standard intensive remission induction chemotherapy with standard anthracycline and cytarabine (AraC)
and	Gemtuzumab ozogamicin to be funded for one course only (one dose at 3 mg per m² body surface area or up to 2 vials of 5 mg as separate doses)

Note: Acute myeloid leukaemia excludes acute promyelocytic leukaemia and acute myeloid leukaemia that is secondary to another haematological disorder (eg myelodysplasia or myeloproliferative disorder).

I confirm that the above details are correct:	
Signed:	Date:

I confirm that the above details are correct:

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Benralizumab		
INITIATION – Severe eosinophilic asthma Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a respiratory physician or clinic endorsed by the Health NZ Hospital.  and  Patient must be aged 12 years or older  and  Patient must have a diagnosis of severe eosinophilic asthma and  Conditions that mimic asthma eg. vocal cord dysfunction, ce and  Patient has a blood eosinophil count of greater than 0.5 × 10 and  Patient must be adherent to optimised asthma therapy include fluticasone propionate) plus long-acting beta-2 agonist, or but maintenance regimen, unless contraindicated or not tolerated and  Patient has had at least 4 exacerbations needing systed defined as either documented use of oral corticosteroids of and  Patient has an Asthma Control Test (ACT) score of 10 or less and oral corticosteroid dose must be made at the time of appressions to treatment  Patient has not previously received an anti-IL5 biologic or  Patient was refractory or intolerant to previous and and  Patient was refractory or intolerant to previous and and	ling inhaled corticosteroids (equivalent to at least 1000 mcg per day of indesonide/formoterol as part of the anti-inflammatory reliever therapy plus of emic corticosteroids in the previous 12 months, where an exacerbation is dis for at least 3 days or parenteral corticosteroids at least the equivalent of 10 mg per day over the previous 3 months repolizumab  s. Baseline measurements of the patient's asthma control using the ACT plication, and again at around 52 weeks after the first dose to assess all therapy for their severe eosinophilic asthma	
endorsed by the Health NZ Hospital.  An increase in the Asthma Control Test (ACT) score of at lead and		
or  Reduction in continuous oral corticosteroid use by 50%	% as a result of treatment with benralizumab 6 or by 10 mg/day while maintaining or improving asthma control	

I confirm that the above details are correct:

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIB	BER	PATIENT:		
Name:		Name:		
Ward:		NHI:		
Ustekinu	ımab			
Re-assess	sment requires (tick	n's disease - adults uired after 6 months boxes where appropriate)  ent is currently on treatment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) w at the time of commencing treatment  Patient has active Crohn's disease		
	Ol	Patient has had an initial approval for prior biologic therapy for Crohn's disease and has experienced intolerable side effects or insufficient benefit to meet renewal criteria  Patient meets the initiation criteria for prior biologic therapies for Crohn's disease  Other biologics for Crohn's disease are contraindicated		
Re-assess	CONTINUATION – Crohn's disease - adults Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)			
and	$\sim$	CDAI score has reduced by 100 points, or HBI score has reduced by 3 points, from when the patient was initiated on biologic therapy  CDAI score is 150 or less, or HBI is 4 or less  The patient has experienced an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed ekinumab to be administered at a dose no greater than 90 mg every 8 weeks		
INITIATION – Crohn's disease - children* Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)				
or	Pation belo	ent is currently on treatment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) we at the time of commencing treatment		
	and	Patient has active Crohn's disease  Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria  Patient meets the initiation criteria for prior biologic therapies for Crohn's disease  Other biologics for Crohn's disease are contraindicated		
Note: India	cation ma	rked with * is an unapproved indication.		

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Ustekinumab - continued			
CONTINUATION - Crohn's disease - children*			
Re-assessment required after 12 months  Prerequisites (tick boxes where appropriate)			
O PCDAI score has reduced by 10 points from when th	e patient was initiated on biologic therapy		
O PCDAI score is 15 or less			
The patient has experienced an adequate response to	to treatment, but CDAI score cannot be assessed		
and			
Ustekinumab to administered at a dose no greater than 90	mg every 8 weeks		
Note: Indication marked with * is an unapproved indication.			
or Delow at the time of commencing treatment  O Patient has active ulcerative colitis  and	or biologic therapies for ulcerative colitis		
CONTINUATION – ulcerative colitis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  O The SCCAI score has reduced by 2 points or more from the SCCAI score since initiation on biologic therapy			
or  O PUCAI score has reduced by 10 points or more from the PUCAI score since initiation on biologic therapy*			
O Ustekinumab will be used at a dose no greater than 90 mg	intravenously every 8 weeks		
Note: Criterion marked with * is for an unapproved indication.			

I confirm that the above details are correct:

Signed: Date:

	ER		PATIENT:
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dolizun	mak	)	
-assessr	ment	t requ	oves where appropriate)
and	C	Patie	ent has active Crohn's disease
	or	0	Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)
	or	0	Patient has a CDAI score of greater than or equal to 300, or HBI score of greater than or equal to 10
	or		Patient has extensive small intestine disease affecting more than 50 cm of the small intestine  Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection
	or	0	Patient has an ileostomy or colostomy, and has intestinal inflammation
and			
	or	0	Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids
	or	0	Patient has experienced intolerable side effects from immunomodulators and corticosteroids
		0	Immunomodulators and corticosteroids are contraindicated
assessr	ment	t requ	Crohn's disease - adults  ired after 2 years  poxes where appropriate)
		0	CDAI score has reduced by 100 points, or HBI score has reduced by 3 points, from when the patient was initiated on biologic therapy
	or	0	CDAI score is 150 or less, or HBI is 4 or less
	or	0	The patient has experienced an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed
and	<u> </u>	\/odo	lizumab to administered at a dose no greater than 300 mg every 8 weeks

I confirm that the above details are correct:	
Signed:	Date:

I confirm that the above details are correct:

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

#### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

SCRIB	BER		PATIENT:
ne:			
d:			NHI:
lolizu	mal	<b>)</b> - co	ontinued
assess	men	t requ	n's disease - children* uired after 6 months poxes where appropriate)
and	0	Paec	diatric patient has active Crohn's disease
	<b>0</b> r	0	Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)
	or	0	Patient has a Paediatric Crohn's Disease Activity Index (PCDAI) score of greater than or equal to 30
	or	0	Patient has extensive small intestine disease
and			
	or	0	Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids
		0	Patient has experienced intolerable side effects from immunomodulators and corticosteroids
	or	0	Immunomodulators and corticosteroids are contraindicated
e: Indi	catio	n mar	ked with * is an unapproved indication.
assess	men	t requ	Crohn's disease - children* uired after 2 years poxes where appropriate)
		0	PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy
	or	0	PCDAI score is 15 or less
	or	0	The patient has experienced an adequate response to treatment, but CDAI score cannot be assessed
and	0	Vedo	olizumab to administered at a dose no greater than 300mg every 8 weeks
			ked with * is an unapproved indication.

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.

RESCRIB	BER		PATIENT:
lame:			Name:
Vard:			NHI:
edolizu	mak	<b>)</b> - cc	ontinued
Re-assess	men	requ	itive colitis ired after 6 months boxes where appropriate)
rerequis	<u> </u>		nt has active ulcerative colitis
and	or	0	Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)
	or	$\bigcirc$	Patient has a SCCAI score is greater than or equal to 4  Patient's PUCAI score is greater than or equal to 20*
and		$\bigcirc$	Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response)
	or	0	from prior therapy with immunomodulators and corticosteroids  Patient has experienced intolerable side effects from immunomodulators and corticosteroids
	or	0	Immunomodulators and corticosteroids are contraindicated
Note: Indi	catio	n mar	ked with * is an unapproved indication.
Re-assess	men	requ	ired after 2 years oxes where appropriate)
	or	0	The SCCAI score has reduced by 2 points or more from the SCCAI score since initiation on biologic therapy
	O.	0	The PUCAI score has reduced by 10 points or more from the PUCAI score since initiation on biologic therapy *
and	0	Vedo	lizumab will be used at a dose no greater than 300 mg intravenously every 8 weeks
Note: Indi	catio	n mar	ked with * is an unapproved indication.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	. NHI:
Brentuximab	
INITIATION – relapsed/refractory Hodgkin lymphoma Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
Patient has relapsed/refractory CD30-positive Hand Patient is ineligible for autologous stem cell trans	lodgkin lymphoma after two or more lines of chemotherapy splant
Patient has relapsed/refractory CD30-positive H and Patient has previously undergone autologous st	
Patient has not previously received funded brentuximab ved  and  Response to brentuximab vedotin treatment is to be reviewed  and  Brentuximab vedotin to be administered at doses no greater	ed after a maximum of 6 treatment cycles
CONTINUATION – relapsed/refractory Hodgkin lymphoma Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)	
Patient has achieved a partial or complete response to bren and  Treatment remains clinically appropriate and the patient is b	
Patient is to receive a maximum of 16 total cycles of brentus	cimab vedotin treatment
INITIATION – anaplastic large cell lymphoma Re-assessment required after 9 months Prerequisites (tick boxes where appropriate)	
Patient has relapsed/refractory CD30-positive systemic ana	plastic large cell lymphoma
Patient has an ECOG performance status of 0-1  and Patient has not previously received brentuximab vedotin	
Response to brentuximab vedotin treatment is to be reviewed and	ed after a maximum of 6 treatment cycles
Brentuximab vedotin to be administered at doses no greater	than 1.8 mg/kg every 3 weeks

I confirm that the above details are correct:

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

PRES	CRIBER		PATIENT:
Name	:		Name:
Ward:			NHI:
Bren	tuximal	• continued	
		N – anaplastic large cell lymphoma t required after 9 months	
		(tick boxes where appropriate)	
	O	Patient has achieved a partial or complete response to brentus	ximab vedotin after 6 treatment cycles
	and	Treatment remains clinically appropriate and the patient is ben	efitting from treatment and treatment is being tolerated
		Patient is to receive a maximum of 16 total cycles of brentuxim	nab vedotin treatment

SCRIBER	PATIENT:
ie:	Name:
d:	NHI:
stuzumab	(Herzuma)
assessment	required after 12 months tick boxes where appropriate)
and	The patient has early breast cancer expressing HER-2 IHC 3+ or ISH + (including FISH or other current technology)  Maximum cumulative dose of 106 mg/kg (12 months' treatment)
assessment	N – early breast cancer* required after 12 months tick boxes where appropriate)
and	The patient received prior adjuvant trastuzumab treatment for early breast cancer  The patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer  The patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst on lapatinib  He cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab
and	Or Trastuzumab will not be given in combination with pertuzumab  Or Trastuzumab to be administered in combination with pertuzumab  and O Patient has not received prior treatment for their metastatic disease and has had a treatment-free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer and  The patient has good performance status (ECOG grade 0-1)
	O Trastuzumab to be discontinued at disease progression
or and	O Patient has signs of disease progression

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	PATIENT:
Name:	
Vard:	NHI:
rastuzuma	b (Herzuma) - continued
Re-assessmer	metastatic breast cancer nt required after 12 months (tick boxes where appropriate)
and	The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
or	The patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer  The patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst on lapatinib
and	O Trastuzumab will not be given in combination with pertuzumab
	Trastuzumab to be administered in combination with pertuzumab  and  Patient has not received prior treatment for their metastatic disease and has had a treatment-free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer  and  The patient has good performance status (ECOG grade 0-1)
Re-assessmer	Trastuzumab to be discontinued at disease progression  ON – metastatic breast cancer nt required after 12 months  (tick boxes where appropriate)
or an an	The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab  Trastuzumab to be discontinued at disease progression  Patient has previously discontinued treatment with trastuzumab for reasons other than severe toxicity or disease progression  Patient has signs of disease progression
	gastric, gastro-oesophageal junction and oesophageal cancer nt required after 12 months (tick boxes where appropriate)
	(lick boxes where appropriate)

I confirm that the above details are correct:

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

Page 413

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	PATIENT:
Name:	Name:
Ward:	NHI:
Trastuzumab (Herzuma) - continued	
CONTINUATION – gastric, gastro-oesophageal junction and oesophageal Re-assessment required after 12 months	al cancer
Prerequisites (tick boxes where appropriate)	
O The cancer has not progressed at any time point during the pr	revious 12 months whilst on trastuzumab
Trastuzumab to be discontinued at disease progression	

PRESCRIBER	ATIENT:
Name:	lame:
Ward:	IHI:
Trastuzumab deruxtecan	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
Patient has metastatic breast cancer expressing HER-2 IHC3+ cand Patient has previously received trastuzumab and chemotherapy, and	
The patient has received prior therapy for metastatic diseasor  The patient developed disease recurrence during, or within	
and O Patient has a good performance status (ECOG 0-1) and O Patient has not received prior funded trastuzumab deruxtecan trand O Treatment to be discontinued at disease progression	eatment
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
The cancer has not progressed at any time point during the prevand  Treatment to be discontinued at disease progression	ious approval period whilst on trastuzumab deruxtecan
Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy, bio	ogical drugs, or endocrine therapy.

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I confirm that the above details are correct:

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	PATIENT:
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rd:	NHI:
vacizum	ab
-assessm	unresectable hepatocellular carcinoma nt required after 6 months s (tick boxes where appropriate)
	Patient is currently on treatment with bevacizumab, and met all remaining criteria prior to commencing treatment
or	Patient has locally advanced or metastatic, unresectable hepatocellular carcinoma
	Patient has preserved liver function (Child-Pugh A)
	Transarterial chemoembolisation (TACE) is unsuitable
	O Patient has not received prior systemic therapy for the treatment of hepatocellular carcinoma or
	O Patient received funded lenvatinib before 1 March 2025  or
	Patient has experienced treatment-limiting toxicity from treatment with lenvatinib
	O No disease progression since initiation of lenvatinib
	nd .
	Patient has an ECOG performance status of 0-2
	O Patient has an ECOG performance status of 0-2
£	Patient has an ECOG performance status of 0-2  To be given in combination with atezolizumab
ONTINUAT assessm	Patient has an ECOG performance status of 0-2  To be given in combination with atezolizumab  ON – unresectable hepatocellular carcinoma nt required after 6 months
ONTINUAT assessmerequisite	Patient has an ECOG performance status of 0-2  To be given in combination with atezolizumab  ON – unresectable hepatocellular carcinoma nt required after 6 months a (tick box where appropriate)
ONTINUAT assessmerequisite	Patient has an ECOG performance status of 0-2  To be given in combination with atezolizumab  ON – unresectable hepatocellular carcinoma nt required after 6 months
DNTINUATassessmerequisite  No	Patient has an ECOG performance status of 0-2  To be given in combination with atezolizumab  ON – unresectable hepatocellular carcinoma nt required after 6 months a (tick box where appropriate)
DNTINUAT -assessmerequisite  No ITIATIONassessmeres	Patient has an ECOG performance status of 0-2  To be given in combination with atezolizumab  ON – unresectable hepatocellular carcinoma nt required after 6 months (c) (tick box where appropriate)  evidence of disease progression  advanced or metastatic ovarian cancer
ONTINUAT D-assessmerequisite  O No  ITIATIONassessmerequisite	Patient has an ECOG performance status of 0-2  To be given in combination with atezolizumab  ON – unresectable hepatocellular carcinoma nt required after 6 months a (tick box where appropriate)  evidence of disease progression  advanced or metastatic ovarian cancer nt required after 4 months a (tick boxes where appropriate)  The patient has FIGO Stage IV epithelial ovarian, fallopian tube, or primary peritoneal cancer
DNTINUAT -assessmerequisite  No ITIATIONassessmeres	Patient has an ECOG performance status of 0-2  To be given in combination with atezolizumab  ON – unresectable hepatocellular carcinoma nt required after 6 months s (tick box where appropriate) evidence of disease progression  advanced or metastatic ovarian cancer nt required after 4 months s (tick boxes where appropriate)  The patient has FIGO Stage IV epithelial ovarian, fallopian tube, or primary peritoneal cancer  The patient has previously untreated advanced (FIGO Stage IIIB or IIIC) epithelial ovarian, fallopian tube, or primary
ONTINUAT D-assessmerequisite  O No  ITIATIONassessmerequisite	Patient has an ECOG performance status of 0-2  To be given in combination with atezolizumab  ON – unresectable hepatocellular carcinoma nt required after 6 months s (tick box where appropriate)  evidence of disease progression  advanced or metastatic ovarian cancer nt required after 4 months s (tick boxes where appropriate)  O The patient has FIGO Stage IV epithelial ovarian, fallopian tube, or primary peritoneal cancer
ONTINUAT D-assessmerequisite  O No  ITIATIONassessmerequisite	Patient has an ECOG performance status of 0-2  To be given in combination with atezolizumab  ON – unresectable hepatocellular carcinoma nt required after 6 months a (tick box where appropriate)  evidence of disease progression  advanced or metastatic ovarian cancer nt required after 4 months a (tick boxes where appropriate)  The patient has FIGO Stage IV epithelial ovarian, fallopian tube, or primary peritoneal cancer  The patient has previously untreated advanced (FIGO Stage IIIB or IIIC) epithelial ovarian, fallopian tube, or primary peritoneal cancer  On Debulking surgery is inappropriate
ONTINUAT D-assessmerequisite  O No  ITIATIONassessmerequisite	Patient has an ECOG performance status of 0-2  To be given in combination with atezolizumab  ON – unresectable hepatocellular carcinoma nt required after 6 months a (tick box where appropriate)  evidence of disease progression  advanced or metastatic ovarian cancer nt required after 4 months a (tick boxes where appropriate)  The patient has FIGO Stage IV epithelial ovarian, fallopian tube, or primary peritoneal cancer  The patient has previously untreated advanced (FIGO Stage IIIB or IIIC) epithelial ovarian, fallopian tube, or primary peritoneal cancer  and
ONTINUAT D-assessmerequisite  O No  ITIATIONassessmerequisite	Patient has an ECOG performance status of 0-2  To be given in combination with atezolizumab  ON – unresectable hepatocellular carcinoma nt required after 6 months s (tick box where appropriate) evidence of disease progression  advanced or metastatic ovarian cancer nt required after 4 months s (tick boxes where appropriate)  The patient has FIGO Stage IV epithelial ovarian, fallopian tube, or primary peritoneal cancer  The patient has previously untreated advanced (FIGO Stage IIIB or IIIC) epithelial ovarian, fallopian tube, or primary peritoneal cancer  and  Debulking surgery is inappropriate  The cancer is sub-optimally debulked (maximum diameter of any gross residual disease greater than 1cm)
DNTINUAT assessmerequisite  No  TIATION assessmerequisite	Patient has an ECOG performance status of 0-2  To be given in combination with atezolizumab  ON – unresectable hepatocellular carcinoma nt required after 6 months s (tick box where appropriate)  evidence of disease progression  advanced or metastatic ovarian cancer nt required after 4 months s (tick boxes where appropriate)  O The patient has FIGO Stage IV epithelial ovarian, fallopian tube, or primary peritoneal cancer  The patient has previously untreated advanced (FIGO Stage IIIB or IIIC) epithelial ovarian, fallopian tube, or primary peritoneal cancer  O Debulking surgery is inappropriate  O Debulking surgery is inappropriate

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Bevacizumab - continued				
CONTINUATION – advanced or metastatic ovarian cancer Re-assessment required after 4 months Prerequisites (tick box where appropriate)				
O No evidence of disease progression				
INITIATION – Recurrent Respiratory Papillomatosis Re-assessment required after 12 months  Prerequisites (tick boxes where appropriate)   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)				
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)				
O Ocular neovascularisation or O Exudative ocular angiopathy				

I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Inotuzumab ozogamicin	
INITIATION Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
	te lymphoblastic leukaemia/lymphoma, including minimal residual disease
Patient has ECOG performance status of 0-2  and	
Patient has Philadelphia chromosome positive and Patient has previously received a tyrosine kinas  or Patient has received one prior line of treatment involved.	se inhibitor
and  Treatment is to be administered for a maximum of 3 cycles	In ginterisive cremourerapy
CONTINUATION Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
O Patient is not proceeding to a stem cell transplant and	
O Patient has experienced complete disease response	
O Patient has experienced complete remission with incomplete remission	omplete haematological recovery
Treatment with inotuzumab ozogamicin is to cease after a t	otal duration of 6 cycles

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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.

PRESCR	IBER	PATIENT:
Name: .		
Ward:		NHI:
Faricim	ab	
Re-asse	ssmer	Diabetic macular oedema It required after 4 months (tick boxes where appropriate)
		Patient has centre involving diabetic macular oedema (DMO)  Patient's disease is nonresponsive to 4 doses of intravitreal bevacizumab when administered 4-6 weekly  Patient has reduced visual acuity between 6/9 – 6/36 with functional awareness of reduction in vision  Patient has DMO within central OCT (ocular coherence tomography) subfield > 350 micrometers  There is no centre-involving sub-retinal fibrosis or foveal atrophy  Patient has not previously been treated with aflibercept for longer than 3 months  DN – Diabetic macular oedema
	old	trequired after 12 months (tick boxes where appropriate)  There is stability or two lines of Snellen visual acuity gain  There is structural improvement on OCT scan (with reduction in intra-retinal cysts, central retinal thickness, and sub-retinal fluid)
ar		Patient's vision is 6/36 or better on the Snellen visual acuity score  There is no centre-involving sub-retinal fibrosis or foveal atrophy
Re-asse	ssmer	Wet age related macular degeneration It required after 3 months (tick boxes where appropriate)
	or or	O Wet age-related macular degeneration (wet AMD) O Polypoidal choroidal vasculopathy O Choroidal neovascular membrane from causes other than wet AMD
ar	or	O The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab  O There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart
ar	$\circ$	There is no structural damage to the central fovea of the treated eye  Patient has not previously been treated with ranibizumab or aflibercept for longer than 3 months

Page 419

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.

PRES	CRIBER	PATIENT:
Name	:	Name:
Ward:		NHI:
CON	Fimab - continued  TINUATION – Wet age related macular degeneration ssessment required after 12 months	
	equisites (tick boxes where appropriate)	
	O Patient's vision is 6/36 or better on the Snellen visual acuity so	core
	There is no structural damage to the central fovea of the treating	ed eye

SCRIBER	PATIENT:
e:	Name:
::	NHI:
tuzumab wit	h trastuzumab
	uired after 12 months boxes where appropriate)
and O	The individual has received an initial Special Authority approval for intravenous pertuzumab and trastuzumab for metastatic breast cancer  Pertuzumab with trastuzumab to be administered subcutaneously at a maximum dose of 600 mg pertuzumab with 600 mg trastuzumab every three weeks (or equivalent)
or	
and	The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
o	Patient is chemotherapy treatment naïve  Patient has not received prior treatment for their metastatic disease and has had a treatment free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer
and and	The patient has good performance status (ECOG grade 0-1)  Loading dose of pertuzumab with trastuzumab to be administered subcutaneously at a maximum dose of 1200 mg pertuzumab with 600 mg trastuzumab, respectively
and	Maintenance doses of pertuzumab with trastuzumab to be administered subcutaneously at a maximum dose of 600 mg pertuzumab with 600 mg trastuzumab every three weeks (or equivalent)
	Pertuzumab with trastuzumab to be discontinued at disease progression
	uired after 12 months boxes where appropriate)
and O	The individual has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)  The cancer has not progressed at any time point during the previous 12 months whilst on pertuzumab and trastuzumab
or O	Individual has previously discontinued treatment with pertuzumab with trastuzumab for reasons other than severe toxicity or disease progression
and	
and and	Individual has signs of disease progression

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Basiliximab	
INITIATION Prerequisites (tick box where appropriate)	
O For use in solid organ transplants	

PRESCRIB	ER		PATIENT:
Name:			
Ward:			NHI:
Rituxima	<b>b</b> (Ma	abthe	ora)
Re-assess	ment	requi	atoid arthritis - prior TNF inhibitor use ired after 4 months oxes where appropriate)
	The patient has had an initial community Special Authority approval for at least one of etanercept and/or adalimumab for rheumatoid arthritis		
		or	O The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept O Following at least a four month trial of adalimumab and/or etanercept, the patient did not meet the renewal criteria for adalimumab and/or etanercept for rheumatoid arthritis
and			
	or	$\circ$	Rituximab to be used as an adjunct to methotrexate or leflunomide therapy
	OI .	$\circ$	Patient is contraindicated to both methotrexate and leflunomide, requiring rituximab monotherapy to be used
and (	( C	Лахіг	num of two 1,000 mg infusions of rituximab given two weeks apart

CRIB	ER			PATIENT:
e:				Name:
:				NHI:
ximal	<b>b</b> (M	labthe	era) - continued	
ssessi	ment	t requ	natoid arthritis - TNF inhibitors contraindicated ired after 4 months poxes where appropriate)	
and and and	C C	Patie citrul Patie maxi	linated peptide (CCP) antibody positive) for six months durent has tried and not responded to at least three months of mum tolerated dose and not responded to at least three months of exychloroquine sulphate (at maximum tolerated doses)  Patient has tried and not responded to at least three months as tried and not responded to at least three months of exychloroguine sulphate (at maximum tolerated doses)  Patient has tried and not responded to at least three months of expensions.	(either confirmed by radiology imaging, or the patient is cyclic ration or longer oral or parenteral methotrexate at a dose of at least 20 mg weekly or a oral or parenteral methotrexate in combination with sulfasalazine and other oral or parenteral methotrexate in combination with the other oral or parenteral methotrexate in combination with intramuscular
and	or	O O	in combination with oral or parenteral methotrexate  Patient has persistent symptoms of poorly controlled and	active disease in at least 20 swollen, tender joints  active disease in at least four joints from the following: wrist, elbow,
and	or	O O	Patient has a C-reactive protein level greater than 15 mg application	y/L measured no more than one month prior to the date of this ently receiving prednisone therapy at a dose of greater than 5 mg per
and	or	O O	Rituximab to be used as an adjunct to methotrexate or le	
and (	C	Maxi	mum of two 1,000 mg infusions of rituximab given two wee	eks apart

I confirm that the above details are correct:	
Signed:	Date:

e:			
:			NHI:
xima	<b>b</b> (N	/labthe	era) - continued
ıssessı	men	t requ	heumatoid arthritis - re-treatment in 'partial responders' to rituximab ired after 4 months oxes where appropriate)
	or or	<ul><li>O</li><li>O</li><li>O</li></ul>	At 4 months following the initial course of rituximab infusions the patient had between a 30% and 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician  At 4 months following the second course of rituximab infusions the patient had at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician  At 4 months following the third and subsequent courses of rituximab infusions, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician
and ( and	C	Ritux	imab re-treatment not to be given within 6 months of the previous course of treatment
	or	0	Rituximab to be used as an adjunct to methotrexate or leflunomide therapy
and			Patient is contraindicated to both methotrexate and leflunomide, requiring rituximab monotherapy to be used
ıssessı	men	N – r	mum of two 1,000 mg infusions of rituximab given two weeks apart  heumatoid arthritis - re-treatment in 'responders' to rituximab ired after 4 months
ITINUA assessi	men	N – r	mum of two 1,000 mg infusions of rituximab given two weeks apart heumatoid arthritis - re-treatment in 'responders' to rituximab
ITINUA assessi	men	N – r	mum of two 1,000 mg infusions of rituximab given two weeks apart  heumatoid arthritis - re-treatment in 'responders' to rituximab ired after 4 months loxes where appropriate)  At 4 months following the initial course of rituximab infusions the patient had at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician
ITINUA assessi	men ites	ON - required trick to	mum of two 1,000 mg infusions of rituximab given two weeks apart  heumatoid arthritis - re-treatment in 'responders' to rituximab ired after 4 months oxes where appropriate)  At 4 months following the initial course of rituximab infusions the patient had at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician  At 4 months following the second and subsequent courses of rituximab infusions, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the
and	men ites	ON - required trick to	heumatoid arthritis - re-treatment in 'responders' to rituximab ired after 4 months loxes where appropriate)  At 4 months following the initial course of rituximab infusions the patient had at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician  At 4 months following the second and subsequent courses of rituximab infusions, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician

I confirm that the above details are correct:

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

#### RS1922 - Adalimumab (Humira - Alternative brand)

Arthritis - polyarticular course juvenile idiopathic - INITIATION	434
Arthritis - polyarticular course juvenile idiopathic - CONTINUATION	434
Arthritis - psoriatic - INITIATION	434
Arthritis - psoriatic - CONTINUATION	435
Arthritis – oligoarticular course juvenile idiopathic - INITIATION	433
Arthritis – oligoarticular course juvenile idiopathic - CONTINUATION	434
Arthritis – rheumatoid - INITIATÍON	435
Arthritis – rheumatoid - CONTINUATION	
Behcet's disease – severe - INITIATION	426
Behcet's disease – severe - CONTINUATION	426
Crohn's disease - adult - INITIATION	429
Crohn's disease - adult - CONTINUATION	
Crohn's disease - children - INITIATION	430
Crohn's disease - children - CONTINUATION	
Crohn's disease - fistulising - INITIATION	
Crohn's disease - fistulising - CONTINUATION	
Hidradenitis suppurativa - INITIATION	426
Hidradenitis suppurativa - CONTINUATION	427
Ocular inflammation – chronic - INITIATION	
Ocular inflammation – chronic - CONTINUATION	
Ocular inflammation – severe - INITIATION	
Ocular inflammation – severe - CONTINUATION	
Psoriasis - severe chronic plaque - INITIATION	427
Psoriasis - severe chronic plaque - CONTINUATION	428
Pyoderma gangrenosum - INITIATION	428
Pyoderma gangrenosum - CONTINUATION	
Still's disease – adult-onset (AOSD) - INITIATION	
Still's disease – adult-onset (AOSD) - CONTINUATION	436
Ankylosing spondylitis - INITIATION	433
Ankylosing spondylitis - CONTINUATION	433

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				PATIENT:		
Name:				Name:		
Ward:				NHI:		
Adal	imur	mab	(Humira - Alternative brand)			
Re-a	ssess equisi	ment ites	Behcet's disease – severe t required after 6 months (tick boxes where appropriate) ribed by, or recommended by any relevant practitioner, or in acospital.	cordance with a protocol or guideline that has been endorsed by the Health		
		or		trol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen		
	and and and	$\overline{}$	Patient has received a maximum of 6 months treatment with A Patient has previously had a Special Authority approval for the	Humira brand of adalimumab for this indication		
			Adalimumab to be administered at doses no greater than 40 m	ng every 14 days		
Re-a	ssess equisi	resc NZ Ho	N – Behcet's disease – severe t required after 6 months (tick boxes where appropriate)  rribed by, or recommended by any relevant practitioner, or in acceptial.  The patient has had a good clinical response to treatment with Adalimumab to be administered at doses no greater than 40 m			
Re-a	ssess equisi	ment ites	didradenitis suppurativa t required after 6 months (tick boxes where appropriate)			
and			deline that has been endorsed by the Health NZ Hospital.	n the recommendation of a dermatologist, or in accordance with a protocol		
	and (and (and	or O	Patient has developed symptoms of loss of disease con (Amgevita) and clinician attributes this loss of disease re  Patient has received a maximum of 6 months treatment with A  Patient has previously had a Special Authority approval for the	Imgevita  Humira brand of adalimumab for this indication		
			Adalimumab to be administered at doses no greater than 40 m	ng every 7 days. Fortnightly dosing has been considered		

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Signed.	Date.
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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.

PRES	CRIBER		PATIENT:		
Name	:		Name:		
Ward:			NHI:		
Adal	imumal	(Humira - Alternative brand) - continued			
Re-a	ssessmen	ON – Hidradenitis suppurativa It required after 6 months (tick boxes where appropriate)			
( and		cribed by, or recommended by a dermatologist or Practitioner or ideline that has been endorsed by the Health NZ Hospital.	n the recommendation of a dermatologist, or in accordance with a protocol		
	and O and O	The patient has a reduction in active lesions (e.g. inflammator The patient has a Dermatology Quality of Life Index improvemental Adalimumab is to be administered at doses no greater than 40			
Re-a	ssessmen	Psoriasis - severe chronic plaque trequired after 6 months (tick boxes where appropriate)			
( and		cribed by, or recommended by a dermatologist or Practitioner or ideline that has been endorsed by the Health NZ Hospital.	n the recommendation of a dermatologist, or in accordance with a protocol		
	or		rol following a minimum of 4 weeks treatment with adalimumab sponse to a change in treatment regimen		
	and and	Patient has received a maximum of 6 months treatment with A  Patient has previously had a Special Authority approval for the			
Adalimumab to be administered at doses no greater than 40 mg every 14 days					

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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.

PRESCRIE	BER	PATIENT:
Name:		
Nard:		NHI:
Adalimu	mab	o (Humira - Alternative brand) - continued
Re-assess Prerequis	sment sites ( Presc	N – Psoriasis - severe chronic plaque t required after 6 months (tick boxes where appropriate)  bribed by, or recommended by a dermatologist or Practitioner on the recommendation of a dermatologist, or in accordance with a protocol deline that has been endorsed by the Health NZ Hospital.
		O Patient had "whole body" severe chronic plaque psoriasis at the start of treatment
		Following each prior adalimumab treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-adalimumab treatment baseline value
		Following each prior adalimumab treatment course the patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, when compared with the pre-treatment baseline value
	or	
		O Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment and
		Following each prior adalimumab treatment course the patient has a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values
		Following each prior adalimumab treatment course the patient has a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-adalimumab treatment baseline value
and	$\sim$	Adalimumab to be administered at doses no greater than 40 mg every 14 days
Re-assess	sment	Pyoderma gangrenosum t required after 6 months (tick boxes where appropriate)
	Presc Hospi	cribed by, or recommended by a dermatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.
		O The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment
	or	O Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen
and	$\circ$	Patient has received a maximum of 6 months treatment with Amgevita
	$\circ$	Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication
and	O	A maximum of 8 doses

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Oigilica.	 Duic.	

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	PATIENT:
Name:	Name:
Ward:	NHI:
Adalimumab (Humira - Alternative brand) - continued	
CONTINUATION – Pyoderma gangrenosum Re-assessment required after 6 months	
Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a dermatologist, or in accordance Hospital.	e with a protocol or guideline that has been endorsed by the Health NZ
The patient has demonstrated clinical improvement and contin	ues to require treatment
O A maximum of 8 doses	
INITIATION – Crohn's disease - adult Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a gastroenterologist or Practition protocol or guideline that has been endorsed by the Health NZ Hosp and	er on the recommendation of a gastroenterologist, or in accordance with a ital.
or  Patient has developed symptoms of loss of disease cont 6 months treatment with Amgevita and clinician attribute	trol following a minimum of 4 weeks treatment, and a maximum of s this loss of disease response to a change in treatment regimen sease destabilisation if there were to be a change to current treatment
Patient has previously had a Special Authority approval for the and Adalimumab to be administered at doses no greater than 40 m	
CONTINUATION – Crohn's disease - adult Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a gastroenterologist or Practition protocol or guideline that has been endorsed by the Health NZ Hosp and	er on the recommendation of a gastroenterologist, or in accordance with a ital.
O CDAI score has reduced by 100 points from the CDAI score O CDAI score is 150 or less Or O The patient has demonstrated an adequate response to  and O Adalimumab to be administered at doses no greater than 40 m	treatment, but CDAI score cannot be assessed

I confirm that the above details are correct:

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRES	CRIE	BER		PATIENT:
Name:				
Ward:				NHI:
Adali	imu	mak	(Hu	mira - Alternative brand) - continued
Re-as	ssess	smen	t requ	's disease - children ired after 6 months oxes where appropriate)
and				by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
		or	<ul><li>O</li><li>O</li><li>O</li></ul>	The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita  Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen  Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment
	and	$\circ$		nt has previously had a Special Authority approval for the Humira brand of adalimumab for this indication mumab to be administered at doses no greater than 40 mg every 14 days
Re-as	ssess equis	smen sites Preso	t requ (tick b cribed	by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.  PCDAI score has reduced by 10 points from the PCDAI score when the patient was initiated on adalimumab  PCDAI score is 15 or less  The patient has demonstrated an adequate response to treatment, but PCDAI score cannot be assessed
	and	0	Adali	mumab to be administered at doses no greater than 40 mg every 14 days
Re-as	ssess equis	smen sites Preso	t requ (tick b cribed	's disease - fistulising ired after 6 months oxes where appropriate)  by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
	and	or	0	The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita  Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen  Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment
	and	0		nt has previously had a Special Authority approval for the Humira brand of adalimumab for this indication mumab to be administered at doses no greater than 40 mg every 14 days

I confirm that the above details are correct:

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Name:			
		•••••	Name:
Ward: .			NHI:
Adalin	numa	b (Hu	ımira - Alternative brand) - continued
Re-ass	essmer	nt requ	Crohn's disease - fistulising ired after 6 months poxes where appropriate)
and _			by, or recommended by a gastroenterologist or Practitioner on the recommendation of a gastroenterologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
	or	0	The number of open draining fistulae have decreased from baseline by at least 50%
		0	There has been a marked reduction in drainage of all fistula(e) from baseline as demonstrated by a reduction in the Fistula Assessment score, together with less induration and patient-reported pain
а	O	Adali	mumab to be administered at doses no greater than 40 mg every 14 days
Re-ass	essmer	nt requ	r inflammation – chronic ired after 12 months poxes where appropriate)
and		cribed łospita	by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health II.
	or	0	The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita  Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with Amgevita, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen  Patient has uveitis and is considered to be at risk of vision loss if they were to change treatment
	and O		nt has previously had a Special Authority approval for the Humira brand of adalimumab for this indication mumab to be administered at doses no greater than 40 mg every 14 days
Re-ass	essmer uisites	nt requ (tick b	Ocular inflammation – chronic ired after 12 months poxes where appropriate)  by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
and		lospita	
	or	0	The patient has had a good clinical response following 12 weeks' initial treatment  Following each 12-month treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)  Following each 12-month treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old
а	O	Adali	mumab to be administered at doses no greater than 40 mg every 14 days

PRESC	RIBER		PATIENT:
Name:			Name:
Ward:			NHI:
Adalir	numal	o (Hu	ımira - Alternative brand) - continued
INITIA Re-ass Prerec	TION – Gessmer quisites	Ocula It requi (tick b	r inflammation – severe irred after 12 months poxes where appropriate)  by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health
	and O		mumab to be administered at doses no greater than 40 mg every 14 days
Re-ass	sessmer <b>quisites</b> Prese	it requ (tick b	Ocular inflammation – severe lired after 12 months boxes where appropriate)  by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health al.
4	or or	O O Adali	The patient has had a good clinical response following 3 initial doses  Following each 12-month treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema)  Following each 12-month treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old  mumab to be administered at doses no greater than 40 mg every 14 days

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.

PRES	CRIBER PATIENT:
Name	Name:
Ward	NHI:
Adal	numab (Humira - Alternative brand) - continued
INITI Re-a	TION – ankylosing spondylitis sessment required after 6 months quisites (tick boxes where appropriate)  Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment or Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita)  Patient has received a maximum of 6 months treatment with Amgevita  Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication
	Adalimumab to be administered at doses no greater than 40 mg every 14 days
Re-a	Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point scale, or an improvement in BASDAI of 50%, whichever is less  Adalimumab to be administered at doses no greater than 40 mg every 14 days
Re-a	TION – Arthritis – oligoarticular course juvenile idiopathic sessment required after 6 months quisites (tick boxes where appropriate)  Prescribed by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment or Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen  Patient has received a maximum of 6 months treatment with Amgevita
	O Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication

I confirm that the above details are correct:

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

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

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Adalimumab (Humira - Alternative brand) - continued	
CONTINUATION – Arthritis – oligoarticular course juvenile idiopathic Re-assessment required after 6 months  Prerequisites (tick box where appropriate)	
by the Health NZ Hospital.	ogist, or in accordance with a protocol or guideline that has been endorsed
For patients that demonstrate at least a continuing 30% improvement assessment from baseline	it in active joint count and continued improvement in physician's global
INITIATION – Arthritis - polyarticular course juvenile idiopathic Re-assessment required after 6 months  Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a named specialist or rheumatolo by the Health NZ Hospital.	ogist, or in accordance with a protocol or guideline that has been endorsed
	n adalimumab (Amgevita) following a minimum of 4 weeks treatment
Patient has developed symptoms of loss of disease cont (Amgevita) and clinician attributes this loss of disease re	crol following a minimum of 4 weeks treatment with adalimumab esponse to a change in treatment regimen
Patient has received a maximum of 6 months treatment with A	mgevita
Patient has previously had a Special Authority approval for the	Humira brand of adalimumab for this indication
CONTINUATION – Arthritis - polyarticular course juvenile idiopathic	
Re-assessment required after 6 months	
Prerequisites (tick box where appropriate)	
by the Health NZ Hospital.	ogist, or in accordance with a protocol or guideline that has been endorsed
For patients that demonstrate at least a continuing 30% improvement assessment from baseline	it in active joint count and continued improvement in physician's global
INITIATION – Arthritis - psoriatic Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a named specialist or rheumatolo by the Health NZ Hospital.	ogist, or in accordance with a protocol or guideline that has been endorsed
	n adalimumab (Amgevita) following a minimum of 4 weeks treatment
Patient has developed symptoms of loss of disease cont (Amgevita) and clinician attributes this loss of disease re	rrol following a minimum of 4 weeks treatment with adalimumab sponse to a change in treatment regimen
and O Patient has received a maximum of 6 months treatment with A	mgevita
and O Patient has previously had a Special Authority approval for the	
Adalimumab to be administered at doses no greater than 40 m	
	)

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			PATIENT:	
Name:				Name:
Ward: NHI:			NHI:	
Adal	limu	mak	(Hu	umira - Alternative brand) - continued
CON Re-a Prer	and	Prescoy the	t required the seribed to the Hear The presponsition Adalia	Arthritis - psoriatic lired after 6 months poxes where appropriate)  by, or recommended by a named specialist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed lith NZ Hospital.  patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant conse to prior adalimumab treatment in the opinion of the treating physician imumab to be administered at doses no greater than 40 mg every 14 days
Re-a	equis	smen sites Presc	t requ (tick b cribed	tis – rheumatoid uired after 6 months coxes where appropriate)  by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a guideline that has been endorsed by the Health NZ Hospital.
	and and	or O		The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment  Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen  ent has received a maximum of 6 months treatment with Amgevita  ent has previously had a Special Authority approval for the Humira brand of adalimumab for this indication  Adalimumab to be administered at doses no greater than 40 mg every 14 days
		or	0	Patient cannot take concomitant methotrexate and requires doses of adalimumab higher than 40 mg every 14 days to maintain an adequate response
CONTINUATION – Arthritis – rheumatoid Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.				
and	and	0		patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant onse to prior adalimumab treatment in the opinion of the treating physician
		or	0	Adalimumab to be administered at doses no greater than 40 mg every 14 days  Patient cannot take concomitant methotrexate and requires doses of adalimumab higher than 40 mg every 14 days to maintain an adequate response

I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:			
Name:	Name:			
Ward:	NHI:			
Adalimumab (Humira - Alternative brand) - continued				
INITIATION – Still's disease – adult-onset (AOSD) Re-assessment required after 6 months				
Prerequisites (tick boxes where appropriate)				
Prescribed by, or recommended by a rheumatologist or Practitioner protocol or guideline that has been endorsed by the Health NZ Hosp and	on the recommendation of a rheumatologist, or in accordance with a bital.			
O Patient has developed symptoms of loss of disease con	O The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment O Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen			
and O Patient has received a maximum of 6 months treatment with A and O Patient has previously had a Special Authority approval for the				
CONTINUATION – Still's disease – adult-onset (AOSD) Re-assessment required after 6 months Prerequisites (tick box where appropriate)  O Prescribed by, or recommended by a rheumatologist or Practitioner on the recommendation of a rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  and  The patient has demonstrated a sustained improvement in inflammatory markers and functional status				
The patient has demonstrated a sustained improvement infillialinia	and infinite and infinitional status			

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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.

PRES	SCRI	BER	PATIENT:
Name	e:		Name:
Ward	:		NHI:
Abci	ixim	nab	
INITI Prer		ON isites (tick boxes where appropriate)	
		O For use in patients with acute coronary syndromes undergoing percutaneous coronary intervention	
	O For use in patients undergoing intra-cranial intervention		

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	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Nivolumab		
INITIATION – unresectable or metastatic melanoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a relevant specialist or an accordance with a protocol or guideline that has been endors and  The individual has metastatic or unresectable melanor and  Baseline measurement of overall tumour burden is doc and  The individual has ECOG performance 0-2 and  The individual has not received funded pembrolis or	ma (excluding uveal) stage III or IV cumented clinically and radiologically zumab cial Authority approval for pembrolizumab and has discontinued pembrolizumab	
and  The individual did not experience disease and	tatic or unresectable stage III or IV setting	

I confirm that the above details are correct:

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

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PAII	ENT:
Nam	e:
NHI:	
ntinued	
unresectable or metastatic melanoma, less than 24 months quired after 4 months a boxes where appropriate)  ed by, or recommended by a relevant specialist or any relevant prace with a protocol or guideline that has been endorsed by the He	actitioner on the recommendation of a relevant specialist, or in
The individual's disease has had a partial response to to The individual has stable disease  Response to treatment in target lesions has been determined treatment period	by comparable radiologic assessment following the most recent
progression  The individual has signs of disease progression  Disease has not progressed during previous treatment with ni  unresectable or metastatic melanoma, more than 24 month quired after 4 months	volumab
s boxes where appropriate) ed by, or recommended by a relevant specialist or any relevant pr ice with a protocol or guideline that has been endorsed by the He	
e individual has been on treatment for more than 24 months	
or O The individual's disease has had a partial response or O The individual has stable disease  And O Response to treatment in target lesions has been determined the most recent treatment period	nined by comparable radiologic or clinical assessment following th nivolumab for reasons other than severe toxicity or disease
	unresectable or metastatic melanoma, less than 24 months bid boxes where appropriate)  d by, or recommended by a relevant specialist or any relevant proceed with a protocol or guideline that has been endorsed by the Hele  The individual's disease has had a complete response to the individual has stable disease  Response to treatment in target lesions has been determined treatment period  The individual has previously discontinued treatment with niver progression  The individual has signs of disease progression  Disease has not progressed during previous treatment with niver progression  Unresectable or metastatic melanoma, more than 24 months uired after 4 months boxes where appropriate)  d by, or recommended by a relevant specialist or any relevant proceed with a protocol or guideline that has been endorsed by the Helevant proceed with a protocol or guideline that has been endorsed by the Helevant proceed with a protocol or guideline that has been endorsed by the Helevant proceed with a protocol or guideline that has been endorsed by the Helevant proceed with a protocol or guideline that has been endorsed by the Helevant proceed with a protocol or guideline that has been endorsed by the Helevant proceed with a protocol or guideline that has been endorsed by the Helevant proceed with a protocol or guideline that has been endorsed by the Helevant proceed with a protocol or guideline that has been endorsed by the Helevant protocol or guideline that has been endorsed by the Helevant protocol or guideline that has been endorsed by the Helevant protocol or guideline that has been endorsed by the Helevant protocol or guideline that has been endorsed by the Helevant protocol or guideline that has been endorsed by the Helevant protocol or guideline that has been endorsed by the Helevant protocol or guideline that has been endorsed by the Helevant protocol or guideline that has been endorsed by the Helevant protocol or guideline that has been endorsed by the Helevant protocol or guideline that has been determined the mo

RESCRIBER	PATIENT:
ame:	
/ard:	NHI:
ivolumab - continu	ued
Prerequisites (tick bo  Patient  or  and  and  and	ell carcinoma, first line
and	Nivolumab is to be used in combination with ipilimumab for the first four treatment cycles at a maximum dose of 3 mg/kg  Nivolumab is to be used at a maximum maintenance dose of 240 mg every 2 weeks (or equivalent)
NITIATION – renal ce	ell carcinoma, second line
Re-assessment require	
and	t has metastatic renal-cell carcinoma
and	sease is of predominant clear-cell histology t has ECOG performance status 0-2
	t has documented disease progression following one or two previous regimens of antiangiogenic therapy
	t has not previously received a funded immune checkpoint inhibitor
	mab is to be used as monotherapy at a maximum dose of 240 mg every 2 weeks (or equivalent) and discontinued at disease ssion

I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Nivolumab - continued	
CONTINUATION – renal cell carcinoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
O Patient's disease has had a complete response to treatron O Patient's disease has had a partial response to treatmen or O Patient has stable disease	
And  No evidence of disease progression and  Nivolumab is to be used as monotherapy at a maximum dose progression	of 240 mg every 2 weeks (or equivalent) and discontinued at disease

#### RS2154 - Pembrolizumab

MSI-H/dMMR advanced colorectal cancer - INITIATION	453
MSI-H/dMMR advanced colorectal cancer - CONTINUATION	454
Urothelial carcinoma - INITIATION	454
Urothelial carcinoma - CONTINUATION	454
Breast cancer, advanced - INITIATION	451
Breast cancer, advanced - CONTINUATION	452
Head and neck squamous cell carcinoma - INITIATION	452
Head and neck squamous cell carcinoma - CONTINUATION	453
Non-small cell lung cancer first-line combination therapy - INITIATION	
Non-small cell lung cancer first-line combination therapy - CONTINUATION	451
Non-small cell lung cancer first-line monotherapy - INITIATION	449
Non-small cell lung cancer first-line monotherapy - CONTINUATION	450
Relapsed/refractory Hodgkin lymphoma - INITIATION	455
Relapsed/refractory Hodgkin lymphoma - CONTINUATION	455
Stage III or IV resectable melanoma - neoadjuvant - INITIATION	443
Stage III or IV resectable melanoma - neoadjuvant - CONTINUATION	444
Stage III or IV resected melanoma - adjuvant - INITIATION	445
Stage III or IV resected melanoma - adjuvant - CONTINUATION	446
Unresectable or metastatic melanoma - INITIATION	447
Unresectable or metastatic melanoma, less than 24 months on treatment - CONTINUATION	448
Unresectable or metastatic melanoma, more than 24 months on treatment - CONTINUATION	

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		PATIENT:
Name:		Name:
Ward:		NHI:
Pembrolizum	nab	
Re-assessment Prerequisites (  Presc accord and  and  and  and  and  and  and  an	dance with a protocol or guideline that has been endorsed by t  The individual has resectable stage IIIB, IIIC, IIID or IV meland	oma (excluding uveal) (see note) Int in the perioperative setting for their stage IIIB, IIIC, IIID or IV

I confirm that the above details are correct:	

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

PRES	SCRIE	BER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Pem	brol	izumab	- continued	
Re-a	ssess	sment requ	stage III or IV resectable melanoma - neoadjuva uired after 4 months boxes where appropriate)	int
and			d by, or recommended by a relevant specialist or an se with a protocol or guideline that has been endors	ny relevant practitioner on the recommendation of a relevant specialist, or in sed by the Health NZ Hospital.
		and	The individual has received neoadjuvant treatment.  The individual meets initiation criteria for pembrol	nt with an immune checkpoint inhibitor lizumab for stage III or IV resected melanoma – adjuvant
	or	and	•	uvant treatment with an immune checkpoint inhibitor  nbrolizumab for stage III or IV resected melanoma – adjuvant
	or	and O and O	The individual has metastatic or unresectable me	elanoma (excluding uveal) stage III or IV
	or	and on and	The individual has received treatment with an imm	uvant treatment with an immune checkpoint inhibitor mune checkpoint inhibitor for unresectable or metastatic melanoma abrolizumab for unresectable or metastatic melanoma
b) li	Stage nitiatin	ng treatme	IIID or IV melanoma defined as per American Joint ent within 13 weeks of complete surgical resection reduled date of the resection (primary or lymphadene	means either 13 weeks after resection (primary or lymphadenectomy) or 13 weeks

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Signed.	Date:	
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PRES	CRIBER		PATIENT:
Name	e:		Name:
Ward	:		NHI:
Pem	brolizur	mab - continued	
		stage III or IV resected melanoma - adjuvant It required after 4 months	
Prer	equisites	(tick boxes where appropriate)	
and		cribed by, or recommended by a relevant specialist or any relev rdance with a protocol or guideline that has been endorsed by t	ant practitioner on the recommendation of a relevant specialist, or in the Health NZ Hospital.
	and	The individual has resected stage IIIB, IIIC, IIID or IV melanon	na (excluding uveal) (see note a)
	$\circ$	Adjuvant treatment with pembrolizumab is required	
	and and	The individual has not received prior funded systemic treatme	nt in the adjuvant setting for stage IIIB, IIIC, IIID or IV melanoma
		Treatment must be in addition to complete surgical resection	
	and	Treatment must be initiated within 13 weeks of complete surgi (see note b)	cal resection, unless delay is necessary due to post-surgery recovery
	and	Pembrolizumab must be administered as monotherapy	
		The individual has ECOG performance score 0-2	
	and	Pembrolizumab to be administered at a fixed dose of 200 mg	every 3 weeks (or equivalent)
Note	:		
a) S	tage IIIB,	IIIC, IIID or IV melanoma defined as per American Joint Comm	ittee on Cancer (AJCC) 8th Edition
b) Ir	nitiating tre	eatment within 13 weeks of complete surgical resection means	13 weeks after resection (primary or lymphadenectomy)

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Signed.	Date:	
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PRES	CRIE	BER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Pem	broli	izumab	- continued	
Re-a	ssess	ment requ	stage III or IV resected melanoma - adjuvant sired after 4 months	
Prer	equis	ites (tick b	poxes where appropriate)	
and			by, or recommended by a relevant specialist or any relevant a protocol or guideline that has been endorsed by t	ant practitioner on the recommendation of a relevant specialist, or in he Health NZ Hospital.
		and	No evidence of disease recurrence  Pembrolizumab must be administered as monotherapy	
		and and	total treatment course, including any systemic neoadjuva	ence or at completion of 12 months total treatment course (equivalent to
	or			
		and and	The individual has received adjuvant treatment with an in.  The individual has metastatic or unresectable melanoma.  The individual meets initiation criteria for pembrolizumatic	a (excluding uveal) stage III or IV
	or			
		and on and	The individual has received adjuvant treatment with an in.  The individual has received treatment with an immune comparison of the individual meets continuation criteria for pembrolizur	heckpoint inhibitor for unresectable or metastatic melanoma

PRESCRIBER		PATIENT:
Name:		Name:
Ward:		NHI:
Pembrolizui	mab - continued	
Re-assessmer	unresectable or metastatic melanoma nt required after 4 months (tick boxes where appropriate)	
	cribed by, or recommended by a relevant specialist or any relevance with a protocol or guideline that has been endorsed by the	ant practitioner on the recommendation of a relevant specialist, or in he Health NZ Hospital.
and O and O and	The individual has metastatic or unresectable melanoma (excl Baseline measurement of overall tumour burden is documented The individual has ECOG performance 0-2	
or	The individual has not received funded nivolumab  The individual has received an initial Special Author 12 weeks of starting treatment due to intolerance and  The cancer did not progress while the individual was a second or se	prity approval for nivolumab and has discontinued nivolumab within as on nivolumab
and or or	The individual received treatment in the perioperate and The individual did not experience disease recurrer and	tive setting with a PD-1/PD-L1 inhibitor

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

	IBER		PATIENT:
Name:			Name:
Ward:			NHI:
Pembro	lizum	nab - continued	
CONTIN Re-asses	UATION ssment	N – unresectable or metast required after 4 months	atic melanoma, less than 24 months on treatment
Prerequi	isites (t	tick boxes where appropriate	
and	Prescr accord	ibed by, or recommended by lance with a protocol or guide	a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in eline that has been endorsed by the Health NZ Hospital.
		O The individual's o	disease has had a complete response to treatment
			disease has had a partial response to treatment
		The individual ha	as stable disease
	and	$\sim$	in target lesions has been determined by comparable radiologic assessment following the most recent
or	and	progression	viously discontinued treatment with pembrolizumab for reasons other than severe toxicity or disease
		O The individual has sign	s of disease progression
	and	$\sim$	essed during previous treatment with pembrolizumab
Prerequi	ssment isites (t Prescr	required after 4 months tick boxes where appropriate fibed by, or recommended by	atic melanoma, more than 24 months on treatment  a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in eline that has been endorsed by the Health NZ Hospital.
Re-asses	Prescr accord	required after 4 months tick boxes where appropriate ibed by, or recommended by lance with a protocol or guide	a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in
Prerequi	Prescr accord	required after 4 months tick boxes where appropriate bibed by, or recommended by dance with a protocol or guid.  The individual has been on to	a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in eline that has been endorsed by the Health NZ Hospital.
Prerequi	Prescr accord	required after 4 months tick boxes where appropriate bibed by, or recommended by dance with a protocol or guid.  The individual has been on to	a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in eline that has been endorsed by the Health NZ Hospital.
Prerequi	Prescr accord	required after 4 months tick boxes where appropriate bed by, or recommended by dance with a protocol or guid.  The individual has been on to the individual bed been on the correct or the individual bed been on the correct or the individual bed been on the correct or the individual bed been on the individual bed belonging the individual bed belonging the individual bed been on the individual bed been on the individual bed belonging the individual bed belonging the individual bed belonging the individual bed belonging the individual belonging	a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in eline that has been endorsed by the Health NZ Hospital.
Prerequi	Prescr accord	required after 4 months tick boxes where appropriate bed by, or recommended by dance with a protocol or guid.  The individual has been on to the individual for the i	a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in eline that has been endorsed by the Health NZ Hospital.  reatment for more than 24 months  dual's disease has had a complete response to treatment
Prerequi	Prescr accord	required after 4 months tick boxes where appropriate ribed by, or recommended by dance with a protocol or guide The individual has been on to  The individual	a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in eline that has been endorsed by the Health NZ Hospital.  The eatment for more than 24 months  The eatment for more than 24 month
Prerequi	Prescr accord	required after 4 months tick boxes where appropriate block boxes b	a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in eline that has been endorsed by the Health NZ Hospital.  The eatment for more than 24 months  The eatment for more than 24 month
Prerequi	Prescr accord	required after 4 months tick boxes where appropriate block boxes block boxes block boxes where appropriate block boxes block b	a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in eline that has been endorsed by the Health NZ Hospital.  The eatment for more than 24 months  Itual's disease has had a complete response to treatment  Itual's disease has had a partial response to treatment  Itual has stable disease  Itual has stable disease  Itual has stable disease  Itual has been determined by comparable radiologic or clinical assessment following reatment period  Itual has stable disease has has been determined by comparable radiologic or clinical assessment following reatment period  Itual has stable disease has has been determined by comparable radiologic or clinical assessment following reatment period  Itual has stable disease has has been determined by comparable radiologic or clinical assessment following reatment period  Itual has stable disease
Prerequi	Prescr accord	required after 4 months tick boxes where appropriate block boxes w	a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in eline that has been endorsed by the Health NZ Hospital.  The eatment for more than 24 months  Itual's disease has had a complete response to treatment  Itual's disease has had a partial response to treatment  Itual has stable disease  Itual has stable disease  Itual has stable disease  Itual has been determined by comparable radiologic or clinical assessment following reatment period  Itual has stable disease has has been determined by comparable radiologic or clinical assessment following reatment period  Itual has stable disease has has been determined by comparable radiologic or clinical assessment following reatment period  Itual has stable disease has has been determined by comparable radiologic or clinical assessment following reatment period  Itual has stable disease
Prerequi	Prescr accord	required after 4 months tick boxes where appropriate block boxes b	a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist, or in pline that has been endorsed by the Health NZ Hospital.  Treatment for more than 24 months  The disease has had a complete response to treatment that a partial response to treatment that has stable disease  The disease has had a partial response to treatment that has stable disease  The disease has had a partial response to treatment that a partial response to treatment that has stable disease  The disease has had a partial response to treatment that has stable disease  The disease has had a partial response to treatment that has stable disease  The disease has had a partial response to treatment that has stable disease  The disease has had a partial response to treatment that has stable disease  The disease has had a partial response to treatment that has stable disease  The disease has had a partial response to treatment that has stable disease.

PRESCRIBE	ER	PATIENT:
Name:		Name:
Ward:		NHI:
Pembroliz	zumab - continued	
Re-assessn	I – non-small cell lung cancer first-line monotherapy ment required after 4 months tes (tick boxes where appropriate)	
	rescribed by, or recommended by a medical oncologist or any rele eccordance with a protocol or guideline that has been endorsed by	vant practitioner on the recommendation of a medical oncologist, or in the Health NZ Hospital.
and	Patient has locally advanced or metastatic, unresectable, non     Patient has not had chemotherapy for their disease in the pall	
and and	Patient has not received prior funded treatment with an immunity  For patients with non-squamous histology there is documentated EGFR or ALK tyrosine kinase unless not possible to ascertain	tion confirming that the disease does not express activating mutations of
and and	Pembrolizumab to be used as monotherapy	
	O There is documentation confirming the disease express validated test unless not possible to ascertain or	es PD-L1 at a level greater than or equal to 50% as determined by a
	by a validated test unless not possible to ascertai	expresses PD-L1 at a level greater than or equal to 1% as determined in the control of the patient based on clinician assessment
and and and	Patient has an ECOG 0-2  Pembrolizumab to be used at a maximum dose of 200 mg even  Baseline measurement of overall tumour burden is document	ery three weeks (or equivalent) for a maximum of 16 weeks

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Signed.	Date:	
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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		ΓΙΕΝΤ:	
Name:	Na	ne:	
Ward:	NH	l:	
Pembrolizumab - co	ontinued		
CONTINUATION – non- Re-assessment required Prerequisites (tick boxe			
O Prescribed by.	or recommended by a medical oncologist or any relevant	practitioner on the recommendation of a medical oncologist, or in	
	ith a protocol or guideline that has been endorsed by the F		
or Pa	atient's disease has had a complete response to treatment		
	atient's disease has had a partial response to treatment		
	atient has stable disease		
and Respons treatmer		omparable radiologic assessment following the most recent	
	ence of disease progression		
O The trea	atment remains clinically appropriate and patient is benefitt	ng from treatment	
O Pembrol	Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent)		
Treatme every 3		months from commencement (or equivalent of 35 cycles dosed	
Re-assessment required  Prerequisites (tick boxe)  Prescribed by,	es where appropriate)	practitioner on the recommendation of a medical oncologist, or in ealth NZ Hospital.	
_	has locally advanced or metastatic, unresectable, non-sma	Il cell lung cancer	
· ·	ient has not had chemotherapy for their disease in the palli	ative setting	
and Patient h	has not received prior funded treatment with an immune ch	eckpoint inhibitor for NSCLC	
	ents with non-squamous histology there is documentation or ALK tyrosine kinase unless not possible to ascertain	confirming that the disease does not express activating mutations of	
and Pembrol	lizumab to be used in combination with platinum-based ch	emotherapy	
Patient h	has an ECOG 0-2		
	lizumab to be used at a maximum dose of 200 mg every the	ree weeks (or equivalent) for a maximum of 16 weeks	
	e measurement of overall tumour burden is documented cl	nically and radiologically	

I confirm that the above details are correct:

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

Name:	PRESCRIBER PATIENT:		
	e:Name:		
Ward:	l:NHI:		
Pembrol	embrolizumab - continued		
Re-assess	IATION – non-small cell lung cancer first-line combination thera sment required after 4 months sites (tick boxes where appropriate)	ру	
O is	Prescribed by, or recommended by a medical oncologist or any relevaccordance with a protocol or guideline that has been endorsed by the	ant practitioner on the recommendation of a medical oncologist, or in the Health NZ Hospital.	
	O Patient's disease has had a complete response to treatmon Or O Patient's disease has had a partial response to treatmen Or O Patient has stable disease		
and and and	Response to treatment in target lesions has been determined by treatment period     No evidence of disease progression     The treatment remains clinically appropriate and patient is ben		
and		f 24 months from commencement (or equivalent of 35 cycles dosed	
	N – breast cancer, advanced sment required after 6 months		
O	sites (tick boxes where appropriate)  Prescribed by, or recommended by a relevant specialist or any relevance with a protocol or guideline that has been endorsed by the		
0 1	Prescribed by, or recommended by a relevant specialist or any releva	ne Health NZ Hospital.	
O I	Prescribed by, or recommended by a relevant specialist or any relevant accordance with a protocol or guideline that has been endorsed by the Patient is currently on treatment with pembrolizumab and met a Patient has recurrent or de novo unresectable, ino express ER, PR or HER2 IHC3+ or ISH+ [including or express ER, PR or HER2 IHC3+ or ISH+ [including or express ER]	all remaining criteria prior to commencing treatment  berable locally advanced triple-negative breast cancer (that does not	
O I	Prescribed by, or recommended by a relevant specialist or any relevant accordance with a protocol or guideline that has been endorsed by the Patient is currently on treatment with pembrolizumab and met at the Patient has recurrent or de novo unresectable, inolexpress ER, PR or HER2 IHC3+ or ISH+ [including or Patient has recurrent or de novo metastatic triplenor ISH+ [including FISH or other technology])  and  Patient is treated with palliative intent and  Patient's cancer has confirmed PD-L1 Combined Positive and  Patient has received no prior systemic therapy in the pall and  Patient has an ECOG score of 0–2	perable locally advanced triple-negative breast cancer (that does not prish or other technology) egative breast cancer (that does not express ER, PR or HER2 IHC3+	
O I	Prescribed by, or recommended by a relevant specialist or any relevant accordance with a protocol or guideline that has been endorsed by the Patient is currently on treatment with pembrolizumab and met at Patient has recurrent or de novo unresectable, inolexpress ER, PR or HER2 IHC3+ or ISH+ [including or Patient has recurrent or de novo metastatic triplenor ISH+ [including FISH or other technology])  and  Patient is treated with palliative intent and  Patient's cancer has confirmed PD-L1 Combined Positive and  Patient has received no prior systemic therapy in the pall and	perable locally advanced triple-negative breast cancer (that does not prish or other technology)) egative breast cancer (that does not express ER, PR or HER2 IHC3+ e Score (CPS) is greater than or equal to 10 iative setting	
O I	Prescribed by, or recommended by a relevant specialist or any relevant accordance with a protocol or guideline that has been endorsed by the Patient is currently on treatment with pembrolizumab and met at Patient has recurrent or de novo unresectable, inor express ER, PR or HER2 IHC3+ or ISH+ [including or ISH+ [including FISH or other technology])	te Health NZ Hospital.  all remaining criteria prior to commencing treatment  perable locally advanced triple-negative breast cancer (that does not perable or other technology])	

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	PATIENT:	
Name:	Name:	
rd:NHI:		
Pembrolizumab - continued		
CONTINUATION – breast cancer, advanced Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by any relevant practitioner, or in a NZ Hospital.  and  O Patient's disease has had a complete response to treat or O Patient's disease has had a partial response to treatment or O Patient has stable disease  and O No evidence of disease progression and O Response to treatment in target lesions has been determined treatment period and O Pembrolizumab is to be used at a maximum dose of 200 mg and	by a comparable radiologic assessment following the most recent every three weeks (or equivalent)	
every 3 weeks)  INITIATION – head and neck squamous cell carcinoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	on of 24 months from commencement (or equivalent of 35 cycles dosed	
accordance with a protocol or guideline that has been endorsed by		
carcinoma) that is incurable by local therapies  and  Patient has not received prior systemic therapy in the re and  Patient has a positive PD-L1 combined positive score ( and  Patient has an ECOG performance score of 0-2  and  Pembrolizumab to be used in combination with pi  or  Pembrolizumab to be used as monotherapy  and	amous cell carcinoma of mucosal origin (excluding nasopharyngeal ecurrent or metastatic setting CPS) of greater than or equal to 1	

I confirm that the above details are correct:

Old 160	

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.

<b>R</b>	PATIENT:	
	Name:	
'd:NHI:		
ımab - continued		
Patient's disease has had a complete response to treatment  Patient's disease has had a partial response to treatment  Patient has stable disease  No evidence of disease progression  Pembrolizumab is to be used at a maximum dose of 200 mg evidence.		
MSI-H/dMMR advanced colorectal cancer ent required after 4 months s (tick boxes where appropriate) scribed by, or recommended by a relevant specialist or any relevant ordance with a protocol or guideline that has been endorsed by the	nt practitioner on the recommendation of a relevant specialist, or in e Health NZ Hospital.	
O Individual has deficient mismatch repair (dMMR) or	microsatellite instability-high (MSI-H) metastatic colorectal cancer microsatellite instability-high (MSI-H) unresectable colorectal cancer	
Individual is treated with palliative intent  Individual has not previously received funded treatment word  Individual has an ECOG performance score of 0-2  Individual has an ECOG performance score of 0-2  Individual has an ECOG performance score of 0-2  Individual has an ECOG performance score of 0-2	ith pembrolizumab for MSI-H/dMMR advanced colorectal cancer	
m n	mab - continued  ON - head and neck squamous cell carcinoma It required after 4 months (tick boxes where appropriate)  oribed by, or recommended by any relevant practitioner, or in accospital.  O Patient's disease has had a complete response to treatment  O Patient's disease has had a partial response to treatment  O Patient has stable disease  No evidence of disease progression  Pembrolizumab is to be used at a maximum dose of 200 mg every 3 weeks)  MSI-H/dMMR advanced colorectal cancer It required after 4 months (tick boxes where appropriate)  Oribed by, or recommended by a relevant specialist or any relevant required with a protocol or guideline that has been endorsed by the color or guideline that has been endorsed by the color or or or or or Individual has deficient mismatch repair (dMMR) or or or or Individual has deficient mismatch repair (dMMR) or or or or Individual has deficient mismatch repair (dMMR) or or or or Individual has not previously received funded treatment with Individual	

I confirm that the above details are correct:

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

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

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pembrolizumab - continued	
CONTINUATION – MSI-H/dMMR advanced colorectal cancer Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by any relevant practitioner, or in a NZ Hospital.  and O No evidence of disease progression and O Pembrolizumab to be used at a maximum dose of 200 mg evant	accordance with a protocol or guideline that has been endorsed by the Health very three weeks (or equivalent) ion of 24 months from commencement (or equivalent of 35 cycles dosed
INITIATION – Urothelial carcinoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by a relevant specialist or any relevant spec	
Patient has inoperable locally advanced (T4) or metast and Patient has an ECOG performance score of 0-2 and Patient has documented disease progression following and Pembrolizumab to be used as monotherapy at a maximal 16 weeks	
CONTINUATION – Urothelial carcinoma Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by any relevant practitioner, or in a NZ Hospital.  and  Patient's disease has had a complete response to treat or O Patient's disease has had a partial response to treatment or O Patient has stable disease  and _	
No evidence of disease progression  and  Pembrolizumab is to be used as monotherapy at a maximum and	n dose of 200 mg every three weeks (or equivalent) ion of 24 months from commencement (or equivalent of 35 cycles dosed

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.

	Name:
	NHI:
mab - continued	
relapsed/refractory Hodgkin lymphoma at required after 4 months (tick boxes where appropriate)  cribed by, or recommended by a relevant specialist or any relevant reduce with a protocol or guideline that has been endorsed by the second seco	et all remaining criteria prior to commencing treatment rmphoma after two or more lines of chemotherapy
Individual has not previously received funded pembrolizud  Pembrolizumab to be administered at doses no greater the	
ON - relapsed/refractory Hodgkin lymphoma It required after 6 months (tick boxes where appropriate) cribed by, or recommended by any relevant practitioner, or in acc	cordance with a protocol or guideline that has been endorsed by the Health
Patient has received a partial or complete response to pembrol	
	elapsed/refractory Hodgkin lymphoma t required after 4 months (tick boxes where appropriate)  ribed by, or recommended by a relevant specialist or any relevadance with a protocol or guideline that has been endorsed by the Individual is currently on treatment with pembrolizumab and months and Individual has relapsed/refractory Hodgkin lympho  Individual has relapsed/refractory Hodgkin lympho  Individual has not previously received funded pembrolizumab to be administered at doses no greater to the previous of the protocological and the protocological steps of the protocological steps o

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

PRESCRIE	BER	PATIENT:	
Name:	me:Name:		
Ward:		NHI:	
Durvalur	mab		
Re-assess	smen	Non-small cell lung cancer t required after 4 months (tick boxes where appropriate)	
and	or	O Patient has histologically or cytologically documented stage III, locally advanced, unresectable non-small cell lung cancer (NSCLC) O Patient has histologically or cytologically documented stage IIb (T1N2a only), locally advanced, unresectable non-small cell lung cancer (NSCLC)	
and	$\circ$	Patient has received two or more cycles of platinum-based chemotherapy concurrently with definitive radiation therapy  Patient has no disease progression following the second or subsequent cycle of platinum-based chemotherapy with definitive radiation therapy treatment	
and and and		Patient has a ECOG performance status of 0 or 1  Patient has completed last radiation dose within 8 weeks of starting treatment with durvalumab  Patient must not have received prior PD-1 or PD-L1 inhibitor therapy for this condition  O Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks	
and	0	Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks  Treatment with durvalumab to cease upon signs of disease progression	
Re-assess	smen	t required after 4 months (tick boxes where appropriate)	
and	O	The treatment remains clinically appropriate and the patient is benefitting from treatment  O Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks	
and		O Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks  Treatment with durvalumab to cease upon signs of disease progression  Total continuous treatment duration must not exceed 12 months	

I confirm that the above details are correct:

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

Name:	PRESCRIBER	PATIENT:
INITIATION – non-small cell lung cancer second line monotherapy Re-assessment required after 4 months Prerequisites (lick boxes where appropriate)  Prescribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  And Patient has locally advanced or metastatic non-small cell lung cancer and Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC and Postients with non-squamous histology there is documentation confirming that the disease does not express activating mutations of EGFR or ALK tyrosine kinase unless not possible to ascertain Patient has an ECOG 0-2 and Patient has documented disease progression following treatment with at least two cycles of platinum-based chemotherapy and Atezolizumab is to be used as monotherapy at a dose of 1200 mg every three weeks (or equivalent) for a maximum of 16 weeks and Baseline measurement of overall tumour burden is documented clinically and radiologically  CONTINUATION – non-small cell lung cancer second line monotherapy Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period and No evidence of disease progression The treatment remains clinically appropriate and patient is benefitting from treatment The treatment remains clinically appropriate and patient is benefitting from treatment (or equivalent of 35 cycles dosed every	Name:	Name:
INITIATION – non-small cell lung cancer second line monotherapy Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  And Patient has locally advanced or metastatic non-small cell lung cancer and Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC and For patients with non-squamous histology there is documentation confirming that the disease does not express activating mutations of EGFR or ALK tyrosine kinase unless not possible to ascertain Patient has an ECOG 0-2 and Patient has documented disease progression following treatment with at least two cycles of platinum-based chernotherapy and Alezoilizumab is to be used as monotherapy at a dose of 1200 mg every three weeks (or equivalent) for a maximum of 16 weeks and Baseline measurement of overall tumour burden is documented clinically and radiologically  CONTINUATION – non-small cell tung cancer second line monotherapy Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Patient's disease has had a complete response to treatment  or Patient's disease has had a partial response to treatment  or Patient's disease has had a partial response to treatment  or Patient's disease has had a partial response to treatment  or Patient's disease has had a partial response to treatment  or Patient's disease has had a partial response to treatment  or Patient's disease has had a partial response to treatment  or Patient's disease has had a partial response to treatment for treatment period  Alezoizumab to be used at a maximum do	Ward:	NHI:
Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Patient has locally advanced or metastatic non-small cell lung cancer and Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC and Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC and Patient has an ECOG 0-2 and Patient has an ECOG 0-2 and Patient has documented disease progression following treatment with at least two cycles of platinum-based chemotherapy and Alezolizumab is to be used as monotherapy at a dose of 1200 mg every three weeks (or equivalent) for a maximum of 16 weeks and Baseline measurement of overall tumour burden is documented clinically and radiologically  CONTINUATION – non-small cell lung cancer second line monotherapy Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Patient's disease has had a complete response to treatment or Patient's disease has had a partial response to treatment or Patient's disease has had a partial response to treatment or Patient's disease has had a partial response to treatment or Patient's disease progression and No evidence of disease progression The treatment remains clinically appropriate and patient is benefitting from treatment Alezolizumab to be used at a maximum dose of 1200 mg every three weeks (or equivalent) and Treatment with atezolizumab to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every	Atezolizuma	b
Re-assessment required after 4 months Prerequisites (tick boxes where appropriate)  Prescribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Patient's disease has had a complete response to treatment or Patient's disease has had a partial response to treatment or Patient has stable disease  and  Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period  and  No evidence of disease progression  and  The treatment remains clinically appropriate and patient is benefitting from treatment and  Atezolizumab to be used at a maximum dose of 1200 mg every three weeks (or equivalent)  Treatment with atezolizumab to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every	INITIATION - r Re-assessmen Prerequisites  Presc accor and  and and and and and and and	trequired after 4 months (tick boxes where appropriate)  pribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in redance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Patient has locally advanced or metastatic non-small cell lung cancer  Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC  For patients with non-squamous histology there is documentation confirming that the disease does not express activating mutations of EGFR or ALK tyrosine kinase unless not possible to ascertain  Patient has an ECOG 0-2  Patient has documented disease progression following treatment with at least two cycles of platinum-based chemotherapy  Atezolizumab is to be used as monotherapy at a dose of 1200 mg every three weeks (or equivalent) for a maximum of 16 weeks
	Re-assessmen Prerequisites  Presc accor and  or or and  and  and  and  and	trequired after 4 months (tick boxes where appropriate)  pribed by, or recommended by a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist, or in dance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Patient's disease has had a complete response to treatment  Patient's disease has had a partial response to treatment  Patient has stable disease  Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period  No evidence of disease progression  The treatment remains clinically appropriate and patient is benefitting from treatment  Atezolizumab to be used at a maximum dose of 1200 mg every three weeks (or equivalent)  Treatment with atezolizumab to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every
*		

I confirm that the above details are correct:

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Signeg	 Date	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Atezolizumab - continued	
INITIATION – unresectable hepatocellular carcinoma Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  O Patient is currently on treatment with atezolizumab and met all or  Patient has locally advanced or metastatic, unresectable and O Patient has preserved liver function (Child-Pugh A) and O Transarterial chemoembolisation (TACE) is unsuitable and O Patient has not received prior systemic therapy for O Patient received funded lenvatinib before 1 March or O Patient has experienced treatment-limiting to and O No disease progression since initiation of le  and O Patient has an ECOG performance status of 0-2 and O To be given in combination with bevacizumab	e hepatocellular carcinoma  r the treatment of hepatocellular carcinoma  2025  oxicity from treatment with lenvatinib
CONTINUATION – unresectable hepatocellular carcinoma Re-assessment required after 6 months Prerequisites (tick box where appropriate)  O No evidence of disease progression	

I confirm that the above details are correct:

Signed: Date:

PRESCRIBER	PATIENT:
Name:	
Ward:	NHI:
pilimumab	
INITIATION – renal cell carcinoma Re-assessment required after 4 months Prerequisites (tick boxes where approp	
O The patient is currently of	on treatment with ipilimumab and met all remaining criteria prior to commencing treatment
and The patient is treated and The patient has Evand The disease is preated and The disease is preated and The patient has Evand The patient or Haemoglobic or Corrected so Or Neutrophils Or Platelets gree Or Interval of let Or Karnofsky p	etastatic renal cell carcinoma  tment naive  COG performance status 0-2  edominantly of clear cell histology  has sarcomatoid histology  n levels less than the lower limit of normal  erum calcium level greater than 10 mg/dL (2.5 mmol/L)  greater than the upper limit of normal  eater than the upper limit of normal  easter than 1 year from original diagnosis to the start of systemic therapy  erformance score of less than or equal to 70  e used at a maximum dose of 1 mg/kg for up to four cycles in combination with nivolumab

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- 3	Ziuneu.	Date:	
•	Jigi ica.	 Duic.	

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

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRES	SCRIB	ER PATIENT:
Name	e:	Name:
Ward	:	NHI:
Evei	olim	us
Re-a	equisi	ment required after 3 months ites (tick boxes where appropriate)  Prescribed by, or recommended by a neurologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Patient has tuberous sclerosis  Patient has progressively enlarging sub-ependymal giant cell astrocytomas (SEGAs) that require treatment
Re-a	equisi	ATION ment required after 12 months ites (tick boxes where appropriate)
and	and (	Prescribed by, or recommended by a neurologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Documented evidence of SEGA reduction or stabilisation by MRI within the last 3 months  The treatment remains appropriate and the patient is benefiting from treatment  Everolimus to be discontinued at progression of SEGAs
Re-a	ssess	N – renal cell carcinoma ment required after 4 months ites (tick boxes where appropriate)
	or	The patient has metastatic renal cell carcinoma  The disease is of predominant clear-cell histology  and The patient has documented disease progression following one previous line of treatment  The patient has an ECOG performance status of 0-2  and Everolimus is to be used in combination with lenvatinib
		Patient has received funded treatment with nivolumab for the second line treatment of metastatic renal cell carcinoma  Patient has experienced treatment limiting toxicity from treatment with nivolumab  and  Everolimus is to be used in combination with lenvatinib  and  There is no evidence of disease progression
Re-a	equisi	ATION – renal cell carcinoma ment required after 4 months ites (tick box where appropriate) There is no evidence of disease progression

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

SCRIBER	PATIENT:	
e:	Name:	
l:	NHI:	
limus		
IATION		
·	s (tick box where appropriate)	
e: Rescue	rescue therapy for an organ transplant recipient e therapy defined as unresponsive to calcineurin inhibitor treatment as define e to any of the following:	d by refractory rejection; or intolerant to calcineurin inhibitor
GFR < 30 n	ml/min; or	
Rapidly pro	rogressive transplant vasculopathy; or	
Rapidly pro	rogressive obstructive bronchiolitis; or	
HUS or TTF	TP; or	
eukoence	epthalopathy; or	
Significant i	t malignant disease	
	- severe non-malignant lymphovascular malformations* ent required after 6 months	
	s (tick boxes where appropriate)	
and	Patient has severe non-malignant lymphovascular malformation*	
	O Malformations are not adequately controlled by sclerotherapy and su	rgery
or	O Malformations are widespread/extensive and sclerotherapy and surg	ory are not considered clinically appropriate
or	or _	
	O Sirolimus is to be used to reduce malformation prior to consideration	of surgery
and	Patient is being treated by a specialist lymphovascular malformation multi-	disciplinary toam
and	Patient is being treated by a specialist lymphovascular mailor multi-	disciplinary team
	Patient has measurable disease as defined by RECIST version 1.1 (see No.	ote)
	ION – severe non-malignant lymphovascular malformations* ent required after 12 months	
	s (tick boxes where appropriate)	
	<ul> <li>Patient's disease has had either a complete response or a partial res according to RECIST version 1.1 (see Note)</li> </ul>	sponse to treatment, or patient has stable disease
or		reconnect to treatment has been clearly documents in
	patient notes	esponse to treatment has been clearly documents in
and		
and	No evidence of progressive disease	
0	The treatment remains clinically appropriate and the patient is benefitting for	rom the treatment
Eisenhaue	ne assessment and disease responses to be assessed according to the Respuer et al. Eur J Cancer 2009;45:228-47) arked with * are unapproved indications	onse Evaluation Criteria in Solid Tumours (RECIST) version

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

PRES	CRIB	BER	PATIENT:
Name:	:		Name:
Ward:	rd:NHI:		
Siroli	imus	<b>S</b> - 0	continued
Re-as	ssess	men	enal angiomyolipoma(s) associated with tuberous sclerosis complex* t required after 6 months (tick boxes where appropriate)
Prescribed by, or recommended by a nephrologist or urologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
	and	0	Patient has tuberous sclerosis complex*
		$\bigcirc$	Evidence of renal angiomyolipoma(s) measuring 3 cm or greater and that have shown interval growth
Re-as	ssess	men	N – renal angiomyolipoma(s) associated with tuberous sclerosis complex* t required after 12 months (tick boxes where appropriate)
	and	0	Documented evidence of renal angiomyolipoma reduction or stability by magnetic resonance imaging (MRI) or ultrasound
	and	$\bigcirc$	Demonstrated stabilisation or improvement in renal function
	and	0	The patient has not experienced angiomyolipoma haemorrhage or significant adverse effects to sirolimus treatment
		$\cup$	The treatment remains appropriate and the patient is benefitting from treatment
Note:	Indi	catio	ns marked with * are unapproved indications
Re-as	ssess equis	men ites	efractory seizures associated with tuberous sclerosis complex* t required after 6 months (tick boxes where appropriate) cribed by, or recommended by a neurologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.
and	and	0	Patient has epilepsy with a background of documented tuberous sclerosis complex*
			O Vigabatrin has been trialled and has not adequately controlled seizures
			Seizures are not adequately controlled by, or the patient has experienced unacceptable side effects from, optimal treatment with at least two of the following: sodium valproate, topiramate, levetiracetam, carbamazepine, lamotrigine, phenytoin sodium, and lacosamide (see Note)
		or	O Vigabatrin is contraindicated and
			Seizures are not adequately controlled by, or the patient has experienced unacceptable side effects from, optimal treatment with at least three of the following: sodium valproate, topiramate, levetiracetam, carbamazepine, lamotrigine, phenytoin sodium, and lacosamide (see Note)
	and	$\bigcirc$	Seizures have a significant impact on quality of life
	and (	0	Patient has been assessed and surgery is considered inappropriate for this patient, or the patient has been assessed and would benefit from mTOR inhibitor treatment prior to surgery
			childbearing potential are not required to trial phenytoin sodium, sodium valproate, and topiramate. Those who can father children are not sodium valproate.

Page 463

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Sirolimus - continued		
CONTINUATION – refractory seizures associated with tuberous sclerosis Re-assessment required after 12 months  Prerequisites (tick box where appropriate)	s complex*	
O Prescribed by, or recommended by a neurologist, or in accordance of Hospital.	with a protocol or guideline that has been endorsed by the Health NZ	
Demonstrated significant and sustained improvement in seizure rate (e.g. 50% reduction in seizure frequency) or severity and/or patient quality of life compared with baseline prior to starting sirolimus treatment  Note: Indications marked with * are unapproved indications		

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Bacillus calmette-guerin (BCG)			
INITIATION Prerequisites (tick box where appropriate)			
O For use in bladder cancer			

#### RS2120 - Upadacitinib

Atopic dermatitis - INITIATION	466
Atopic dermatitis - CONTINUATION	
Crohn's disease – adult - INITIATION	467
Crohn's disease – adult - CONTINUATION	467
Crohn's disease – children - INITIATION	468
Crohn's disease - children - CONTINUATION	468
Rheumatoid Arthritis - CONTINUATION	
Rheumatoid Arthritis (patients previously treated with adalimumab or etanercept) - INITIATION .	466
Ulcerative colitis - INITIATION	468
Ulcerative colitis - CONTINUATION	468

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

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	d:NHI:	
Jpadacitinik		
INITIATION - F	theumatoid Arthritis (patients previously treated with adalimumab or etanercept) required after 6 months tick boxes where appropriate)  The individual has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis  The individual has experienced intolerable side effects with adalimumab and/or etanercept  The individual has received insufficient benefit from at least a three-month trial of adalimumab and/or etanercept such that they do not meet the renewal criteria for rheumatoid arthritis	
Rituximab is not clinically appropriate  Or  The individual is seronegative for both anti-cyclic citrullinated peptide (CCP) antibodies and rheumatoid factor  or  The individual has been started on rituximab for rheumatoid arthritis in a Health NZ Hospital  Or  At four months following the initial course of rituximab the individual has received insufficient benefit such that they do not meet the renewal criteria for rheumatoid arthritis  CONTINUATION – Rheumatoid Arthritis  Re-assessment required after 6 months		
or O	Following 6 months' initial treatment, the individual has experienced at least a 50% decrease in active joint count from baseline  On subsequent reapplications, the individual has experienced at least a continuing 30% improvement in active joint count from baseline	
Re-assessmen	topic dermatitis required after 6 months tick boxes where appropriate)	
or and	O Individual has received insufficient benefit from topical therapy (including topical corticosteroids or topical calcineurin inhibitors) for a 28-day trial within the last 6 months, unless contraindicated to all	

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Upadacitinib - continued		
CONTINUATION – Atopic dermatitis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  Individual has received a 75% or greater reduction in EASI so upadacitinib  or  Individual has received a DLQI improvement of 4 or more as or	ore (EASI 75) as compared to baseline EASI prior to commencing compared to baseline DLQI prior to commencing upadacitinib	
INITIATION – Crohn's disease – adult Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)		
Individual is currently on treatment with upadacitinib for Crohn's disease and met all remaining criteria prior to commencing treatment  Individual has active Crohn's disease  Individual has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria  Individual meets the initiation criteria for prior biologic therapies for Crohn's disease  Other biologic therapies for Crohn's disease are contraindicated		
CONTINUATION – Crohn's disease – adult Re-assessment required after 2 years Prerequisites (tick boxes where appropriate)		
O CDAI score has reduced by 100 points from the CDAI score word HBI score has reduced by 3 points from when individual was in Or CDAI score is 150 or less  Or HBI score is 4 or less  Or The individual has experienced an adequate response to treat	nitiated on biologic therapy	

I confirm that the above details are correct:	
Signed:	Date:

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

#### HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

PRESCRIBER	PATIENT:
Name:	
Ward:	NHI:
Upadacitini	<b>b</b> - continued
INITIATION – Re-assessme	Crohn's disease – children nt required after 6 months (tick boxes where appropriate)
or	Individual is currently on treatment with upadacitinib for Crohn's disease and met all remaining criteria prior to commencing treatment
ar	Child has active Crohn's disease
	Or Child has had an initial approval for prior biologic therapy for Crohn's disease and has experienced intolerable side effects or insufficient benefit to meet renewal criteria
	Child meets the initiation criteria for prior biologic therapies for Crohn's disease
	O Other biologic therapies for Crohn's disease are contraindicated
Re-assessme	DN – Crohn's disease – children  nt required after 2 years  (tick boxes where appropriate)
	PCDAI score has reduced by 10 points from when the child was initiated on treatment
or O	PCDAI score is 15 or less
or	The child has experienced an adequate response to treatment, but PCDAI score cannot be assessed
Note: Indication	ons marked with * are unapproved indications.
Re-assessme	Ulcerative colitis nt required after 6 months (tick boxes where appropriate)
or _	Individual is currently on treatment with upadacitinib for ulcerative colitis and met all remaining criteria prior to commencing treatment
aı	O Individual has active ulcerative colitis
	Individual has had an initial approval for prior biologic therapy for ulcerative colitis and has experienced intolerable side effects or insufficient benefit to meet renewal criteria
	Individual meets the initiation criteria for prior biologic therapies for ulcerative colitis
	Other biologic therapies for ulcerative colitis are contraindicated
Re-assessme	ON – Ulcerative colitis nt required after 2 years (tick boxes where appropriate)
or O	The SCCAI score has reduced by 2 points or more from the SCCAI score when the individual was initiated on treatment
O	PUCAI score has reduced by 10 points or more from the PUCAI score when the individual was initiated on treatment

### **Respiratory System and Allergies**



Page 470

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Icatibant	
endorsed by the Health NZ Hospital.	
CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate)  O The treatment remains appropriate and the patient is benefiting from	n treatment

I	confirm	that the	above	details	are corre	ct:	

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Zigneg.	i jate:	
Oigilica.	 Duic.	

PRES	CRI	IBER		PATIENT:
Name	e:			Name:
Ward:	·			NHI:
Adre	nal	line		
1			anaphylaxis (tick boxes where appropriate)	
	O Patient has experienced a previous anaphylactic reaction which has resulted in presentation to a hospital or emergency department			h has resulted in presentation to a hospital or emergency department
O Patient has been assessed to be at significant risk of anaphylaxis by a relevant practitioner			axis by a relevant practitioner	

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:			PATIENT:		
			Name:		
Bee	venom				
	ATION equisites	(tick boxes where appropriate)			
	O	RAST or skin test positive			
O Patient has had severe generalised reaction to the sensitising agent			agent		

Signed: Date:

PRES	SCRIBER	PATIENT:		
		Name:		
		NHI:		
Pape	er wasp venom			
	IATION requisites (tick boxes where appropriate)			
	RAST or skin test positive			
	O Patient has had severe generalised reaction to the sensitising	agent		

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PRESCRIBER  Name:		PATIENT:	
		Name:	
		NHI:	
Yello	ow jacket wasp venom		
	IATION requisites (tick boxes where appropriate)		
	RAST or skin test positive		
O Patient has had severe generalised reaction to the sensitising agent			

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.

PRES	CRIBER		PATIENT:
Name	:		Name:
Ward:			NHI:
Long	J-Acting	Muscarinic Antagonists with Long-Acting Beta	a-Adrenoceptor Agonists
	ATION equisites	(tick boxes where appropriate)	
	and	Patient has been stabilised on a long acting muscarinic antago	pnist
		The prescriber considers that the patient would receive addition	onal benefit from switching to a combination product

PRESCRIBER		PATIENT:
Name:		
Ward:		NHI:
Fluticasone	furoa	te with umeclidinium and vilanterol
INITIATION		
Prerequisites	(tick bo	xes where appropriate)
and	Patient possib	t has a diagnosis of COPD confirmed by spirometry or spirometry has been attempted and technically acceptable results are not le
	and	Patient is currently receiving an inhaled corticosteroid with long acting beta-2 agonist (ICS/LABA) or a long acting muscarinic antagonist with long acting beta-2 agonist (LAMA/LABA)
or	le	Clinical criteria:  Patient has a COPD Assessment Test (CAT) score greater than 10  Patient has had 2 or more exacerbations in the previous 12 months  Patient has had one exacerbation requiring hospitalisation in the previous 12 months  Patient has had an eosinophil count greater than or equal to 0.3 × 10°9 cells/L in the previous 12 months  Patient is currently receiving multiple inhaler triple therapy (inhaled corticosteroid with long acting muscarinic antagonist and ong acting beta-2 agonist – ICS/LAMA/LABA) and met at least one of the clinical criteria above prior to commencing multiple inhaler triple therapy

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Signed.	Date:	
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PRESCRIBER	PA	TIENT:
Name:	Na	me:
Ward:	NH	l:
Budesonide with g	glycopyrronium and eformoterol	
and possible and and or Pa	has a diagnosis of COPD confirmed by spirometry or spirole  Patient is currently receiving an inhaled corticosteroid muscarinic antagonist with long acting beta-2 agonist of Clinical criteria:  Patient has a COPD Assessment Test (CAT) socon Patient has had 2 or more exacerbations in the por Patient has had one exacerbation requiring hospor Patient has had an eosinophil count greater than Patient is currently receiving multiple inhaler triple therapy (in	ore greater than 10 orevious 12 months

C:	D-1	
Signed.	Date:	
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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.

PRES	CRIE	BER	3	PATIENT:
Name	:			Name:
Ward:				NHI:
Pirfe	nido	one	В	
Re-a	ssess siups	smer sites Preso	- idiopathic pulmonary fibrosis ent required after 12 months s (tick boxes where appropriate) scribed by, or recommended by a respiratory specialist, or in accommodate.  Patient has been diagnosed with idiopathic pulmonary fibrosis	ordance with a protocol or guideline that has been endorsed by the Health
	and and and	$\bigcirc$	Patient has been diagnosed with idiopatric pulmonary librosis  Forced vital capacity is between 50% and 90% predicted  Pirfenidone is to be discontinued at disease progression (See I)  Pirfenidone is not to be used in combination with subsidised nin	Notes)
		or or	O Patient has previously received nintedanib, but discontinuous	ued nintedanib within 12 weeks due to intolerance  nt's disease has not progressed (disease progression defined as 10%
Re-a	ssess siups	smer sites Preso	ION – idiopathic pulmonary fibrosis ent required after 12 months s (tick boxes where appropriate) scribed by, or recommended by a respiratory specialist, or in according to the spital.  Treatment remains clinically appropriate and patient is benefitti Pirfenidone is not to be used in combination with subsidised nin Pirfenidone is to be discontinued at disease progression (See I	ntedanib
Note peri		ease	se progression is defined as a decline in percent predicted FVC o	of 10% or more within any 12 month

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	PATIENT:
Name:	Name:
Ward:	NHI:
Nintedanib	
INITIATION – idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a respiratory specialist, or in ac NZ Hospital.  and  Patient has been diagnosed with idiopathic pulmonary fibrosi and  Forced vital capacity is between 50% and 90% predicted and  Nintedanib is to be discontinued at disease progression (See and  Nintedanib is not to be used in combination with subsidised pand  The patient has not previously received treatment with or  Patient has previously received pirfenidone, but discontinued or	Note)  pirfenidone  pirfenidone  tinued pirfenidone within 12 weeks due to intolerance  cient's disease has not progressed (disease progression defined as 10%
CONTINUATION – idiopathic pulmonary fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a respiratory specialist, or in ac NZ Hospital.  and  Treatment remains clinically appropriate and patient is benefit and  Nintedanib is not to be used in combination with subsidised pand  Nintedanib is to be discontinued at disease progression (See	irfenidone
Note: disease progression is defined as a decline in percent predicted FVC period.	of 10% or more within any 12 month

I confirm that the above details are correct:

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

PRES	CRIB	ER		PATIENT:
Name	):			Name:
Ward	:			NHI:
lvaca	aftor			
	Э ғ	<b>ites</b> Presc	ribed	boxes where appropriate) by, or recommended by a respiratory specialist or paediatrician, or in accordance with a protocol or guideline that has been by the Health NZ Hospital.
and	and	0	Patie	nt has been diagnosed with cystic fibrosis
	unu	or	0	Patient must have G551D mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene on at least 1 allele
			0	Patient must have other gating (class III) mutation (G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N and S549R) in the CFTR gene on at least 1 allele
	and (	0		nts must have a sweat chloride value of at least 60 mmol/L by quantitative pilocarpine iontophoresis or by Macroduct sweat ction system
	and ( and	O	Treat	ment with ivacaftor must be given concomitantly with standard therapy for this condition
	and	$\circ$		nt must not have an acute upper or lower respiratory infection, pulmonary exacerbation, or changes in therapy (including iotics) for pulmonary disease in the last 4 weeks prior to commencing treatment with ivacaftor
	and	O	The	dose of ivacaftor will not exceed one tablet or one sachet twice daily
	(	$\cup$	Appli	cant has experience and expertise in the management of cystic fibrosis

PRESCRIBE	ER		PATIENT:
Name:			
Ward:			NHI:
Elexacafto	or v	with	tezacaftor, ivacaftor and ivacaftor
INITIATION Prerequisit		(tick b	poxes where appropriate)
and	)	Patie	ent has been diagnosed with cystic fibrosis
and	)	Patie	ent is 6 years of age or older
		0	Patient has two cystic fibrosis-causing mutations in the cystic fibrosis transmembrane regulator (CFTR) gene (one from each parental allele)
	or	0	Patient has a sweat chloride value of at least 60 mmol/L by quantitative pilocarpine iontophoresis or by Macroduct sweat collection system
and			
		$\circ$	Patient has a heterozygous or homozygous F508del mutation
	or	0	Patient has a G551D mutation or other mutation responsive in vitro to elexacaftor/tezacaftor/ivacaftor (see note a)
and and	)	The t	treatment must be the sole funded CFTR modulator therapy for this condition
	)	Treat	tment with elexacaftor/tezacaftor/ivacaftor must be given concomitantly with standard therapy for this condition
Note:			
a) Eligible i	muta ctr-c	ations	s are listed in the Food and Drug Administration (FDA) Trikafta prescribing information a.gov/fdalabel/services/spl/set-ids/f354423a-85c2-41c3-a9db-0f3aee135d8d/spl-doc

I confirm that the above details are correct:

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Oigilica.	 Duic.	

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	PATIENT:
Name:	Name:
Ward:	NHI:
Dornase alfa	
INITIATION – cystic fibrosis Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)  O Prescribed by, or recommended by a respiratory physician or paedic endorsed by the Health NZ Hospital.  and O Patient has a confirmed diagnosis of cystic fibrosis and O Patient has previously undergone a trial with, or is currently be and O Patient has required one or more hospital inpatient response or Patient has had 3 exacerbations due to CF, requiring or or	poiratory admissions in the previous 12 month period ral or intravenous (IV) antibiotics in in the previous 12 month period al or IV antibiotics in the previous 12 month period and a Brasfield score
CONTINUATION – cystic fibrosis Prerequisites (tick box where appropriate)  O Prescribed by, or recommended by a respiratory physician or paedi endorsed by the Health NZ Hospital.  and  The treatment remains appropriate and the patient continues to ber	atrician, or in accordance with a protocol or guideline that has been
INITIATION – significant mucus production Re-assessment required after 4 weeks Prerequisites (tick boxes where appropriate)  Patient is an in-patient and The mucus production cannot be cleared by first line chest te	chniques
INITIATION – pleural emphyema Re-assessment required after 3 days Prerequisites (tick boxes where appropriate)  O Patient is an in-patient and Patient diagnoses with pleural emphyema	

### **Sensory Organs**



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.

PRES	CRIBER		PATIENT:
Name	e:		Name:
Ward:	:		NHI:
Dexa	methaso	ne	
INITI Re-a	ATION - Dia ssessment requisites (tide Hospital	abetic macular oedema equired after 12 months ck boxes where appropriate)  ped by, or recommended by an ophthalmologist, or in accorda l.  atients have diabetic macular oedema with pseudophakic len atient has reduced visual acuity of between 6/9 – 6/48 with fu  Patient's disease has progressed despite 3 injections with Patient is unsuitable or contraindicated to treatment with	unctional awareness of reduction in vision th bevacizumab
Re-a	Prescrit Hospita	I. atient's vision is stable or has improved (prescriber determine	ance with a protocol or guideline that has been endorsed by the Health NZ ed) quently than once every 4 months into each eye, and up to a maximum
Re-a	ssessment reequisites (tide) Prescribe Hospita		ance with a protocol or guideline that has been endorsed by the Health NZ
	and P and D	atient has reduced visual acuity of between 6/9 – 6/48 with fu	

I confirm that the above details are correct:

O:I-	D - 1 - 1	

PRES	CRIBER		PATIENT:
Name	e:		Name:
Ward:	:		NHI:
Dexa	amethas	sone - continued	
Re-a	ssessmer equisites		lema ance with a protocol or guideline that has been endorsed by the Health NZ
	and O	Patient's vision is stable or has improved (prescriber determine Patient is of child bearing potential and has not yet completed	
	and	Dexamethasone implants are to be administered not more free of 3 implants per eye per year	quently than once every 4 months into each eye, and up to a maximum

I confirm that the above details are correct:	
Cimadi	Data

### **Various**



RESCRIBER	3	PATIENT:
ame:		Name:
/ard:		NHI:
eferasiro	K	
NITIATION Re-assessme Prerequisites Preservition	ent required after 2 years s (tick boxes where appropriate) scribed by, or recommended by a haematologist, or in accordance spital.  The patient has been diagnosed with chronic iron overload du Deferasirox is to be given at a daily dose not exceeding 40 mg  Treatment with maximum tolerated doses of deferiprone have proven ineffective as measured by serum ferritin left Treatment with deferiprone has resulted in arthritis Treatment with deferiprone is contraindicated due to a harmonic property of the provence of the proven	g/kg/day e monotherapy or deferiprone and desferrioxamine combination therapy evels, liver or cardiac MRI T2*
rerequisites	ent required after 2 years s (tick boxes where appropriate)	
	scribed by, or recommended by a haematologist, or in accordance pital.	ce with a protocol or guideline that has been endorsed by the Health NZ
or O	parameters namely serum ferritin, cardiac MRI T2* and liver M	nd has resulted in clinical stability or continued improvement in all three

I confirm that the above details are correct:	
Signod:	Date:

#### Form RS1445 January 2026

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 488

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	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Deferiprone		
INITIATION Prerequisites (tick box where appropriate)		
O Patient has been diagnosed with chronic iron overload due to congenital inherited anaemia or acquired red cell aplasia		

I confirm that the above details are correct:

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Page 489

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	PATIENT:
Name:	Name:
Ward:	NHI:
Povidone-iodine - Vaginal tab 200 mg	
INITIATION	
Prerequisites (tick box where appropriate)	
O Rectal administration pre-prostate biopsy	

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

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Chlorhexidine with cetrimide	
INITIATION Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)  O Patient has burns that are greater than 30% of total body surface and O For use in the perioperative preparation and cleansing of large and O The use of 30 ml ampoules is impractical due to the size of the	e burn areas requiring debridement/skin grafting
CONTINUATION Re-assessment required after 3 months Prerequisites (tick box where appropriate)  The treatment remains appropriate for the patient and the patient is	benefiting from the treatment

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Signed.	Date:	
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### Special Foods



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

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Carbohydrate	
INITIATION – Use as an additive Prerequisites (tick boxes where appropriate)	
Cystic fibrosis  or  Chronic kidney disease  or  Cancer in children  or  Cancers affecting alimentary tract where there are malabsorp  or  Faltering growth in an infant/child  or  Bronchopulmonary dysplasia  or  Premature and post premature infant  or  Inborn errors of metabolism	ption problems in patients over the age of 20 years
For use as a component in a modular formula made from at least of the Pharmaceutical Schedule or breast milk  Note: Patients are required to meet any Special Authority criteria associated	one nutrient module and at least one further product listed in Section D of with all of the products used in the modular formula.

I confirm that the above details are correct:

Cianad.	Doto.	
Sidned.	 Date.	

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	PATIENT:
Name:	Name:
Ward:	NHI:
Fat	
INITIATION – Use as an additive Prerequisites (tick boxes where appropriate)	
Patient has inborn errors of metabolism  or Faltering growth in an infant/child  or Bronchopulmonary dysplasia  or Lymphangiectasia  or Short bowel syndrome  or Infants with necrotising enterocolitis  or Biliary atresia  or Chyle leak  or Ascites  or	
O Patient has increased energy requirements, and for whom diet	ary measures have not been successful
INITIATION – Use as a module Prerequisites (tick box where appropriate)  For use as a component in a modular formula made from at least on the Pharmaceutical Schedule or breast milk.  Note: Patients are required to meet any Special Authority criteria associated with the pharmaceutical schedule or breast milk.	e nutrient module and at least one further product listed in Section D of with all of the products used in the modular formula.

Page 494

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	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Protein		
INITIATION – Use as an additive Prerequisites (tick boxes where appropriate)		
O Protein losing enteropathy or O High protein needs		
INITIATION – Use as a module Prerequisites (tick box where appropriate)  Or For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk.  Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.		

I confirm that the above details are correct:

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Carbohydrate and fat supplement	
INITIATION Prerequisites (tick boxes where appropriate)  O Infant or child aged four years or under and O Cystic fibrosis or O Cancer in children or O Faltering growth	
or O Bronchopulmonary dysplasia or O Premature and post premature infants	

I confirm that the above details are correct:	
Signed:	Date:

PRES	SCR	RIBER	PATIENT:
Name	e:		Name:
Ward	l:		NHI:
Meta	abo	olic Products	
INITI Prer		ION uisites (tick boxes where appropriate)	
		O For the dietary management of inherited metabolic disease	
	or	Patient has adrenoleukodystrophy	

Page 497

PRES	CRIE	BER		PATIENT:
Name:				Name:
Ward:				NHI:
Diabe	etic	Pro	ducts	
INITIA Prere			(tick boxes where appropriate)	
	or	0	For patients with type I or type II diabetes suffering weight loss	and malnutrition that requires nutritional support
	or	0	For patients with pancreatic insufficiency	
		0	For patients who have, or are expected to, eat little or nothing	for 5 days
	or or	0	For patients who have a poor absorptive capacity and/or high catabolism	nutrient losses and/or increased nutritional needs from causes such as
		0	For use pre- and post-surgery	
	or or	0	For patients being tube-fed	
	٥.	0	For tube-feeding as a transition from intravenous nutrition	

I confirm that the above details are correct:	
Signed:	Date:

PRES	CRI	BER		PATIENT:
Name	e:			Name:
Ward:	·			NHI:
Elem	en	tal a	nd Semi-Elemental Products	
INITI Prere			(tick boxes where appropriate)	
	or or or or	0 0 0 0 0 0	Malabsorption Short bowel syndrome Enterocutaneous fistulas Eosinophilic enteritis (including oesophagitis) Inflammatory bowel disease Acute pancreatitis where standard feeds are not tolerated Patients with multiple food allergies requiring enteral feeding	
		0	Patients with multiple food allergies requiring enteral feeding	

PRES	CRI	BER		PATIENT:
Name	:			Name:
Ward:				NHI:
Fat-r	nod	lified	l feed	
INITI Prere			(tick boxes where appropriate)	
		O	Patient has metabolic disorders of fat metabolism	
	or	0	Patient has a chyle leak	
	or		Modified as a modular feed, made from at least one nutrient me Pharmaceutical Schedule, for adults	nodule and at least one further product listed in Section D of the

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

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	PATIENT:
Name:	Name:
Ward:	NHI:
Hepatic Products	
INITIATION Prerequisites (tick box where appropriate)	
O For children (up to 18 years) who require a liver transplant	

I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
High Calorie Products	
INITIATION Prerequisites (tick boxes where appropriate)  Patient is fluid volume or rate restricted or Patient requires low electrolyte  Or Cystic fibrosis or Any condition causing malabsorption or Faltering growth in an infant/child or Increased nutritional requirements  and  Patient has substantially increased metabolic requirements	ents

I confirm that the above details are correct:

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PATIENT:
Name:
NHI:
g high calorie product

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Zigneg.	i jate:	
Oigilica.	 Duic.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Extensively hydrolysed formula	
INITIATION Prerequisites (tick boxes where appropriate)	
Cows' milk formula is inappropriate due to severe intole  O Soy milk formula has been reasonably trialled wit	
O Soy milk formula is considered clinically inapprop	riate or contraindicated
or Severe malabsorption or Short bowel syndrome or Intractable diarrhoea or Biliary atresia or Cholestatic liver diseases causing malsorption or Cystic fibrosis or Proven fat malabsorption or Severe intestinal motility disorders causing significant malabs or Intestinal failure or For step down from Amino Acid Formula	orption
Note: A reasonable trial is defined as a 2-4 week trial, or signs of an immedia	te IgE mediated allergic reaction.
CONTINUATION Prerequisites (tick boxes where appropriate)	
O An assessment as to whether the infant can be transitioned to and O The outcome of the assessment is that the infant continues to	o a cows' milk protein or soy infant formula has been undertaken require an extensively hydrolysed infant formula

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	PATIENT:
Name:	Name:
Ward:	NHI:
Preterm formula	
INITIATION Prerequisites (tick box where appropriate)	
O For infants born before 33 weeks' gestation or weighing less than 1.	5 kg at birth

Page 505

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	PATIENT:
Name:	Name:
Ward:	NHI:
Paediatric oral/enteral feed 1 kcal/ml	
INITIATION – Fluid restricted or volume intolerance with faltering growth Prerequisites (tick boxes where appropriate)  Or  The patient is fluid restricted or volume intolerant or  The patient has increased nutritional requirements due to and  Patient is under 18 months old and weighs less than 8kg	o faltering growth
Note: 'Volume intolerant' patients are those who are unable to tolerate an ade patients should have first trialled appropriate clinical alternative treatments, su	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Enteral liquio	d peptide formula
INITIATION Prerequisites (	(tick boxes where appropriate)
and	Patient has impaired gastrointestinal function and either cannot tolerate polymeric feeds, or polymeric feeds are unsuitable
	O Severe malabsorption
or	O Short bowel syndrome
or	O Intractable diarrhoea
or	O Biliary atresia
or	Cholestatic liver diseases causing malabsorption
or	O Cystic fibrosis
or	O Proven fat malabsorption O Severe intestinal motility disorders causing significant malabsorption
or	O Intestinal failure
or	The patient is currently receiving funded amino acid formula
	The patient is to be trialled on, or transitioned to, an enteral liquid peptide formula
and	
or	A semi-elemental or partially hydrolysed powdered feed has been reasonably trialled and considered unsuitable
	O For step down from intravenous nutrition
Note: A reason	able trial is defined as a 2-4 week trial.
CONTINUATIO Prerequisites (	N (tick boxes where appropriate)
_	An assessment as to whether the patient can be transitioned to a cows milk protein or soy infant formula or extensively hydrolysed formula has been undertaken
and	The outcome of the assessment is that the patient continues to require an enteral liquid peptide formula

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Amino acid formula		
INITIATION Prerequisites (tick boxes where appropriate)		
Extensively hydrolysed formula has been reasonably trialled for or allergy or malabsorption  History of anaphylaxis to cows' milk protein formula or dairy proor  Eosinophilic oesophagitis  Or  Ultra-short gut  Or  Severe Immune deficiency	or 2-4 weeks and is inappropriate due to documented severe intolerance oducts	
CONTINUATION Prerequisites (tick boxes where appropriate)		
An assessment as to whether the infant can be transitioned to been undertaken  The outcome of the assessment is that the infant continues to and  Amino acid formula is required for a nutritional deficit	a cows' milk protein, soy, or extensively hydrolysed infant formula has require an amino acid infant formula	
INITIATION – patients who are currently funded under RS1502 or SA1557 Re-assessment required after 3 months Prerequisites (tick boxes where appropriate)  O Patient has a valid initiation or renewal approval for extensively hydrolysed formula (RS1502) and Patient is unable to source funded Aptamil powder at this time and The approval only applies to funded dispensings of Neocate Gold and Neocate Syneo  Note: This criteria is short term funding to cover an out-of-stock situation on some extensively hydrolysed formula powder funded under Hospital Restriction RS1502. There is no continuation criteria under this criterion.		
I confirm that the above details are correct:		
Signed: Date:		

Page 508

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	PAHENI:
Name:	Name:
Ward:	NHI:
High fat formula	
INITIATION	
Prerequisites (tick box where appropriate)	
For patients with intractable epilepsy, pyruvate dehydrogenase defice requiring a ketogenic diet	ciency or glucose transported type-1 deficiency and other conditions

PRESCRIBER	PATIENT:
Name:	
Ward:	NHI:
Paediatric Produ	cts
	oxes where appropriate) is aged one to ten years
and  or  or  or  or  or  or  or  or  or  o	The child is being fed via a tube or a tube is to be inserted for the purposes of feeding  Any condition causing malabsorption  Faltering growth in an infant/child  Increased nutritional requirements  The child is being transitioned from TPN or tube feeding to oral feeding  The child has eaten, or is expected to eat, little or nothing for 3 days

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	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Low electrolyte oral feed		
INITIATION Prerequisites (tick box where appropriate)		
O For children (up to 18 years) with acute or chronic kidney disease		

I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	. NHI:		
Low electrolyte oral feed			
INITIATION Prerequisites (tick box where appropriate)			
O For patients with acute or chronic kidney disease			

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	PATIENT:
Name:	Name:
Ward:	NHI:
Preoperative carbohydrate feed 0.5 kcal/ml	
INITIATION Prerequisites (tick box where appropriate)	
O Maximum of 400 ml as part of an Enhanced Recovery After Surgery	y (ERAS) protocol 2 to 3 hours before major abdominal surgery

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.

IENT:
ne:
r neck surgery
16

PRESCRI	BER	PATIENT:
Name:		Name:
Ward:		NHI:
Standar	d Fe	eds
INITIATIO Prerequi		(tick boxes where appropriate)
	For p	patients with malnutrition, defined as any of the following:
	or	O BMI < 18.5 O Greater than 10% weight loss in the last 3-6 months
	or	BMI < 20 with greater than 5% weight loss in the last 3-6 months
or	0	For patients who have, or are expected to, eat little or nothing for 5 days
or	0	For patients who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism
or	$\bigcirc$	For use pre- and post-surgery  For patients being tube-fed
or	0	For tube-feeding as a transition from intravenous nutrition
or	O	For any other condition that meets the community Special Authority criteria

#### **Vaccines**



PRESCRIBER			IENT:
Name: .		Narr	ne:
Ward:		NHI:	
Diphth	eria, t	tetanus, pertussis and polio vaccine	
INITIATI Prerequ		s (tick boxes where appropriate)	
or	0	A single dose for children up to the age of 7 who have completed pr	imary immunisation
or	$\circ$	A course of up to four vaccines is funded for catch up programmes immunisation	for children (to the age of 10 years) to complete full primary
		onal four doses (as appropriate) are funded for (re-)immunisation for patients post HSCT, or chemotherapy; pre- or post omy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens	
	О	Five doses will be funded for children requiring solid organ transplan	ntation

Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes

PRESCRIBER		BER	R PATIENT:	PATIENT:	
Name	:				
Ward:			NHI:		
Diph	the	ria, t	a, tetanus, pertussis, polio, hepatitis B and haemophilus influenzae type B vaccine		
INITI Prere			es (tick boxes where appropriate)		
		O	Up to four doses for children under the age of 10 years for primary immunisation		
	or	0	An additional four doses (as appropriate) for (re-)immunisation of children under the age of 18 years post haematopoietic stern transplantation	n cell	
	or	0	An additional four doses (as appropriate) for (re-)immunisation of children under the age of 10 years who are post chemothers or post splenectomy; undergoing renal dialysis and other severely immunosuppressive regimens	apy; pre	
	<u> </u>	0	Up to five doses for children under the age of 10 years receiving solid organ transplantation		

Note: A course of up-to four vaccines is funded for catch up programmes for children (up to and under the age of 10 years) to complete full primary immunisation. Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

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	PATIENT:	
Name:	Name:	
Ward:	NHI:	
Bacillus calmette-guerin vaccine		
INITIATION Prerequisites (tick boxes where appropriate)		
For infants at increased risk of tuberculosis defined as:  Living in a house or family with a person with current or past h  and  Having one or more household members or carers who within  100,000 for 6 months or longer  and	istory of TB the last 5 years lived in a country with a rate of TB > or equal to 40 per	
O During their first 5 years will be living 3 months or longer in a c	country with a rate of TB > or equal to 40 per 100,000	

Note: A list of countries with high rates of TB are available at http://www.health.govt.nz/tuberculosis (Search for Downloads) or www.bcgatlas.org/index.php

RESCR	IBER	ER PATIENT:	
lame: .		Name:	
Vard:		NHI:	
iphth	eria,	ia, tetanus and pertussis vaccine	
INITIATI Prerequ		ites (tick boxes where appropriate)	
	0	A single dose for pregnant women in the second or third trimester of each pregnancy; or	
or	0	A single dose for parents or primary caregivers of infants admitted to a Neonatal Intensive C more than 3 days, who had not been exposed to maternal vaccination at least 14 days prior	
or	$\circ$	A course of up to four doses is funded for children from age 7 up the age of 18 years inclusi	ive to complete full primary immunisation
	0	An additional four doses (as appropriate) are funded for (re-)immunisation for patients post or chemotherapy; pre or post splenectomy; pre- or post solid organ transplant, renal dialysis regimens	
or	$\circ$	A single dose for vaccination of patients aged from 65 years old	
or	$\circ$	${\sf O}$ A single dose for vaccination of patients aged from 45 years old who have not had 4 previou	us tetanus doses
or	$\circ$	For vaccination of previously unimmunised or partially immunised patients	
or	$\circ$	O For revaccination following immunosuppression	
or	0	For boosting of patients with tetanus-prone wounds	

Note: Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER				PATIENT:
Name	e:			Name:
Ward:			NHI:	
Haer	nop	ohilu	s influenzae type B vaccine	
	sses	ssmen	it required after 1 dose (tick boxes where appropriate)	
		0	For primary vaccination in children	
An additional dose (as appropriate) is funded for (re-)immunisation for patients post haematopoietic stem cell tra chemotherapy; functional asplenic; pre or post splenectomy; pre- or post solid organ transplant, pre- or post coch dialysis and other severely immunosuppressive regimens				
	or	0	For use in testing for primary immunodeficiency diseases, on t	the recommendation of an internal medicine physician or paediatrician

3	PATIENT:
	Name:
	NHI:
occal (	(A, C, Y and W-135) conjugate vaccine
s (tick b	poxes where appropriate)
	Up to three doses and a booster every five years for patients pre- and post splenectomy and for patients with HIV, complement deficiency (acquired or inherited), functional or anatomic asplenia or pre or post solid organ transplant
$\circ$	One dose for close contacts of meningococcal cases of any group
$\circ$	One dose for person who has previously had meningococcal disease of any group
O A maximum of two doses for bone marrow transplant patients	
	A maximum of two doses for person pre and post-immunosuppression*
ond	Person is aged between 13 and 25 years, inclusive
	One dose for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, or prisons
or	One dose for individuals who turn 13 years of age while living in boarding school hostels
	r O

Note: children under seven years of age require two doses 8 weeks apart, a booster dose three years after the primary series and then five yearly.

*Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than

28 days.

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIB	ER	PATIENT:	
Name:		Name:	
Ward:		NHI:	
Meningo	coccal (A, C, Y and W-135) conjugate vaccine		
	N – Children under 12 months of age ites (tick boxes where appropriate)		
or ( or ( or ( or ( or (	anatomic asplenia, HIV, complement deficiency (acquired or in A maximum of three doses (dependant on age at first dose) f	for close contacts of meningococcal cases of any group for child who has previously had meningococcal disease of any group for bone marrow transplant patients	
Note: infa	ants from 6 weeks to less than 6 months of age require a 2+1 sch	edule, infants from 6 months to less	

Note: infants from 6 weeks to less than 6 months of age require a 2+1 schedule, infants from 6 months to less than 12 months of age require a 1+1 schedule. Refer to the Immunisation Handbook for recommended booster schedules with meningococcal ACWY vaccine.

*Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than 28 days.

I confirm that the above details are correct:	
Signed:	Date:

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Pneumococcal (PCV13) conjugate vaccine	
INITIATION – Primary course for previously unvaccin Re-assessment required after 3 doses Prerequisites (tick box where appropriate)	ated children aged under 5 years
A primary course of three doses for previously	unvaccinated children up to the age of 59 months inclusive
INITIATION – High risk individuals who have received Re-assessment required after 2 doses  Prerequisites (tick box where appropriate)  Two doses are funded for high risk individuals (primary course of PCV10	Over the age of 12 months and under 18 years) who have previously received two doses of the
INITIATION – High risk children aged under 5 years Re-assessment required after 4 doses Prerequisites (tick boxes where appropriate)	
O Up to an additional four doses (as approp	oriate) are funded for the (re)immunisation of high-risk children aged under 5 years
	radiation therapy, vaccinate when there is expected to be a sufficient immune response
O Primary immune deficiencies	
O HIV infection	
O Renal failure, or nephrotic syndrom	e
O Are immune-suppressed following	organ transplantation (including haematopoietic stem cell transplant)
O Cochlear implants or intracranial sh	nunts
O Cerebrospinal fluid leaks	
	r more than two weeks, and who are on an equivalent daily dosage of prednisone of 2 mg/kg weigh more than 10 kg on a total daily dosage of 20 mg or greater
	ing asthma treated with high-dose corticosteroid therapy)
O Pre term infants, born before 28 we	eeks gestation
O Cardiac disease, with cyanosis or f	ailure
O Diabetes	
O Down syndrome	
O Who are pre-or post-splenectomy, o	or with functional asplenia

I confirm that the above details are correct:	
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PRESCRIBER	PATIENT:		
Name:	Name:		
Ward:	NHI:		
Pneumococcal (PCV13) conjugate vaccine - continued			
INITIATION – High risk individuals 5 years and over Re-assessment required after 4 doses			
Prerequisites (tick box where appropriate)			
O Up to an additional four doses (as appropriate) are funded for the (re-)immunisation of individuals 5 years and over with HIV, pre or post haematopoietic stem cell transplantation, or chemotherapy; pre- or post splenectomy; functional asplenia, pre- or post- solid organ transplant, renal dialysis, complement deficiency (acquired or inherited), cochlear implants, intracranial shunts, cerebrospinal fluid leaks or primary immunodeficiency			
INITIATION – Testing for primary immunodeficiency diseases			
Prerequisites (tick box where appropriate)			
O For use in testing for primary immunodeficiency diseases, on the rec	commendation of an internal medicine physician or paediatrician		
Note: Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes			

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I confirm that the above details are correct:

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

RESCRI	BER		PATIENT:
ame:			Name:
Vard: NHI:			
neumo	сосса	l (PPV23) polysaccharide vacc	ine
		h risk patients equired after 3 doses	<u> </u>
rerequis	sites (tic	k box where appropriate)	
	asplenia		oietic stem cell transplant, or chemotherapy; pre- or post-splenectomy; or with functional al dialysis, complement deficiency (acquired or inherited), cochlear implants, or primary
		h risk children equired after 2 doses	
rerequis	sites (tic	k boxes where appropriate)	
and		atient is a child under 18 years for (re-)im	munisation
	or		adiation therapy, vaccinate when there is expected to be a sufficient immune response
	or	With primary immune deficiencies     With HIV infection	
	or	With First Intection     With renal failure, or nephrotic syndromals	ome
	or C	Who are immune-suppressed following	ng organ transplantation (including haematopoietic stem cell transplant)
	or or	With cochlear implants or intracrania	I shunts
	or	With cerebrospinal fluid leaks	
	or	Receiving corticosteroid therapy for r per day or greater, or children who w	more than two weeks, and who are on an equivalent daily dosage of prednisone of 2 mg/kg eigh more than 10 kg on a total daily dosage of 20 mg or greater
	or	With chronic pulmonary disease (incl	luding asthma treated with high-dose corticosteroid therapy)
	or	Pre term infants, born before 28 wee	ks gestation
		With cardiac disease, with cyanosis of	or failure
	or or	With diabetes	
	or	With Down syndrome	
		Who are pre-or post-splenectomy, or	with functional asplenia
		eting for primary immunodeficiency dis	seases
0	For use	in testing for primary immunodeficiency of	diseases, on the recommendation of an internal medicine physician or paediatrician

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Salmonella typhi vaccine	
INITIATION Prerequisites (tick box where appropriate)	
O For use during typhoid fever outbreaks	

Name:	PRESCRIE	BER		PATIENT:
Meningococcal B multicomponent vaccine  INITIATION – Primary immunisation for children up to 59 months of age inclusive Re-assessment required after 3 doses Prerequisites (tick box where appropriate)  A primary course of up to three doses (dependent on age at first dose) for previously unvaccinated children up to the age of 59 months inclusive  INITIATION – High-risk individuals 5 years of age or over Prerequisites (tick boxes where appropriate)  Person is aged at least 5 years  O Up to two doses and a booster every five years for patients pre- and post-splenectomy or Up to two doses and a booster every five years for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited)  or Up to two doses and a booster every five years pre- or post-solid organ transplant or Up to two doses for close contacts of meningococcal cases of any group or Up to two doses for person who has previously had meningococcal disease of any group or Up to two doses for person who has previously had meningococcal disease of any group or Up to two doses for person pre- and post-immunosuppression*  INITIATION – Person is aged between 13 and 25 years (inclusive)  Re-assessment required after 2 doses Prerequisites (tick boxes where appropriate)  Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, or Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, or Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, or Two doses for individuals who turn 13 years of age while living in boarding school hostels	Name:			Name:
INITIATION – Primary immunisation for children up to 59 months of age inclusive Re-assessment required after 3 doses Prerequisites (tick box where appropriate)  A primary course of up to three doses (dependent on age at first dose) for previously unvaccinated children up to the age of 59 months inclusive  INITIATION – High-risk individuals 5 years of age or over Prerequisites (tick boxes where appropriate)  Person is aged at least 5 years  Up to two doses and a booster every five years for patients pre- and post-splenectomy or Up to two doses and a booster every five years for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited) or Up to two doses and a booster every five years pre- or post-solid organ transplant or Up to two doses for close contacts of meningococcal cases of any group or Up to two doses for person who has previously had meningococcal disease of any group or Up to two doses for person who has previously had meningococcal disease of any group or Up to two doses for person pre- and post-immunosuppression*  INITIATION – Person is aged between 13 and 25 years (inclusive) Re-assessment required after 2 doses Prerequisites (tick boxes where appropriate)  Or and Or and Or anatomic appropriate or	Ward:			NHI:
Re-assessment required after 3 doses  Prerequisites (tick box where appropriate)  A primary course of up to three doses (dependent on age at first dose) for previously unvaccinated children up to the age of 59 months inclusive  INITIATION – High-risk individuals 5 years of age or over  Prerequisites (tick boxes where appropriate)  Person is aged at least 5 years  O Up to two doses and a booster every five years for patients pre- and post-splenectomy  or O Up to two doses and a booster every five years for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited)  or O Up to two doses and a booster every five years pre- or post-solid organ transplant  or O Up to two doses for close contacts of meningococcal cases of any group  or O Up to two doses for person who has previously had meningococcal disease of any group  or O Up to two doses for person who has previously had meningococcal disease of any group  or O Up to two doses for person pre- and post-immunosuppression*  INITIATION – Person is aged between 13 and 25 years (inclusive)  Re-assessment required after 2 doses  Prerequisites (tick boxes where appropriate)  O Person is aged between 13 and 25 years (inclusive)  Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, terliary education halls of residence, military barracks, Youth Justice residences, or prisons  or O Two doses for individuals who turn 13 years of age while living in boarding school hostels	Meningo	coccal	B multicomponent vaccine	
Prerequisites (tick boxes where appropriate)  Person is aged at least 5 years and  O Up to two doses and a booster every five years for patients pre- and post-splenectomy or O Up to two doses and a booster every five years for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited)  Or O Up to two doses and a booster every five years pre- or post-solid organ transplant or O Up to two doses for close contacts of meningococcal cases of any group or O Up to two doses for person who has previously had meningococcal disease of any group or O Up to two doses for bone marrow transplant patients or O Up to two doses for person pre- and post-immunosuppression*  INITIATION – Person is aged between 13 and 25 years (inclusive)  Re-assessment required after 2 doses  Prerequisites (tick boxes where appropriate)  O Person is aged between 13 and 25 years (inclusive)  and  O Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons  Two doses for individuals who turn 13 years of age while living in boarding school hostels  Note: *Immunosuppression due to corticosteroid or other immunosuppressive therapy must be for a period of	Re-assess Prerequis	sment req sites (tick A primary	uired after 3 doses box where appropriate)	
Prerequisites (tick boxes where appropriate)  Person is aged at least 5 years and  O Up to two doses and a booster every five years for patients pre- and post-splenectomy or O Up to two doses and a booster every five years for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited)  Or O Up to two doses and a booster every five years pre- or post-solid organ transplant or O Up to two doses for close contacts of meningococcal cases of any group or O Up to two doses for person who has previously had meningococcal disease of any group or O Up to two doses for bone marrow transplant patients or O Up to two doses for person pre- and post-immunosuppression*  INITIATION – Person is aged between 13 and 25 years (inclusive)  Re-assessment required after 2 doses  Prerequisites (tick boxes where appropriate)  O Person is aged between 13 and 25 years (inclusive)  and  O Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons  Two doses for individuals who turn 13 years of age while living in boarding school hostels  Note: *Immunosuppression due to corticosteroid or other immunosuppressive therapy must be for a period of	INITIATIO	N – High	risk individuals 5 years of age or over	
up to two doses and a booster every five years for patients pre- and post-splenectomy  or  Up to two doses and a booster every five years for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited)  Up to two doses and a booster every five years pre- or post-solid organ transplant  or  Up to two doses for close contacts of meningococcal cases of any group  or  Up to two doses for person who has previously had meningococcal disease of any group  or  Up to two doses for bone marrow transplant patients  or  Up to two doses for person pre- and post-immunosuppression*  INITIATION - Person is aged between 13 and 25 years (inclusive)  Re-assessment required after 2 doses  Prerequisites (tick boxes where appropriate)  Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons  Two doses for individuals who turn 13 years of age while living in boarding school hostels  Note: *Immunosuppression due to corticosteroid or other immunosuppressive therapy must be for a period of				
or Up to two doses and a booster every five years for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited) or Up to two doses and a booster every five years pre- or post-solid organ transplant or Up to two doses for close contacts of meningococcal cases of any group or Up to two doses for person who has previously had meningococcal disease of any group or Up to two doses for bone marrow transplant patients or Up to two doses for person pre- and post-immunosuppression*  INITIATION – Person is aged between 13 and 25 years (inclusive) Re-assessment required after 2 doses Prerequisites (tick boxes where appropriate)  Or Person is aged between 13 and 25 years (inclusive) and Or Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons Two doses for individuals who turn 13 years of age while living in boarding school hostels  Note: *Immunosuppression due to corticosteroid or other immunosuppressive therapy must be for a period of	and	O Per	son is aged at least 5 years	
Up to two doses and a booster every five years pre- or post-solid organ transplant  or  Up to two doses for close contacts of meningococcal cases of any group  or  Up to two doses for person who has previously had meningococcal disease of any group  or  Up to two doses for bone marrow transplant patients  or  Up to two doses for person pre- and post-immunosuppression*  INITIATION – Person is aged between 13 and 25 years (inclusive)  Re-assessment required after 2 doses  Prerequisites (tick boxes where appropriate)  Person is aged between 13 and 25 years (inclusive)  and  Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons  Two doses for individuals who turn 13 years of age while living in boarding school hostels  Note: *Immunosuppression due to corticosteroid or other immunosuppressive therapy must be for a period of		0	Up to two doses and a booster every five years for patie	
INITIATION – Person is aged between 13 and 25 years (inclusive) Re-assessment required after 2 doses Prerequisites (tick boxes where appropriate)  O Person is aged between 13 and 25 years (inclusive) and O Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons or Two doses for individuals who turn 13 years of age while living in boarding school hostels  Note: *Immunosuppression due to corticosteroid or other immunosuppressive therapy must be for a period of			Up to two doses for close contacts of meningococcal ca	ses of any group
INITIATION – Person is aged between 13 and 25 years (inclusive)  Re-assessment required after 2 doses  Prerequisites (tick boxes where appropriate)  O Person is aged between 13 and 25 years (inclusive)  and  Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons  or  Two doses for individuals who turn 13 years of age while living in boarding school hostels  Note: *Immunosuppression due to corticosteroid or other immunosuppressive therapy must be for a period of			Up to two doses for bone marrow transplant patients	
Re-assessment required after 2 doses  Prerequisites (tick boxes where appropriate)  O Person is aged between 13 and 25 years (inclusive)  and  O Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons  O Two doses for individuals who turn 13 years of age while living in boarding school hostels  Note: *Immunosuppression due to corticosteroid or other immunosuppressive therapy must be for a period of			Up to two doses for person pre- and post-immunosuppre	ession*
Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons  Two doses for individuals who turn 13 years of age while living in boarding school hostels  Note: *Immunosuppression due to corticosteroid or other immunosuppressive therapy must be for a period of	Re-assess	sment req	uired after 2 doses	
tertiary education halls of residence, military barracks, Youth Justice residences, or prisons  Two doses for individuals who turn 13 years of age while living in boarding school hostels  Note: *Immunosuppression due to corticosteroid or other immunosuppressive therapy must be for a period of	and	O Per	son is aged between 13 and 25 years (inclusive)	
Note: *Immunosuppression due to corticosteroid or other immunosuppressive therapy must be for a period of		or O	tertiary education halls of residence, military barracks, Y	outh Justice residences, or prisons
	Two doses for individuals who turn 13 years of age while living in boarding school hostels			
Ulealer man 20 days.				ive therapy must be for a period of
g	g. 53.67 ti		,	

PRES	SCR	BER		PATIENT:
Name	e:			Name:
Ward	:			NHI:
Нера	atiti	s A	vaccine	
INITI Prer			(tick boxes where appropriate)	
		O	Two vaccinations for use in transplant patients	
	or	0	Two vaccinations for use in children with chronic liver disease	
One dose of vaccine for close contacts of known hepatitis A cases				ases

PRES	CRIE	BER		PATIENT:
Name:				Name:
Ward:				NHI:
Нера	titis	s B ı	recombinant vaccine	
INITI/ Prere			(tick boxes where appropriate)	
	or	0	For household or sexual contacts of known acute hepatitis B p	atients or hepatitis B carriers
	or	0	For children born to mothers who are hepatitis B surface antige	en (HBsAg) positive
	or	0	For children up to and under the age of 18 years inclusive who additional vaccination or require a primary course of vaccination	o are considered not to have achieved a positive serology and require
		0	For HIV positive patients	
	or	0	For hepatitis C positive patients	
	or or	0	For patients following non-consensual sexual intercourse	
		0	For patients prior to planned immunosuppression for greater th	nan 28 days
	or	0	For patients following immunosuppression	
	or	0	For solid organ transplant patients	
	or	0	For post-haematopoietic stem cell transplant (HSCT) patients	
	or	0	Following needle stick injury	
	or	0	For dialysis patients	
	or	0	For liver or kidney transplant patients	

I confirm that the above details are correct:	

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

PRES	CRII	BER	PA	ATIENT:
Name			Na	ame:
Ward:			NI	H:
Нера	titis	s B ı	recombinant vaccine	
INITI			(Aigh bears and an annual sinks)	
Prere	quis	sites	(tick boxes where appropriate)	
		0	For household or sexual contacts of known acute hepatitis B patie	ents or hepatitis B carriers
	or	0	For children born to mothers who are hepatitis B surface antigen	(HBsAg) positive
	or	0	For children up to and under the age of 18 years inclusive who ar additional vaccination or require a primary course of vaccination	e considered not to have achieved a positive serology and require
	or	0	For HIV positive patients	
	or	0	For hepatitis C positive patients	
	or	0	For patients following non-consensual sexual intercourse	
	or	0	For patients prior to planned immunosuppression for greater than	28 days
	or	0	For patients following immunosuppression	
	or	0	For solid organ transplant patients	
	or	0	For post-haematopoietic stem cell transplant (HSCT) patients	
	or	0	Following needle stick injury	

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Oigilica.	 Duic.	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Influenza vaccine Inj 60 mcg in 0.5 ml syringe (quadrivalen	t vaccine)
INITIATION – People over 65 Prerequisites (tick box where appropriate)  The patient is 65 years of age or over	
INITIATION – cardiovascular disease Prerequisites (tick boxes where appropriate)	
Ischaemic heart disease  Or O Congestive heart failure  Or O Rheumatic heart disease  Or O Congenital heart disease  Or O Cerebro-vascular disease	
Note: hypertension and/or dyslipidaemia without evidence of end-organ disea	se is excluded from funding.
INITIATION – chronic respiratory disease Prerequisites (tick boxes where appropriate)	
O Asthma, if on a regular preventative therapy O Other chronic respiratory disease with impaired lung function Note: asthma not requiring regular preventative therapy is excluded from func	ing.

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I confirm that the above details are correct:

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

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	. NHI:
Influenza vaccine Inj 60 mcg in 0.5 ml syringe (quadrivale	nt vaccine) - continued
INITIATION – Other conditions Prerequisites (tick boxes where appropriate)	
O Diabetes  or O Chronic renal disease  or O Any cancer, excluding basal and squamous skin cance  or O Autoimmune disease  or O Immune suppression or immune deficiency  or O HIV  or O Transplant recipient  or O Neuromuscular and CNS diseases/ disorders  or O Haemoglobinopathies  or O Is a child on long term aspirin  or O Has a cochlear implant  or O Errors of metabolism at risk of major metabolic decome  or O Down syndrome  or O Is a child 4 years of age or under (inclusive) who has respiratory illness	
O Schizophrenia	
or O Major depressive disorder	
or O Bipolar disorder	
or O Schizoaffective disorder	
or Person is currently accessing secondary or tertiary mental h	ealth and addiction services

PRESCR	IBER	PATIENT:
Name:		Name:
Ward:		NHI:
Measle	s, mumps and rubella vaccine	
Re-asse	ON – first dose prior to 12 months ssment required after 3 doses isites (tick boxes where appropriate)  O For primary vaccination in children O For revaccination following immunosuppression O For any individual susceptible to measles, mumps or rubella	
Re-asse	ON – first dose after 12 months ssment required after 2 doses isites (tick boxes where appropriate)  O For primary vaccination in children	
or	O For revaccination following immunosuppression O For any individual susceptible to measles, mumps or rubella	
Note: P	lease refer to the Immunisation Handbook for appropriate schedule for	or catch up programmes.

I confirm that the above details are correct:	
Signed:	Date:

PRES	SCR	IBER	PATIENT:
Name	e:		Name:
Ward	:		NHI:
Poli	omy	yelitis vaccine	
	sse	ON ssment required after 3 doses isites (tick boxes where appropriate)	
		O For partially vaccinated or previously unvaccinated individuals	
	or	O For revaccination following immunosuppression	

Note: Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

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Signed.	Date:	
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PRESCRIBER		PATIENT:
Name:		Name:
Ward:		NHI:
Varicella vad	ccine [Chickenpox vaccine]	
Re-assessmen	primary vaccinations at required after 1 dose (tick boxes where appropriate)	
or O	Any infant born on or after 1 April 2016  For previously unvaccinated children turning 11 years old on o (chickenpox)	or after 1 July 2017, who have not previously had a varicella infection
Re-assessmen	other conditions It required after 2 doses (tick boxes where appropriate)	
or or or	for non-immune patients:  With chronic liver disease who may in future be candidated.  With deteriorating renal function before transplantation.  Prior to solid organ transplant.  Prior to any elective immunosuppression*  For post exposure prophylaxis who are immune competer.	
or O or O or O	where the household contact has no clinical history of varicella	py, on advice of their specialist moderate immunosuppression on advice of HIV specialist netabolic decompensation, with no clinical history of varicella ecompromised, or undergoing a procedure leading to immune compromise a history of varicella and who are severely immunocompromised or
Note: * immur	nosuppression due to steroid or other immunosuppressive thera 28 days	apy must be for a treatment period of

Clause al.	
Olgrica Date:	

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Human papillomavirus (6, 11, 16, 18, 31, 33, 45, 52 and 58)	vaccine [HPV]
INITIATION – Children aged 14 years and under Re-assessment required after 2 doses Prerequisites (tick box where appropriate)  Children aged 14 years and under	
INITIATION – other conditions Prerequisites (tick boxes where appropriate)	
O Up to 3 doses for people aged 15 to 26 years inclusive or	
People aged 9 to 26 years inclusive	
O Up to 3 doses for confirmed HIV infection or	
O Up to 3 doses people with a transplant (including or	stem cell)
O Up to 4 doses for Post chemotherapy	
INITIATION – Recurrent Respiratory Papillomatosis Prerequisites (tick boxes where appropriate)	
O Maximum of two doses for children aged 14 years and	under
O Maximum of three doses for people aged 15 years and	over
The person has recurrent respiratory papillomatosis	
O The person has not previously had an HPV vaccine	

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Rotavirus oral vaccine	
INITIATION Re-assessment required after 2 doses	
Prerequisites (tick boxes where appropriate)	
First dose to be administered in infants aged under 14 weeks	of age
No vaccination being administered to children aged 24 weeks	s or over

contirm	tnat tn	e above	aetaiis	are correct:	

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PRESCRIB	BER		PATIENT:
Name:			Name:
Ward:			NHI:
Varicella	zoste	r vaccine [shingles vaccine]	
Re-assess	ment re	pple aged 18 years and over (Shingrix) equired after 2 doses k boxes where appropriate)	
or (	O Pre O Ha O Pe O Pla pol	olymyalgia rheumatica, systemic lupus erythematosus or rheund stage kidney disease (CKD 4 or 5);	DMARDs – targeted synthetic, biologic, or conventional synthetic) for
	<b>O</b> Pri	imary immunodeficiency	

I confirm that the above details are correct:	
Signed:	Date:

#### Form RS2042 January 2026

# HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Page 539

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	PATIENT:
Name:	Name:
Ward:	NHI:
COVID-19 vaccine	
INITIATION – initial dose Prerequisites (tick box where appropriate)	
O Up to three doses for previously unvaccinated children aged 6 mon	ths – 4 years at high risk of severe illness

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PRES	SCRI	BER	PATIENT:
Name	e:		Name:
Ward	:		NHI:
cov	ID-	19 vaccine	
		ON – initial dose sites (tick boxes where appropriate)	
		One dose for previously unvaccinated children aged 5-11 year	rs old
	or	O Up to three doses for immunocompromised children aged 5-1	1 years old

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	PATIENT:
Name:	Name:
Ward:	NHI:
COVID-19 vaccine	
INITIATION – initial dose Prerequisites (tick boxes where appropriate)	
One dose for previously unvaccinated people aged 12-15 year  Up to three doses for immunocompromised people aged 12-15  Or  Up to two doses for previously unvaccinated people 16-29 year  Up to four doses for people aged 16-29 at high risk of severe if  One dose for previously unvaccinated people aged 30 and old	s years old rs old Iness
INITIATION – additional dose Prerequisites (tick box where appropriate)  One additional dose every 6 months for people aged 30 years and o	ver, additional dose is given at least 6 months after last dose
CONTINUATION – additional dose  Prerequisites (tick box where appropriate)  One additional dose every 6 months for people aged 30 years and of the contract of	ver additional dose is given at least 6 months after last dose
Site additional dose every 6 months for people aged 50 years and 0	additional access given at least 6 months after last dose

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Signed.	Date:	
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#### Index of form numbers

RS1001	Ajmaline	79	RS1	1173	Naltrexone hydrochloride	262
	Levosimendan				Sodium hyaluronate	
RS1008	Hydralazine hydrochloride - Tab 25 mg	88	RS1	1176	Alpha tocopheryl acetate	42
RS1015	Edrophonium chloride	224	RS1	1178	Multivitamins - Powder	39
	Rasburicase		RS1	1181	Bivalirudin	63
RS1027	Omeprazole - Tab dispersible 10 mg and 20 mg	8	RS1	1182	Danaparoid	64
RS1028	Diazoxide	11	RS1	1183	Defibrotide	65
	Levocarnitine		RS1	1184	Fondaparinux sodium	66
RS1041	Amikacin	133			Filgrastim	
RS1043	Streptomycin sulphate	132			Abciximab	
	Tobramycin		RS1	1203	Basiliximab	421
	Ertapenem				Bacillus calmette-guerin (BCG)	
	Imipenem with cilastatin				Carbohydrate and fat supplement	
	Meropenem				Standard Feeds	
	Ceftazadime				Diabetic Products	
	Cefepime				Elemental and Semi-Elemental Products	
	Piperacillin with tazobactam				Hepatic Products	
	Ticarcillin with clavulanic acid				Preterm formula	
	Ciprofloxacin				High fat formula	
	Tigecycline				Low electrolyte oral feed	
	Clindamycin				Low electrolyte oral feed	
	Colistin sulphomethate [Colestimethate]				High arginine oral feed 1.4 kcal/ml	
	Daptomycin				Bacillus calmette-guerin vaccine	
	Fusidic acid				Salmonella typhi vaccine	
RS1065	Lincomycin	156			L-ornithine L-aspartate	
	Linezolid				Captopril - Oral liq 5 mg per ml	
	Sulphadiazine		RS	1276	Propylthiouracil	130
	Teicoplanin				Aztreonam, Chloramphenicol	
	Vancomycin				Flucytosine	
	Amphotericin B - Inj (liposomal) 50 mg vial				Isoniazid	
RS1072	Fluconazole	170			Isoniazid with rifampicin	
	Itraconazole				Ivermectin	
	Caspofungin				Methoxyflurane	
	Clofazimine				Sodium chloride – Inj	
	Dapsone				Mafenide acetate	
	Cycloserine		BQ1	1200	Liothyronine sodium - Tab 20 mcg	120
	Ethambutol hydrochloride				Oxandrolone - Tab 2.5 mg	
	Para-aminosalicylic Acid				Oseltamivir	
DC1003	Protionamide	100			Capsaicin	
	Pyrazinamide				Fosfomycin	
	Rifabutin				Amphotericin B - Inj 50 mg vial	
					High Calorie Products	
	Rifampicin				Pivmecillinam	
	Artemether with lumefantrine				High protein enteral feed	
	Artesunate				Biotin	
	Atovaquone with proguanil hydrochloride				Pyridoxal-5-phosphate	
	Chloroquine phosphate					
	Mefloquine hydrochloride				Aprotinin	234
					Povidone-iodine - Vaginal tab 200 mg	
	Nitazoxanide Pentamidine isethionate				Zanamivir - Powder for inhalation 5 mg	
					· · · · · · · · · · · · · · · · · · ·	
	Primaquine phosphate				Sugammadex  Diphtheria, tetanus, pertussis and polio vaccine	
	Pyrimethamine					
	Quinine dihydrochloride				Poliomyelitis vaccine	
	3				· · · · · · · · · · · · · · · · · · ·	
	Spiramycin				Preoperative carbohydrate feed 0.5 kcal/ml	
	CidofovirFoscarnet sodium				Ferric carboxymaltose	
					•	
	Ganciclovir				Midodrine	
	Interferon gamma				Tobramycin Solution for inhalation 60 mg per ml, 5 ml	
	Bee venom				Deferiprone	
	' '				•	
	Yellow jacket wasp venom  Betamethasone valerate with cliquinol				Carbohydrate	
	· ·				•	
	Methyl aminolevulinate hydrochloride				Fat	
	Terbutaline				Protein	
	Finasteride				Fat-modified feed	
	Tamsulosin				Paediatric Products	
	Potassium citrate				Tobramcyin	
	Teriparatide				Measles, mumps and rubella vaccine	
	Capsaicin				Multivitamin and mineral supplement	
	Paracetamol				Multivitamin renal	
	Aprepitant				Aluminium chloride	
	Hyoscine hydrobromide - Patch 1.5 mg				Icatibant	
H511/2	Buprenorphine with naloxone	265	HS1	1502	Extensively hydrolysed formula	503

#### INDEX OF FORM NUMBERS

RS1520	Haemophilus influenzae type B vaccine	520	RS1	868	Rosuvastatin	85
RS1525	Siltuximab	353	RS1	873	Nicotine	263
	Ledipasvir with sofosbuvir		RS1	888	Abiraterone acetate	309
	Idarucizumab				COVID-19 treatments	
	Idursulfase				Taliglucerase alfa	
	Aminolevulinic acid hydrochloride				Non-Nucleoside Reverse Transcriptase Inhibitors	
	Ivabradine				Nucleoside Reverse Transcriptase Inhibitors	
	Roxithromycin tab dispersible 50 mg				Protease Inhibitors	
	Melatonin				Strand Transfer Inhibitors	
RS1587	Pneumococcal (PPV23) polysaccharide vaccine	525	RS ₁	902	Emtricitabine with tenofovir disoproxil	214
	Rotavirus oral vaccine				Benralizumab	
	Varicella vaccine [Chickenpox vaccine]				Adalimumab (Humira - Alternative brand)	
	Etoricoxib				Gemtuzumab ozogamicin	
	Azithromycin				Olaparib	
RS1603	Paromomycin	137			Copper chloride	
	Dexamethasone		RS1	929	Selenium	36
RS1607	Laronidase	26	RS ₁	930	Tolvaptan	84
	Paediatric oral/enteral feed 1 kcal/ml				Cinacalcet	
	Multivitamins - Cap				Paliperidone palmitate	
	•					
	Alpha tocopheryl				Pneumococcal (PCV13) conjugate vaccine	
	Mercaptopurine				Nusinersen	
	Hepatitis A vaccine				Ustekinumab	
RS1640	Eplerenone	83	RS1	943	Vedolizumab	406
RS1648	Eltrombopag	50	RS ₁	944	Adrenaline	471
	Omalizumab				Risdiplam	
	Epoetin alfa				Bedaquiline	
	Epoetin beta				Lacosamide	
	Raloxifene				Stiripentol	
	Nonacog gamma				Sirolimus	
	Rurioctocog alfa pegol [Recombinant factor VIII]				Alprostadil	
RS1683	Chlorhexidine with cetrimide	490	RS ₁	993	Multiple Sclerosis	250
RS1684	Eftrenonacog alfa	60			Temozolomide	
	Lysine acetylsalicylate				Pertuzumab	
	Dexrazoxane				Multiple Sclerosis	
	Calcium carbonate				Emicizumab	
	Nicardipine hydrochloride				Brentuximab	
RS1702	Varenicline	264	RS2	2005	Trastuzumab (Herzuma)	411
RS1703	Ranitidine	7	RS2	010	Nilotinib	283
RS1704	Eptacog alfa	62	RS ₂	013	Influenza vaccine Inj 60 mcg in 0.5 ml syringe (quadrivalent	vaccine)
	Factor eight inhibitor bypassing fraction		531		, , , , , , , , , , , , , , , , , , , ,	<i>'</i>
RS1706	Moroctocog alfa [Recombinant factor VIII]	55		014	Sacubitril with valsartan	77
					Olanzapine	
	Octocog alfa [Recombinant factor VIII] (Advate)					
	Octocog alfa [Recombinant factor VIII] (Kogenate FS)				Meningococcal (A, C, Y and W-135) conjugate vaccine	
	Clarithromycin				Mepolizumab	
RS1712	Alectinib	285	RS2	026	Trientine	33
RS1723	Budesonide	5	RS2	027	Niraparib	276
RS1726	Ruxolitinib	284	RS ₂	028	Fluticasone furoate with umeclidinium and vilanterol	476
<b>BS1732</b>	Fulvestrant	311	RS2	033	Midostaurin	287
	Pegfilgrastim				Palbociclib (Ibrance)	
	Eptifibatide				Meningococcal (A, C, Y and W-135) conjugate vaccine	
	Sucrose				Human papillomavirus (6, 11, 16, 18, 31, 33, 45, 52 and 58)	
	Enteral liquid peptide formula					
	Pimecrolimus				Varicella zoster vaccine [shingles vaccine]	
	Dornase alfa		RS ₂	040	COVID-19 vaccine	541
RS1788	Pegaspargase	282	RS2	041	COVID-19 vaccine	540
RS1790	Diphtheria, tetanus and pertussis vaccine	519	RS2	042	COVID-19 vaccine	539
	Alglucosidase Alfa				Bortezomib	
	Betaine				Lenalidomide	
	Galsulfase				Pomalidomide	
	Sapropterin dihydrochloride				Thalidomide	
	Sodium phenylbutyrate				Metabolic Products	
RS1813	Nintedanib	479	RS2	049	Hepatitis B recombinant vaccine	530
RS1814	Pirfenidone	478	RS ₂	050	Hepatitis B recombinant vaccine	529
RS1818	Ivacaftor	480			Diphtheria, tetanus, pertussis, polio, hepatitis B and haei	
	Somatropin				te type B vaccine	
	Pegylated interferon alfa-2a				Posaconazole	
	Lapatinib				Voriconazole	
	Carglumic Acid				Diazepam	
	Coenzyme Q10				Dasatinib	
RS1833	Riboflavin	31			Methylnaltrexone bromide	
RS1834	Taurine	32	RS2	058	Aripiprazole	248
	sodium picosulfate				Paliperidone	
	Febuxostat				Risperidone	
	Cabergoline				Bendamustine hydrochloride	
	· ·					
	Tacrolimus Ointment				Etanercept	
	Vigabatrin				Cetuximab	
<b>HS1867</b>	Amino acid formula	507	HS2	:069	Empagliflozin; Empagliflozin with metformin hydrochloride .	14

#### INDEX OF FORM NUMBERS

RS2070 Lisdexamfetamine dimesilate	258	RS2126 Nivolumab	438
RS2071 Dexamphetamine sulphate	260	RS2129 Moxifloxacin	152
RS2076 Everolimus	460	RS2131 Ribociclib	288
RS2078 Erlotinib	302	RS2133 Rituximab	366
RS2079 Gefitinib	307	RS2135 Dulaglutide	12
RS2080 Osimertinib	291	RS2136 Liraglutide	13
RS2081 Palivizumab	400	RS2137 Valganciclovir	212
RS2082 Trastuzumab deruxtecan	414	RS2139 Rivastigmine	
RS2083 Trastuzumab emtansine	363	RS2140 Adalimumab (Amgevita)	385
RS2084 Durvalumab		RS2141 Meningococcal B multicomponent vaccine	527
RS2085 Budesonide with glycopyrronium and eformoterol	477	RS2142 Ticagrelor	69
RS2089 Pazopanib		RS2143 Methylphenidate hydrochloride	259
RS2097 Denosumab	225	RS2144 Crizotinib	
RS2098 Lenvatinib	289	RS2145 Dabrafenib	
RS2099 Atezolizumab		RS2146 Entrectinib	
RS2100 Long-acting Somatostatin Analogues	312	RS2147 Trametinib	
RS2103 Ursodeoxycholic acid		RS2148 Aflibercept	
RS2104 Ceftazidime with avibactam	141	RS2149 Faricimab	
RS2106 Modafinil		RS2150 Obinutuzumab	354
RS2107 Axitinib	292	RS2151 Ranibizumab	
RS2109 Sunitinib		RS2152 Pertuzumab with trastuzumab	
RS2110 Tacrolimus	315	RS2153 Rituximab	
RS2111 Bevacizumab		RS2154 Pembrolizumab	
RS2112 Inotuzumab ozogamicin		RS2155 Long-Acting Muscarinic Antagonists with Long-Actin	ng Beta-Adrenoceptor
RS2114 Elexacaftor with tezacaftor, ivacaftor and ivacaftor		Agonists	
RS2115 Ipilimumab		RS2156 Bevacizumab	
RS2116 Azacitidine		RS2157 Plerixafor	
RS2117 Ibrutinib		RS2158 Adenosine - Inj 3 mg per ml, 10 ml vial	
RS2118 Venetoclax		RS2159 Ambrisentan	
RS2119 Secukinumab		RS2160 Bosentan	
RS2120 Upadacitinib		RS2161 Sildenafil (Vedafil)	
RS2124 Infliximab		RS2162 Epoprostenol	
RS2125 Tocilizumab		RS2163 lloprost	102

#### INDEX OF TITLES

#### **Index of titles**

	. 437	Clarithromycin (RS1709)	146
Abciximab (RS1202)		Clindamycin (RS1061)	
Adalimumab (Amgevita) (RS2140)		Clofazimine (RS1077)	
Adalimumab (Humira - Alternative brand) (RS1922)	. 426	Coenzyme Q10 (RS1832)	
Adenosine - Inj 3 mg per ml, 10 ml vial (RS2158)		Colistin sulphomethate [Colestimethate] (RS1062)	
Adrenaline (RS1944)		Copper chloride (RS1928)	
Aflibercept (RS2148)	357	Crizotinib (RS2144)	
Aimaline (RS1001)		Cycloserine (RS1079)	
Albendazole (RS1088)		Dabrafenib (RS2145)	
Alektroseides Affe (BS1700)		Danaparoid (RS1182)	
Alglucosidase Alfa (RS1793)	24	Dapsone (RS1078)	1/8
Alpha tocopheryl (RS1632)	43	Daptomycin (RS1063)	
Alpha tocopheryl acetate (RS1176)		Dasatinib (RS2055)	
Alprostadil (RS1992)		Deferasirox (RS1444)	
Aluminium chloride (RS1500)		Deferiprone (RS1445)	
Ambrisentan (RS2159)		Defibrotide (RS1183)	
Amikacin (RS1041)		Denosumab (RS2097)	
Amino acid formula (RS1867)	507	Dexamethasone (RS1606)	
Aminolevulinic acid hydrochloride (RS1565)	314	Dexamphetamine sulphate (RS2071)	
Amphotericin B - Inj (liposomal) 50 mg vial (RS1071)	168	Dexrazoxane (RS1695)	308
Amphotericin B - Inj 50 mg vial (RS1316)		Diabetic Products (RS1215)	497
Aprepitant (RS1154)		Diazepam (RS2054)	
Aprotinin (RS1332)		Diazoxide (RS1028)	
Aripiprazole (RS2058)		Diphtheria, tetanus and pertussis vaccine (RS1790)	
Artemether with lumefantrine (RS1090)		Diphtheria, tetanus, pertussis and polio vaccine (RS1387)	
Artesunate (RS1091)	193	Diphtheria, tetanus, pertussis, polio, hepatitis B and haemophilus infl	
Atezolizumab (RS2099)		type B vaccine (RS2051)	
Atovaquone with proguanil hydrochloride (RS1092)	10/	Dornase alfa (RS1787)	
Axitinib (RS2107)		Dulaglutide (RS2135)	
Azacitidine (RS2116)		Durvalumab (RS2084)	450
Azithromycin (RS1598)		Edrophonium chloride (RS1015)	
Aztreonam, Chloramphenicol (RS1277)		Eftrenonacog alfa (RS1684)	
Bacillus calmette-guerin (BCG) (RS1206)		Elemental and Semi-Elemental Products (RS1216)	
Bacillus calmette-guerin vaccine (RS1233)	518	Elexacaftor with tezacaftor, ivacaftor and ivacaftor (RS2114)	
Basiliximab (RS1203)	421	Eltrombopag (RS1648)	50
Bedaquiline (RS1977)	184	Emicizumab (RS1998)	
Bee venom (RS1117)		Empagliflozin; Empagliflozin with metformin hydrochloride (RS2069)	14
Bendamustine hydrochloride (RS2061)	267	Emtricitabine with tenofovir disoproxil (RS1902)	214
Benralizumab (RS1920)	403	Enteral liquid peptide formula (RS1775)	
Betaine (RS1794)	10	Entrectinib (RS2146)	300
	10		
Betamethasone valerate with cliquinol (RS1125)	108		83
Betamethasone valerate with clioquinol (RS1125)	108	Eplerenone (RS1640)	
Betamethasone valerate with clioquinol (RS1125)	108 327	Eplerenone (RS1640)	47
Betamethasone valerate with clioquinol (RS1125)  Bevacizumab (RS2156)  Bevacizumab (RS2111)	108 327 415	Eplerenone (RS1640)  Epoetin alfa (RS1660)  Epoetin beta (RS1661)	47
Betamethasone valerate with clioquinol (RS1125)  Bevacizumab (RS2156)  Bevacizumab (RS2111)  Biotin (RS1330)	108 327 415 21	Eplerenone (RS1640) Epoetin alfa (RS1660) Epoetin beta (RS1661) Epoprostenol (RS2162)	45 45
Betamethasone valerate with clioquinol (RS1125)  Bevacizumab (RS2156)  Bevacizumab (RS2111)  Biotin (RS1330)  Bivalirudin (RS1181)	108 327 415 21 63	Eplerenone (RS1640) Epoetin alfa (RS1660) Epoetin beta (RS1661) Epoprostenol (RS2162) Eptacog alfa (RS1704)	45 99
Betamethasone valerate with clioquinol (RS1125)  Bevacizumab (RS2156)  Bevacizumab (RS2111)  Biotin (RS1330)  Bivalirudin (RS1181)  Bortezomib (RS2043)	108 327 415 21 63 281	Eplerenone (RS1640) Epoetin alfa (RS1660) Epoetin beta (RS1661) Epoprostenol (RS2162) Eptacog alfa (RS1704) Eptifibatide (RS1759)	45 99 62
Betamethasone valerate with clioquinol (RS1125)  Bevacizumab (RS2156)  Bevacizumab (RS2111)  Biotin (RS1330)  Bivalirudin (RS1181)  Bortezomib (RS2043)  Bosentan (RS2160)	108 327 415 21 63 281 89	Eplerenone (RS1640) Epoetin alfa (RS1660) Epoetin beta (RS1661) Epoprostenol (RS2162) Eptacog alfa (RS1704) Eptifibatide (RS1759) Erlotinib (RS2078)	45 99 62 68
Betamethasone valerate with clioquinol (RS1125)  Bevacizumab (RS2156)  Bevacizumab (RS2111)  Biotin (RS1330)  Bivalirudin (RS1181)  Bortezomib (RS2043)  Bosentan (RS2160)  Brentuximab (RS2002)	108 327 415 21 63 281 89 409	Eplerenone (RS1640) Epoetin alfa (RS1660) Epoetin beta (RS1661) Epoprostenol (RS2162) Eptacog alfa (RS1704) Eptifibatide (RS1759) Erlotinib (RS2078) Ertapenem (RS1045)	47 99 62 68 302
Betamethasone valerate with clioquinol (RS1125)  Bevacizumab (RS2156)  Bevacizumab (RS2111)  Biotin (RS1330)  Bivalirudin (RS1181)  Bortezomib (RS2043)  Bosentan (RS2160)  Brentuximab (RS2002)  Budesonide (RS1723)	108 327 415 21 63 281 89 409	Eplerenone (RS1640) Epoetin alfa (RS1660) Epoetin beta (RS1661) Epoprostenol (RS2162) Eptacog alfa (RS1704) Eptifibatide (RS1759) Erlotinib (RS2078) Ertapenem (RS1045) Etanercept (RS2062)	47 45 62 68 302 139
Betamethasone valerate with clioquinol (RS1125)  Bevacizumab (RS2156)  Bevacizumab (RS2111)  Biotin (RS1330)  Bivalirudin (RS1181)  Bortezomib (RS2043)  Bosentan (RS2160)  Brentuximab (RS2002)  Budesonide (RS1723)  Budesonide with glycopyrronium and eformoterol (RS2085)	108 327 415 21 63 281 89 409 5	Eplerenone (RS1640) Epoetin alfa (RS1660) Epoetin beta (RS1661) Epoprostenol (RS2162) Eptacog alfa (RS1704) Eptifibatide (RS1759) Erlotinib (RS2078) Ertapenem (RS1045) Etanercept (RS2062) Ethambutol hydrochloride (RS1080)	47 45 62 68 302 139 317
Betamethasone valerate with clioquinol (RS1125)  Bevacizumab (RS2156)  Bevacizumab (RS2111)  Biotin (RS1330)  Bivalirudin (RS1181)  Bortezomib (RS2043)  Bosentan (RS2160)  Brentuximab (RS2002)  Budesonide (RS1723)  Budesonide with glycopyrronium and eformoterol (RS2085)  Buprenorphine with naloxone (RS1172)	108 327 415 21 63 281 89 409 5 477	Eplerenone (RS1640) Epoetin alfa (RS1660) Epoetin beta (RS1661) Epoprostenol (RS2162) Eptacog alfa (RS1704) Eptifibatide (RS1759) Erlotinib (RS2078) Ertapenem (RS1045) Etanercept (RS2062) Ethambutol hydrochloride (RS1080) Etoricoxib (RS1592)	45 99 68 302 139 317 317
Betamethasone valerate with clioquinol (RS1125)  Bevacizumab (RS2156)  Bevacizumab (RS2111)  Biotin (RS1330)  Bivalirudin (RS1181)  Bortezomib (RS2043)  Bosentan (RS2160)  Brentuximab (RS2002)  Budesonide (RS1723)  Budesonide with glycopyrronium and eformoterol (RS2085)  Buprenorphine with naloxone (RS1172)  COVID-19 treatments (RS1894)	108 327 415 21 63 281 89 409 5 477 265 217	Eplerenone (RS1640) Epoetin alfa (RS1660) Epoetin beta (RS1661) Epoprostenol (RS2162) Eptacog alfa (RS1704) Eptifibatide (RS1759) Erlotinib (RS2078) Ertapenem (RS1045) Etanercept (RS2062) Ethambutol hydrochloride (RS1080) Etoricoxib (RS1592) Everolimus (RS2076)	
Betamethasone valerate with clioquinol (RS1125)  Bevacizumab (RS2156)  Bevacizumab (RS2111)  Biotin (RS1330)  Bivalirudin (RS1181)  Bortezomib (RS2043)  Bosentan (RS2160)  Brentuximab (RS2002)  Budesonide (RS1723)  Budesonide with glycopyrronium and eformoterol (RS2085)  Buprenorphine with naloxone (RS1172)  COVID-19 treatments (RS1894)  COVID-19 vaccine (RS2042)	108 327 415 21 63 281 89 409 5 477 265 217	Eplerenone (RS1640) Epoetin alfa (RS1660) Epoetin beta (RS1661) Epoprostenol (RS2162) Eptacog alfa (RS1704) Eptifibatide (RS1759) Erlotinib (RS2078) Ertapenem (RS1045) Etanercept (RS2062) Ethambutol hydrochloride (RS1080) Etoricoxib (RS1592) Everolimus (RS2076) Extensively hydrolysed formula (RS1502)	
Betamethasone valerate with clioquinol (RS1125)  Bevacizumab (RS2156)  Bevacizumab (RS2111)  Biotin (RS1330)  Bivalirudin (RS1181)  Bortezomib (RS2043)  Bosentan (RS2160)  Brentuximab (RS2002)  Budesonide (RS1723)  Budesonide with glycopyrronium and eformoterol (RS2085)  Buprenorphine with naloxone (RS1172)  COVID-19 treatments (RS1894)  COVID-19 vaccine (RS2042)  COVID-19 vaccine (RS2041)	108 327 415 21 63 281 89 409 5 477 265 217 539 540	Eplerenone (RS1640) Epoetin alfa (RS1660) Epoetin beta (RS1661) Epoprostenol (RS2162) Eptacog alfa (RS1704) Eptifibatide (RS1759) Erlotinib (RS2078) Ertapenem (RS1045) Etanercept (RS2062) Ethambutol hydrochloride (RS1080) Etoricoxib (RS1592) Everolimus (RS2076) Extensively hydrolysed formula (RS1502) Factor eight inhibitor bypassing fraction (RS1705)	
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Betamethasone valerate with clioquinol (RS1125)  Bevacizumab (RS2156)  Bevacizumab (RS2111)  Biotin (RS1330)  Bivalirudin (RS1181)  Bortezomib (RS2043)  Bosentan (RS2160)  Brentuximab (RS2002)  Budesonide (RS1723)  Budesonide with glycopyrronium and eformoterol (RS2085)  Buprenorphine with naloxone (RS1172)  COVID-19 treatments (RS1894)  COVID-19 vaccine (RS2042)  COVID-19 vaccine (RS2041)  COVID-19 vaccine (RS2040)  Cabergoline (RS1855)	108 327 415 21 63 281 89 409 5 477 265 217 539 540 541 121	Eplerenone (RS1640) Epoetin alfa (RS1660) Epoetin beta (RS1661) Epoprostenol (RS2162) Eptacog alfa (RS1704) Eptifibatide (RS1759) Erlotinib (RS2078) Ertapenem (RS1045) Etanercept (RS2062) Ethambutol hydrochloride (RS1080) Etoricoxib (RS1592) Everolimus (RS2076) Extensively hydrolysed formula (RS1502) Factor eight inhibitor bypassing fraction (RS1705) Faricimab (RS2149) Fat (RS1468)	
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Betamethasone valerate with clioquinol (RS1125)  Bevacizumab (RS2156)  Bevacizumab (RS2111)  Biotin (RS1330)  Bivalirudin (RS1181)  Bortezomib (RS2043)  Bosentan (RS2160)  Brentuximab (RS2002)  Budesonide (RS1723)  Budesonide with glycopyrronium and eformoterol (RS2085)  Buprenorphine with naloxone (RS1172)  COVID-19 treatments (RS1894)  COVID-19 vaccine (RS2042)  COVID-19 vaccine (RS2041)  COVID-19 vaccine (RS2040)  Cabergoline (RS1855)	108 327 415 21 63 281 89 409 5 477 265 217 539 540 541 121	Eplerenone (RS1640) Epoetin alfa (RS1660) Epoetin beta (RS1661) Epoprostenol (RS2162) Eptacog alfa (RS1704) Eptifibatide (RS1759) Erlotinib (RS2078) Ertapenem (RS1045) Etanercept (RS2062) Ethambutol hydrochloride (RS1080) Etoricoxib (RS1592) Everolimus (RS2076) Extensively hydrolysed formula (RS1502) Factor eight inhibitor bypassing fraction (RS1705) Faricimab (RS2149) Fat (RS1468)	
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Betamethasone valerate with clioquinol (RS1125) Bevacizumab (RS2156) Bevacizumab (RS2111) Biotin (RS1330) Bivalirudin (RS1181) Bortezomib (RS2043) Bosentan (RS2160) Brentuximab (RS2002) Budesonide (RS1723) Budesonide with glycopyrronium and eformoterol (RS2085) Buprenorphine with naloxone (RS1172) COVID-19 treatments (RS1894) COVID-19 vaccine (RS2042) COVID-19 vaccine (RS2041) COVID-19 vaccine (RS2040) Cabergoline (RS1855) Calcium carbonate (RS1698) Capsaicin (RS1309) Capsaicin (RS1145) Captopril - Oral liq 5 mg per ml (RS1263) Carbohydrate (RS1467) Carbohydrate and fat supplement (RS1212) Caspofungin (RS1076) Cefepime (RS1049) Ceftazadime (RS1048) Ceftazadime (RS1048)	108 327 415 21 63 281 409 409 5 477 265 217 539 540 541 4 232 238 492 495 492 495 492 495 492 495 492 493 492 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 493 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 494 49	Eplerenone (RS1640) Epoetin alfa (RS1660) Epoetin beta (RS1661) Epoprostenol (RS2162) Eptacog alfa (RS1704) Eptifibatide (RS1759) Erlotinib (RS2078) Erlotinib (RS2078) Ertapenem (RS1045) Etanercept (RS2062) Ethambutol hydrochloride (RS1080) Etoricoxib (RS1592) Everolimus (RS2076) Extensively hydrolysed formula (RS1502) Factor eight inhibitor bypassing fraction (RS1705) Faricimab (RS2149) Fat (RS1468) Fat-modified feed (RS1470) Febuxostat (RS1844) Ferric carboxymaltose (RS1417) Filgrastim (RS1188) Finasteride (RS1131) Fluconazole (RS1072) Flucticasone furoate with umeclidinium and vilanterol (RS2028) Fondaparinux sodium (RS1109) Fosfomycin (RS1315) Fulvestrant (RS1335)	
Betamethasone valerate with clioquinol (RS1125) Bevacizumab (RS2156) Bevacizumab (RS2111) Biotin (RS1330) Bivalirudin (RS1181) Bortezomib (RS2043) Bosentan (RS2160) Brentuximab (RS2002) Budesonide (RS1723) Budesonide with glycopyrronium and eformoterol (RS2085) Buprenorphine with naloxone (RS1172) COVID-19 treatments (RS1894) COVID-19 vaccine (RS2042) COVID-19 vaccine (RS2041) COVID-19 vaccine (RS2040) Cabergoline (RS1855) Calcium carbonate (RS1698) Capsaicin (RS1309) Capsaicin (RS1145) Captopril - Oral liq 5 mg per ml (RS1263) Carbohydrate (RS1467) Carbohydrate and fat supplement (RS1212) Caspofungin (RS1076) Cefepime (RS1049) Ceftazadime (RS1048) Ceftazadime (RS1048) Ceftazadime (RS1048) Ceftazidime with avibactam (RS2104) Cetuximab (RS2064)	108 327 415 21 63 281 409 5 477 265 217 539 540 541 4 232 238 49 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495 495	Eplerenone (RS1640) Epoetin alfa (RS1660) Epoetin beta (RS1661) Epoprostenol (RS2162) Eptacog alfa (RS1704) Eptifibatide (RS1759) Erlotinib (RS2078) Ertapenem (RS1045) Etanercept (RS2062) Ethambutol hydrochloride (RS1080) Etoricoxib (RS1592) Everolimus (RS2076) Extensively hydrolysed formula (RS1502) Factor eight inhibitor bypassing fraction (RS1705) Faricimab (RS2149) Fat (RS1468) Fat-modified feed (RS1470) Febuxostat (RS1844) Ferric carboxymaltose (RS1417) Filgrastim (RS1188) Finasteride (RS1131) Fluconazole (RS1072) Flucytosine (RS1279) Fluticasone furoate with umeclidinium and vilanterol (RS2028) Fondaparinux sodium (RS1184) Foscarnet sodium (RS1109) Fosfomycin (RS1315) Fulvestrant (RS1732) Fusidic acid (RS1064)	
Betamethasone valerate with clioquinol (RS1125) Bevacizumab (RS2156) Bevacizumab (RS2111) Biotin (RS1330) Bivalirudin (RS1181) Bortezomib (RS2043) Bosentan (RS2160) Brentuximab (RS2002) Budesonide (RS1723) Budesonide with glycopyrronium and eformoterol (RS2085) Buprenorphine with naloxone (RS1172) COVID-19 treatments (RS1894) COVID-19 vaccine (RS2042) COVID-19 vaccine (RS2041) COVID-19 vaccine (RS2040) Cabergoline (RS1855) Calcium carbonate (RS1698) Capsaicin (RS1309) Capsaicin (RS1145) Captopril - Oral liq 5 mg per ml (RS1263) Carbohydrate and fat supplement (RS1212) Carglumic Acid (RS1831) Caspofungin (RS1076) Cefepime (RS1049) Ceftazidime (RS1446) Ceftazadime (RS1048) Ceftazidime (RS1048) Ceftazidime with avibactam (RS2104) Cetuximab (RS2064) Chlorhexidine with cetrimide (RS1683)	108 327 415 21 89 409 5 477 265 217 539 540 4 232 238 76 495 495 29 177 143 144 141 142 141 142 141 142 141	Eplerenone (RS1640) Epoetin alfa (RS1660) Epoetin beta (RS1661) Epoprostenol (RS2162) Eptacog alfa (RS1704) Epifibatide (RS1759) Erlotinib (RS2078) Ertapenem (RS1045) Etanercept (RS2062) Ethambutol hydrochloride (RS1080) Etoricoxib (RS1592) Everolimus (RS2076) Extensively hydrolysed formula (RS1502) Factor eight inhibitor bypassing fraction (RS1705) Faricimab (RS2149) Fat (RS1468) Fat-modified feed (RS1470) Febuxostat (RS1844) Ferric carboxymaltose (RS1417) Filgrastim (RS1188) Finasteride (RS1131) Fluconazole (RS1072) Fluticasone furoate with umeclidinium and vilanterol (RS2028) Fondaparinux sodium (RS1109) Foscarnet sodium (RS1109) Fosfomycin (RS1315) Fulvestrant (RS1732) Fusidic acid (RS1795)	
Betamethasone valerate with clioquinol (RS1125) Bevacizumab (RS2156) Bevacizumab (RS2111) Biotin (RS1330) Bivalirudin (RS1181) Bortezomib (RS2043) Bosentan (RS2160) Brentuximab (RS2002) Budesonide (RS1723) Budesonide with glycopyrronium and eformoterol (RS2085) Buprenorphine with naloxone (RS1172) COVID-19 treatments (RS1894) COVID-19 vaccine (RS2042) COVID-19 vaccine (RS2041) COVID-19 vaccine (RS2040) Cabergoline (RS1855) Calcium carbonate (RS1698) Capsaicin (RS1145) Captopril - Oral liq 5 mg per ml (RS1263) Carbohydrate and fat supplement (RS1212) Carglumic Acid (RS1831) Caspofungin (RS1076) Ceftepime (RS1049) Ceftaroline (RS1048) Ceftazadime (RS1048) Ceftazadime (RS1048) Ceftazidime with avibactam (RS2104) Chlorhexidine with cetrimide (RS1683) Chloroquine phosphate (RS1093)	108 327 415 21 89 409 5 477 265 217 539 540 4 232 238 76 495 238 76 495 29 177 143 141 449 141 141 141 141 141 141 141 141 141 142 141 141 141 141 141 141 141 142 141 141 141 141 141 141 141 142 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 141 142 141 141 141 141 141 141 141 142 141	Eplerenone (RS1640) Epoetin alfa (RS1660) Epoetin beta (RS1661) Epoprostenol (RS2162) Eptacog alfa (RS1704) Epifibatide (RS1759) Erlotinib (RS2078) Ertapenem (RS1045) Etanercept (RS2062) Ethambutol hydrochloride (RS1080) Etoricoxib (RS1592) Everolimus (RS2076) Extensively hydrolysed formula (RS1502) Factor eight inhibitor bypassing fraction (RS1705) Faricimab (RS2149) Fat (RS1468) Fat-modified feed (RS1470) Febuxostat (RS1844) Ferric carboxymaltose (RS1417) Filgrastim (RS1188) Finasteride (RS1131) Fluconazole (RS1072) Flucytosine (RS1279) Fluticasone furoate with umeclidinium and vilanterol (RS2028) Fondaparinux sodium (RS1109) Foscarnet sodium (RS1109) Fosfomycin (RS1315) Fulvestrant (RS1732) Fusidic acid (RS1795) Ganciclovir (RS1110)	
Betamethasone valerate with clioquinol (RS1125) Bevacizumab (RS2156) Bevacizumab (RS2111) Biotin (RS1330) Bivalirudin (RS1181) Bortezomib (RS2043) Bosentan (RS2160) Brentuximab (RS2002) Budesonide (RS1723) Budesonide with glycopyrronium and eformoterol (RS2085) Buprenorphine with naloxone (RS1172) COVID-19 treatments (RS1894) COVID-19 vaccine (RS2042) COVID-19 vaccine (RS2041) COVID-19 vaccine (RS2040) Cabergoline (RS1855) Calcium carbonate (RS1698) Capsaicin (RS1309) Capsaicin (RS1145) Captopril - Oral liq 5 mg per ml (RS1263) Carbohydrate (RS1467) Carbohydrate and fat supplement (RS1212) Carglumic Acid (RS1831) Caspofungin (RS1076) Cefepime (RS1049) Ceftazolime (RS1048) Ceftazolime (RS1048) Ceftazolime with avibactam (RS2104) Chlorhexidine with cetrimide (RS1683) Chloroquine phosphate (RS1093) Cidofovir (RS1108)	108 327 415 21 63 281 89 409 5 477 265 217 539 540 541 121 4 232 238 76 495 238 76 495 29 177 143 144 141 356 490 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 19	Eplerenone (RS1640) Epoetin alfa (RS1660) Epoetin beta (RS1661) Epoprostenol (RS2162) Eptacog alfa (RS1704) Eptifibatide (RS1759) Erlotinib (RS2078) Ertapenem (RS1045) Etanercept (RS2062) Ethambutol hydrochloride (RS1080) Etoricoxib (RS1592) Everolimus (RS2076) Extensively hydrolysed formula (RS1502) Factor eight inhibitor bypassing fraction (RS1705) Faricimab (RS2149) Fat (RS1468) Fat-modified feed (RS1470) Febuxostat (RS1844) Ferric carboxymaltose (RS1417) Filgrastim (RS1188) Finasteride (RS1131) Fluconazole (RS1072) Flucytosine (RS1279) Fluticasone furoate with umeclidinium and vilanterol (RS2028) Fondaparinux sodium (RS1184) Foscarnet sodium (RS1109) Fosfomycin (RS1315) Fulvestrant (RS1732) Fusidic acid (RS1064) Galsulfase (RS1795) Ganciclovir (RS1110) Gefitinib (RS2079)	
Betamethasone valerate with clioquinol (RS1125) Bevacizumab (RS2156) Bevacizumab (RS2111) Biotin (RS1330) Bivalirudin (RS1181) Bortezomib (RS2043) Bosentan (RS2160) Brentuximab (RS2002) Budesonide (RS1723) Budesonide with glycopyrronium and eformoterol (RS2085) Buprenorphine with naloxone (RS1172) COVID-19 treatments (RS1894) COVID-19 vaccine (RS2042) COVID-19 vaccine (RS2041) COVID-19 vaccine (RS2040) Cabergoline (RS1855) Calcium carbonate (RS1698) Capsaicin (RS1145) Captopril - Oral liq 5 mg per ml (RS1263) Carbohydrate and fat supplement (RS1212) Carglumic Acid (RS1831) Caspofungin (RS1076) Ceftepime (RS1049) Ceftaroline (RS1048) Ceftazadime (RS1048) Ceftazadime (RS1048) Ceftazidime with avibactam (RS2104) Chlorhexidine with cetrimide (RS1683) Chloroquine phosphate (RS1093)	108 327 415 21 63 281 89 409 5 217 539 540 541 121 4 232 238 76 495 29 143 144 143 144 144 145 195 195 490 195 490 195 490 195 490 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 195 	Eplerenone (RS1640) Epoetin alfa (RS1660) Epoetin beta (RS1661) Epoprostenol (RS2162) Eptacog alfa (RS1704) Epifibatide (RS1759) Erlotinib (RS2078) Ertapenem (RS1045) Etanercept (RS2062) Ethambutol hydrochloride (RS1080) Etoricoxib (RS1592) Everolimus (RS2076) Extensively hydrolysed formula (RS1502) Factor eight inhibitor bypassing fraction (RS1705) Faricimab (RS2149) Fat (RS1468) Fat-modified feed (RS1470) Febuxostat (RS1844) Ferric carboxymaltose (RS1417) Filgrastim (RS1188) Finasteride (RS1131) Fluconazole (RS1072) Flucytosine (RS1279) Fluticasone furoate with umeclidinium and vilanterol (RS2028) Fondaparinux sodium (RS1109) Foscarnet sodium (RS1109) Fosfomycin (RS1315) Fulvestrant (RS1732) Fusidic acid (RS1795) Ganciclovir (RS1110)	

#### INDEX OF TITLES

	<b>500</b>	N. I (D01170)	
Hepatic Products (RS1217)		Naltrexone hydrochloride (RS1173)	
Hepatitis A vaccine (RS1638)		Nicardipine hydrochloride (RS1699)	
Hepatitis B recombinant vaccine (RS2050)		Nicotine (RS1873)	
Hepatitis B recombinant vaccine (RS2049)	530	Nilotinib (RS2010)	283
High Calorie Products (RS1317)		Nintedanib (RS1813)	
High arginine oral feed 1.4 kcal/ml (RS1231)	513	Niraparib (RS2027)	276
High fat formula (RS1225)	508	Nitazoxanide (RS1095)	203
High protein enteral feed (RS1327)		Nivolumab (RS2126)	438
Human papillomavirus (6, 11, 16, 18, 31, 33, 45, 52 and 58) vacc		Non-Nucleoside Reverse Transcriptase Inhibitors (RS1898)	
(RS2038)		Nonacog gamma (RS1679)	58
Hydralazine hydrochloride - Tab 25 mg (RS1008)		Nucleoside Reverse Transcriptase Inhibitors (RS1899)	205
Hyoscine hydrobromide - Patch 1.5 mg (RS1155)		Nusinersen (RS1938)	
Ibrutinib (RS2117)		Obinutuzumab (RS2150)	
Icatibant (RS1501)		Octocog alfa [Recombinant factor VIII] (Advate) (RS1707)	
Idarucizumab (RS1535)		Octocog alfa [Recombinant factor VIII] (Kogenate FS) (RS1708)	
Idursulfase (RS1546)		Olanzapine (RS2018)	246
lloprost (RS2163)	102	Olaparib (RS1925)	
Imipenem with cilastatin (RS1046)	138	Omalizumab (RS1652)	
Infliximab (RS2124)	330	Omeprazole - Tab dispersible 10 mg and 20 mg (RS1027)	8
Influenza vaccine Inj 60 mcg in 0.5 ml syringe (quadrivalent vaccine)		Oseltamivir (RS1307)	
531	( /	Osimertinib (RS2080)	
Inotuzumab ozogamicin (RS2112)	417	Oxandrolone - Tab 2.5 mg (RS1302)	
Interferon gamma (RS1113)		Paediatric Products (RS1473)	
Ipilimumab (RS2115)		Paediatric oral/enteral feed 1 kcal/ml (RS1614)	
Isoniazid (RS1281)		Palbociclib (Ibrance) (RS2034)	
Isoniazid with rifampicin (RS1282)		Paliperidone (RS2059)	244
Itraconazole (RS1073)		Paliperidone palmitate (RS1932)	
Ivabradine (RS1566)	80	Palivizumab (RS2081)	400
Ivacaftor (RS1818)	480	Paper wasp venom (RS1118)	473
Ivermectin (RS1283)	191	Para-aminosalicylic Acid (RS1083)	188
Ketoconazole - Tab 200 mg (RS1410)		Paracetamol (RS1146)	
L-ornithine L-aspartate (RS1261)		Paromomycin (RS1603)	
Lacosamide (RS1988)		Pazopanib (RS2089)	
Lapatinib (RS1828)		Pegaspargase (RS1788)	
Laronidase (RS1607)	26	Pegfilgrastim (RS1743)	/ 2
Ledipasvir with sofosbuvir (RS1528)		Pegylated interferon alfa-2a (RS1827)	
Lenalidomide (RS2044)		Pembrolizumab (RS2154)	
Lenvatinib (RS2098)		Pentamidine isethionate (RS1096)	197
Levocarnitine (RS1035)		Pertuzumab (RS1995)	
Levosimendan (RS1007)	86	Pertuzumab with trastuzumab (RS2152)	420
Lincomycin (RS1065)	156	Pimecrolimus (RS1781)	109
Linezolid (RS1066)		Piperacillin with tazobactam (RS1053)	
Liothyronine sodium - Tab 20 mcg (RS1301)	129	Pirfenidone (RS1814)	
Liraglutide (RS2136)		Pivmecillinam (RS1322)	
Lisdexamfetamine dimesilate (RS2070)		Plerixafor (RS2157)	
Long-Acting Muscarinic Antagonists with Long-Acting Beta-Adr		` '	
		Pneumococcal (PCV13) conjugate vaccine (RS1936)	
Agonists (RS2155)		Pneumococcal (PPV23) polysaccharide vaccine (RS1587)	
Long-acting Somatostatin Analogues (RS2100)	312	Poliomyelitis vaccine (RS1398)	534
Low electrolyte oral feed (RS1227)		Pomalidomide (RS2045)	
Low electrolyte oral feed (RS1228)		Posaconazole (RS2052)	174
Lysine acetylsalicylate (RS1689)	67	Potassium citrate (RS1133)	116
Mafenide acetate (RS1299)	107	Povidone-iodine - Vaginal tab 200 mg (RS1354)	489
Measles, mumps and rubella vaccine (RS1487)	533	Preoperative carbohydrate feed 0.5 kcal/ml (RS1415)	
Mefloquine hydrochloride (RS1094)		Preterm formula (RS1224)	
Melatonin (RS1576)		Primaquine phosphate (RS1097)	
Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2019)		Propylthiouracil (RS1276)	
Meningococcal (A, C, Y and W-135) conjugate vaccine (RS2037)		Protease Inhibitors (RS1900)	
		,	
Meningococcal B multicomponent vaccine (RS2141)		Protein (RS1469)	
Mepolizumab (RS2024)		Protionamide (RS1084)	
Mercaptopurine (RS1635)		Pyrazinamide (RS1085)	182
Meropenem (RS1047)		Pyridoxal-5-phosphate (RS1331)	
Metabolic Products (RS2047)	496	Pyrimethamine (RS1098)	199
Methoxyflurane (RS1292)	236	Quinine dihydrochloride (RS1099)	200
Methyl aminolevulinate hydrochloride (RS1127)		Raloxifene (RS1666)	
Methylnaltrexone bromide (RS2057)		Ranibizumab (RS2151)	
Methylphenidate hydrochloride (RS2143)		Ranitidine (RS1703)	
Midodrine (RS1427)		Rasburicase (RS1016)	
Midostaurin (RS2033)		Ribociclib (RS2131)	
Modafinil (RS2106)		Riboflavin (RS1833)	
Moroctocog alfa [Recombinant factor VIII] (RS1706)		Rifabutin (RS1086)	
Moxifloxacin (RS2129)		Rifampicin (RS1087)	
Multiple Sclerosis (RS1993)	250	Rifaximin (RS1416)	10
Multiple Sclerosis (RS1997)		Riluzole (RS1351)	234
Multivitamin and mineral supplement (RS1498)		Risdiplam (RS1954)	
Multivitamin renal (RS1499)		Risperidone (RS2060)	
Multivitamins - Cap (RS1620)		Rituximab (RS2153)	
Multivitamins – Powder (RS1178)		Rituximab (RS2133)	
Widely Real Hills I Owder (1101170)		1 110A1111aD (1102 100)	300

#### INDEX OF TITLES

Rosuvastatin (RS1888)	Rivastigmine (RS2139)	261	Teicoplanin (RS1068)	159
Roxithromycin tab dispersible 50 mg (RS1569)   145   Teriparatide (RS1143)   227   Rurioctocog alfa pegol [Recombinant factor VIII] (RS1682)   59   Thalldomide (RS2046)   280   Ruxolitinib (RS1726)   284   Ticagrelor (RS2142)   69   Sacubitril with valsartan (RS2014)   77   Ticarcillin with clavulanic acid (RS1054)   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149	Rosuvastatin (RS1868)	85	Temozolomide (RS1994)	279
Roxithromycin tab dispersible 50 mg (RS1569)   145   Teriparatide (RS1143)   227   Rurioctocog alfa pegol [Recombinant factor VIII] (RS1682)   59   Thalldomide (RS2046)   280   Ruxolitinib (RS1726)   284   Ticagrelor (RS2142)   69   Sacubitril with valsartan (RS2014)   77   Ticarcillin with clavulanic acid (RS1054)   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149	Rotavirus oral vaccine (RS1590)	537	Terbutaline (RS1130)	113
Rurolitatio   Responsibility   Respons	Roxithromycin tab dispersible 50 mg (RS1569)	145	Teriparatide (RS1143)	227
Sacubitril with valsartan (RS2014)   77   Ticarcillin with clavulanic acid (RS1054)   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   149   14			Thalidomide (RS2046)	280
Salmonella typhi vaccine (RS1243)         526         Tigecycline (RS1059)         154           Sapropterin dihydrochloride (RS1796)         28         Tobramcyin (RS1475)         136           Secukinumab (RS2119)         359         Tobramycin (RS1044)         134           Selenium (RS1929)         36         Tobramycin Solution for inhalation 60 mg per ml, 5 ml (RS1435)         135           Sildenafil (Vedafil) (RS2161)         97         Tocilizumab (RS2125)         344           Silduximab (RS1525)         353         Tobramycin Solution for inhalation 60 mg per ml, 5 ml (RS1435)         135           Silduximab (RS1525)         353         Tobramycin RS2125)         344           Sirolimus (RS1991)         461         Trametinib (RS2125)         344           Sodium klajuronate (RS1197)         74         Trastuzumab (Herzuma) (RS2005)         411           Sodium phayluvrate (RS1175)         37         Trastuzumab emtansine (RS2082)         414           Sodium stibogluconate (RS1100)         201         Traentine (RS2026)         33           Somatropin (RS1826)         123         Upadacitinib (RS2120)         466           Spiramycin (RS1101)         202         Ursodeoxycholic acid (RS2103)         15           Standard Feeds (RS1214)         514         Ustekinumab (RS1942)			Ticagrelor (RS2142)	69
Sapropterin dihydrochloride (RS1796)   28   Tobramcyin (RS1475)   136   Secukinumab (RS2119)   359   Tobramcyin (RS1044)   359   Tobramcyin (RS1045)   359   Tobramcyin (RS1045)   359   Tobramcyin (RS1045)   359   Tobramcyin (RS1045)   341   359   Tobramcyin (RS1045)   359   Trastuzumab (RS2045)   359   Trastuzumab (RS2045)   359   Trastuzumab (RS2085)   359   Trastuzumab deruxtecan (RS2082)   359   Trastuzumab deruxtecan (RS2082)   359   Trastuzumab deruxtecan (RS2083)   363   Trastuzumab deruxtecan (RS2083)   363   363   Trastuzumab deruxtecan (RS2083)   363   Tobramcyin (RS1045)   363   Tobramcyin (RS	Sacubitril with valsartan (RS2014)	77	Ticarcillin with clavulanic acid (RS1054)	149
Sapropterin dihydrochloride (RS1796)   28   Tobramcyin (RS1475)   136   Secukinumab (RS2119)   359   Tobramcyin (RS1044)   134   136   Selenium (RS1929)   36   Tobramcyin (RS1044)   134   135   Sildenafil (Vedafil) (RS2161)   97   Tobramcyin (RS1040)   134   135   Sildenafil (Vedafil) (RS2161)   97   Tobramcyin (RS1030)   344   344   344   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345   345	Salmonella typhi vaccine (RS1243)	526	Tigecycline (RS1059)	154
Secukinumab (RS2119)   359   Tobramycin (RS1044)   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   134   1			Tobramcyin (RS1475)	136
Sildenafil (Vedafil) (RS2161)       97       Tocilizumab (RS1225)       344         Siltuximab (RS1525)       353       Tolvaptan (RS1930)       84         Sirolimus (RS1991)       461       Trametinib (RS2147)       297         Sodium chloride – Inj (RS1297)       74       Trastuzumab (Herzuma) (RS2005)       411         Sodium ptiopulourate (RS1175)       37       Trastuzumab deruxtecan (RS2082)       414         Sodium ptiopulourate (RS1797)       20       Trastuzumab deruxtecan (RS2083)       363         Sodium stibogluconate (RS1100)       201       Trientine (RS2026)       33         Somatropin (RS1826)       123       Upadacitinib (RS2120)       466         Spiramycin (RS1101)       202       Ursodeoxycholic acid (RS2103)       15         Standard Feeds (RS1214)       514       Ustekinumab (RS1942)       404         Stripentol (RS1989)       241       Valganciclovir (RS2137)       212         Streptomycin sulphate (RS1901)       207       Vancomycin (RS1069)       162         Streptomycin sulphate (RS1043)       132       Varenicline (RS1702)       264         Sugammadex (RS1370)       230       Varicella vaccine [Chickenpox vaccine] (RS1591)       535         Sugammadex (RS1667)       158       Vedolizumab (RS1943)       <			Tobramycin (RS1044)	134
Siltuximab (RS1525)       353       Tolvaptan (RS1930)       84         Sirolimus (RS1991)       461       Trametinib (RS2147)       297         Sodium chloride – Inj (RS1297)       74       Trastuzumab (Herzuma) (RS2005)       411         Sodium hyaluronate (RS1175)       37       Trastuzumab deruxtecan (RS2082)       414         Sodium phenylbutyrate (RS1797)       20       Trastuzumab emtansine (RS2083)       363         Sodium stibogluconate (RS1100)       201       Trientine (RS2026)       33         Somatropin (RS1826)       123       Upadacitinib (RS2120)       466         Spiramycin (RS1101)       202       Ursodeoxycholic acid (RS2103)       15         Standard Feeds (RS1214)       514       Ustekinumab (RS1942)       404         Stiripentol (RS1989)       241       Valganciclovir (RS2137)       212         Strand Transfer Inhibitors (RS1901)       207       Vancomycin (RS1069)       162         Sterptomycin sulphate (RS1043)       132       Varenicline (RS1702)       264         Sucrose (RS1763)       235       Varicella vaccine [Chickenpox vaccine] (RS1591)       535         Sugammadex (RS1370)       230       Varicella zoster vaccine [shingles vaccine] (RS2039)       538         Sulphadiazine (RS1067)       158       Vedoli	Selenium (RS1929)	36	Tobramycin Solution for inhalation 60 mg per ml, 5 ml (RS1435)	135
Sirolimus (RS1991)       461       Trametinib (RS2147)       297         Sodium chloride – Inj (RS1297)       74       Trastuzumab (Herzuma) (RS2005)       411         Sodium phanylbutyrate (RS1175)       37       Trastuzumab deruxtecan (RS2082)       414         Sodium phanylbutyrate (RS1797)       20       Trastuzumab demtansine (RS2083)       363         Sodium stibogluconate (RS1100)       201       Trientine (RS2026)       33         Somatropin (RS1826)       123       Upadacitinib (RS2120)       466         Spiramycin (RS1101)       202       Ursodeoxycholic acid (RS2103)       15         Standard Feeds (RS1214)       514       Ustekinumab (RS1942)       404         Stiripentol (RS1989)       241       Valganciclovir (RS2137)       212         Strand Transfer Inhibitors (RS1901)       207       Vancomycin (RS1069)       162         Streptomycin sulphate (RS1043)       132       Varenicline (RS1702)       264         Sucarose (RS1763)       235       Varicella zoster vaccine [Shingles vaccine] (RS1591)       535         Sulphadiazine (RS1067)       158       Vedolizumab (RS1943)       406         Sulphadiazine (RS1067)       158       Vedolizumab (RS2118)       271         Tacrolimus (RS210)       315       Vigabatrin (RS1865) <td>Sildenafil (Vedafil) (RS2161)</td> <td>97</td> <td>Tocilizumab (RS2125)</td> <td>344</td>	Sildenafil (Vedafil) (RS2161)	97	Tocilizumab (RS2125)	344
Sirolimus (RS1991)       461       Trametinib (RS2147)       297         Sodium chloride – Inj (RS1297)       74       Trastuzumab (Herzuma) (RS2005)       411         Sodium phanylbutyrate (RS1175)       37       Trastuzumab deruxtecan (RS2082)       414         Sodium phanylbutyrate (RS1797)       20       Trastuzumab demtansine (RS2083)       363         Sodium stibogluconate (RS1100)       201       Trientine (RS2026)       33         Somatropin (RS1826)       123       Upadacitinib (RS2120)       466         Spiramycin (RS1101)       202       Ursodeoxycholic acid (RS2103)       15         Standard Feeds (RS1214)       514       Ustekinumab (RS1942)       404         Stiripentol (RS1989)       241       Valganciclovir (RS2137)       212         Strand Transfer Inhibitors (RS1901)       207       Vancomycin (RS1069)       162         Streptomycin sulphate (RS1043)       132       Varenicline (RS1702)       264         Sucarose (RS1763)       235       Varicella zoster vaccine [Shingles vaccine] (RS1591)       535         Sulphadiazine (RS1067)       158       Vedolizumab (RS1943)       406         Sulphadiazine (RS1067)       158       Vedolizumab (RS2118)       271         Tacrolimus (RS210)       315       Vigabatrin (RS1865) <td>Siltuximab (RS1525)</td> <td>353</td> <td>Tolvaptan (RS1930)</td> <td>84</td>	Siltuximab (RS1525)	353	Tolvaptan (RS1930)	84
Sodium hyaluronate (RS1175)         .37         Trastuzumab deruxtecan (RS2082)         .414           Sodium phenylbutyrate (RS1797)         .20         Trastuzumab emtansine (RS2083)         .363           Sodium stibogluconate (RS1100)         .201         Trientine (RS2026)         .33           Somatropin (RS1826)         .123         Upadacitinib (RS2120)         .466           Spiramycin (RS1101)         .202         Ursodeoxycholic acid (RS2103)         .15           Standard Feeds (RS1214)         .514         Ustekinumab (RS1942)         .404           Stiripentol (RS1989)         .241         Valganciclovir (RS2137)         .212           Strand Transfer Inhibitors (RS1901)         .207         Vancomycin (RS1069)         .162           Sucrose (RS1763)         .207         Varcicella vaccine (RS1702)         .264           Sucrose (RS1763)         .235         Varicella vaccine (Chickenpox vaccine) (RS1591)         .535           Sugammadex (RS1370)         .230         Varicella zoster vaccine [shingles vaccine] (RS2039)         .538           Sulphadiazine (RS1067)         .158         Vedolizumab (RS1943)         .406           Sunitinib (RS2109)         .303         Venetoclax (RS2118)         .271           Tacrolimus (RS1136)         .33         Vigabatrin (RS1865)	Sirolimus (RS1991)	461		
Sodium phenylbutyrate (RS1797)         20         Trastuzumab emtansine (RS2083)         363           Sodium stibogluconate (RS1100)         201         Trientine (RS2026)         33           Somatropin (RS1826)         123         Upadacitinib (RS2120)         466           Spiramycin (RS1101)         202         Ursodeoxycholic acid (RS2103)         15           Standard Feeds (RS1214)         514         Ustekinumab (RS1942)         404           Stripentol (RS1989)         241         Valganciclovir (RS2137)         212           Strand Transfer Inhibitors (RS1901)         207         Vancomycin (RS1069)         162           Streptomycin sulphate (RS1043)         132         Varenicline (RS1702)         264           Sucrose (RS1763)         235         Varicella vaccine [Chickenpox vaccine] (RS1591)         535           Sugammadex (RS1370)         230         Varicella zoster vaccine [shingles vaccine] (RS2039)         538           Sulphadiazine (RS1067)         158         Vedolizumab (RS1943)         406           Sunitinib (RS2109)         303         Venetoclax (RS2118)         271           Tacrolimus (RS2110)         315         Vigabatrin (RS1865)         239           Tacrolimus (RS2110)         315         Vigabatrin (RS1865)         239	Sodium chloride – Inj (RS1297)	74	Trastuzumab (Herzuma) (RS2005)	411
Sodium phenylbutyrate (RS1797)         20         Trastuzumab emtansine (RS2083)         363           Sodium stibogluconate (RS1100)         201         Trientine (RS2026)         33           Somatropin (RS1826)         123         Upadacitinib (RS2120)         466           Spiramycin (RS1101)         202         Ursodeoxycholic acid (RS2103)         15           Standard Feeds (RS1214)         514         Ustekinumab (RS1942)         404           4tripentol (RS1989)         241         Valganciclovir (RS2137)         212           Strand Transfer Inhibitors (RS1901)         207         Vancomycin (RS1069)         162           Streptomycin sulphate (RS1043)         132         Varenicline (RS1702)         264           Sucrose (RS1763)         235         Varicella vaccine [Chickenpox vaccine] (RS1591)         535           Sugammadex (RS1370)         230         Varicella zoster vaccine [shingles vaccine] (RS2039)         538           Sulphadiazine (RS1067)         158         Vedolizumab (RS1943)         406           Sunitinib (RS2109)         303         Venetoclax (RS2118)         271           Tacrolimus (RS2110)         315         Vigabatrin (RS1865)         239           Tacrolimus (RS2110)         315         Vigabatrin (RS1865)         239			Trastuzumab deruxtecan (RS2082)	414
Sodium stibogluconate (RS1100)         201         Trientine (RS2026)         33           Somatropin (RS1826)         123         Upadacitinib (RS2120)         466           Spiramycin (RS1101)         202         Ursodeoxycholic acid (RS2103)         15           Standard Feeds (RS1214)         514         Ustekinumab (RS1942)         404           Stiripentol (RS1989)         241         Valganciclovir (RS2137)         212           Strand Transfer Inhibitors (RS1901)         207         Vancomycin (RS1069)         162           Streptomycin sulphate (RS1043)         132         Varenicline (RS1702)         264           Sucrose (RS1763)         235         Varicella vaccine [Chickenpox vaccine] (RS1591)         535           Sugammadex (RS1370)         230         Varicella zoster vaccine [shingles vaccine] (RS2039)         538           Sulphadiazine (RS1067)         158         Vedolizumab (RS1943)         406           Sunitinib (RS2109)         303         Venetoclax (RS2118)         271           Tacrolimus (RS2110)         315         Vigabatrin (RS1865)         239           Tacrolimus Ointment (RS1859)         110         Voriconazole (RS2053)         172           Tamsulosin (RS1132)         115         Zanamivir - Powder for inhalation 5 mg (RS1369)         216 </td <td>Sodium phenylbutyrate (RS1797)</td> <td>20</td> <td></td> <td></td>	Sodium phenylbutyrate (RS1797)	20		
Spiramycin (RS1101)         202         Ursodeoxycholic acid (RS2103)         15           Standard Feeds (RS1214)         514         Ustekinumab (RS1942)         404           Stiripentol (RS1989)         241         Valganciclovir (RS2137)         212           Strand Transfer Inhibitors (RS1901)         207         Vancomycin (RS1069)         162           Streptomycin sulphate (RS1043)         132         Varenicline (RS1702)         264           Sucrose (RS1763)         235         Varicella vaccine [Chickenpox vaccine] (RS1591)         535           Sugammadex (RS1370)         230         Varicella zoster vaccine [shingles vaccine] (RS2039)         538           Sulphadiazine (RS1067)         158         Vedolizumab (RS1943)         406           Sunitinib (RS2109)         303         Venetoclax (RS2118)         271           Tacrolimus (RS2110)         315         Vigabatrin (RS1865)         239           Tacrolimus Ointment (RS1859)         110         Voriconazole (RS2053)         172           Taliglucerase alfa (RS1897)         27         Yellow jacket wasp venom (RS1119)         474           Tamsulosin (RS1132)         115         Zanamivir - Powder for inhalation 5 mg (RS1369)         216			Trientine (RS2026)	33
Standard Feeds (RS1214)       514       Ustekinumab (RS1942)       404         Stiripentol (RS1989)       241       Valganciclovir (RS2137)       212         Strand Transfer Inhibitors (RS1901)       207       Vancomycin (RS1069)       162         Streptomycin sulphate (RS1043)       132       Varenicline (RS1702)       264         Sucrose (RS1763)       235       Varicella vaccine [Chickenpox vaccine] (RS1591)       535         Sugammadex (RS1370)       230       Varicella zoster vaccine [shingles vaccine] (RS2039)       538         Sulphadiazine (RS1067)       158       Vedolizumab (RS1943)       406         Sunitinib (RS2109)       303       Venetoclax (RS2118)       271         Tacrolimus (RS2110)       315       Vigabatrin (RS1865)       239         Tacrolimus Ointment (RS1859)       110       Voriconazole (RS2053)       172         Taliglucerase alfa (RS1897)       27       Yellow jacket wasp venom (RS1119)       474         Tamsulosin (RS1132)       115       Zanamivir - Powder for inhalation 5 mg (RS1369)       216	Somatropin (RS1826)	123	Upadacitinib (RS2120)	466
Stiripentol (RS1989)       241       Valganciclovir (RS2137)       212         Strand Transfer Inhibitors (RS1901)       207       Vancomycin (RS1069)       162         Streptomycin sulphate (RS1043)       132       Varenicline (RS1702)       264         Sucrose (RS1763)       235       Varicella vaccine [Chickenpox vaccine] (RS1591)       535         Sugammadex (RS1370)       230       Varicella zoster vaccine [shingles vaccine] (RS2039)       538         Sulphadiazine (RS1067)       158       Vedolizumab (RS1943)       406         Sunitinib (RS2109)       303       Venetoclax (RS2118)       271         Tacrolimus (RS2110)       315       Vigabatrin (RS1865)       239         Tacrolimus Ointment (RS1859)       110       Voriconazole (RS2053)       172         Taliglucerase alfa (RS1897)       27       Yellow jacket wasp venom (RS1119)       474         Tamsulosin (RS1132)       115       Zanamivir - Powder for inhalation 5 mg (RS1369)       216	Spiramycin (RS1101)	202	Ursodeoxycholic acid (RS2103)	15
Strand Transfer Inhibitors (RS1901)         207         Vancomycin (RS1069)         162           Streptomycin sulphate (RS1043)         132         Varenicline (RS1702)         264           Sucrose (RS1763)         235         Varicella vaccine [Chickenpox vaccine] (RS1591)         535           Sugammadex (RS1370)         230         Varicella zoster vaccine [shingles vaccine] (RS2039)         538           Sulphadiazine (RS1067)         158         Vedolizumab (RS1943)         406           Sunitinib (RS2109)         303         Venetoclax (RS2118)         271           Tacrolimus (RS2110)         315         Vigabatrin (RS1865)         239           Tacrolimus Ointment (RS1859)         110         Voriconazole (RS2053)         172           Taliglucerase alfa (RS1897)         27         Yellow jacket wasp venom (RS1119)         474           Tamsulosin (RS1132)         115         Zanamivir - Powder for inhalation 5 mg (RS1369)         216	Standard Feeds (RS1214)	514	Ustekinumab (RS1942)	404
Strand Transfer Inhibitors (RS1901)         207         Vancomycin (RS1069)         162           Streptomycin sulphate (RS1043)         132         Varenicline (RS1702)         264           Sucrose (RS1763)         235         Varicella vaccine [Chickenpox vaccine] (RS1591)         535           Sugammadex (RS1370)         230         Varicella zoster vaccine [shingles vaccine] (RS2039)         538           Sulphadiazine (RS1067)         158         Vedolizumab (RS1943)         406           Sunitinib (RS2109)         303         Venetoclax (RS2118)         271           Tacrolimus (RS2110)         315         Vigabatrin (RS1865)         239           Tacrolimus Ointment (RS1859)         110         Voriconazole (RS2053)         172           Taliglucerase alfa (RS1897)         27         Yellow jacket wasp venom (RS1119)         474           Tamsulosin (RS1132)         115         Zanamivir - Powder for inhalation 5 mg (RS1369)         216	Stiripentol (RS1989)	241	Valganciclovir (RS2137)	212
Sucrose (RS1763)       235       Varicella vaccine [Chickenpox vaccine] (RS1591)       535         Sugammadex (RS1370)       230       Varicella zoster vaccine [shingles vaccine] (RS2039)       538         Sulphadiazine (RS1067)       158       Vedolizumab (RS1943)       406         Sunitinib (RS2109)       303       Venetoclax (RS2118)       271         Tacrolimus (RS2110)       315       Vigabatrin (RS1865)       239         Tacrolimus Ointment (RS1859)       110       Voriconazole (RS2053)       172         Taliglucerase alfa (RS1897)       27       Yellow jacket wasp venom (RS1119)       474         Tamsulosin (RS1132)       115       Zanamivir - Powder for inhalation 5 mg (RS1369)       216	Strand Transfer Inhibitors (RS1901)	207		
Sugammadex (RS1370)       230       Varicella zoster vaccine [shingles vaccine] (RS2039)       538         Sulphadiazine (RS1067)       158       Vedolizumab (RS1943)       406         Sunitinib (RS2109)       303       Venetoclax (RS2118)       271         Tacrolimus (RS2110)       315       Vigabatrin (RS1865)       239         Tacrolimus Ointment (RS1859)       110       Voriconazole (RS2053)       172         Taliglucerase alfa (RS1897)       27       Yellow jacket wasp venom (RS1119)       474         Tamsulosin (RS1132)       115       Zanamivir - Powder for inhalation 5 mg (RS1369)       216	Streptomycin sulphate (RS1043)	132	Varenicline (RS1702)	264
Sulphadiazine (RS1067)       158       Vedolizumab (RS1943)       406         Sunitinib (RS2109)       303       Venetoclax (RS2118)       271         Tacrolimus (RS2110)       315       Vigabatrin (RS1865)       239         Tacrolimus Ointment (RS1859)       110       Voriconazole (RS2053)       172         Taliglucerase alfa (RS1897)       27       Yellow jacket wasp venom (RS1119)       474         Tamsulosin (RS1132)       115       Zanamivir - Powder for inhalation 5 mg (RS1369)       216			Varicella vaccine [Chickenpox vaccine] (RS1591)	535
Sunitinib (RS2109)       303       Venetoclax (RS2118)       271         Tacrolimus (RS2110)       315       Vigabatrin (RS1865)       239         Tacrolimus Ointment (RS1859)       110       Voriconazole (RS2053)       172         Taliglucerase alfa (RS1897)       27       Yellow jacket wasp venom (RS1119)       474         Tamsulosin (RS1132)       115       Zanamivir - Powder for inhalation 5 mg (RS1369)       216	Sugammadex (RS1370)	230	Varicella zoster vaccine [shingles vaccine] (RS2039)	538
Tacrolimus (RS2110)       315       Vigabatrin (RS1865)       239         Tacrolimus Ointment (RS1859)       110       Voriconazole (RS2053)       172         Taliglucerase alfa (RS1897)       27       Yellow jacket wasp venom (RS1119)       474         Tamsulosin (RS1132)       115       Zanamivir - Powder for inhalation 5 mg (RS1369)       216	Sulphadiazine (RS1067)	158	Vedolizumab (RS1943)	406
Tacrolimus Ointment (RS1859)       110       Voriconazole (RS2053)       172         Taliglucerase alfa (RS1897)       27       Yellow jacket wasp venom (RS1119)       474         Tamsulosin (RS1132)       115       Zanamivir - Powder for inhalation 5 mg (RS1369)       216	Sunitinib (RS2109)	303	Venetoclax (RS2118)	271
Taliglucerase alfa (RS1897)       27       Yellow jacket wasp venom (RS1119)       474         Tamsulosin (RS1132)       115       Zanamivir - Powder for inhalation 5 mg (RS1369)       216	Tacrolimus (RS2110)	315	Vigabatrin (RS1865)	239
Tamsulosin (RS1132)	Tacrolimus Ointment (RS1859)	110		
	Taliglucerase alfa (RS1897)	27	Yellow jacket wasp venom (RS1119)	474
Taurine (RS1834)	Tamsulosin (RS1132)	115	Zanamivir - Powder for inhalation 5 mg (RS1369)	216
	Taurine (RS1834)	32	sodium picosulfate (RS1843)	17