

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to [Section H](#) of the Pharmaceutical Schedule. For community funding, see the [Special Authority Criteria](#).

PRESCRIBER

Name:

Ward: NHI:

Siltuximab

INITIATION

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

Prescribed by, or recommended by a haematologist or rheumatologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

Patient has severe HHV-8 negative idiopathic multicentric Castleman's Disease

and

Treatment with an adequate trial of corticosteroids has proven ineffective

and

Siltuximab is to be administered at doses no greater than 11 mg/kg every 3 weeks

CONTINUATION

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by 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 sustained improvement in inflammatory markers and functional status

I confirm that the above details are correct:

Signed: Date: