

RS1827 - Pegylated interferon alfa-2a

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

PRESCRIBER

Name: Name:

Ward: NHI:

Pegylated interferon alfa-2a

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

Re-assessment required after 48 weeks

Prerequisites (tick boxes where appropriate)

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

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

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

CONTINUATION – Chronic hepatitis C - genotype 1 infection

Re-assessment required after 48 weeks

Prerequisites (tick boxes where appropriate)

- Prescribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
- and
- Patient has chronic hepatitis C, genotype 1
- and
- Patient has had previous treatment with pegylated interferon and ribavirin
- and

 - Patient has responder relapsed
 - or
 - Patient was a partial responder

- and
- Patient is to be treated in combination with boceprevir

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

Re-assessment required after 48 weeks

Prerequisites (tick boxes where appropriate)

- Prescribed by, or recommended by a gastroenterologist, infectious disease specialist or general physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
- and
- Patient has chronic hepatitis C, genotype 1
- and
- Patient has had previous treatment with pegylated interferon and ribavirin
- and

 - Patient has responder relapsed
 - or
 - Patient was a partial responder
 - or
 - Patient received interferon treatment prior to 2004

- and
- Patient is to be treated in combination with boceprevir

I confirm that the above details are correct:

Signed: Date:

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PRESCRIBER

Name: Name:

Ward: NHI:

Pegylated interferon alfa-2a - continued

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

Re-assessment required after 6 months

Prerequisites (tick box where appropriate)

Patient has chronic hepatitis C, genotype 2 or 3 infection

INITIATION – Hepatitis B

Re-assessment required after 48 weeks

Prerequisites (tick boxes where appropriate)

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

and

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

and

Patient is Hepatitis B treatment-naive

and

ALT > 2 times Upper Limit of Normal

and

HBV DNA < 10 log10 IU/ml

and

HBeAg positive

or

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

and

Compensated liver disease

and

No continuing alcohol abuse or intravenous drug use

and

Not co-infected with HCV, HIV or HDV

and

Neither ALT nor AST > 10 times upper limit of normal

and

No history of hypersensitivity or contraindications to pegylated interferon

INITIATION – myeloproliferative disorder or cutaneous T cell lymphoma

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

Patient has a cutaneous T cell lymphoma*

or

Patient has a myeloproliferative disorder*

and

Patient is intolerant of hydroxyurea

and

Treatment with anagrelide and busulfan is not clinically appropriate

or

Patient has a myeloproliferative disorder

and

Patient is pregnant, planning pregnancy or lactating

I confirm that the above details are correct:

Signed: Date:

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PRESCRIBER

Name: Name:

Ward: NHI:

Pegylated interferon alfa-2a - *continued*

CONTINUATION – myeloproliferative disorder or cutaneous T cell lymphoma

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

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

Note: Indications marked with * are unapproved indications

INITIATION – ocular surface squamous neoplasia

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

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

CONTINUATION – ocular surface squamous neoplasia

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

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

Note: Indications marked with * are unapproved indications

INITIATION – post-allogenic bone marrow transplant

Re-assessment required after 3 months

Prerequisites (tick box where appropriate)

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

CONTINUATION – post-allogenic bone marrow transplant

Re-assessment required after 3 months

Prerequisites (tick box where appropriate)

- Patient is responding and ongoing treatment remains appropriate

Note: Indications marked with * are unapproved indications

I confirm that the above details are correct:

Signed: Date: