

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:

Tolvaptan

INITIATION – autosomal dominant polycystic kidney disease

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

Prescribed by, or recommended by a renal physician or any relevant practitioner on the recommendation of a renal physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
and
 Patient has a confirmed diagnosis of autosomal dominant polycystic kidney disease
and
 Patient has an estimated glomerular filtration rate (eGFR) of greater than or equal to 25 mL/min/1.73 m² at treatment initiation
and
 Patient's disease is rapidly progressing, with a decline in eGFR of greater than or equal to 5 mL/min/1.73 m² within one-year
or
 Patient's disease is rapidly progressing, with an average decline in eGFR of greater than or equal to 2.5 mL/min/1.73 m² per year over a five-year period

CONTINUATION – autosomal dominant polycystic kidney disease

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

Prescribed by, or recommended by a renal physician or any relevant practitioner on the recommendation of a renal physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
and
 Patient has not developed end-stage renal disease, defined as an eGFR of less than 15 mL/min/1.73 m²
and
 Patient has not undergone a kidney transplant

I confirm that the above details are correct:

Signed: Date: