

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: .....

**Long-acting Somatostatin Analogues**

**INITIATION – Malignant bowel obstruction**

**Prerequisites** (tick boxes where appropriate)

The patient has nausea\* and vomiting\* due to malignant bowel obstruction\*

and

Treatment with antiemetics, rehydration, antimuscarinic agents, corticosteroids and analgesics for at least 48 hours has not been successful

and

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

and

Treatment with surgery and radiotherapy is not suitable or was unsuccessful

or

Treatment is for an interim period while awaiting the beneficial effects of radiotherapy

and

Treatment with a dopamine agonist has been unsuccessful

**CONTINUATION – acromegaly**

**Prerequisites** (tick box where appropriate)

Without reassessment for applications where IGF1 levels have decreased since starting treatment

Note: In patients with acromegaly, treatment should be discontinued if IGF1 levels have no decreased 3 months after treatment. In patients treated with radiotherapy treatment should be withdrawn every 2 years, for 1 month, for assessment of remission. Treatment should be stopped where there is biochemical evidence of remission (normal IGF1 levels) following treatment withdrawal for at least 4 weeks.

I confirm that the above details are correct:

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

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**Long-acting Somatostatin Analogues - *continued***

**INITIATION – Other indications**

**Prerequisites** (tick boxes where appropriate)

- VIPomas and glucagonomas - for patients who are seriously ill in order to improve their clinical state prior to definitive surgery
- or
- Gastrinoma
- and
- Surgery has been unsuccessful
- or
- Patient has metastatic disease after treatment with H2 antagonist or proton pump inhibitors has been unsuccessful

  

- or
- Insulinomas
- and
- Surgery is contraindicated or has not been successful

  

- or
- For pre-operative control of hypoglycaemia and for maintenance therapy

  

- or
- Carcinoid syndrome (diagnosed by tissue pathology and/or urinary 5HIAA analysis)
- and
- Disabling symptoms not controlled by maximal medical therapy

**INITIATION – pre-operative acromegaly**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- Patient has acromegaly
- and
- Patient has a large pituitary tumour, greater than 10 mm at its widest
- and
- Patient is scheduled to undergo pituitary surgery in the next six months

Note: Indications marked with \* are unapproved indications

Note: The use of a long-acting somatostatin analogue in patients with fistulae, oesophageal varices, miscellaneous diarrhoea and hypotension will not be funded under Special Authority

I confirm that the above details are correct:

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