

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: .....

**PATIENT:**

Name: .....

NHI: .....

**Ustekinumab**

**INITIATION – Crohn’s disease - adults**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- Patient is currently on treatment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) below at the time of commencing treatment
- or
- Patient has active Crohn’s disease
- and
- 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
- or
- and
  - Patient meets the initiation criteria for prior biologic therapies for Crohn’s disease
  - Other biologics for Crohn’s disease are contraindicated

**CONTINUATION – Crohn’s disease - adults**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- 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
- CDAI score is 150 or less, or HBI is 4 or less
- or
- The patient has experienced an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed
- and
- Ustekinumab 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)

- Patient is currently on treatment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) below at the time of commencing treatment
- or
- Patient has active Crohn’s disease
- and
- Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria
- or
- and
  - Patient meets the initiation criteria for prior biologic therapies for Crohn’s disease
  - Other biologics for Crohn’s disease are contraindicated

Note: Indication marked with \* is an unapproved indication.

I confirm that the above details are correct:

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

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**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

**Ustekinumab - continued**

**CONTINUATION – Crohn’s disease - children\***

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy
- or
- PCDAI score is 15 or less
- or
- The patient has experienced an adequate response 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.

**INITIATION – ulcerative colitis**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- Patient is currently on treatment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) below at the time of commencing treatment

or

- Patient has active ulcerative colitis

and

- Patient 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

or

- Patient meets the initiation criteria for prior biologic therapies for ulcerative colitis
- and
- Other biologics for ulcerative colitis are contraindicated

**CONTINUATION – ulcerative colitis**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- The SCCAI score has reduced by 2 points or more from the SCCAI score since initiation on biologic therapy
- or
- PUCAI score has reduced by 10 points or more from the PUCAI score since initiation on biologic therapy\*

and

- 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: .....