

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:

Faricimab

INITIATION – Diabetic macular oedema

Re-assessment required after 4 months

Prerequisites (tick boxes where appropriate)

- Patient has centre involving diabetic macular oedema (DMO)
- and Patient's disease is nonresponsive to 4 doses of intravitreal bevacizumab when administered 4-6 weekly
- and Patient has reduced visual acuity between 6/9 – 6/36 with functional awareness of reduction in vision
- and Patient has DMO within central OCT (ocular coherence tomography) subfield > 350 micrometers
- and There is no centre-involving sub-retinal fibrosis or foveal atrophy
- and Patient has not previously been treated with aflibercept for longer than 3 months

CONTINUATION – Diabetic macular oedema

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

- There is stability or two lines of Snellen visual acuity gain
- and There is structural improvement on OCT scan (with reduction in intra-retinal cysts, central retinal thickness, and sub-retinal fluid)
- and Patient's vision is 6/36 or better on the Snellen visual acuity score
- and There is no centre-involving sub-retinal fibrosis or foveal atrophy

INITIATION – Wet age related macular degeneration

Re-assessment required after 3 months

Prerequisites (tick boxes where appropriate)

- Wet age-related macular degeneration (wet AMD)
- or Polypoidal choroidal vasculopathy
- or Choroidal neovascular membrane from causes other than wet AMD
- and The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab
- or There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart
- and There is no structural damage to the central fovea of the treated eye
- and Patient has not previously been treated with ranibizumab or aflibercept for longer than 3 months

I confirm that the above details are correct:

Signed: Date:

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

PATIENT:

Name:

Name:

Ward:

NHI:

Faricimab - *continued*

CONTINUATION – Wet age related macular degeneration

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

- Patient's vision is 6/36 or better on the Snellen visual acuity score
- and**
- There is no structural damage to the central fovea of the treated eye

HOSPITAL

I confirm that the above details are correct:

Signed: Date: