

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: .....

**Emicizumab**

**INITIATION – Severe Haemophilia A with or without FVIII inhibitors**

**Prerequisites** (tick boxes where appropriate)

Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

**and**

Patient has severe congenital haemophilia A with a severe bleeding phenotype (endogenous factor VIII activity less than or equal to 2%)

**and**

Emicizumab is to be administered at a dose of no greater than 3 mg/kg weekly for 4 weeks followed by the equivalent of 1.5 mg/kg weekly

I confirm that the above details are correct:

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