

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: .....

**Epoetin alfa**

**INITIATION – chronic renal failure**

**Prerequisites** (tick boxes where appropriate)

- Patient in chronic renal failure
- and
- Haemoglobin is less than or equal to 100g/L
- and
- Patient does not have diabetes mellitus
- and
- Glomerular filtration rate is less than or equal to 30ml/min
- or
- Patient has diabetes mellitus
- and
- Glomerular filtration rate is less than or equal to 45ml/min
- or
- Patient is on haemodialysis or peritoneal dialysis

**INITIATION – myelodysplasia\***

Re-assessment required after 2 months

**Prerequisites** (tick boxes where appropriate)

- Patient has a confirmed diagnosis of myelodysplasia (MDS)
- and
- Has had symptomatic anaemia with haemoglobin < 100g/L and is red cell transfusion-dependent
- and
- Patient has very low, low or intermediate risk MDS based on the WHO classification-based prognostic scoring system for myelodysplastic syndrome (WPSS)
- and
- Other causes of anaemia such as B12 and folate deficiency have been excluded
- and
- Patient has a serum epoetin level of < 500 IU/L
- and
- The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

**CONTINUATION – myelodysplasia\***

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- The patient's transfusion requirement continues to be reduced with epoetin treatment
- and
- Transformation to acute myeloid leukaemia has not occurred
- and
- The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

I confirm that the above details are correct:

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

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**PRESCRIBER**

**PATIENT:**

Name: .....

Name: .....

Ward: .....

NHI: .....

**Epoetin alfa** - *continued*

**INITIATION – all other indications**

**Prerequisites** (tick box 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**

For use in patients where blood transfusion is not a viable treatment alternative

Note: Indications marked with \* are unapproved indications

HOSPITAL

I confirm that the above details are correct:

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