

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: .....

Ward: ..... 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

Patient meets the initiation criteria for prior biologic therapies for Crohn’s disease

and

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

Patient meets the initiation criteria for prior biologic therapies for Crohn’s disease

and

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: .....