

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: .....

**Vedolizumab**

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

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

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 (unless contraindicated)
- or
- Patient has a CDAI score of greater than or equal to 300, or HBI score of greater than or equal to 10
- or
- Patient has extensive small intestine disease affecting more than 50 cm of the small intestine
- or
- Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection
- or
- Patient has an ileostomy or colostomy, and has intestinal inflammation

and

- Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids
- or
- Patient has experienced intolerable side effects from immunomodulators and corticosteroids
- or
- Immunomodulators and corticosteroids are contraindicated

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

Re-assessment required after 2 years

**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

Vedolizumab to administered at a dose no greater than 300 mg every 8 weeks

I confirm that the above details are correct:

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

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**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

**Vedolizumab - continued**

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

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

Paediatric 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 (unless contraindicated)

or

Patient has a Paediatric Crohn’s Disease Activity Index (PCDAI) score of greater than or equal to 30

or

Patient has extensive small intestine disease

and

Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids

or

Patient has experienced intolerable side effects from immunomodulators and corticosteroids

or

Immunomodulators and corticosteroids are contraindicated

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

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

Re-assessment required after 2 years

**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

Vedolizumab to administered at a dose no greater than 300mg every 8 weeks

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

I confirm that the above details are correct:

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

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**PRESCRIBER**

**PATIENT:**

Name: .....

Name: .....

Ward: .....

NHI: .....

**Vedolizumab - continued**

**INITIATION – ulcerative colitis**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

Patient has active ulcerative colitis

and

Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)

or

Patient has a SCCAI score is greater than or equal to 4

or

Patient's PUCAI score is greater than or equal to 20\*

and

Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids

or

Patient has experienced intolerable side effects from immunomodulators and corticosteroids

or

Immunomodulators and corticosteroids are contraindicated

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

**CONTINUATION – ulcerative colitis**

Re-assessment required after 2 years

**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

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

and

Vedolizumab will be used at a dose no greater than 300 mg intravenously every 8 weeks

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

I confirm that the above details are correct:

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