

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: .....

**Ranibizumab**

**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 aflibercept or faricimab for longer than 3 months

- or
- Patient has current approval to use aflibercept or faricimab for treatment of wAMD and was found to be intolerant within 3 months

**CONTINUATION – Wet Age Related Macular Degeneration**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- Documented benefit must be demonstrated to continue
- and
- 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

I confirm that the above details are correct:

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