

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: