

# June 2026

## Volume 33

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### Circulation

You can register to have an electronic version of the Pharmaceutical Schedule (link to PDF copy) emailed to your nominated email address each month by subscribing at [pharmac.govt.nz/subscribe](http://pharmac.govt.nz/subscribe).

### Production

Typeset automatically from XML and T<sub>E</sub>X.  
XML version of the Schedule available from [schedule.pharmac.govt.nz/pub/schedule](http://schedule.pharmac.govt.nz/pub/schedule)

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ISSN 1179-3686

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## Introducing Pharmac

The Pharmaceutical Management Agency (Pharmac) makes decisions that help control Government spending on pharmaceuticals. This includes community pharmaceuticals, hospital pharmaceuticals, vaccines and increasingly, hospital medical devices. Pharmac negotiates prices, sets subsidy levels and conditions, and makes decisions on changes to the subsidised list.

### Pharmac's role:

***“to secure for eligible people in need of pharmaceuticals, the best health outcomes that are reasonably achievable from pharmaceutical treatment and from within the amount of funding provided.”***

Pae Ora (Healthy Futures) Act 2022

To ensure our decisions are as fair and robust as possible we use a decision-making process that incorporates clinical, economic and commercial issues. We also seek the views of users and the wider community through consultation. The processes we generally use are outlined in our Operating Policies and Procedures.

Further information about Pharmac and the way we make funding decisions can be found on the Pharmac website at <https://pharmac.govt.nz/about>.

## Purpose of the Pharmaceutical Schedule

The purpose of the Schedule is to list:

- the Community Pharmaceuticals that are subsidised by the Government and to show the amount of the subsidy paid to contractors, as well as the manufacturer's price and any access conditions that may apply;
- the Hospital Pharmaceuticals that may be used in Health NZ Hospitals, as well as any access conditions that may apply; and
- the Pharmaceuticals, including Medical Devices, used in Health NZ Hospitals for which national prices have been negotiated by Pharmac.

The Schedule does not show the final cost to Government of subsidising each Community Pharmaceutical or to Health NZ Hospitals in purchasing each Pharmaceutical, since that will depend on any rebate and other arrangements Pharmac has with the supplier and, for Pharmaceuticals used in Health NZ Hospitals, on any logistics arrangements put in place.

This book contains sections A to D and Section I of the Pharmaceutical Schedule and lists the Pharmaceuticals funded for use in the community, including vaccines, as well as haemophilia and cancer treatments given in Health NZ Hospitals. Section H lists the Pharmaceuticals that can be used in Health NZ Hospitals and is a separate publication.

The Pharmaceuticals in this book are listed by therapeutic group, which is based on the WHO Anatomical Therapeutic Chemical (ATC) system. The listings are displayed alphabetically under each heading.

The index lists both chemical entities and product brand names.

# Explaining pharmaceutical entries

The Pharmaceutical Schedule lists pharmaceuticals subsidised by the Government, the subsidy, the supplier's price and the access conditions that may apply.

## Example

		Subsidy (Manufacturer's Price)		Fully Brand or Subsidised Generic
		\$	Per	Manufacturer
<b>ANATOMICAL HEADING</b>				
<b>THERAPEUTIC HEADING</b>				
<p>Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.</p> <p>Practitioner's Supply Order</p> <p>Conditions of and restrictions on prescribing (including Special Authority where it applies)</p> <p>Three months or six months, as applicable, dispensed at one time</p>	CHEMICAL			
	▲ Presentation, form and strength .....	10.00	100	Brand A ✓ Brand B
	Presentation - Available on a PSO .....	15.00	50	✓ Brand C
	Presentation - Retail pharmacy-specialist .....	18.00	250 ml OP	✓ Brand D
	<p>a) Prescriptions must be written by a paediatrician or paediatric cardiologist; or</p> <p>b) on the recommendation of a paediatrician or a paediatric cardiologist</p>			
	CHEMICAL			
	* Presentation, form and strength .....	26.53	100	Brand E
		(35.27)		
<p><u>Sole Supply/Principal Supply</u>    ▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.</p> <p>✓ Fully Subsidised</p>				

Brand or manufacturer's name

Sole Subsidised Supply product or Principal Supply Status

Fully subsidised product

Original Pack - Subsidy is rounded up to a multiple of whole packs

Quantity the Subsidy applies to

Subsidy paid on a product before mark-ups and GST

Manufacturer's Price if different from Subsidy

# Glossary

## Units of Measure

gram ..... g  
kilogram ..... kg  
international unit ..... iu

microgram ..... mcg  
milligram ..... mg  
millilitre ..... ml

millimole ..... mmol  
unit ..... u

## Abbreviations

Ampoule ..... Amp  
Capsule ..... Cap  
Cream ..... Crm  
Device ..... Dev  
Dispersible ..... Disp  
Effervescent ..... Eff  
Emulsion ..... Emul  
Enteric Coated ..... EC

Gelatinous ..... Gel  
Granules ..... Gran  
Infusion ..... Inf  
Injection ..... Inj  
Liquid ..... Liq  
Long Acting ..... LA  
Ointment ..... Oint  
Sachet ..... Sach

Solution ..... Soln  
Suppository ..... Supp  
Tablet ..... Tab  
Tincture ..... Tinc  
Trans Dermal Delivery  
System ..... TDDS

Read the [General Rules](https://pharmac.govt.nz/section-a) : <https://pharmac.govt.nz/section-a>.

## SECTION B: ALIMENTARY TRACT AND METABOLISM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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### Antacids and Antiflatulents

#### Antacids and Reflux Barrier Agents

##### ALGINIC ACID

Sodium alginate 225 mg and magnesium alginate 87.5 mg per sachet.....	8.06	30	✓	Gaviscon Infant
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##### SODIUM ALGINATE

* Tab 500 mg with sodium bicarbonate 267 mg and calcium carbonate 160 mg - peppermint flavour.....	1.80 (17.99)	60		Gaviscon Extra Strength
* Oral liq 500 mg with sodium bicarbonate 267 mg and calcium carbonate 160 mg per 10 ml.....	1.50 (7.50)	500 ml		Acidex

#### Phosphate Binding Agents

##### ALUMINIUM HYDROXIDE

* Tab 600 mg.....	12.56	100	✓	Alu-Tab
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##### CALCIUM CARBONATE

Oral liq 1,250 mg per 5 ml (500 mg elemental per 5 ml) –				
Subsidy by endorsement.....	39.00 47.30	500 ml 473 ml	✓	Roxane Calcium carbonate PAI <sup>S29</sup>

Only when prescribed for patients unable to swallow calcium carbonate tablets or where calcium carbonate tablets are inappropriate and the prescription is endorsed accordingly.

### Antidiarrhoeals

#### Agents Which Reduce Motility

##### LOPERAMIDE HYDROCHLORIDE – Up to 30 cap available on a PSO

* Tab 2 mg.....	10.75	400	✓	Nodia
* Cap 2 mg.....	12.00	400	✓	Diamide Relief

#### Rectal and Colonic Anti-inflammatories

##### BUDESONIDE

Cap modified-release 3 mg – Special Authority see SA2535 below – Retail pharmacy.....	33.38	90	✓	Budesonide Te Arai
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➔SA2535 Special Authority for Subsidy

**Initial application — (Crohn's disease)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- Mild to moderate ileal, ileocaecal or proximal Crohn's disease; and
- Any of the following:
  - Diabetes; or

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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continued...

- 2.2 Cushingoid habitus; or
- 2.3 Osteoporosis where there is significant risk of fracture; or
- 2.4 Severe acne following treatment with conventional corticosteroid therapy; or
- 2.5 History of severe psychiatric problems associated with corticosteroid treatment; or
- 2.6 History of major mental illness (such as bipolar affective disorder) where the risk of conventional corticosteroid treatment causing relapse is considered to be high; or
- 2.7 Relapse during pregnancy (where conventional corticosteroids are considered to be contraindicated).

**Initial application — (collagenous and lymphocytic colitis (microscopic colitis))** from any relevant practitioner. Approvals valid without further renewal unless notified where patient has a diagnosis of microscopic colitis (collagenous or lymphocytic colitis) by colonoscopy with biopsies.

**Initial application — (gut Graft versus Host disease)** from any relevant practitioner. Approvals valid for 6 months where patient has a gut Graft versus Host disease following allogenic bone marrow transplantation\*.

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

**Initial application — (non-cirrhotic autoimmune hepatitis)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has autoimmune hepatitis\*; and
- 2 Patient does not have cirrhosis; and
- 3 Any of the following:
  - 3.1 Diabetes; or
  - 3.2 Cushingoid habitus; or
  - 3.3 Osteoporosis where there is significant risk of fracture; or
  - 3.4 Severe acne following treatment with conventional corticosteroid therapy; or
  - 3.5 History of severe psychiatric problems associated with corticosteroid treatment; or
  - 3.6 History of major mental illness (such as bipolar affective disorder) where the risk of conventional corticosteroid treatment causing relapse is considered to be high; or
  - 3.7 Relapse during pregnancy (where conventional corticosteroids are considered to be contraindicated); or
  - 3.8 Adolescents with poor linear growth (where conventional corticosteroid use may limit further growth) .

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

**Renewal — (gut Graft versus Host disease)** from any relevant practitioner. Approvals valid for 6 months where the treatment remains appropriate and the patient is benefiting from treatment.

**Renewal — (non-cirrhotic autoimmune hepatitis)** from any relevant practitioner. Approvals valid for 6 months where the treatment remains appropriate and the patient is benefiting from treatment.

**HYDROCORTISONE ACETATE**

Rectal foam 10%, CFC-Free (14 applications).....	57.09	15 g OP	✓ Colifoam
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**HYDROCORTISONE ACETATE WITH PRAMOXINE HYDROCHLORIDE**

Topical aerosol foam, 1% with pramoxine hydrochloride 1%.....	26.55	10 g OP	✓ Proctofoam S29
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**MESALAZINE**

Tab 400 mg .....	49.50	100	✓ Asacol
	71.00	90	✓ Octasa S29
Tab long-acting 500 mg.....	56.10	100	✓ Pentasa
Tab 800 mg .....	85.50	90	✓ Asacol
			✓ Asacol S29 S29
Tab 1,600 mg .....	85.50	60	✓ Asacol S29
Modified release granules, 1 g .....	118.10	100 OP	✓ Pentasa
Enema 1 g per 100 ml .....	41.30	7	✓ Pentasa
Suppos 500 mg .....	22.80	20	✓ Asacol
Suppos 1 g .....	50.96	28	✓ Pentasa

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# ALIMENTARY TRACT AND METABOLISM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>OLSALAZINE</b>				
Tab 500 mg .....	56.02	60	✓	<b>Atnahs</b>
				<b>Olsalazine</b> <sup>S29</sup>
	93.37	100	✓	<b>Dipentum</b>
Cap 250 mg .....	53.00	100	✓	<b>Dipentum</b>
<b>SODIUM CROMOGLICATE</b>				
Cap 100 mg .....	44.50	20	✓	<b>Nalcrom</b> <sup>S29</sup>
	113.35	100	✓	<b>Ralicrom</b>
	125.70		✓	<b>Allergoval</b> <sup>S29</sup>
	365.00		✓	<b>Somex</b> <sup>S29</sup>
<b>SULFASALAZINE</b>				
* Tab 500 mg .....	19.49	100	✓	<b>Salazopyrin</b>
* Tab EC 500 mg .....	20.54	100	✓	<b>Salazopyrin EN</b>

## Local preparations for Anal and Rectal Disorders

### Antihaemorrhoidal Preparations

<b>FLUOCORTOLONE CAPROATE WITH FLUOCORTOLONE PIVALATE AND CINCHOCAINE</b>				
Oint 950 mcg, with fluocortolone pivalate 920 mcg, and cinchocaine hydrochloride 5 mg per g .....	13.05	30 g OP	✓	<b>Ultraproct</b>
Suppos 630 mcg, with fluocortolone pivalate 610 mcg, and cinchocaine hydrochloride 1 mg .....	8.61	12	✓	<b>Ultraproct</b>
<b>HYDROCORTISONE WITH CINCHOCAINE</b>				
Oint 5 mg with cinchocaine hydrochloride 5 mg per g .....	15.00	30 g OP	✓	<b>Proctosedyl</b>
Suppos 5 mg with cinchocaine hydrochloride 5 mg per g .....	9.90	12	✓	<b>Proctosedyl</b>
<b>PREDNISOLONE HEXANOATE WITH CINCHOCAINE HYDROCHLORIDE</b>				
Suppos 1.3 mg with cinchocaine hydrochloride 1 mg per g .....	8.61	12	✓	<b>Scheriproct</b> <sup>S29</sup>

### Management of Anal Fissures

<b>GLYCERYL TRINITRATE</b> – Special Authority see <a href="#">SA1329 below</a> – Retail pharmacy				
* Oint 0.2% .....	22.00	30 g OP	✓	<b>Rectogesic</b>

► [SA1329](#) Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified where the patient has a chronic anal fissure that has persisted for longer than three weeks.

### Antispasmodics and Other Agents Altering Gut Motility

<b>GLYCOPYRRONIUM BROMIDE</b>				
Inj 200 mcg per ml, 1 ml ampoule – Up to 10 inj available on a PSO .....	11.99	10	✓	<b>Glycopyrronium-AFT</b>
	19.00	5	✓	<b>Robinul</b>

Glycopyrronium-AFT to be Principal Supply on 1 July 2026  
(Robinul Inj 200 mcg per ml, 1 ml ampoule to be delisted 1 July 2026)

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>HYOSCINE BUTYLBROMIDE</b>				
* Tab 10 mg .....	2.25	20	✓	<b>Hyoscine Butylbromide (Adiramédica)</b>
* Inj 20 mg, 1 ml – Up to 5 inj available on a PSO .....	1.91	5	✓	<b>Spazmol</b>
<b>MEBEVERINE HYDROCHLORIDE</b>				
* Tab 135 mg .....	8.50	90	✓	<b>Colofac</b>

## Antiulcerants

### Antisecretory and Cytoprotective

MISOPROSTOL – Wastage claimable

* Tab 200 mcg – Up to 120 tab available on a PSO .....	47.73	120	✓	<b>Cytotec</b>
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### Helicobacter Pylori Eradication

CLARITHROMYCIN

Tab 500 mg – Subsidy by endorsement .....	14.58	14	✓	<b>Klacid</b>
a) Maximum of 28 tab per prescription				
b) Subsidised only if prescribed for helicobacter pylori eradication and prescription is endorsed accordingly.				
Note: the prescription is considered endorsed if clarithromycin is prescribed in conjunction with a proton pump inhibitor and either amoxicillin or metronidazole.				

## H2 Antagonists

FAMOTIDINE – Only on a prescription

* Tab 20 mg .....	4.86	100	✓	<b>Famotidine Hovid <sup>S29</sup></b>
* Tab 40 mg .....	10.27	100	✓	<b>Famotidine Hovid MY <sup>S29</sup></b>
* Inj 10 mg per ml, 4 ml – Subsidy by endorsement .....	CBS	10	✓	<b>Mylan <sup>S29</sup></b>
Subsidy by endorsement – Subsidised for patients receiving treatment as part of palliative care.				

## Proton Pump Inhibitors

LANSOPRAZOLE

* Cap 15 mg .....	1.21	30	✓	<b>Lanzol Relief</b>
	4.04	100	✓	<b>Lanzol Relief</b>
* Cap 30 mg .....	5.43	100	✓	<b>Lanzol Relief</b>

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# ALIMENTARY TRACT AND METABOLISM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>OMEPRAZOLE</b>				
For omeprazole suspension refer Standard Formulae, <a href="#">page 285</a>				
* Cap 10 mg.....	2.06	90	✓	<b>Omeprazole Teva</b> ✓ <b>Omeprazole actavis</b> <b>10</b>
* Cap 20 mg.....	2.02	90	✓	<b>Omeprazole Teva</b> ✓ <b>Omeprazole actavis</b> <b>20</b>
* Cap 40 mg.....	3.18	90	✓	<b>Omeprazole Teva</b> ✓ <b>Omeprazole actavis</b> <b>40</b>
* Powder – Only in combination.....	52.00	5 g	✓	<b>Midwest</b>
Only in extemporaneously compounded omeprazole suspension.				
* Inj 40 mg ampoule with diluent.....	37.38	5	✓	<b>Dr Reddy's</b> <b>Omeprazole</b> ✓ <b>Ocicare</b> <sup>S29</sup>
<b>PANTOPRAZOLE</b>				
* Tab EC 20 mg.....	1.81	90	✓	<b>Panzop Relief</b>
* Tab EC 40 mg.....	2.70	90	✓	<b>Panzop Relief</b>

## Site Protective Agents

<b>COLLOIDAL BISMUTH SUBCITRATE</b>				
Tab 120 mg.....	14.51	50	✓	<b>Gastrodenol</b> <sup>S29</sup>
<b>SUCRALFATE</b>				
Tab 1 g.....	35.50 (48.28)	120		Carafate

## Bile and Liver Therapy

<b>RIFAXIMIN</b> – Special Authority see <a href="#">SA1461 below</a> – Retail pharmacy				
Tab 550 mg.....	625.00	56	✓	<b>Xifaxan</b>

### ➔SA1461 Special Authority for Subsidy

**Initial application** only from a gastroenterologist, hepatologist or Practitioner on the recommendation of a gastroenterologist or hepatologist. Approvals valid for 6 months where the patient has hepatic encephalopathy despite an adequate trial of maximum tolerated doses of lactulose.

**Renewal** only from a gastroenterologist, hepatologist or Practitioner on the recommendation of a gastroenterologist or hepatologist. Approvals valid without further renewal unless notified where the treatment remains appropriate and the patient is benefiting from treatment.

## Diabetes

### Hyperglycaemic Agents

<b>DIAZOXIDE</b> – Special Authority see <a href="#">SA1320 on the next page</a> – Retail pharmacy				
Cap 25 mg.....	110.00	100	✓	<b>Proglificem</b> <sup>S29</sup>
Cap 100 mg.....	280.00	100	✓	<b>Proglificem</b> <sup>S29</sup>
Oral liq 50 mg per ml.....	620.00	30 ml OP	✓	<b>e5 Pharma</b> <sup>S29</sup>

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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►SA1320 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid for 12 months where used for the treatment of confirmed hypoglycaemia caused by hyperinsulinism.

**Renewal** from any relevant practitioner. Approvals valid without further renewal unless notified where the treatment remains appropriate and the patient is benefiting from treatment.

GLUCAGON HYDROCHLORIDE

Inj 1 mg syringe kit – Up to 5 kit available on a PSO.....	32.00	1	✓ Glucagen Hypokit
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**Insulin - Short-acting Preparations**

INSULIN NEUTRAL

▲ Inj human 100 u per ml, 3 ml.....	42.66	5	✓ Actrapid Penfill ✓ Humulin R
▲ Inj human 100 u per ml, 10 ml vial.....	25.26	1 OP	✓ Actrapid ✓ Humulin R

**Insulin - Intermediate-acting Preparations**

INSULIN ASPART WITH INSULIN ASPART PROTAMINE

▲ Inj 100 iu per ml, 3 ml prefilled pen.....	52.15	5	✓ NovoMix 30 FlexPen
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INSULIN DEGLUDEC WITH INSULIN ASPART

▲ Inj degludec 70 u with insulin aspart 30 u, 100 u per ml, 3 ml.....	80.00	5	✓ Ryzodeg 70/30 Penfill
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INSULIN ISOPHANE

▲ Inj human 100 u per ml, 3 ml.....	29.86	5	✓ Humulin NPH ✓ Protaphane Penfill
▲ Inj human 100 u per ml, 10 ml vial.....	17.68	1 OP	✓ Humulin NPH ✓ Protaphane

INSULIN ISOPHANE WITH INSULIN NEUTRAL

▲ Inj human with neutral insulin 100 u per ml, 3 ml .....	42.66	5	✓ Humulin 30/70
▲ Inj human with neutral insulin 100 u per ml, 10 ml vial.....	25.26	1 OP	✓ Humulin 30/70

INSULIN LISPRO WITH INSULIN LISPRO PROTAMINE

▲ Inj lispro 25% with insulin lispro protamine 75% 100 u per ml, 3 ml.....	42.66	5	✓ Humalog Mix 25
▲ Inj lispro 50% with insulin lispro protamine 50% 100 u per ml, 3 ml.....	42.66	5	✓ Humalog Mix 50

**Insulin - Long-acting Preparations**

INSULIN GLARGINE

▲ Inj 100 u per ml, 10 ml.....	63.00	1	✓ Lantus
▲ Inj 100 u per ml, 3 ml.....	94.50	5	✓ Lantus
▲ Inj 100 u per ml, 3 ml disposable pen.....	94.50	5	✓ Lantus SoloStar

**Insulin - Rapid Acting Preparations**

INSULIN ASPART

▲ Inj 100 u per ml, 10 ml.....	30.03	1	✓ NovoRapid
▲ Inj 100 u per ml, 3 ml.....	51.19	5	✓ NovoRapid Penfill
▲ Inj 100 u per ml, 3 ml syringe .....	51.19	5	✓ NovoRapid FlexPen

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# ALIMENTARY TRACT AND METABOLISM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>INSULIN GLULISINE</b>				
▲ Inj 100 u per ml, 10 ml.....	27.03	1	✓	<b>Apidra</b>
▲ Inj 100 u per ml, 3 ml.....	46.07	5	✓	<b>Apidra</b>
▲ Inj 100 u per ml, 3 ml disposable pen.....	46.07	5	✓	<b>Apidra SoloStar</b>
<b>INSULIN LISPRO</b>				
▲ Inj 100 u per ml, 3 ml.....	59.52	5	✓	<b>Humalog</b>
▲ Inj 100 u per ml, 10 ml vial.....	34.92	1 OP	✓	<b>Humalog</b>

## Alpha Glucosidase Inhibitors

<b>ACARBOSE</b>				
* Tab 50 mg .....	11.20	90	✓	<b>Accarb</b>
* Tab 100 mg .....	17.38	90	✓	<b>Accarb</b>

## Oral Hypoglycaemic Agents

<b>GLIBENCLAMIDE</b>				
* Tab 5 mg .....	7.50	100	✓	<b>Daonil</b>
<b>GLICLAZIDE</b>				
* Tab 80 mg .....	20.10	500	✓	<b>Glizide</b>
<b>GLIPIZIDE</b>				
* Tab 5 mg .....	6.86	100	✓	<b>Minidiab</b>
<b>METFORMIN HYDROCHLORIDE</b>				
* Tab immediate-release 500 mg.....	14.74	1,000	✓	<b>Metformin Viatris</b>
* Tab immediate-release 850 mg.....	11.28	500	✓	<b>Metformin Viatris</b>
<b>PIOGLITAZONE</b>				
* Tab 15 mg .....	6.15	90	✓	<b>Vexazone</b>
* Tab 30 mg .....	7.25	90	✓	<b>Vexazone</b>
* Tab 45 mg .....	12.00	90	✓	<b>Vexazone</b>
<b>VILDAGLIPTIN</b>				
* Tab 50 mg .....	35.00	60	✓	<b>Galvus</b>
<b>VILDAGLIPTIN WITH METFORMIN HYDROCHLORIDE</b>				
* Tab 50 mg with 1,000 mg metformin hydrochloride .....	35.00	60	✓	<b>Galvumet</b>
* Tab 50 mg with 850 mg metformin hydrochloride .....	35.00	60	✓	<b>Galvumet</b>

## GLP-1 Agonists

DULAGLUTIDE – Special Authority see [SA2509 below](#) – Retail pharmacy

Note: Not to be given in combination with another funded GLP-1 agonist or empagliflozin / empagliflozin with metformin hydrochloride unless receiving empagliflozin / empagliflozin with metformin hydrochloride for the treatment of heart failure.

Inj 1.5mg per 0.5 ml prefilled pen ..... 115.23 4 ✓ **Trulicity**

### ►SA2509 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Patient has type 2 diabetes; and
- 2 Target HbA1c (of 53 mmol/mol or less) has not been achieved despite the regular use of all of the following funded blood glucose lowering agents for a period of least 6 months, where clinically appropriate: empagliflozin, metformin, and

continued...



Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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## SGLT2 Inhibitors

### ►SA2408 Special Authority for Subsidy

**Initial application — (heart failure reduced ejection fraction)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Patient has heart failure; and
- 2 Patient is in NYHA functional class II or III or IV; and
- 3 Either:
  - 3.1 Patient has a documented left ventricular ejection fraction (LVEF) of less than or equal to 40%; or
  - 3.2 An ECHO is not reasonably practicable, and in the opinion of the treating practitioner the patient would benefit from treatment; and
- 4 Patient is receiving concomitant optimal standard funded chronic heart failure treatment.

**Initial application — (Type 2 Diabetes)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 Patient has previously received an initial approval for a GLP-1 agonist; or
- 2 All of the following:
  - 2.1 Patient has type 2 diabetes; and
  - 2.2 Any of the following:
    - 2.2.1 Patient is Māori or any Pacific ethnicity\*; or
    - 2.2.2 Patient has pre-existing cardiovascular disease or risk equivalent (see note a)\*; or
    - 2.2.3 Patient has an absolute 5-year cardiovascular disease risk of 15% or greater according to a validated cardiovascular risk assessment calculator\*; or
    - 2.2.4 Patient has a high lifetime cardiovascular risk due to being diagnosed with type 2 diabetes during childhood or as a young adult\*; or
    - 2.2.5 Patient has diabetic kidney disease (see note b)\*; and
  - 2.3 Target HbA1c (of 53 mmol/mol or less) has not been achieved despite the regular use of at least one blood-glucose lowering agent (e.g. metformin, vildagliptin, or insulin) for at least 3 months.

Notes: \* Criteria intended to describe patients at high risk of cardiovascular or renal complications of diabetes.

- a) Pre-existing cardiovascular disease or risk equivalent defined as: prior cardiovascular disease event (i.e. angina, myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, transient ischaemic attack, ischaemic stroke, peripheral vascular disease), congestive heart failure or familial hypercholesterolaemia.
- b) Diabetic kidney disease defined as: persistent albuminuria (albumin:creatinine ratio greater than or equal to 3 mg/mmol, in at least two out of three samples over a 3-6 month period) and/or eGFR less than 60 mL/min/1.73m<sup>2</sup> in the presence of diabetes, without alternative cause.
- c) Funded [empagliflozin / empagliflozin with metformin hydrochloride] treatment is not to be given in combination with a funded GLP-1 unless receiving (empagliflozin / empagliflozin with metformin hydrochloride) for the treatment of heart failure.

EMPAGLIFLOZIN – Special Authority see [SA2408 above](#) – Retail pharmacy

* Tab 10 mg .....	58.56	30	✓ <b>Jardiance</b>
* Tab 25 mg .....	58.56	30	✓ <b>Jardiance</b>

EMPAGLIFLOZIN WITH METFORMIN HYDROCHLORIDE – Special Authority see [SA2408 above](#) – Retail pharmacy

* Tab 5 mg with 1,000 mg metformin hydrochloride .....	58.56	60	✓ <b>Jardiamet</b>
* Tab 5 mg with 500 mg metformin hydrochloride .....	58.56	60	✓ <b>Jardiamet</b>
* Tab 12.5 mg with 1,000 mg metformin hydrochloride .....	58.56	60	✓ <b>Jardiamet</b>
* Tab 12.5 mg with 500 mg metformin hydrochloride .....	58.56	60	✓ <b>Jardiamet</b>

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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**Diabetes Management**

**Ketone Testing**

BLOOD KETONE DIAGNOSTIC TEST STRIP – Subsidy by endorsement

- a) Not on a BSO
  - b) Maximum of 20 strip per prescription
  - c) Up to 10 strip available on a PSO
  - d) Patient has any of the following:
    - 1) type 1 diabetes; or
    - 2) permanent neonatal diabetes; or
    - 3) undergone a pancreatectomy; or
    - 4) cystic fibrosis-related diabetes; or
    - 5) metabolic disease or epilepsy under the care of a paediatrician, neurologist or metabolic specialist.
- The prescription must be endorsed accordingly.

Test strips ..... 15.50      10 strip OP      ✓ **KetoSens**

**Dual Blood Glucose and Blood Ketone Testing**

DUAL BLOOD GLUCOSE AND BLOOD KETONE DIAGNOSTIC TEST METER – Subsidy by endorsement

- a) Maximum of 1 pack per prescription
- b) Up to 1 pack available on a PSO
- c) A dual blood glucose and blood ketone diagnostic test meter is subsidised for a patient who has:
  - 1) type 1 diabetes; or
  - 2) permanent neonatal diabetes; or
  - 3) undergone a pancreatectomy; or
  - 4) cystic fibrosis-related diabetes; or
  - 5) metabolic disease or epilepsy under the care of a paediatrician, neurologist or metabolic specialist.

The prescription must be endorsed accordingly. Only 1 meter per patient will be subsidised (no repeat prescriptions). For the avoidance of doubt patients who have previously received a funded meter, other than CareSens, are eligible for a funded CareSens meter.

Meter with 50 lancets, a lancing device and 10 blood glucose  
diagnostic test strips ..... 20.00      1 OP      ✓ **CareSens Dual**

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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## Blood Glucose Testing

**BLOOD GLUCOSE DIAGNOSTIC TEST METER – Subsidy by endorsement**

- a) Maximum of 1 pack per prescription
- b) Up to 1 pack available on a PSO
- c) A diagnostic blood glucose test meter is subsidised for a patient who:
  - 1) is receiving insulin or sulphonylurea therapy; or
  - 2) is pregnant with diabetes; or
  - 3) is on home TPN at risk of hypoglycaemia or hyperglycaemia; or
  - 4) has a genetic or an acquired disorder of glucose homeostasis, excluding type 1 or type 2 diabetes and metabolic syndrome.

The prescription must be endorsed accordingly. Only one CareSens meter per patient will be subsidised (no repeat prescriptions). Patients already using the CareSens N POP meter and CareSens N meter are not eligible for a new meter, unless they have:

- 1) type 1 diabetes; or
- 2) permanent neonatal diabetes; or
- 3) undergone a pancreatectomy; or
- 4) cystic fibrosis-related diabetes.

For the avoidance of doubt patients who have previously received a funded meter, other than CareSens, are eligible for a funded CareSens meter.

Meter with 50 lancets, a lancing device and 10 diagnostic test strips.....	10.00	1 OP	✓ CareSens N ✓ CareSens N POP ✓ CareSens N Premier
	20.00		

Note: Only 1 meter available per PSO

**BLOOD GLUCOSE DIAGNOSTIC TEST STRIP – Up to 50 test available on a PSO**

The number of test strips available on a prescription is restricted to 50 unless:

- 1) Prescribed for a patient on insulin or a sulphonylurea and endorsed accordingly. Pharmacists may annotate the prescription as endorsed where there exists a record of prior dispensing of insulin or sulphonylurea; or
- 2) Prescribed on the same prescription as insulin or a sulphonylurea in which case the prescription is deemed to be endorsed; or
- 3) Prescribed for a pregnant woman with diabetes and endorsed accordingly; or
- 4) Prescribed for a patient on home TPN at risk of hypoglycaemia or hyperglycaemia and endorsed accordingly; or
- 5) Prescribed for a patient with a genetic or an acquired disorder of glucose homeostasis excluding type 1 or type 2 diabetes and metabolic syndrome and endorsed accordingly.

Test strips.....	10.56	50 test OP	✓ CareSens N ✓ CareSens PRO
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**BLOOD GLUCOSE TEST STRIPS (VISUALLY IMPAIRED)**

The number of test strips available on a prescription is restricted to 50 unless:

- 1) Prescribed for a patient on insulin or a sulphonylurea and endorsed accordingly. Pharmacists may annotate the prescription as endorsed where there exists a record of prior dispensing of insulin or sulphonylurea; or
- 2) Prescribed on the same prescription as insulin or a sulphonylurea in which case the prescription is deemed to be endorsed; or
- 3) Prescribed for a pregnant woman with diabetes and endorsed accordingly; or
- 4) Prescribed for a patient on home TPN at risk of hypoglycaemia or hyperglycaemia and endorsed accordingly; or
- 5) Prescribed for a patient with a genetic or an acquired disorder of glucose homeostasis excluding type 1 or type 2 diabetes and metabolic syndrome and endorsed accordingly.

Blood glucose test strips.....	33.69	50 test OP	✓ SensoCard
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Subsidy (Manufacturer's Price)	Fully Subsidised	Brand or Generic Manufacturer
\$	Per ✓	

### Insulin Syringes and Needles

Subsidy is available for disposable insulin syringes, needles, and pen needles if prescribed on the same form as the one used for the supply of insulin or liraglutide or when prescribed for a patient and the prescription is endorsed accordingly. Pharmacists may annotate the prescription as endorsed where there exists a record of prior dispensing of insulin or liraglutide.

#### INSULIN PEN NEEDLES

Maximum of 200 dev per three months

* 29 g x 12.7 mm .....	10.95	100	✓ B-D Micro-Fine
* 31 g x 5 mm .....	12.26	100	✓ B-D Micro-Fine
* 31 g x 6 mm .....	9.50	100	✓ Berpu
* 31 g x 8 mm .....	10.95	100	✓ B-D Micro-Fine
* 32 g x 4 mm .....	10.95	100	✓ B-D Micro-Fine

#### INSULIN SYRINGES, DISPOSABLE WITH ATTACHED NEEDLE

Maximum of 200 dev per three months

* Syringe 0.3 ml with 29 g x 12.7 mm needle .....	13.56	100	✓ B-D Ultra Fine
	1.36	10	
	(1.99)		B-D Ultra Fine
* Syringe 0.3 ml with 31 g x 8 mm needle .....	13.56	100	✓ B-D Ultra Fine II
	1.30	10	
	(1.99)		B-D Ultra Fine II
* Syringe 0.5 ml with 29 g x 12.7 mm needle .....	13.56	100	✓ B-D Ultra Fine
	1.36	10	
	(1.99)		B-D Ultra Fine
* Syringe 0.5 ml with 31 g x 8 mm needle .....	13.56	100	✓ B-D Ultra Fine II
	1.36	10	
	(1.99)		B-D Ultra Fine II
* Syringe 1 ml with 29 g x 12.7 mm needle .....	13.56	100	✓ B-D Ultra Fine
	1.36	10	
	(1.99)		B-D Ultra Fine
* Syringe 1 ml with 31 g x 8 mm needle .....	13.56	100	✓ B-D Ultra Fine II
	1.36	10	
	(1.99)		B-D Ultra Fine II

### Insulin Pumps

INSULIN PUMP WITH ALGORITHM – Special Authority see [SA2367 on the next page](#) – Retail pharmacy

- a) Maximum of 1 dev per prescription
- b) Only on a prescription
- c) Maximum of 1 insulin pump per patient each four year period.

Min basal rate 0.02 U/h .....	8,970.00	1	✓ mylife YpsoPump with CamAPS FX
Min basal rate 0.1 U/h .....	7,653.00	1	✓ Tandem t:slim X2 with Basal-IQ
			✓ Tandem t:slim X2 with Control-IQ+

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
		✓

➔SA2367 **Special Authority for Subsidy**

**Initial application — (type 1 diabetes)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Any of the following:
  - 1.1 The patient has type 1 diabetes; or
  - 1.2 The patient has permanent neonatal diabetes or specific monogenic diabetes subtypes with insulin deficiency, considered by the treating endocrinologist as likely to benefit; or
  - 1.3 The patient has Type 3c diabetes considered by the treating endocrinologist as likely to benefit (Type 3c diabetes includes insulin deficiency due to pancreatectomy, insulin deficiency secondary to cystic fibrosis or pancreatitis); or
  - 1.4 The patient has atypical inherited forms of diabetes; and
- 2 Patient has been evaluated by a diabetes multidisciplinary team for their suitability for insulin pump therapy; and
- 3 In the opinion of the treating relevant practitioner the patient would benefit from an Automated Insulin Delivery (AID) system.

**Renewal — (type 1 diabetes)** from any relevant practitioner. Approvals valid for 6 months where the patient is continuing to derive benefit according to the treatment plan agreed at induction.

**Insulin Pump Consumables**

➔SA2536 **Special Authority for Subsidy**

**Initial application — (type 1 diabetes)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Any of the following:
  - 1.1 The patient has type 1 diabetes; or
  - 1.2 The patient has permanent neonatal diabetes or specific monogenic diabetes subtypes with insulin deficiency, considered by the treating endocrinologist as likely to benefit; or
  - 1.3 The patient has Type 3c diabetes considered by the treating endocrinologist as likely to benefit (Type 3c diabetes includes insulin deficiency due to pancreatectomy, insulin deficiency secondary to cystic fibrosis or pancreatitis); or
  - 1.4 The patient has atypical inherited forms of diabetes; and
- 2 Patient has been evaluated by a diabetes multidisciplinary team for their suitability for insulin pump therapy; and
- 3 In the opinion of the treating relevant practitioner the patient would benefit from an Automated Insulin Delivery (AID) system.

INSULIN PUMP CARTRIDGE – Special Authority see SA2536 above – Retail pharmacy

- a) Only on a prescription
- b) Maximum of 190 cartridges will be funded per year.
- c) Maximum of 50 cart per three months

\* Cartridge 300 u, t:lock x 10 ..... 86.00      10 OP      ✓ Tandem Cartridge

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
INSULIN PUMP INFUSION SET (STEEL CANNULA) – Special Authority see <a href="#">SA2536 on the previous page</a> – Retail pharmacy			
a) Only on a prescription			
b) Maximum of 19 infusion sets will be funded per year.			
c) Maximum of 5 set per three months			
* 6 mm steel needle; 60 cm tubing x 10 .....	219.00	1 OP	✓ MiniMed Sure-T MMT-864A
* 6 mm steel needle; 80 cm tubing x 10 .....	219.00	1 OP	✓ MiniMed Sure-T MMT-866A
* 8 mm steel needle; 60 cm tubing x 10 .....	219.00	1 OP	✓ MiniMed Sure-T MMT-874A
* 8 mm steel needle; 80 cm tubing x 10 .....	219.00	1 OP	✓ MiniMed Sure-T MMT-876A

*(MiniMed Sure-T MMT-864A 6 mm steel needle; 60 cm tubing x 10 to be delisted 1 October 2026)*

*(MiniMed Sure-T MMT-866A 6 mm steel needle; 80 cm tubing x 10 to be delisted 1 October 2026)*

*(MiniMed Sure-T MMT-874A 8 mm steel needle; 60 cm tubing x 10 to be delisted 1 October 2026)*

*(MiniMed Sure-T MMT-876A 8 mm steel needle; 80 cm tubing x 10 to be delisted 1 October 2026)*

INSULIN PUMP INFUSION SET (STEEL CANNULA, STRAIGHT INSERTION) – Special Authority see [SA2536 on the previous page](#) – Retail pharmacy

a) Only on a prescription			
b) Maximum of 19 infusion sets will be funded per year.			
c) Maximum of 5 sets per three months			
* 5.5 mm steel cannula; straight insertion; 45 cm line x 10 with 10 needles .....	136.00	1 OP	✓ mylife Orbit micro
* 5.5 mm steel needle; straight insertion; 60 cm line x 10 with 10 needles .....	136.00	1 OP	✓ mylife Orbit micro
* 5.5 mm steel needle; straight insertion; 80 cm line x 10 with 10 needles .....	136.00	1 OP	✓ mylife Orbit micro
* 8.5 mm steel needle; straight insertion; 60 cm line x 10 with 10 needles .....	136.00	1 OP	✓ mylife Orbit micro
* 8.5 mm steel needle; straight insertion; 80 cm line x 10 with 10 needles .....	136.00	1 OP	✓ mylife Orbit micro
6 mm steel cannula; straight insertion; 80 cm line x 10 with 10 needles .....	182.00	1 OP	✓ TruSteel
8 mm steel cannula; straight insertion; 80 cm line x 10 with 10 needles .....	182.00	1 OP	✓ TruSteel
6 mm steel cannula; straight insertion; 60 cm line x 10 with 10 needles .....	182.00	1 OP	✓ TruSteel
8 mm steel cannula; straight insertion; 60 cm line x 10 with 10 needles .....	182.00	1 OP	✓ TruSteel

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# ALIMENTARY TRACT AND METABOLISM

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Fully Subsidised ✓	Brand or Generic Manufacturer
INSULIN PUMP INFUSION SET (TEFLON CANNULA) – Special Authority see <a href="#">SA2536 on page 18</a> – Retail pharmacy				
a) Only on a prescription				
b) Maximum of 19 infusion sets will be funded per year.				
c) Maximum of 5 set per three months				
* 13 mm teflon needle, 60 cm tubing x 10 .....	219.00	1 OP	✓	<b>MiniMed Silhouette MMT-381A</b>
* 17 mm teflon needle, 110 cm tubing x 10 .....	219.00	1 OP	✓	<b>MiniMed Silhouette MMT-377A</b>
* 17 mm teflon needle, 60 cm tubing x 10 .....	219.00	1 OP	✓	<b>MiniMed Silhouette MMT-378A</b>
* 6 mm teflon needle, 110 cm tubing x 10 .....	219.00	1 OP	✓	<b>MiniMed Quick-Set MMT-398A</b>
* 6 mm teflon needle, 60 cm tubing x 10 .....	219.00	1 OP	✓	<b>MiniMed Quick-Set MMT-399A</b>
* 9 mm teflon needle, 110 cm tubing x 10 .....	219.00	1 OP	✓	<b>MiniMed Quick-Set MMT-396A</b>
* 9 mm teflon needle, 60 cm tubing x 10 .....	219.00	1 OP	✓	<b>MiniMed Quick-Set MMT-397A</b>

*(MiniMed Silhouette MMT-381A 13 mm teflon needle, 60 cm tubing x 10 to be delisted 1 October 2026)*

*(MiniMed Silhouette MMT-377A 17 mm teflon needle, 110 cm tubing x 10 to be delisted 1 October 2026)*

*(MiniMed Silhouette MMT-378A 17 mm teflon needle, 60 cm tubing x 10 to be delisted 1 October 2026)*

*(MiniMed Quick-Set MMT-398A 6 mm teflon needle, 110 cm tubing x 10 to be delisted 1 October 2026)*

*(MiniMed Quick-Set MMT-399A 6 mm teflon needle, 60 cm tubing x 10 to be delisted 1 October 2026)*

*(MiniMed Quick-Set MMT-396A 9 mm teflon needle, 110 cm tubing x 10 to be delisted 1 October 2026)*

*(MiniMed Quick-Set MMT-397A 9 mm teflon needle, 60 cm tubing x 10 to be delisted 1 October 2026)*

## ALIMENTARY TRACT AND METABOLISM

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>INSULIN PUMP INFUSION SET (TEFLON CANNULA, ANGLE INSERTION WITH INSERTION DEVICE) – Special Authority see SA2536 on page 18 – Retail pharmacy</b>				
a) Only on a prescription				
b) Maximum of 19 infusion sets will be funded per year.				
c) Maximum of 5 sets per three months				
* 6 mm teflon cannula; angle insertion; insertion device; 60 cm line x 4 with 4 needles.....	210.00	1 OP	✓	<b>Med Adv Ext Infusion Set MDT-MMT-431AK</b>
* 6 mm teflon cannula; angle insertion; insertion device; 80 cm line x 4 with 4 needles.....	210.00	1 OP	✓	<b>Med Adv Ext Infusion Set MDT-MMT-432AK</b>
* 9 mm teflon cannula; angle insertion; insertion device; 60 cm line x 4 with 4 needles.....	210.00	1 OP	✓	<b>Med Adv Ext Infusion Set MDT-MMT-441AK</b>
* 9 mm teflon cannula; angle insertion; insertion device; 80 cm line x 4 with 4 needles.....	210.00	1 OP	✓	<b>Med Adv Ext Infusion Set MDT-MMT-442AK</b>
* 13 mm teflon cannula; angle insertion; insertion device; 110 cm line x 10 with 10 needles.....	182.00	1 OP	✓	<b>AutoSoft 30</b>
* 13 mm teflon cannula; angle insertion; insertion device; 60 cm line x 10 with 10 needles.....	182.00	1 OP	✓	<b>AutoSoft 30</b>
<i>(Med Adv Ext Infusion Set MDT-MMT-431AK 6 mm teflon cannula; angle insertion; insertion device; 60 cm line x 4 with 4 needles to be delisted 1 October 2026)</i>				
<i>(Med Adv Ext Infusion Set MDT-MMT-432AK 6 mm teflon cannula; angle insertion; insertion device; 80 cm line x 4 with 4 needles to be delisted 1 October 2026)</i>				
<i>(Med Adv Ext Infusion Set MDT-MMT-441AK 9 mm teflon cannula; angle insertion; insertion device; 60 cm line x 4 with 4 needles to be delisted 1 October 2026)</i>				
<i>(Med Adv Ext Infusion Set MDT-MMT-442AK 9 mm teflon cannula; angle insertion; insertion device; 80 cm line x 4 with 4 needles to be delisted 1 October 2026)</i>				
<b>INSULIN PUMP INFUSION SET (TEFLON CANNULA, FLEXIBLE INSERTION WITH INSERTION DEVICE) – Special Authority see SA2536 on page 18 – Retail pharmacy</b>				
a) Only on a prescription				
b) Maximum of 19 infusion sets will be funded per year.				
c) Maximum of 5 set per three months				
* 6 mm teflon cannula; flexible insertion; insertion device; 46 cm line x 10 with 10 needles.....	157.00	1 OP	✓	<b>mylife Inset soft</b>
* 6 mm teflon cannula; flexible insertion; insertion device; 60 cm line with integrated inserter x 10 with 10 needles.....	157.00	1 OP	✓	<b>mylife Inset soft</b>
* 6 mm teflon cannula; flexible insertion; insertion device; 80 cm line x 10 with 10 needles.....	157.00	1 OP	✓	<b>mylife Inset soft</b>
* 9 mm teflon cannula; flexible insertion; insertion device; 60 cm line x 10 with 10 needles.....	157.00	1 OP	✓	<b>mylife Inset soft</b>
* 9 mm teflon cannula; flexible insertion; insertion device; 80 cm line x 10 with 10 needles.....	157.00	1 OP	✓	<b>mylife Inset soft</b>

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# ALIMENTARY TRACT AND METABOLISM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
INSULIN PUMP INFUSION SET (TEFLON CANNULA, STRAIGHT INSERTION WITH INSERTION DEVICE) – Special Authority see <a href="#">SA2536 on page 18</a> – Retail pharmacy				
a) Only on a prescription				
b) Maximum of 19 infusion sets will be funded per year.				
c) Maximum of 5 sets per three months				
* 6 mm teflon cannula; straight insertion; insertion device; 110 cm line x 10 with 10 needles .....	182.00	1 OP	✓	<b>AutoSoft 90</b>
* 6 mm teflon cannula; straight insertion; insertion device; 60 cm line x 10 with 10 needles .....	182.00	1 OP	✓	<b>AutoSoft 90</b>
* 9 mm teflon cannula; straight insertion; insertion device; 110 cm line x 10 with 10 needles .....	182.00	1 OP	✓	<b>AutoSoft 90</b>
* 9 mm teflon cannula; straight insertion; insertion device; 60 cm line x 10 with 10 needles .....	182.00	1 OP	✓	<b>AutoSoft 90</b>
INSULIN PUMP INFUSION SET (TEFLON CANNULA, VARIABLE INSERTION) – Special Authority see <a href="#">SA2536 on page 18</a> – Retail pharmacy				
a) Only on a prescription				
b) Maximum of 19 infusion sets will be funded per year.				
c) Maximum of 5 set per three months				
* 13 mm teflon cannula; variable insertion; 60 cm line x 10 with 10 needles .....	182.00	1 OP	✓	<b>VariSoft</b>
INSULIN PUMP RESERVOIR – Special Authority see <a href="#">SA2536 on page 18</a> – Retail pharmacy				
a) Only on a prescription				
b) Maximum of 360 reservoirs will be funded per year.				
c) Maximum of 90 cart per three months				
* 10 x 1.6 ml glass reservoir for YpsoPump .....	50.00	10 OP	✓	<b>mylife YpsoPump Reservoir</b>
* 10 x luer lock conversion cartridges 1.8 ml for paradigm pumps .....	50.00	10 OP	✓	<b>ADR Cartridge 1.8</b>
* Cartridge for 7 series pump; 3.0 ml x 10 .....	98.00	10 OP	✓	<b>MiniMed 3.0 Reservoir MMT-332A</b>
* Cartridge for 7 series pump; 3.0 ml x 5 .....	102.00	5 OP	✓	<b>MiniMed 3.0 Ext Reservoir MDT-MMT-342G</b>
<i>(ADR Cartridge 1.8 10 x luer lock conversion cartridges 1.8 ml for paradigm pumps to be delisted 1 October 2026)</i>				
<i>(MiniMed 3.0 Reservoir MMT-332A Cartridge for 7 series pump; 3.0 ml x 10 to be delisted 1 October 2026)</i>				
<i>(MiniMed 3.0 Ext Reservoir MDT-MMT-342G Cartridge for 7 series pump; 3.0 ml x 5 to be delisted 1 October 2026)</i>				

## Continuous Glucose Monitor

CONTINUOUS GLUCOSE MONITOR (INTEROPERABLE) – Special Authority see <a href="#">SA2537 on the next page</a> – Retail pharmacy				
Only on a prescription				
* Sensor (9) and transmitter (Dexcom G6) .....	990.00	1 OP	✓	<b>Dexcom G6</b>
a) Maximum of 5 dev will be funded per year.				
b) Maximum of 1 dev per three months				
* Sensor (Dexcom G7) .....	110.00	1	✓	<b>Dexcom G7</b>
a) Maximum of 40 dev will be funded per year.				
b) Maximum of 9 dev per three months				
* Sensor (Freestyle Libre 3 Plus) .....	99.46	1	✓	<b>Freestyle Libre 3 Plus</b>
a) Maximum of 28 dev will be funded per year.				
b) Maximum of 6 dev per three months				

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

►SA2537 Special Authority for Subsidy

**Initial application — (type 1 diabetes)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

- Both:
- 1 Any of the following:
    - 1.1 The patient has type 1 diabetes; or
    - 1.2 The patient has permanent neonatal diabetes or specific monogenic diabetes subtypes with insulin deficiency, considered by the treating endocrinologist or relevant secondary health care professional as practicable, as likely to benefit; or
    - 1.3 The patient has Type 3c diabetes considered by the treating endocrinologist or relevant secondary health care professional as practicable, as likely to benefit (Type 3c diabetes includes insulin deficiency due to pancreatectomy, insulin deficiency secondary to cystic fibrosis or pancreatitis); or
    - 1.4 The patient has atypical inherited forms of diabetes; and
  - 2 In the opinion of the treating relevant practitioner the patient would benefit from an Automated Insulin Delivery (AID) system.

CONTINUOUS GLUCOSE MONITOR (STANDALONE) – Special Authority see SA2538 below – Retail pharmacy

Only on a prescription			
* Sensor (Dexcom ONE+).....	81.00	1	✓ Dexcom ONE+
a) Maximum of 40 dev will be funded per year.			
b) Maximum of 9 dev per three months			
* Sensor (Freestyle Libre 2 Plus).....	99.46	1	✓ Freestyle Libre 2 Plus
a) Maximum of 28 dev will be funded per year.			
b) Maximum of 6 dev per three months			

►SA2538 Special Authority for Subsidy

**Initial application — (type 1 diabetes)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

- Any of the following:
- 1 The patient has type 1 diabetes; or
  - 2 The patient has permanent neonatal diabetes or specific monogenic diabetes subtypes with insulin deficiency, considered by the treating endocrinologist or relevant secondary health care professional as practicable, as likely to benefit; or
  - 3 The patient has Type 3c diabetes considered by the treating endocrinologist or relevant secondary health care professional as practicable, as likely to benefit (Type 3c diabetes includes insulin deficiency due to pancreatectomy, insulin deficiency secondary to cystic fibrosis or pancreatitis); or
  - 4 The patient has atypical inherited forms of diabetes.

**Digestives Including Enzymes**

PANCREATIC ENZYME

Cap pancreatin 150 mg (amylase 8,000 Ph Eur U, lipase 10,000 Ph Eur U, total protease 600 Ph Eur U) .....	34.93	100	✓ Creon 10000
Cap pancreatin 300 mg (amylase 18,000 Ph Eur U, lipase 25,000 Ph Eur U, total protease 1,000 Ph Eur U) .....	94.38	100	✓ Creon 25000
Modified release granules pancreatin 60.12 mg (amylase 3,600 Ph Eur U, lipase 5,000 Ph Eur U, protease 200 Ph Eur U) .....	34.93	20 g OP	✓ Creon Micro
URSODEOXYCHOLIC ACID – Special Authority see SA2448 on the next page – Retail pharmacy			
Cap 250 mg.....	33.95	100	✓ Ursosan

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# ALIMENTARY TRACT AND METABOLISM

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

## ►SA2448 Special Authority for Subsidy

**Initial application — (Alagille syndrome or progressive familial intrahepatic cholestasis)** from any relevant practitioner.

Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 Patient has been diagnosed with Alagille syndrome; or
- 2 Patient has progressive familial intrahepatic cholestasis.

**Initial application — (Chronic severe drug induced cholestatic liver injury)** from any relevant practitioner. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 Patient has chronic severe drug induced cholestatic liver injury; and
- 2 Cholestatic liver injury not due to Total Parenteral Nutrition (TPN) use in adults; and
- 3 Treatment with ursodeoxycholic acid may prevent hospital admission or reduce duration of stay.

**Initial application — (Primary biliary cholangitis)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Primary biliary cholangitis confirmed by antimitochondrial antibody titre (AMA) > 1:80, and raised cholestatic liver enzymes with or without raised serum IgM or, if AMA is negative, by liver biopsy; and
- 2 Patient not requiring a liver transplant (bilirubin > 100 umol/l; decompensated cirrhosis).

**Initial application — (Pregnancy)** from any relevant practitioner. Approvals valid for 6 months where the patient diagnosed with cholestasis of pregnancy.

**Initial application — (Haematological Transplant)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Patient at risk of veno-occlusive disease or has hepatic impairment and is undergoing conditioning treatment prior to allogeneic stem cell or bone marrow transplantation; and
- 2 Treatment for up to 13 weeks.

**Initial application — (Total parenteral nutrition induced cholestasis)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Paediatric patient has developed abnormal liver function as indicated on testing which is likely to be induced by Total Parenteral Nutrition (TPN); and
- 2 Liver function has not improved with modifying the TPN composition.

**Renewal — (Chronic severe drug induced cholestatic liver injury)** from any relevant practitioner. Approvals valid for 6 months where the patient continues to benefit from treatment.

**Renewal — (Pregnancy/Primary biliary cholangitis)** from any relevant practitioner. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefiting from treatment.

**Renewal — (Total parenteral nutrition induced cholestasis)** from any relevant practitioner. Approvals valid for 6 months where the paediatric patient continues to require TPN and who is benefiting from treatment, defined as a sustained improvement in bilirubin levels.

**Initial application — (prevention of sinusoidal obstruction syndrome)** from any relevant practitioner. Approvals valid without further renewal unless notified where the individual has leukaemia/lymphoma and requires prophylaxis for medications/therapies with a high risk of sinusoidal obstruction syndrome.

## Laxatives

### Bulk-forming Agents

ISPAGHULA (PSYLLIUM) HUSK – Only on a prescription

\* Powder for oral soln.....22.10 500 g OP ✓ **Konsyl-D**

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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**Faecal Softeners**

DOCUSATE SODIUM – Only on a prescription

* Tab 50 mg .....	3.20	100	✓	<b>Coloxyl</b>
* Tab 120 mg .....	4.98	100	✓	<b>Coloxyl</b>

DOCUSATE SODIUM WITH SENNOSIDES

Tab 50 mg with sennosides 8 mg .....	1.50	100	✓	<b>Solax</b>
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POLOXAMER – Only on a prescription

Not funded for use in the ear.

* Oral drops 10%.....	4.17	30 ml OP	✓	<b>Coloxyl</b>
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**Opioid Receptor Antagonists - Peripheral**

METHYLNALTREXONE BROMIDE – Special Authority see [SA1691 below](#) – Retail pharmacy

Inj 12 mg per 0.6 ml vial .....	36.00	1	✓	<b>Relistor</b>
	246.00	7	✓	<b>Relistor</b>

►[SA1691](#) **Special Authority for Subsidy**

**Initial application — (Opioid induced constipation)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 The patient is receiving palliative care; and
- 2 Either:
  - 2.1 Oral and rectal treatments for opioid induced constipation are ineffective; or
  - 2.2 Oral and rectal treatments for opioid induced constipation are unable to be tolerated.

**Osmotic Laxatives**

GLYCEROL

* Suppos 2.8/4.0 g – Only on a prescription .....	12.39	20	✓	<b>Lax-suppositories Glycerol</b>
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LACTULOSE – Only on a prescription

* Oral liq 10 g per 15 ml .....	6.16	500 ml	✓	<b>Laevolac</b>
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MACROGOL 3350 WITH POTASSIUM CHLORIDE, SODIUM BICARBONATE AND SODIUM CHLORIDE

Powder for oral soln 13.125 g with potassium chloride 46.6 mg, sodium bicarbonate 178.5 mg and sodium chloride 350.7 mg.....	10.15	30	✓	<b>Molaxole</b>
	12.19		✓	<b>Movicol</b>

SODIUM ACID PHOSPHATE – Only on a prescription

Enema 16% with sodium phosphate 8% .....	3.70	1	✓	<b>Fleet Phosphate Enema</b>
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SODIUM CITRATE WITH SODIUM LAURYL SULPHOACETATE – Only on a prescription

Enema 90 mg with sodium lauryl sulphoacetate 9 mg per ml, 5 ml.....	36.89	50	✓	<b>Micolette</b>
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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>Stimulant Laxatives</b>				
BISACODYL – Only on a prescription				
* Tab 5 mg .....	6.28	200	✓	<b>Bisacodyl-AFT</b>
	10.00			✓ <b>Bisacodyl Viatris</b>
Bisacodyl-AFT to be Principal Supply on 1 July 2026				
* Suppos 10 mg .....	4.14	10	✓	<b>Lax-Suppositories</b>
<i>(Bisacodyl Viatris Tab 5 mg to be delisted 1 July 2026)</i>				
SENNA – Only on a prescription				
* Tab, standardised .....	2.17	100		
	(9.38)			Senokot
	0.43	20		
	(2.06)			Senokot
SODIUM PICOSULFATE – Special Authority see <a href="#">SA2053 below</a> – Retail pharmacy				
Oral soln 7.5 mg per ml .....	7.40	30 ml OP	✓	<b>Dulcolax SP Drop</b>

➔ **SA2053 Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:  
Both:

- 1 The patient is a child with problematic constipation despite an adequate trial of other oral pharmacotherapies including macrogol where practicable; and
- 2 The patient would otherwise require a high-volume bowel cleansing preparation or hospital admission.

**Renewal** from any relevant practitioner. Approvals valid for 12 months where the treatment remains appropriate and the patient is benefiting from treatment.

## Metabolic Disorder Agents

ALGLUCOSIDASE ALFA – Special Authority see [SA1986 below](#) – Retail pharmacy

Inj 50 mg vial ..... 1,142.60 1 ✓ **Myozyme**

➔ **SA1986 Special Authority for Subsidy**

**Initial application** only from a metabolic physician. Approvals valid for 12 months for applications meeting the following criteria:  
All of the following:

- 1 The patient is aged up to 24 months at the time of initial application and has been diagnosed with infantile Pompe disease; and
- 2 Any of the following:
  - 2.1 Diagnosis confirmed by documented deficiency of acid alpha-glucosidase by prenatal diagnosis using chorionic villus biopsies and/or cultured amniotic cells; or
  - 2.2 Documented deficiency of acid alpha-glucosidase, and urinary tetrasaccharide testing indicating a diagnostic elevation of glucose tetrasaccharides; or
  - 2.3 Documented deficiency of acid alpha-glucosidase, and documented molecular genetic testing indicating a disease-causing mutation in the acid alpha-glucosidase gene (GAA gene); or
  - 2.4 Documented urinary tetrasaccharide testing indicating a diagnostic elevation of glucose tetrasaccharides, and molecular genetic testing indicating a disease-causing mutation in the GAA gene; and
- 3 Patient has not required long-term invasive ventilation for respiratory failure prior to starting enzyme replacement therapy (ERT); and
- 4 Patient does not have another life-threatening or severe disease where the prognosis is unlikely to be influenced by ERT or might be reasonably expected to compromise a response to ERT; and
- 5 Alglucosidase alfa to be administered at doses no greater than 20 mg/kg every 2 weeks.

**Renewal** only from a metabolic physician. Approvals valid for 12 months for applications meeting the following criteria:

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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continued...

All of the following:

- 1 The treatment remains appropriate for the patient and the patient is benefiting from treatment; and
- 2 Aglucosidase alfa to be administered at doses no greater than 20 mg/kg every 2 weeks; and
- 3 Patient has not had severe infusion-related adverse reactions which were not preventable by appropriate pre-medication and/or adjustment of infusion rates; and
- 4 Patient has not developed another life threatening or severe disease where the long term prognosis is unlikely to be influenced by ERT; and
- 5 Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT; and
- 6 There is no evidence of life threatening progression of respiratory disease as evidenced by the needed for > 14 days of invasive ventilation; and
- 7 There is no evidence of new or progressive cardiomyopathy.

ARGININE – Special Authority see [SA2042 below](#) – Retail pharmacy

Tab 1,000 mg .....	CBS	90	✓ Clinicians
Cap 500 mg .....	CBS	50	✓ Solgar
Powder .....	CBS	400 g	✓ Biomed

► **SA2042** Special Authority for Subsidy

**Initial application** only from a metabolic physician. Approvals valid for 6 months where patient has a suspected inborn error of metabolism that may respond to arginine supplementation.

**Renewal** only from a metabolic physician. Approvals valid for 24 months for applications meeting the following criteria:

Both:

- 1 The patient has a confirmed diagnosis of an inborn error of metabolism that responds to arginine supplementation; and
- 2 The treatment remains appropriate and the patient is benefiting from treatment.

BETAINE – Special Authority see [SA1987 below](#) – Retail pharmacy

Powder for oral soln.....	575.00	180 g OP	✓ Cystadane
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► **SA1987** Special Authority for Subsidy

**Initial application** only from a metabolic physician. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has a confirmed diagnosis of homocystinuria; and
- 2 Any of the following:
  - 2.1 A cystathionine beta-synthase (CBS) deficiency; or
  - 2.2 A 5,10-methylene-tetrahydrofolate reductase (MTHFR) deficiency; or
  - 2.3 A disorder of intracellular cobalamin metabolism; and
- 3 An appropriate homocysteine level has not been achieved despite a sufficient trial of appropriate vitamin supplementation.

**Renewal** only from a metabolic physician. Approvals valid for 12 months where the treatment remains appropriate and the patient is benefiting from treatment.

COENZYME Q10 – Special Authority see [SA2039 below](#) – Retail pharmacy

Cap 120 mg .....	CBS	30	✓ Solgar
Cap 160 mg .....	CBS	60	✓ Go Healthy

► **SA2039** Special Authority for Subsidy

**Initial application** only from a metabolic physician. Approvals valid for 6 months where patient has a suspected inborn error of metabolism that may respond to coenzyme Q10 supplementation.

**Renewal** only from a metabolic physician. Approvals valid for 24 months for applications meeting the following criteria:

Both:

- 1 The patient has a confirmed diagnosis of an inborn error of metabolism that responds to coenzyme Q10 supplementation; and
- 2 The treatment remains appropriate and the patient is benefiting from treatment.

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# ALIMENTARY TRACT AND METABOLISM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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GALSULFASE – Special Authority see [SA1988 below](#) – Retail pharmacy

Inj 1 mg per ml, 5 ml vial.....2,234.00      1      ✓ Naglazyme

➔**SA1988** Special Authority for Subsidy

**Initial application** only from a metabolic physician. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 The patient has been diagnosed with mucopolysaccharidosis VI; and
- 2 Either:
  - 2.1 Diagnosis confirmed by demonstration of N-acetyl-galactosamine-4-sulfatase (arylsulfatase B) deficiency by either enzyme activity assay in leukocytes or skin fibroblasts; or
  - 2.2 Detection of two disease causing mutations and patient has a sibling who is known to have mucopolysaccharidosis VI.

**Renewal** only from a metabolic physician. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The treatment remains appropriate for the patient and the patient is benefiting from treatment; and
- 2 Patient has not had severe infusion-related adverse reactions which were not preventable by appropriate pre-medication and/or adjustment of infusion rates; and
- 3 Patient has not developed another life threatening or severe disease where the long term prognosis is unlikely to be influenced by Enzyme Replacement Therapy (ERT); and
- 4 Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT.

IDURSULFASE – Special Authority see [SA1623 below](#) – Retail pharmacy

Inj 2 mg per ml, 3 ml vial.....4,608.30      1      ✓ Elaprase

➔**SA1623** Special Authority for Subsidy

**Initial application** only from a metabolic physician. Approvals valid for 24 weeks for applications meeting the following criteria:

All of the following:

- 1 The patient has been diagnosed with Hunter Syndrome (mucopolysaccharidosis II); and
- 2 Either:
  - 2.1 Diagnosis confirmed by demonstration of iduronate 2-sulfatase deficiency in white blood cells by either enzyme assay in cultured skin fibroblasts; or
  - 2.2 Detection of a disease causing mutation in the iduronate 2-sulfatase gene; and
- 3 Patient is going to proceed with a haematopoietic stem cell transplant (HSCT) within the next 3 months and treatment with idursulfase would be bridging treatment to transplant; and
- 4 Patient has not required long-term invasive ventilation for respiratory failure prior to starting Enzyme Replacement Therapy (ERT); and
- 5 Idursulfase to be administered for a total of 24 weeks (equivalent to 12 weeks pre- and 12 weeks post-HSCT) at doses no greater than 0.5 mg/kg every week.

LARONIDASE – Special Authority see [SA1695 below](#) – Retail pharmacy

Inj 100 U per ml, 5 ml vial.....1,335.16      1      ✓ Aldurazyme

➔**SA1695** Special Authority for Subsidy

**Initial application** only from a metabolic physician. Approvals valid for 24 weeks for applications meeting the following criteria:

All of the following:

- 1 The patient has been diagnosed with Hurler Syndrome (mucopolysaccharidosis I-H); and
- 2 Either:
  - 2.1 Diagnosis confirmed by demonstration of alpha-L-iduronidase deficiency in white blood cells by either enzyme assay in cultured skin fibroblasts; or
  - 2.2 Detection of two disease causing mutations in the alpha-L-iduronidase gene and patient has a sibling who is known to have Hurler syndrome; and

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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continued...

- 3 Patient is going to proceed with a haematopoietic stem cell transplant (HSCT) within the next 3 months and treatment with laronidase would be bridging treatment to transplant; and
- 4 Patient has not required long-term invasive ventilation for respiratory failure prior to starting Enzyme Replacement Therapy (ERT); and
- 5 Laronidase to be administered for a total of 24 weeks (equivalent to 12 weeks pre- and 12 post-HSCT) at doses no greater than 100 units/kg every week.

LEVOCARNITINE – Special Authority see [SA2040 below](#) – Retail pharmacy

Tab 500 mg .....	CBS	30	✓ Solgar
Cap 250 mg .....	CBS	30	✓ Solgar
Cap 500 mg .....	CBS	60	✓ Balance
		300	✓ Metabolics
Oral liq 1 g per 10 ml .....	CBS	118 ml	✓ Lacuna <sup>S29</sup>
Oral liq 500 mg per 10 ml .....	CBS	300 ml	✓ Balance

► **SA2040** Special Authority for Subsidy

**Initial application** only from a metabolic physician. Approvals valid for 6 months where patient has a suspected inborn error of metabolism that may respond to carnitine supplementation.

**Renewal** only from a metabolic physician. Approvals valid for 24 months for applications meeting the following criteria:

- Both:
- 1 The patient has a confirmed diagnosis of an inborn error of metabolism that responds to carnitine supplementation; and
  - 2 The treatment remains appropriate and the patient is benefiting from treatment.

NITISINONE – Special Authority see [SA2561 below](#) – Retail pharmacy

Cap 2 mg .....	676.00	60	✓ Nitisinone LogixX Pharma
Nitisinone LogixX Pharma to be Principal Supply on 1 July 2026			
Cap 5 mg .....	1,302.00	60	✓ Nitisinone LogixX Pharma
Nitisinone LogixX Pharma to be Principal Supply on 1 July 2026			
Cap 10 mg .....	1,704.00	60	✓ Nitisinone LogixX Pharma
Nitisinone LogixX Pharma to be Principal Supply on 1 July 2026			

► **SA2561** Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified where patient requires nitisinone for the management of inherited metabolic disorders.

RIBOFLAVIN – Special Authority see [SA2041 below](#) – Retail pharmacy

Tab 100 mg .....	CBS	100	✓ Country Life ✓ Puritan's Pride Vitamin B-2 100 mg <sup>S29</sup>
Cap 100 mg .....	CBS	100	✓ Solgar

► **SA2041** Special Authority for Subsidy

**Initial application** only from a metabolic physician or neurologist. Approvals valid for 6 months where patient has a suspected inborn error of metabolism that may respond to riboflavin supplementation.

**Renewal** only from a metabolic physician or neurologist. Approvals valid for 24 months for applications meeting the following criteria:

- Both:
- 1 The patient has a confirmed diagnosis of an inborn error of metabolism that responds to riboflavin supplementation; and
  - 2 The treatment remains appropriate and the patient is benefiting from treatment.

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# ALIMENTARY TRACT AND METABOLISM

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
SAPROPTERIN DIHYDROCHLORIDE – Special Authority see <a href="#">SA1989 below</a> – Retail pharmacy			
Tab soluble 100 mg.....	1,452.70	30 OP	✓ <b>Kuvan</b>

➔ **SA1989** **Special Authority for Subsidy**

**Initial application** only from a metabolic physician. Approvals valid for 1 month for applications meeting the following criteria:  
All of the following:

- 1 Patient has phenylketonuria (PKU) and is pregnant or actively planning to become pregnant; and
- 2 Treatment with sapropterin is required to support management of PKU during pregnancy; and
- 3 Sapropterin to be administered at doses no greater than a total daily dose of 20 mg/kg; and
- 4 Sapropterin to be used alone or in combination with PKU dietary management; and
- 5 Total treatment duration with sapropterin will not exceed 22 months for each pregnancy (includes time for planning and becoming pregnant) and treatment will be stopped after delivery.

**Renewal** only from a metabolic physician or any relevant practitioner on the recommendation of a metabolic physician.

Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Either:
  - 1.1 Following the initial one-month approval, the patient has demonstrated an adequate response to a 2 to 4 week trial of sapropterin with a clinically appropriate reduction in phenylalanine levels to support management of PKU during pregnancy; or
  - 1.2 On subsequent renewal applications, the patient has previously demonstrated response to treatment with sapropterin and maintained adequate phenylalanine levels to support management of PKU during pregnancy; and
- 2 Any of the following:
  - 2.1 Patient continues to be pregnant and treatment with sapropterin will not continue after delivery; or
  - 2.2 Patient is actively planning a pregnancy and this is the first renewal for treatment with sapropterin; or
  - 2.3 Treatment with sapropterin is required for a second or subsequent pregnancy to support management of their PKU during pregnancy; and
- 3 Sapropterin to be administered at doses no greater than a total daily dose of 20 mg/kg; and
- 4 Sapropterin to be used alone or in combination with PKU dietary management; and
- 5 Total treatment duration with sapropterin will not exceed 22 months for each pregnancy (includes time for planning and becoming pregnant) and treatment will be stopped after delivery.

SODIUM BENZOATE – Special Authority see [SA1599 below](#) – Retail pharmacy

Soln 100 mg per ml.....	CBS	100 ml	✓ <b>Amzoate</b> <sup>S29</sup>
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➔ **SA1599** **Special Authority for Subsidy**

**Initial application** only from a metabolic physician. Approvals valid for 12 months where the patient has a diagnosis of a urea cycle disorder.

**Renewal** only from a metabolic physician. Approvals valid for 12 months where the treatment remains appropriate and the patient is benefiting from treatment.

SODIUM PHENYLBUTYRATE – Special Authority see [SA1990 below](#) – Retail pharmacy

Grans 483 mg per g.....	2,016.00	174 g OP	✓ <b>Pheburane</b>
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➔ **SA1990** **Special Authority for Subsidy**

**Initial application** only from a metabolic physician. Approvals valid for 12 months where the patient has a diagnosis of a urea cycle disorder involving a deficiency of carbamylphosphate synthetase, ornithine transcarbamylase or argininosuccinate synthetase.

**Renewal** only from a metabolic physician. Approvals valid for 12 months where the treatment remains appropriate and the patient is benefiting from treatment.

TAURINE – Special Authority see [SA2043 on the next page](#) – Retail pharmacy

Cap 500 mg.....	CBS	50	✓ <b>Solgar</b>
Cap 1,000 mg.....	CBS	90	✓ <b>Life Extension</b>
Powder.....	CBS	300 g	✓ <b>Life Extension</b>

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

►SA2043 Special Authority for Subsidy

**Initial application** only from a metabolic physician. Approvals valid for 6 months where patient has a suspected specific mitochondrial disorder that may respond taurine supplementation.

**Renewal** only from a metabolic physician. Approvals valid for 24 months for applications meeting the following criteria:

- Both:
- 1 The patient has confirmed diagnosis of a specific mitochondrial disorder which responds to taurine supplementation; and
  - 2 The treatment remains appropriate and the patient is benefiting from treatment.

TRIENTINE – Special Authority see SA2324 below – Retail pharmacy

Cap 250 mg.....	2,022.00	100	✓ Trientine Waymade
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►SA2324 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Patient has confirmed Wilson disease; and
- 2 Treatment with D-penicillamine has been trialled and discontinued because the person has experienced intolerable side effects or has not received sufficient benefit; and
- 3 Treatment with zinc has been trialled and discontinued because the person has experienced intolerable side effects or has not received sufficient benefit, or zinc is considered clinically inappropriate as the person has symptomatic liver disease and requires copper chelation.

**Gaucher's Disease**

TALIGLUCERASE ALFA – Special Authority see SA2137 below – Retail pharmacy

Inj 200 unit vial.....	1,072.00	1	✓ Eleyso
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►SA2137 Special Authority for Subsidy

**Initial application** only from a metabolic physician. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has a diagnosis of symptomatic type 1 or type 3\* Gaucher disease confirmed by the demonstration of specific deficiency of glucocerebrosidase in leukocytes or cultured skin fibroblasts, and genotypic analysis; and
- 2 Patient does not have another life-threatening or severe disease where the prognosis is unlikely to be influenced by enzyme replacement therapy (ERT) or the disease might be reasonably expected to compromise a response to ERT; and
- 3 Any of the following:
  - 3.1 Patient has haematological complications of Gaucher disease; or
  - 3.2 Patient has skeletal complications of Gaucher disease; or
  - 3.3 Patient has significant liver dysfunction or hepatomegaly attributable to Gaucher disease; or
  - 3.4 Patient has reduced vital capacity from clinically significant or progressive pulmonary disease due to Gaucher disease; or
  - 3.5 Patient is a child and has experienced growth failure with significant decrease in percentile linear growth over a 6-12 month period; and
- 4 Taliglucerase alfa is to be administered at a dose no greater than 30 unit/kg every other week rounded to the nearest whole vial (200 units).

Note: Indication marked with \* is an unapproved indication

**Renewal** only from a metabolic physician or any relevant practitioner on the recommendation of a metabolic physician.

Approvals valid for 3 years for applications meeting the following criteria:

All of the following:

- 1 Patient has demonstrated a symptomatic improvement and has maintained improvements in the main symptom or symptoms for which therapy was started; and

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# ALIMENTARY TRACT AND METABOLISM

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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continued...

- 2 Patient has demonstrated a clinically objective improvement or no deterioration in haemoglobin levels, platelet counts and liver and spleen size; and
- 3 Radiological (MRI) signs of bone activity performed at two years since initiation of treatment, and five yearly thereafter, demonstrate no deterioration shown by the MRI, compared with MRI taken immediately prior to commencement of therapy or adjusted dose; and
- 4 Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT; and
- 5 Patient is adherent with regular treatment and taliglucerase alfa is to be administered at a dose no greater than 30 unit/kg every other week rounded to the nearest whole vial (200 units).

## Mouth and Throat

### Agents Used in Mouth Ulceration

#### BENZDAMINE HYDROCHLORIDE

Soln 0.15% – Higher subsidy of \$22.60 per 500 ml with Endorsement .....	9.00 (22.60)	500 ml	Diffiam
Additional subsidy by endorsement for a patient who has oral mucositis as a result of treatment for cancer, and the prescription is endorsed accordingly.			

#### CARMELLOSE SODIUM WITH GELATIN AND PECTIN

Paste .....	17.20	56.7 g OP	✓ <b>Stomahesive</b>
	1.52	5 g OP	
	(3.60)		Orabase
Powder .....	8.48	28 g OP	
	(10.95)		Stomahesive

(Orabase Paste to be delisted 1 August 2026)

#### TRIAMCINOLONE ACETONIDE

Paste 0.1% .....	5.49	5 g OP	✓ <b>Kenalog in Orabase</b>
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### Oropharyngeal Anti-infectives

#### AMPHOTERICIN B

Lozenges 10 mg .....	5.86	20	✓ <b>Fungilin</b>
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#### MICONAZOLE

Oral gel 20 mg per g .....	5.19	40 g OP	✓ <b>Decozol</b>
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#### NYSTATIN

Oral liq 100,000 u per ml .....	2.22	24 ml OP	✓ <b>Niostat</b>
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## Vitamins

### Vitamin B

#### HYDROXOCOBALAMIN

* Inj 1 mg per ml, 1 ml ampoule – Up to 6 inj available on a PSO .....	3.95	3	✓ <b>Hydroxocobalamin Panpharma</b>
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	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>PYRIDOXINE HYDROCHLORIDE</b>				
a) No more than 100 mg per dose				
b) Only on a prescription				
* Tab 25 mg – No patient co-payment payable.....	3.43	90	✓	<b>Vitamin B6 25</b>
* Tab 50 mg .....	23.45	500	✓	<b>Pyridoxine multichem</b>
<b>THIAMINE HYDROCHLORIDE – Only on a prescription</b>				
* Tab 50 mg .....	4.65	100	✓	<b>Thiamine multichem</b>
<b>VITAMIN B COMPLEX</b>				
* Tab, strong, BPC.....	11.25	500	✓	<b>Bplex</b>

**Vitamin C**

<b>ASCORBIC ACID</b>				
a) No more than 100 mg per dose				
b) Only on a prescription				
* Tab 100 mg .....	16.00	500	✓	<b>Cvite</b>

**Vitamin D**

<b>ALFACALCIDOL</b>				
* Cap 0.25 mcg .....	26.32	100	✓	<b>One-Alpha</b>
* Cap 1 mcg .....	87.98	100	✓	<b>One-Alpha</b>
* Oral drops 2 mcg per ml.....	60.68	20 ml OP	✓	<b>One-Alpha</b>
<b>CALCITRIOL</b>				
* Cap 0.25 mcg .....	7.89	100	✓	<b>Calcitriol XL <sup>S29</sup></b>
			✓	<b>Calcitriol-AFT</b>
* Cap 0.5 mcg .....	13.68	100	✓	<b>Calcitriol XL <sup>S29</sup></b>
			✓	<b>Calcitriol-AFT</b>
<b>COLECALCIFEROL</b>				
* Cap 1.25 mg (50,000 iu).....	3.65	12	✓	<b>Vit.D3</b>
Maximum of 12 cap per three months				
* Oral liq 188 mcg per ml (7,500 iu per ml) .....	9.00	5 ml OP	✓	<b>Clinicians</b>

**Multivitamin Preparations**

<b>MULTIVITAMIN RENAL – Special Authority see SA1546 below – Retail pharmacy</b>				
* Cap.....	7.28	30	✓	<b>Clinicians Renal Vit</b>

►SA1546 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 The patient has chronic kidney disease and is receiving either peritoneal dialysis or haemodialysis; or
- 2 The patient has chronic kidney disease grade 5, defined as patient with an estimated glomerular filtration rate of < 15 ml/min/1.73 m<sup>2</sup> body surface area (BSA).

<b>MULTIVITAMINS – Special Authority see SA1036 on the next page – Retail pharmacy</b>				
* Powder .....	74.88	200 g OP	✓	<b>Paediatric Seravit</b>

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# ALIMENTARY TRACT AND METABOLISM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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## ►SA1036 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified where the patient has inborn errors of metabolism.

**Renewal** from any relevant practitioner. Approvals valid without further renewal unless notified where patient has had a previous approval for multivitamins.

### VITAMINS

* Tab (BPC cap strength).....	24.00	1,000	✓	<b>Mvite</b>
* Cap (fat soluble vitamins A, D, E, K) – Special Authority see SA1720 below – Retail pharmacy .....	23.40	60	✓	<b>Vitabdeck</b>

## ►SA1720 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Any of the following:

- 1 Patient has cystic fibrosis with pancreatic insufficiency; or
- 2 Patient is an infant or child with liver disease or short gut syndrome; or
- 3 Patient has severe malabsorption syndrome.

## Minerals

### Calcium

#### CALCIUM CARBONATE

* Tab 1.25 g (500 mg elemental) .....	7.28	250	✓	<b>Calci-Tab 500</b>
* Tab eff 1.25 g (500 mg elemental) – Subsidy by endorsement.....	260.00	100	✓	<b>Calcium 500 mg Hexal <sup>S29</sup></b>

Subsidy by endorsement – Only when prescribed for paediatric patients (< 5 years) where calcium carbonate oral liquid is considered unsuitable.

#### CALCIUM GLUCONATE

* Inj 10%, 10 ml ampoule .....	32.00	10	✓	<b>Max Health - Hameln <sup>S29</sup></b>
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### Iodine

#### POTASSIUM IODATE

* Tab 253 mcg (150 mcg elemental iodine) .....	5.99	90	✓	<b>NeuroTabs</b>
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### Iron

#### FERROUS FUMARATE

* Tab 200 mg (65.7 mg elemental) .....	3.49	100	✓	<b>Ferro-tab</b>
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#### FERROUS FUMARATE WITH FOLIC ACID

* Tab 310 mg (100 mg elemental) with folic acid 350 mcg .....	5.98	100	✓	<b>Ferro-F-Tabs</b>
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#### FERROUS SULFATE

* Oral liq 30 mg (6 mg elemental) per 1 ml .....	10.25	250 ml	✓	<b>Ferro-Liquid</b>
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IRON (AS FERRIC CARBOXYMALTOSE) – Special Authority see SA2394 on the next page – Retail pharmacy

Inj 50 mg per ml, 10 ml vial.....	150.00	1	✓	<b>Ferinject</b>
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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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►SA2394 **Special Authority for Subsidy**

**Initial application — (Anaemia)** from any relevant practitioner. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 Patient has been diagnosed with anaemia; and
- 2 Any of the following:
  - 2.1 Serum ferritin level is 20 mcg/L or less; or
  - 2.2 Both:
    - 2.2.1 Serum ferritin is between 20 and 50 mcg/L; and
    - 2.2.2 C-Reactive Protein (CRP) is at least 5 mg/L; or
  - 2.3 Patient has chronic inflammatory disease with symptoms of anaemia despite normal iron levels; and
- 3 Any of the following:
  - 3.1 Oral iron treatment has proven ineffective; or
  - 3.2 Oral iron treatment has resulted in dose-limiting intolerance; or
  - 3.3 Rapid correction of anaemia is required.

**Renewal — (Anaemia)** from any relevant practitioner. Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 Patient continues to have anaemia with a serum ferritin level of 20 mcg/L, or less or between 20 and 50 mcg/L with CRP of at least 5 mg/L, or has chronic inflammatory disease with symptoms of anaemia despite normal iron levels; and
- 2 A trial (or re-trial) with oral iron is clinically inappropriate.

**Initial application — (iron deficiency anaemia)** only from an internal medicine physician, obstetrician, gynaecologist, anaesthetist or medical practitioner on the recommendation of a internal medicine physician, obstetrician, gynaecologist or anaesthetist. Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 Patient has been diagnosed with iron-deficiency anaemia; and
- 2 Any of the following:
  - 2.1 Patient has been compliant with oral iron treatment and treatment has proven ineffective; or
  - 2.2 Treatment with oral iron has resulted in dose-limiting intolerance; or
  - 2.3 Patient has symptomatic heart failure, chronic kidney disease stage 3 or more or active inflammatory bowel disease and a trial of oral iron is unlikely to be effective; or
  - 2.4 Rapid correction of anaemia is required.

**Renewal — (iron deficiency anaemia)** only from an internal medicine physician, obstetrician, gynaecologist, anaesthetist or medical practitioner on the recommendation of a internal medicine physician, obstetrician, gynaecologist or anaesthetist.

Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 Patient continues to have iron-deficiency anaemia; and
- 2 A re-trial with oral iron is clinically inappropriate.

**IRON POLYMALTOSE**

* Inj 50 mg per ml, 2 ml ampoule .....	41.75	5	✓ <b>Ferrosig</b>
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**Magnesium**

**MAGNESIUM HYDROXIDE**

Suspension 8%.....	33.60	355 ml	✓ <b>Phillips Milk of Magnesia</b> <sup>S29</sup>
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**MAGNESIUM SULPHATE**

* Inj 2 mmol per ml, 5 ml ampoule .....	37.53	10	✓ <b>Martindale</b>
* Inj 2 mmol per ml, 10 ml ampoule .....	75.06	10	✓ <b>Inresa</b> <sup>S29</sup>

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# ALIMENTARY TRACT AND METABOLISM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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## Zinc

### ZINC SULPHATE

* Cap 220 mg (50 mg elemental).....	29.14	100	✓	<b>Rugby</b> <sup>S29</sup>
* Cap 137.4 mg (50 mg elemental).....	11.00	100	✓	<b>Zincaps</b>
			✓	<b>Zincaps S29</b> <sup>S29</sup>

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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**Antianaemics**

**Hypoplastic and Haemolytic**

► **SA2539** Special Authority for Subsidy

**Initial application — (chronic renal failure)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Patient in chronic renal failure; and
- 2 Haemoglobin is less than or equal to 100g/L; and
- 3 Any of the following:
  - 3.1 Both:
    - 3.1.1 Patient does not have diabetes mellitus; and
    - 3.1.2 Glomerular filtration rate is less than or equal to 30ml/min; or
  - 3.2 Both:
    - 3.2.1 Patient has diabetes mellitus; and
    - 3.2.2 Glomerular filtration rate is less than or equal to 45ml/min; or
  - 3.3 Patient is on haemodialysis or peritoneal dialysis.

**Initial application — (myelodysplasia)** from any specialist. Approvals valid for 2 months for applications meeting the following criteria:

All of the following:

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

Note: Indication marked with \* is an unapproved indication

**Renewal — (myelodysplasia)** from any specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

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

Note: Indication marked with \* is an unapproved indication

EPOETIN ALFA – Special Authority see **SA2539 above** – Retail pharmacy

Wastage claimable

Inj 1,000 iu in 0.5 ml, syringe.....	250.00	6	✓ <b>Binocrit</b>
Inj 2,000 iu in 1 ml, syringe.....	100.00	6	✓ <b>Binocrit</b>
Inj 3,000 iu in 0.3 ml, syringe.....	150.00	6	✓ <b>Binocrit</b>
Inj 4,000 iu in 0.4 ml, syringe.....	96.50	6	✓ <b>Binocrit</b>
Inj 5,000 iu in 0.5 ml, syringe.....	125.00	6	✓ <b>Binocrit</b>
Inj 6,000 iu in 0.6 ml, syringe.....	145.00	6	✓ <b>Binocrit</b>
Inj 8,000 iu in 0.8 ml, syringe.....	175.00	6	✓ <b>Binocrit</b>
Inj 10,000 iu in 1 ml, syringe.....	197.50	6	✓ <b>Binocrit</b>
Inj 40,000 iu in 1 ml, syringe.....	250.00	1	✓ <b>Binocrit</b>

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

## BLOOD AND BLOOD FORMING ORGANS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>Megaloblastic</b>				
FOLIC ACID				
* Tab 0.8 mg .....	26.60	1,000	✓	<b>Folic Acid multichem</b>
* Tab 5 mg .....	5.82	100	✓	<b>Folic Acid Viatrix</b>
Oral liq 50 mcg per ml .....	31.77	25 ml OP	✓	<b>Biomed</b>

### Antifibrinolytics, Haemostatics and Local Sclerosants

#### EFTRENONACOG ALFA [RECOMBINANT FACTOR IX] – [Xpharm]

For patients with haemophilia B receiving prophylaxis treatment. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management group.

Inj 250 iu vial.....	612.50	1	✓	<b>Alprolix</b>
Inj 500 iu vial.....	1,225.00	1	✓	<b>Alprolix</b>
Inj 1,000 iu vial.....	2,450.00	1	✓	<b>Alprolix</b>
Inj 2,000 iu vial.....	4,900.00	1	✓	<b>Alprolix</b>
Inj 3,000 iu vial.....	7,350.00	1	✓	<b>Alprolix</b>
Inj 4,000 iu vial.....	9,800.00	1	✓	<b>Alprolix</b>

#### ELTROMBOPAG – Special Authority see SA1743 below – Retail pharmacy

Wastage claimable

Tab 25 mg .....	1,550.00	28	✓	<b>Revolade</b>
Tab 50 mg .....	3,100.00	28	✓	<b>Revolade</b>

#### ➔SA1743 Special Authority for Subsidy

**Initial application — (idiopathic thrombocytopenic purpura - post-splenectomy)** only from a haematologist. Approvals valid for 6 weeks for applications meeting the following criteria:

All of the following:

- 1 Patient has had a splenectomy; and
- 2 Two immunosuppressive therapies have been trialled and failed after therapy of 3 months each (or 1 month for rituximab); and
- 3 Any of the following:
  - 3.1 Patient has a platelet count of 20,000 to 30,000 platelets per microlitre and has evidence of significant mucocutaneous bleeding; or
  - 3.2 Patient has a platelet count of less than or equal to 20,000 platelets per microlitre and has evidence of active bleeding; or
  - 3.3 Patient has a platelet count of less than or equal to 10,000 platelets per microlitre.

**Initial application — (idiopathic thrombocytopenic purpura - preparation for splenectomy)** only from a haematologist.

Approvals valid for 6 weeks where the patient requires eltrombopag treatment as preparation for splenectomy.

**Initial application — (idiopathic thrombocytopenic purpura contraindicated to splenectomy)** only from a haematologist.

Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 Patient has a significant and well-documented contraindication to splenectomy for clinical reasons; and
- 2 Two immunosuppressive therapies have been trialled and failed after therapy of 3 months each (or 1 month for rituximab); and
- 3 Either:
  - 3.1 Patient has immune thrombocytopenic purpura\* with a platelet count of less than or equal to 20,000 platelets per microliter; or
  - 3.2 Patient has immune thrombocytopenic purpura\* with a platelet count of 20,000 to 30,000 platelets per microlitre

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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continued...

and significant mucocutaneous bleeding.

**Initial application — (severe aplastic anaemia)** only from a haematologist. Approvals valid for 3 months for applications meeting the following criteria:

- Both:
- Two immunosuppressive therapies have been trialled and failed after therapy of at least 3 months duration; and
  - Either:
    - Patient has severe aplastic anaemia with a platelet count of less than or equal to 20,000 platelets per microliter; or
    - Patient has severe aplastic anaemia with a platelet count of 20,000 to 30,000 platelets per microlitre and significant mucocutaneous bleeding.

**Renewal — (idiopathic thrombocytopenic purpura - post-splenectomy)** only from a haematologist. Approvals valid for 12 months where the patient has obtained a response (see Note) from treatment during the initial approval or subsequent renewal periods and further treatment is required.

Note: Response to treatment is defined as a platelet count of > 30,000 platelets per microlitre.

**Renewal — (idiopathic thrombocytopenic purpura contraindicated to splenectomy)** only from a haematologist. Approvals valid for 12 months for applications meeting the following criteria:

- All of the following:
- The patient's significant contraindication to splenectomy remains; and
  - The patient has obtained a response from treatment during the initial approval period; and
  - Patient has maintained a platelet count of at least 50,000 platelets per microlitre on treatment; and
  - Further treatment with eltrombopag is required to maintain response.

**Renewal — (severe aplastic anaemia)** only from a haematologist. Approvals valid for 12 months for applications meeting the following criteria:

- Both:
- The patient has obtained a response from treatment of at least 20,000 platelets per microlitre above baseline during the initial approval period; and
  - Platelet transfusion independence for a minimum of 8 weeks during the initial approval period.

**EMICIZUMAB – [Xpharm] – Special Authority see SA2272 below**

Inj 30 mg in 1 ml vial.....	3,570.00	1	✓ Hemlibra
Inj 60 mg in 0.4 ml vial.....	7,138.00	1	✓ Hemlibra
Inj 105 mg in 0.7 ml vial.....	12,492.00	1	✓ Hemlibra
Inj 150 mg in 1 ml vial.....	17,846.00	1	✓ Hemlibra

►SA2272 **Special Authority for Subsidy**

**Initial application — (Severe Haemophilia A with or without FVIII inhibitors)** only from a haematologist. Approvals valid without further renewal unless notified for applications meeting the following criteria:

- Both:
- Patient has severe congenital haemophilia A with a severe bleeding phenotype (endogenous factor VIII activity less than or equal to 2%); and
  - Emicizumab is to be administered at a dose of no greater than 3 mg/kg weekly for 4 weeks followed by the equivalent of 1.5 mg/kg weekly.

**EPTACOG ALFA [RECOMBINANT FACTOR VIIA] – [Xpharm]**

For patients with haemophilia. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group. Rare Clinical Circumstances Brand of bypassing agent for > 14 days predicted use. Access to funded treatment for > 14 days predicted use is by named patient application to the Haemophilia Treaters Group, subject to access criteria.

Inj 1 mg syringe .....	1,178.30	1	✓ NovoSeven RT
Inj 2 mg syringe .....	2,356.60	1	✓ NovoSeven RT
Inj 5 mg syringe .....	5,891.50	1	✓ NovoSeven RT
Inj 8 mg syringe .....	9,426.40	1	✓ NovoSeven RT

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

## BLOOD AND BLOOD FORMING ORGANS

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
<b>FACTOR EIGHT INHIBITOR BYPASSING FRACTION – [Xpharm]</b>			
For patients with haemophilia. Preferred Brand of bypassing agent for > 14 days predicted use. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group.			
Inj 500 U .....	1,315.00	1	✓ <b>FEIBA NF</b>
Inj 1,000 U .....	2,630.00	1	✓ <b>FEIBA NF</b>
Inj 2,500 U .....	6,575.00	1	✓ <b>FEIBA NF</b>
<b>MOROTOCOG ALFA [RECOMBINANT FACTOR VIII] – [Xpharm]</b>			
For patients with haemophilia. Rare Clinical Circumstances Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group, subject to criteria.			
Inj 250 iu prefilled syringe.....	287.50	1	✓ <b>Xyntha</b>
Inj 500 iu prefilled syringe.....	575.00	1	✓ <b>Xyntha</b>
Inj 1,000 iu prefilled syringe.....	1,150.00	1	✓ <b>Xyntha</b>
Inj 2,000 iu prefilled syringe.....	2,300.00	1	✓ <b>Xyntha</b>
Inj 3,000 iu prefilled syringe.....	3,450.00	1	✓ <b>Xyntha</b>
<b>NONACOG GAMMA, [RECOMBINANT FACTOR IX] – [Xpharm]</b>			
For patients with haemophilia. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group.			
Inj 1,000 iu vial.....	870.00	1	✓ <b>RIXUBIS</b>
Inj 2,000 iu vial.....	1,740.00	1	✓ <b>RIXUBIS</b>
Inj 3,000 iu vial.....	2,610.00	1	✓ <b>RIXUBIS</b>
<b>OCTOCOG ALFA [RECOMBINANT FACTOR VIII] (ADVATE) – [Xpharm]</b>			
For patients with haemophilia. Preferred Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group.			
Inj 500 iu vial.....	420.00	1	✓ <b>Advate</b>
Inj 1,000 iu vial.....	840.00	1	✓ <b>Advate</b>
Inj 2,000 iu vial.....	1,680.00	1	✓ <b>Advate</b>
Inj 3,000 iu vial.....	2,520.00	1	✓ <b>Advate</b>
<b>OCTOCOG ALFA [RECOMBINANT FACTOR VIII] (KOGENATE FS) – [Xpharm]</b>			
For patients with haemophilia. Rare Clinical Circumstances Brand of short half-life recombinant factor VIII. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management Group, subject to criteria.			
Inj 250 iu vial.....	237.50	1	✓ <b>Kogenate FS</b>
Inj 500 iu vial.....	475.00	1	✓ <b>Kogenate FS</b>
Inj 1,000 iu vial.....	950.00	1	✓ <b>Kogenate FS</b>
Inj 2,000 iu vial.....	1,900.00	1	✓ <b>Kogenate FS</b>
Inj 3,000 iu vial.....	2,850.00	1	✓ <b>Kogenate FS</b>
<b>RURIOCTOCOG ALFA PEGOL [RECOMBINANT FACTOR VIII] – [Xpharm]</b>			
For patients with haemophilia A receiving prophylaxis treatment. Access to funded treatment is managed by the Haemophilia Treaters Group in conjunction with the National Haemophilia Management group.			
Inj 1,000 iu vial.....	1,200.00	1	✓ <b>Adynovate</b>
Inj 2,000 iu vial.....	2,400.00	1	✓ <b>Adynovate</b>
<b>SODIUM TETRADECYL SULPHATE</b>			
* Inj 3% 2 ml.....	28.50 (140.00)	5	Fibro-vein

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>TRANEXAMIC ACID</b>				
Tab 500 mg .....	9.93	60	✓	<b>Mercury Pharma</b>
Inj 100 mg per ml, 10 ml ampoule – Subsidy by endorsement.....	7.99	5	✓	<b>Tranexamic-AFT</b>
a) Up to 5 inj available on a PSO				
b) Only on a PSO				
c) Subsidised only for use within a Primary Response in Medical Emergencies (PRIME) service or for the treatment of post-partum haemorrhage (PPH) and the PSO is endorsed accordingly.				

### Vitamin K

<b>PHYTOMENADIONE</b>				
Inj 2 mg per 0.2 ml – Up to 5 inj available on a PSO.....	8.00	5	✓	<b>Konakion MM Paediatric</b>
Inj 10 mg per ml, 1 ml – Up to 5 inj available on a PSO.....	9.21	5	✓	<b>Konakion MM</b>

### Antithrombotic Agents

#### Antiplatelet Agents

<b>ASPIRIN</b>				
* Tab 100 mg .....	12.65	990	✓	<b>Ethics Aspirin EC</b>
<b>CLOPIDOGREL</b>				
* Tab 75 mg .....	5.07	84	✓	<b>Arrow - Clopid</b>
<b>DIPYRIDAMOLE</b>				
Note: No new patients to be initiated on dipyridamole.				
Cap modified-release 200 mg .....	55.13	60	✓	<b>Dipyridamole - Strides S29</b>
<b>TICAGRELOR – Special Authority see SA2530 below – Retail pharmacy</b>				
* Tab 90 mg .....	20.35	56	✓	<b>Ticagrelor Sandoz</b>
			✓	<b>Ticagrelor S29 S29</b>
	23.85		✓	<b>Ticagrelor Mylan S29</b>

#### ►SA2530 Special Authority for Subsidy

**Initial application — (acute coronary syndrome)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 Patient has recently (within the last 60 days) been diagnosed with an ST-elevation or a non-ST-elevation acute coronary syndrome; and
- 2 Fibrinolytic therapy has not been given in the last 24 hours and is not planned.

**Renewal — (subsequent acute coronary syndrome)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 Patient has recently (within the last 60 days) been diagnosed with an ST-elevation or a non-ST-elevation acute coronary syndrome; and
- 2 Fibrinolytic therapy has not been given in the last 24 hours and is not planned.

**Initial application — (thrombosis prevention neurological stenting)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

continued...

Both:

1 Either:

- 1.1 Patient has had a neurological stenting procedure\* in the last 60 days; or
- 1.2 Patient is about to have a neurological stenting procedure performed\*; and

2 Either:

- 2.1 Patient has demonstrated clopidogrel resistance using the P2Y12 (VerifyNow) assay or another appropriate platelet function assay and requires antiplatelet treatment with ticagrelor; or
- 2.2 Either:
  - 2.2.1 Clopidogrel resistance has been demonstrated by the occurrence of a new cerebral ischemic event; or
  - 2.2.2 Clopidogrel resistance has been demonstrated by the occurrence of transient ischemic attack symptoms referable to the stent.

**Renewal — (thrombosis prevention neurological stenting)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 Patient is continuing to benefit from treatment; and
- 2 Treatment continues to be clinically appropriate.

**Initial application — (Percutaneous coronary intervention with stent deployment)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has undergone percutaneous coronary intervention; and
- 2 Patient has had a stent deployed in the previous 4 weeks; and
- 3 Patient is clopidogrel-allergic\*\*.

**Renewal — (Percutaneous coronary intervention with stent deployment)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has undergone percutaneous coronary intervention; and
- 2 Patient has had a stent deployed in the previous 4 weeks; and
- 3 Patient is clopidogrel-allergic\*\*.

**Initial application — (Stent thrombosis)** from any relevant practitioner. Approvals valid without further renewal unless notified where patient has experienced cardiac stent thrombosis whilst on clopidogrel.

**Initial application — (acute minor stroke or high-risk transient ischemic attack (TIA)\*)** from any relevant practitioner.

Approvals valid for 1 month for applications meeting the following criteria:

All of the following:

- 1 Patient has been diagnosed with a minor stroke (NIHSS† score 3 or less), high-risk TIA (ABCD2 score 4 or more) or Crescendo TIA; and
- 2 Either:
  - 2.1 Patient is expected to be a poor metaboliser of clopidogrel, with documented clinical rationale; or
  - 2.2 Patient is allergic to clopidogrel\*\*; and
- 3 Ticagrelor to be prescribed for a maximum of 21 days following minor stroke or TIA.

**Renewal — (subsequent minor stroke or TIA, or Crescendo TIA)** from any relevant practitioner. Approvals valid for 1 month where patient has been diagnosed with a minor stroke (NIHSS score 3 or less) or high-risk transient ischemic attack (ABCD2 score 4 or more) or Crescendo TIA.

Notes: indications marked with \* are unapproved indications.

Note:\*\* Clopidogrel allergy is defined as a history of anaphylaxis, urticaria, generalised rash or asthma (in non-asthmatic patients) developing soon after clopidogrel is started and is considered unlikely to be caused by any other treatment.

Note:NIHSS† National Institutes of Health Stroke Scale.

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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## Heparin and Antagonist Preparations

ENOXAPARIN SODIUM – Subsidy by endorsement; can be waived by Special Authority see [SA2628 below](#)

Subsidy by Endorsement - enoxaparin 100 mg syringe available on PSO for use within a Primary Response in Medical Emergencies (PRIME) service and the PSO is endorsed accordingly.

Inj 20 mg in 0.2 ml syringe.....	21.90	10	✓ <b>Clexane</b>
Inj 40 mg in 0.4 ml syringe.....	29.74	10	✓ <b>Clexane</b>
Inj 60 mg in 0.6 ml syringe.....	42.47	10	✓ <b>Clexane</b>
Inj 80 mg in 0.8 ml syringe.....	56.62	10	✓ <b>Clexane</b>
Inj 100 mg in 1 ml syringe – Up to 2 inj available on a PSO.....	70.91	10	✓ <b>Clexane</b>
Inj 120 mg in 0.8 ml syringe.....	88.11	10	✓ <b>Clexane Forte</b>
Inj 150 mg in 1 ml syringe.....	100.70	10	✓ <b>Clexane Forte</b>

### ➔SA2628 Special Authority for Subsidy

**Initial application — (Pregnancy, Malignancy or Haemodialysis)** from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Any of the following:

- 1 Low molecular weight heparin treatment is required during a patients pregnancy; or
- 2 For the treatment of venous thromboembolism where the patient has a malignancy; or
- 3 For the prevention of thrombus formation in the extra-corporeal circulation during haemodialysis.

**Initial application — (Venous thromboembolism other than in pregnancy or malignancy)** from any relevant practitioner.

Approvals valid for 1 month for applications meeting the following criteria:

Any of the following:

- 1 For the short-term treatment of venous thromboembolism prior to establishing a therapeutic level of oral anti-coagulant treatment; or
- 2 For the prophylaxis and treatment of venous thromboembolism in high risk surgery; or
- 3 To enable cessation/re-establishment of existing oral anticoagulant treatment pre/post surgery; or
- 4 For the prophylaxis and treatment of venous thromboembolism in Acute Coronary Syndrome surgical intervention; or
- 5 To be used in association with cardioversion of atrial fibrillation.

**Initial application — (Short-term use during treatment of COVID-19 with nirmatrelvir with ritonavir)** from any relevant practitioner. Approvals valid for 2 weeks for applications meeting the following criteria:

All of the following:

- 1 Patient is receiving an anticoagulation treatment that has drug/drug interactions with ritonavir that increases risk of bleeding; and
- 2 Patient meets the Access Criteria for COVID-19 antivirals published on the Pharmac website\*; and
- 3 Other antiviral treatments for COVID-19 have been considered and are not clinically suitable options.

**Renewal — (Pregnancy, Malignancy or Haemodialysis)** from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Any of the following:

- 1 Low molecular weight heparin treatment is required during a patient's pregnancy; or
- 2 For the treatment of venous thromboembolism where the patient has a malignancy; or
- 3 For the prevention of thrombus formation in the extra-corporeal circulation during haemodialysis.

**Renewal — (Venous thromboembolism other than in pregnancy or malignancy)** from any relevant practitioner. Approvals valid for 1 month where low molecular weight heparin treatment or prophylaxis is required for a second or subsequent event (surgery, ACS, cardioversion, or prior to oral anti-coagulation).

### HEPARIN SODIUM

Inj 1,000 iu per ml, 5 ml ampoule .....	164.40	50	✓ <b>Pfizer</b>
Inj 10 iu per ml, 5 ml ampoule (flushing solution) .....	19.38	10	✓ <b>Wockhardt S29</b>
Inj 5,000 iu per ml, 1 ml .....	70.33	5	✓ <b>Hospira</b>
Inj 5,000 iu per ml, 5 ml ampoule .....	406.15	50	✓ <b>Pfizer</b>
Inj 25,000 iu per ml, 0.2 ml .....	25.78	5	✓ <b>Hospira</b>

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

## BLOOD AND BLOOD FORMING ORGANS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>HEPARINISED SALINE</b>				
Inj 10 iu per ml, 5 ml .....	96.91	50	✓	<b>Pfizer</b>
<b>Oral Anticoagulants</b>				
<b>DABIGATRAN</b>				
Cap 75 mg – No more than 2 cap per day .....	27.99	60	✓	<b>Pradaxa</b>
Cap 110 mg .....	27.99	60	✓	<b>Pradaxa</b>
Cap 150 mg .....	27.99	60	✓	<b>Pradaxa</b>
<b>RIVAROXABAN</b>				
Tab 10 mg – No more than 1 tab per day .....	15.60	30	✓	<b>Xarelto</b>
Tab 15 mg – Up to 14 tab available on a PSO .....	14.56	28	✓	<b>Xarelto</b>
Tab 20 mg .....	14.56	28	✓	<b>Xarelto</b>
<b>WARFARIN SODIUM</b>				
Note: Marevan and Coumadin are not interchangeable.				
* Tab 1 mg .....	3.46	50	✓	<b>Coumadin</b>
	7.50	100	✓	<b>Marevan</b>
* Tab 2 mg .....	4.31	50	✓	<b>Coumadin</b>
* Tab 3 mg .....	12.00	100	✓	<b>Marevan</b>
* Tab 5 mg .....	5.93	50	✓	<b>Coumadin</b>
	13.50	100	✓	<b>Marevan</b>

## Blood Colony-stimulating Factors

<b>FILGRASTIM – Special Authority see SA2613 below – Retail pharmacy</b>				
Inj 300 mcg per 0.5 ml prefilled syringe .....	86.60	10	✓	<b>Nivestim</b>
Inj 480 mcg per 0.5 ml prefilled syringe .....	133.72	10	✓	<b>Nivestim</b>

### ►SA2613 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Any of the following:

- 1 Prevention of neutropenia in patients undergoing high risk chemotherapy for cancer (febrile neutropenia risk greater than or equal to 20%); or
- 2 Peripheral blood stem cell mobilisation in patients undergoing haematological transplantation; or
- 3 Peripheral blood stem cell mobilisation or bone marrow donation from healthy donors for transplantation; or
- 4 Treatment of severe chronic neutropenia ( $ANC < 0.5 \times 10^9/L$ ); or
- 5 Treatment of drug-induced prolonged neutropenia ( $ANC < 0.5 \times 10^9/L$ ).

Note: \*Febrile neutropenia risk greater than or equal to 20% after taking into account other risk factors as defined by the European Organisation for Research and Treatment of Cancer (EORTC) guidelines.

<b>PEGFILGRASTIM – Special Authority see SA2614 below – Retail pharmacy</b>				
Inj 6 mg per 0.6 ml syringe .....	69.50	1	✓	<b>Ziextenzo</b>

### ►SA2614 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified where used for prevention of neutropenia in patients undergoing high risk chemotherapy for cancer (febrile neutropenia risk greater than or equal to 5%\*).

Note: \*Febrile neutropenia risk greater than or equal to 5% after taking into account other risk factors as defined by the European Organisation for Research and Treatment of Cancer (EORTC) guidelines.

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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## Fluids and Electrolytes

### Intravenous Administration

#### GLUCOSE [DEXTROSE]

* Inj 5%, 100 ml bag – Subsidy by endorsement .....	97.00	50	✓ Fresenius Kabi
a) Up to 50 inj available on a PSO			
b) Only on a PSO			
c) Subsidised only for use within a Primary Response in Medical Emergencies (PRIME) service and the PSO is endorsed accordingly.			
* Inj 10%, 500 ml bag – Subsidy by endorsement .....	126.00	18	✓ Baxter Glucose 10%
a) Up to 18 inj available on a PSO			
b) Only on a PSO			
c) Subsidised only for use within a Primary Response in Medical Emergencies (PRIME) service and the PSO is endorsed accordingly.			
* Inj 50%, 10 ml ampoule – Up to 5 inj available on a PSO .....	34.75	5	✓ Biomed
* Inj 50%, 90 ml bottle – Up to 5 inj available on a PSO .....	17.50	1	✓ Biomed

#### POTASSIUM CHLORIDE

* Inj 75 mg per ml, 10 ml .....	65.00	50	✓ Juno ✓ LumaCina ✓ Pfizer S29
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#### SODIUM BICARBONATE

Inj 8.4%, 50 ml .....	24.70	1	✓ Biomed
a) Up to 5 inj available on a PSO			
b) Not in combination			
Inj 8.4%, 100 ml .....	25.31	1	✓ Biomed
a) Up to 5 inj available on a PSO			
b) Not in combination			

#### SODIUM CHLORIDE

Not funded for use as a nasal drop. Not funded for nebuliser use except when used in conjunction with an antibiotic intended for nebuliser use.

Inj 23.4% (4 mmol/ml), 20 ml ampoule .....	40.15	5	✓ Biomed
For Sodium chloride oral liquid formulation refer Standard Formulae, <a href="#">page 285</a>			
Inj 0.9%, 5 ml ampoule – Up to 5 inj available on a PSO .....	4.12	20	✓ Fresenius Kabi
Inj 0.9%, 10 ml ampoule – Up to 5 inj available on a PSO .....	7.50	50	✓ Fresenius Kabi
Inj 0.9%, 20 ml ampoule .....	5.20	20	✓ Fresenius Kabi
Inj 0.9%, 1,000 ml bag – Up to 2 bag available on a PSO .....	1.58	1	✓ Baxter
Only if prescribed on a prescription for renal dialysis, maternity or post-natal care in the home of the patient, or on a PSO for emergency use. (500 ml and 1,000 ml packs)			
Inj 0.9%, 500 ml bag – Up to 4 bag available on a PSO .....	1.53	1	✓ Baxter
Only if prescribed on a prescription for renal dialysis, maternity or post-natal care in the home of the patient, or on a PSO for emergency use. (500 ml and 1,000 ml packs)			

#### TOTAL PARENTERAL NUTRITION (TPN)

Infusion .....	CBS	1 OP	✓ TPN
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▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# BLOOD AND BLOOD FORMING ORGANS

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
<b>WATER</b>			
1) On a prescription or Practitioner's Supply Order only when on the same form as an injection listed in the Pharmaceutical Schedule requiring a solvent or diluent; or			
2) On a bulk supply order; or			
3) When used in the extemporaneous compounding of eye drops; or			
4) When used for the dilution of sodium chloride soln 7% for cystic fibrosis patients only.			
Inj 10 ml ampoule – Up to 5 inj available on a PSO .....	9.50	50	✓ <b>Multichem</b>
Inj 20 ml ampoule – Up to 5 inj available on a PSO .....	5.00	20	✓ <b>Fresenius Kabi</b>

## Oral Administration

<b>CALCIUM POLYSTYRENE SULPHONATE</b>			
Powder .....	169.85	300 g OP	✓ <b>Calcium Resonium</b> ✓ <b>Roma</b> <sup>S29</sup>

### COMPOUND ELECTROLYTES

Note: Direct Provision by a pharmacist permitted under the provisions in Part I of Section A in accordance with the Integrated Community Pharmaceuticals Agreement (ICPSA) – Extended Pharmacy Services.

Powder for oral soln – Up to 5 sach available on a PSO.....	9.50	50	✓ <b>Electral</b>
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### COMPOUND ELECTROLYTES WITH GLUCOSE [DEXTROSE]

Note: Direct Provision by a pharmacist permitted under the provisions in Part I of Section A in accordance with the Integrated Community Pharmaceuticals Agreement (ICPSA) – Extended Pharmacy Services.

Soln with electrolytes.....	6.53	1 OP	✓ <b>Hydralyte - Lemonade</b>
Soln with electrolytes (2 x 500 ml) .....	8.45	1 OP	✓ <b>Pedialyte</b>

Pedialyte to be Principal Supply on 1 July 2026

*(Hydralyte - Lemonade Soln with electrolytes to be delisted 1 July 2026)*

### PHOSPHORUS

Tab eff 500 mg (16 mmol) .....	82.50	100	✓ <b>Phosphate Phebra</b>
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### POTASSIUM CHLORIDE

* Tab eff 548 mg (14 m eq) with chloride 285 mg (8 m eq).....	5.26 (17.10)	60	Chlorvescent
* Tab long-acting 600 mg (8 mmol).....	16.15	200	✓ <b>Span-K</b>

### SODIUM BICARBONATE

Cap 840 mg.....	8.52	100	✓ <b>Sodibic</b>
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### SODIUM POLYSTYRENE SULPHONATE

Powder .....	84.65	454 g OP	✓ <b>Resonium-A</b>
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Subsidy Fully Brand or  
(Manufacturer's Price) Subsidised Generic  
\$ Per ✓ Manufacturer

**Alpha-Adrenoceptor Blockers**

**Alpha Adrenoceptor Blockers**

DOXAZOSIN			
* Tab 2 mg .....	17.35	500	✓ <b>Doxazosin Clinect</b>
* Tab 4 mg .....	20.94	500	✓ <b>Doxazosin Clinect</b>
PHENOXYBENZAMINE HYDROCHLORIDE			
* Cap 10 mg .....	65.00	30	✓ <b>BNM</b> <sup>S29</sup>
PRAZOSIN			
* Tab 1 mg .....	5.53	100	✓ <b>Arrotex-Prazosin</b> <b>S29</b> <sup>S29</sup>
	9.98		✓ <b>Minipress</b> <sup>S29</sup>
* Tab 2 mg .....	7.00	100	✓ <b>Arrotex-Prazosin</b> <b>S29</b> <sup>S29</sup>
	13.29		✓ <b>Minipress</b> <sup>S29</sup>
* Tab 5 mg .....	11.70	100	✓ <b>Arrotex-Prazosin</b> <b>S29</b> <sup>S29</sup>
	22.00		✓ <b>Minipress</b> <sup>S29</sup>
* Cap 1 mg .....	15.40	100	✓ <b>Prazosin Mylan</b> <sup>S29</sup>
* Cap 2 mg .....	15.58	100	✓ <b>Prazosin Mylan</b> <sup>S29</sup>
* Cap 5 mg .....	23.32	100	✓ <b>Prazosin Mylan</b> <sup>S29</sup>

**Agents Affecting the Renin-Angiotensin System**

**ACE Inhibitors**

CAPTOPRIL			
* Oral liq 5 mg per ml .....	86.00	100 ml OP	✓ <b>DP-Captopril</b>
Oral liquid restricted to children under 12 years of age.			
ENALAPRIL MALEATE			
* Tab 5 mg .....	1.40	90	✓ <b>Ipca-Enalapril</b>
	4.25		✓ <b>Acetec</b>
Ipca-Enalapril to be Principal Supply on 1 July 2026			
* Tab 10 mg .....	1.58	90	✓ <b>Ipca-Enalapril</b>
	5.50		✓ <b>Acetec</b>
Ipca-Enalapril to be Principal Supply on 1 July 2026			
* Tab 20 mg .....	2.00	90	✓ <b>Ipca-Enalapril</b>
	6.50		✓ <b>Acetec</b>
Ipca-Enalapril to be Principal Supply on 1 July 2026			
<i>(Acetec Tab 5 mg to be delisted 1 July 2026)</i>			
<i>(Acetec Tab 10 mg to be delisted 1 July 2026)</i>			
<i>(Acetec Tab 20 mg to be delisted 1 July 2026)</i>			
LISINOPRIL			
* Tab 5 mg .....	12.00	90	✓ <b>Teva Lisinopril</b>
* Tab 10 mg .....	12.00	90	✓ <b>Teva Lisinopril</b>
* Tab 20 mg .....	16.00	90	✓ <b>Teva Lisinopril</b>

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# CARDIOVASCULAR SYSTEM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>PERINDOPRIL</b>				
* Tab 2 mg .....	1.79	30	✓	<b>Coversyl</b>
* Tab 4 mg .....	2.44	30	✓	<b>Coversyl</b>
* Tab 8 mg .....	3.94	30	✓	<b>Coversyl</b>
<b>QUINAPRIL</b>				
* Tab 5 mg .....	10.24	90	✓	<b>Arrow-Quinapril 5</b>
* Tab 10 mg .....	12.51	90	✓	<b>Arrow-Quinapril 10</b>
* Tab 20 mg .....	14.83	90	✓	<b>Arrow-Quinapril 20</b>
<b>RAMIPRIL</b>				
* Tab 1.25 mg .....	5.75	30	✓	<b>Ramipril Viatris</b> <sup>S29</sup>
* Tab 2.5 mg .....	5.50	30	✓	<b>Ramipril Viatris</b> <sup>S29</sup>
* Tab 5 mg .....	5.25	28	✓	<b>Ramipril Mylan</b> Generics <sup>S29</sup>
* Tab 10 mg .....	5.48	28	✓	<b>Ramipril Mylan</b> Generics <sup>S29</sup>
* Cap 1.25 mg .....	17.25	90	✓	<b>Tryzan</b>
* Cap 2.5 mg .....	16.50	90	✓	<b>Tryzan</b>
* Cap 5 mg .....	16.88	90	✓	<b>Tryzan</b>
* Cap 10 mg .....	17.63	90	✓	<b>Tryzan</b>

## Angiotensin II Antagonists

<b>CANDESARTAN CILEXETIL</b>				
* Tab 4 mg .....	2.68	90	✓	<b>Candesartan Viatris</b>
			✓	<b>Candesartan Viatris</b> Sante
* Tab 8 mg .....	2.67	90	✓	<b>Candestar</b>
			✓	<b>Candesartan Viatris</b>
			✓	<b>Candestar</b>
* Tab 16 mg .....	4.22	90	✓	<b>Candesartan Viatris</b>
			✓	<b>Candestar</b>
* Tab 32 mg .....	5.24	90	✓	<b>Candesartan Viatris</b>
			✓	<b>Candestar</b>
<b>LOSARTAN POTASSIUM</b>				
* Tab 12.5 mg .....	2.00	84	✓	<b>Losartan Actavis</b>
* Tab 25 mg .....	2.29	84	✓	<b>Losartan Actavis</b>
* Tab 50 mg .....	2.86	84	✓	<b>Losartan Actavis</b>
* Tab 100 mg .....	4.57	84	✓	<b>Losartan Actavis</b>

## Angiotensin II Antagonists with Diuretics

<b>CANDESARTAN CILEXETIL WITH HYDROCHLOROTHIAZIDE</b>				
* Tab 16 mg with hydrochlorothiazide 12.5 mg .....	4.10	30	✓	<b>APO-Candesartan</b> HCTZ 16/12.5
* Tab 32 mg with hydrochlorothiazide 12.5 mg .....	5.25	30	✓	<b>APO-Candesartan</b> HCTZ 32/12.5

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>LOSARTAN POTASSIUM WITH HYDROCHLOROTHIAZIDE</b>				
* Tab 50 mg with hydrochlorothiazide 12.5 mg.....	4.31	30	✓	<b>Arrow-Losartan &amp; Hydrochlorothiazide</b>
	7.25	90	✓	<b>Losartan &amp; Hydrochlorothiazide (Ipca)</b>

Losartan & Hydrochlorothiazide (Ipca) to be Principal Supply on 1 July 2026

(Arrow-Losartan & Hydrochlorothiazide Tab 50 mg with hydrochlorothiazide 12.5 mg to be delisted 1 July 2026)

### Angiotensin II Antagonists with Neprilysin Inhibitors

SACUBITRIL WITH VALSARTAN – Special Authority see [SA2302 below](#) – Retail pharmacy

Tab 24.3 mg with valsartan 25.7 mg .....	190.00	56	✓	<b>Entresto 24/26</b>
Tab 48.6 mg with valsartan 51.4 mg .....	190.00	56	✓	<b>Entresto 49/51</b>
Tab 97.2 mg with valsartan 102.8 mg .....	190.00	56	✓	<b>Entresto 97/103</b>

#### ►SA2302 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Patient has heart failure; and
- 2 Any of the following:
  - 2.1 Patient is in NYHA/WHO functional class II; or
  - 2.2 Patient is in NYHA/WHO functional class III; or
  - 2.3 Patient is in NYHA/WHO functional class IV; and
- 3 Either:
  - 3.1 Patient has a documented left ventricular ejection fraction (LVEF) of less than or equal to 35%; or
  - 3.2 An ECHO is not reasonably practical, and in the opinion of the treating practitioner the patient would benefit from treatment; and
- 4 Patient is receiving concomitant optimal standard chronic heart failure treatments.

### Antiarrhythmics

For lignocaine hydrochloride refer to NERVOUS SYSTEM, Anaesthetics, Local, [page 124](#)

**AMIODARONE HYDROCHLORIDE**

▲ Tab 100 mg .....	4.95	30	✓	<b>Aratac</b>
▲ Tab 200 mg .....	5.86	30	✓	<b>Aratac</b>
Inj 50 mg per ml, 3 ml ampoule – Up to 10 inj available on a PSO .....	17.96	10	✓	<b>Max Health</b>

**ATROPINE SULPHATE**

* Inj 600 mcg per ml, 1 ml ampoule – Up to 5 inj available on a PSO .....	16.10	10	✓	<b>Hikma</b> <sup>S29</sup>
			✓	<b>Martindale</b>

**DIGOXIN**

* Tab 62.5 mcg – Up to 30 tab available on a PSO .....	8.58	240	✓	<b>Lanoxin PG</b>
* Tab 250 mcg – Up to 30 tab available on a PSO .....	18.75	240	✓	<b>Lanoxin</b>
* Oral liq 50 mcg per ml .....	16.60	60 ml	✓	<b>Lanoxin</b>
			✓	<b>Lanoxin S29</b> <sup>S29</sup>

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# CARDIOVASCULAR SYSTEM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>DISOPYRAMIDE PHOSPHATE</b>				
▲ Cap 100 mg.....	55.90	84	✓	<b>Rythmodan - Cheplafarm</b> <sup>S29</sup>
			✓	<b>Rythmodan Neon</b> <sup>S29</sup>
<b>FLECAINIDE ACETATE</b>				
▲ Tab 50 mg .....	19.95	60	✓	<b>Flecainide BNM</b>
▲ Cap long-acting 100 mg .....	35.78	90	✓	<b>Flecainide Controlled Release Teva</b>
▲ Cap long-acting 200 mg .....	54.28	90	✓	<b>Flecainide Controlled Release Teva</b>
Inj 10 mg per ml, 15 ml ampoule .....	102.79 108.16	5	✓	<b>Almarytm</b> <sup>S29</sup>
			✓	<b>Tambacor</b>
			✓	<b>Tambacor German</b> <sup>S29</sup>
<b>MEXILETINE HYDROCHLORIDE</b>				
▲ Cap 150 mg.....	162.00	100	✓	<b>Teva</b> <sup>S29</sup>
▲ Cap 250 mg.....	202.00	100	✓	<b>Teva</b> <sup>S29</sup>
<b>PROPAFENONE HYDROCHLORIDE</b>				
▲ Tab 150 mg .....	40.90	50	✓	<b>Rytmonorm</b>

## Antihypotensives

<b>MIDODRINE – Special Authority see SA1474 below – Retail pharmacy</b>				
Tab 2.5 mg .....	36.68	100	✓	<b>Midodrine Medsurge</b>
Tab 5 mg .....	58.88	100	✓	<b>Midodrine Medsurge</b>

### ►SA1474 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid for 2 years where patient has disabling orthostatic hypotension not due to drugs.

**Renewal** from any relevant practitioner. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefiting from treatment.

## Beta-Adrenoceptor Blockers

### Beta Adrenoceptor Blockers

<b>ATENOLOL</b>				
* Tab 50 mg .....	11.00	500	✓	<b>Viatrix</b>
* Tab 100 mg .....	18.50	500	✓	<b>Atenolol Viatrix</b>
* Oral liq 25 mg per 5 ml .....	49.85	300 ml OP	✓	<b>Atenolol AFT</b>
Restricted to children under 12 years of age.				
<b>BISOPROLOL FUMARATE</b>				
* Tab 2.5 mg .....	1.36	90	✓	<b>Ipca-Bisoprolol</b>
* Tab 5 mg .....	1.91	90	✓	<b>Ipca-Bisoprolol</b>
* Tab 10 mg .....	2.71	90	✓	<b>Ipca-Bisoprolol</b>

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>CARVEDILOL</b>				
* Tab 6.25 mg .....	1.97	60	✓	<b>Carvedilol Sandoz</b>
Carvedilol Sandoz to be Principal Supply on 1 August 2026				
* Tab 12.5 mg .....	2.03	60	✓	<b>Carvedilol Sandoz</b>
Carvedilol Sandoz to be Principal Supply on 1 August 2026				
* Tab 25 mg .....	2.46	60	✓	<b>Carvedilol Sandoz</b>
Carvedilol Sandoz to be Principal Supply on 1 August 2026				
<b>LABETALOL</b>				
* Tab 100 mg .....	14.50	100	✓	<b>Trandate</b>
	49.54		✓	<b>Biocon</b> <sup>S29</sup>
* Tab 200 mg .....	27.00	100	✓	<b>Trandate</b>
	42.07		✓	<b>Presolol</b> <sup>S29</sup>
* Inj 5 mg per ml, 20 ml ampoule .....	59.06 (88.60)	5		Trandate
<b>METOPROLOL SUCCINATE</b>				
* Tab long-acting 23.75 mg .....	4.20	90	✓	<b>Myloc CR</b>
* Tab long-acting 47.5 mg .....	3.65	90	✓	<b>Myloc CR</b>
* Tab long-acting 95 mg .....	5.24	90	✓	<b>Myloc CR</b>
* Tab long-acting 190 mg .....	9.76	90	✓	<b>Myloc CR</b>
<b>METOPROLOL TARTRATE</b>				
* Tab 50 mg .....	5.66	100	✓	<b>IPCA-Metoprolol</b>
* Tab 100 mg .....	7.55	60	✓	<b>IPCA-Metoprolol</b>
* Tab long-acting 200 mg .....	23.40	28	✓	<b>Slow-Lopresor</b>
* Inj 1 mg per ml, 5 ml vial .....	26.50	5	✓	<b>Metoprolol IV Mylan</b>
			✓	<b>Metoprolol IV Viatrix</b>
<b>NADOLOL</b>				
* Tab 40 mg .....	19.19	100	✓	<b>Nadolol BNM</b>
* Tab 80 mg .....	30.39	100	✓	<b>Nadolol BNM</b>
<b>PROPRANOLOL</b>				
* Tab 10 mg .....	7.04	100	✓	<b>Drofate</b>
* Tab 40 mg .....	8.75	100	✓	<b>IPCA-Propranolol</b>
* Cap long-acting 160 mg .....	18.17	100	✓	<b>Cardinol LA</b>
* Oral liq 4 mg per ml – Special Authority see <a href="#">SA1327 below</a> – Retail pharmacy .....	CBS	500 ml	✓	<b>Hikma- Propranolol</b> <sup>S29</sup>
			✓	<b>Roxane- Propranolol</b> <sup>S29</sup>

**►SA1327 Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Either:

- 1 For the treatment of a child under 12 years with an haemangioma causing functional impairment (not for cosmetic reasons only); or
- 2 For the treatment of a child under 12 years with cardiac arrhythmias or congenital cardiac abnormalities.

**Renewal** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Either:

- 1 For the treatment of a child under 12 years with an haemangioma causing functional impairment (not for cosmetic reasons only); or
- 2 For the treatment of a child under 12 years with cardiac arrhythmias or congenital cardiac abnormalities.

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# CARDIOVASCULAR SYSTEM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>SOTALOL</b>				
* Tab 80 mg .....	40.00	500	✓	<u>Mylan</u>
* Tab 160 mg .....	20.00	100	✓	<u>Mylan</u>

## Calcium Channel Blockers

### Dihydropyridine Calcium Channel Blockers

<b>AMLODIPINE</b>				
* Tab 2.5 mg .....	1.45	90	✓	<u>Vasorex</u>
* Tab 5 mg .....	1.21	90	✓	<u>Vasorex</u>
* Tab 10 mg .....	1.31	90	✓	<u>Vasorex</u>
<b>FELODIPINE</b>				
* Tab long-acting 2.5 mg.....	2.18	30	✓	<u>Plendil ER</u>
* Tab long-acting 5 mg.....	6.57	90	✓	<u>Felo 5 ER</u>
* Tab long-acting 10 mg.....	6.95	90	✓	<u>Felo 10 ER</u>
<b>NIFEDIPINE</b>				
* Tab long-acting 10 mg – Subsidy by endorsement .....	19.42	56	✓	<u>Tensipine MR10</u> <sup>§29</sup>
Subsidised for patients who were taking nifedipine tab long-acting 10 mg prior to 1 July 2023 and the prescription is endorsed accordingly. Pharmacists may annotate the prescription as endorsed where there exists a record of prior dispensing of nifedipine tab long-acting 10 mg.				
* Tab long-acting 20 mg.....	9.92	56	✓	<u>Valni Retard</u> <sup>§29</sup>
	17.72	100	✓	<u>Nyefax Retard</u>
* Tab long-acting 30 mg.....	4.78	14	✓	<u>Mylan Italy (24 hr release)</u> <sup>§29</sup>
	34.10	100	✓	<u>Mylan (24 hr release)</u> <sup>§29</sup>
* Tab long-acting 60 mg.....	52.81	100	✓	<u>Mylan (24 hr release)</u> <sup>§29</sup>

### Other Calcium Channel Blockers

<b>DILTIAZEM HYDROCHLORIDE</b>				
* Cap long-acting 120 mg .....	65.35	500	✓	<u>Diltiazem CD Clinect</u>
* Cap long-acting 180 mg .....	7.00	30	✓	<u>Cardizem CD</u>
* Cap long-acting 240 mg .....	9.30	30	✓	<u>Cardizem CD</u>
<b>PERHEXILINE MALEATE</b>				
* Tab 100 mg .....	62.90	100	✓	<u>Pexsig</u>
<b>VERAPAMIL HYDROCHLORIDE</b>				
* Tab 40 mg .....	7.01	100	✓	<u>Isoptin</u>
* Tab 80 mg .....	11.74	100	✓	<u>Isoptin</u>
* Tab long-acting 120 mg.....	36.02	100	✓	<u>Isoptin Retard</u> <sup>§29</sup>
			✓	<u>Isoptin SR</u>
* Tab long-acting 240 mg.....	15.12	30	✓	<u>Isoptin SR</u>
* Inj 2.5 mg per ml, 2 ml ampoule – Up to 5 inj available on a PSO.....	25.00	5	✓	<u>Isoptin</u>

Subsidy (Manufacturer's Price) \$ Fully Subsidised Per ✓ Brand or Generic Manufacturer

**Centrally-Acting Agents**

**CLONIDINE**

* Patch 2.5 mg, 100 mcg per day – Only on a prescription.....	11.70	4	✓ Mylan
* Patch 5 mg, 200 mcg per day – Only on a prescription.....	12.80	4	✓ Mylan
* Patch 7.5 mg, 300 mcg per day – Only on a prescription.....	17.90	4	✓ Mylan

**CLONIDINE HYDROCHLORIDE**

* Tab 25 mcg.....	29.74	112	✓ Clonidine Teva
* Tab 150 mcg.....	40.41	100	✓ Catapres
* Inj 150 mcg per ml, 1 ml ampoule .....	14.10	5	✓ Catapres

**METHYLDOPA**

* Tab 250 mg .....	15.10	100	✓ Methyldopa Viatrix
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**Diuretics**

**Loop Diuretics**

**BUMETANIDE**

* Tab 1 mg .....	16.36	100	✓ Burinex
* Inj 500 mcg per ml, 4 ml vial.....	7.95	5	✓ Burinex

**FUROSEMIDE [FRUSEMIDE]**

* Tab 40 mg – Up to 30 tab available on a PSO .....	12.80	1,000	✓ IPCA-Frusemide
* Tab 500 mg .....	25.00	50	✓ Urex Forte
* Oral liq 10 mg per ml .....	11.20	30 ml OP	✓ Lasix
* Inj 10 mg per ml, 25 ml ampoule .....	60.65	6	✓ Lasix
* Inj 10 mg per ml, 2 ml ampoule – Up to 10 inj available on a PSO ....	2.40	5	✓ Furosemide-Baxter
	3.97	10	✓ Furosemide-AFT

Furosemide-AFT to be Principal Supply on 1 August 2026

(Furosemide-Baxter Inj 10 mg per ml, 2 ml ampoule to be delisted 1 August 2026)

**Potassium Sparing Diuretics**

**AMILORIDE HYDROCHLORIDE**

Tab 5 mg .....	81.07	100	✓ Padagis <sup>S29</sup>
	171.41	28	✓ Wockhardt <sup>S29</sup>
Oral liq 1 mg per ml .....	35.40	25 ml OP	✓ Biomed

**EPLERENONE** – Special Authority see SA1728 below – Retail pharmacy

Tab 25 mg .....	15.84	30	✓ Inspra
Tab 50 mg .....	25.00	30	✓ Inspra

►SA1728 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 Patient has heart failure with ejection fraction less than 40%; and
- 2 Either:
  - 2.1 Patient is intolerant to optimal dosing of spironolactone; or
  - 2.2 Patient has experienced a clinically significant adverse effect while on optimal dosing of spironolactone.

**SPIRONOLACTONE**

* Tab 25 mg .....	4.20	100	✓ Spiractin
* Tab 100 mg .....	11.40	100	✓ Spiractin
Oral liq 5 mg per ml .....	35.70	25 ml OP	✓ Biomed

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>Potassium Sparing Combination Diuretics</b>				
AMILORIDE HYDROCHLORIDE WITH FUROSEMIDE				
* Tab 5 mg with furosemide 40 mg .....	8.63	28	✓	<b>Frumil</b>
AMILORIDE HYDROCHLORIDE WITH HYDROCHLOROTHIAZIDE				
* Tab 5 mg with hydrochlorothiazide 50 mg .....	5.00	50	✓	<b>Moduretic</b>
<b>Thiazide and Related Diuretics</b>				
BENDROFLUMETHIAZIDE [BENDROFLUAZIDE]				
* Tab 2.5 mg – Up to 150 tab available on a PSO .....	51.50	500	✓	<b>Arrow-Bendrofluaizide</b>
May be supplied on a PSO for reasons other than emergency.				
* Tab 5 mg .....	61.00	500	✓	<b>Arrow-Bendrofluaizide</b>
CHLOROTHIAZIDE				
Oral liq 50 mg per ml .....	30.67	25 ml OP	✓	<b>Biomed</b>
CHLORTALIDONE [CHLORTHALIDONE]				
* Tab 25 mg .....	6.95	50	✓	<b>Hygroton</b>
INDAPAMIDE				
* Tab 2.5 mg .....	16.00	90	✓	<b>Dapa-Tabs</b>
METOLAZONE				
Tab 5 mg .....	CBS	50	✓	<b>Zaroxolyn</b> <sup>S29</sup>
<b>Vasopressin receptor antagonists</b>				
TOLVAPTAN – Special Authority see SA2166 below – Retail pharmacy				
Tab 15 mg .....	873.50	28 OP	✓	<b>Jinarc</b>
Tab 30 mg .....	873.50	28 OP	✓	<b>Jinarc</b>
Tab 45 mg + 15 mg .....	1,747.00	56 OP	✓	<b>Jinarc</b>
Tab 60 mg + 30 mg .....	1,747.00	56 OP	✓	<b>Jinarc</b>
Tab 90 mg + 30 mg .....	1,747.00	56 OP	✓	<b>Jinarc</b>
<b>▶ SA2166 Special Authority for Subsidy</b>				
<b>Initial application — (autosomal dominant polycystic kidney disease)</b> only from a renal physician or any relevant practitioner on the recommendation of a renal physician. Approvals valid for 12 months for applications meeting the following criteria:				
All of the following:				
1 Patient has a confirmed diagnosis of autosomal dominant polycystic kidney disease; and				
2 Patient has an estimated glomerular filtration rate (eGFR) of greater than or equal to 25 mL/min/1.73 m <sup>2</sup> at treatment initiation; and				
3 Either:				
3.1 Patient's disease is rapidly progressing, with a decline in eGFR of greater than or equal to 5 mL/min/1.73 m <sup>2</sup> within one-year; or				
3.2 Patient's disease is rapidly progressing, with an average decline in eGFR of greater than or equal to 2.5 mL/min/1.73 m <sup>2</sup> per year over a five-year period.				
<b>Renewal — (autosomal dominant polycystic kidney disease)</b> only from a renal physician or any relevant practitioner on the recommendation of a renal physician. Approvals valid for 12 months for applications meeting the following criteria:				
Both:				
1 Patient has not developed end-stage renal disease, defined as an eGFR of less than 15 mL/min/1.73 m <sup>2</sup> ; and				
2 Patient has not undergone a kidney transplant.				

Subsidy Fully Brand or  
(Manufacturer's Price) Subsidised Generic  
\$ Per ✓ Manufacturer

## Lipid-Modifying Agents

### Fibrates

#### BEZAFIBRATE

* Tab 200 mg .....	22.65	90	✓ <b>Bezalip</b>
* Tab long-acting 400 mg.....	21.54	30	✓ <b>Bezalip Retard</b>

### Other Lipid-Modifying Agents

#### ACIPIMOX

* Cap 250 mg.....	38.19	30	✓ <b>Olbetam</b>
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### Resins

#### COLESTYRAMINE

Powder for oral suspension 4 g sachet .....	61.50	50	✓ <b>Colestyramine - Mylan</b> <sup>\$29</sup> ✓ <b>Quantalan sugar free</b> <sup>\$29</sup> ✓ <b>Questran Light (Neon)</b> <sup>\$29</sup>
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### HMG CoA Reductase Inhibitors (Statins)

#### ATORVASTATIN

* Tab 10 mg .....	0.31	30	✓ <b>Lorstat</b>
	5.16	500	✓ <b>Lorstat</b>
* Tab 20 mg .....	8.12	500	✓ <b>Lorstat</b>
* Tab 40 mg .....	13.79	500	✓ <b>Lorstat</b>
* Tab 80 mg .....	1.52	30	✓ <b>Lorstat</b>
	25.39	500	✓ <b>Lorstat</b>

#### PRAVASTATIN

* Tab 20 mg .....	7.16	100	✓ <b>Clinect</b>
* Tab 40 mg .....	12.25	100	✓ <b>Clinect</b>

#### ROSUVASTATIN – Special Authority see [SA2093 on the next page](#) – Retail pharmacy

* Tab 5 mg .....	1.29	30	✓ <b>Rosuvastatin Viatrix</b> ✓ <b>Rosuvastatin - Sandoz</b>
	4.21		
* Tab 10 mg .....	1.69	30	✓ <b>Rosuvastatin Viatrix</b> ✓ <b>Rosuvastatin - Sandoz</b>
	4.21		
* Tab 20 mg .....	2.71	30	✓ <b>Rosuvastatin Viatrix</b> ✓ <b>Rosuvastatin - Sandoz</b>
	4.21		
* Tab 40 mg .....	4.55	30	✓ <b>Rosuvastatin - Sandoz</b> ✓ <b>Rosuvastatin Viatrix</b>

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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## ►SA2093 Special Authority for Subsidy

**Initial application — (cardiovascular disease risk)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 Patient is considered to be at risk of cardiovascular disease; and
  - 1.2 Patient is Māori or any Pacific ethnicity; or
- 2 Both:
  - 2.1 Patient has a calculated risk of cardiovascular disease of at least 15% over 5 years; and
  - 2.2 LDL cholesterol has not reduced to less than 1.8 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin.

**Initial application — (familial hypercholesterolemia)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 Patient has familial hypercholesterolemia (defined as a Dutch Lipid Criteria score greater than or equal to 6); and
- 2 LDL cholesterol has not reduced to less than 1.8 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin.

**Initial application — (established cardiovascular disease)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 Any of the following:
  - 1.1 Patient has proven coronary artery disease (CAD); or
  - 1.2 Patient has proven peripheral artery disease (PAD); or
  - 1.3 Patient has experienced an ischaemic stroke; and
- 2 LDL cholesterol has not reduced to less than 1.4 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin.

**Initial application — (recurrent major cardiovascular events)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 Patient has experienced a recurrent major cardiovascular event (defined as myocardial infarction, ischaemic stroke, coronary revascularisation, hospitalisation for unstable angina) in the last 2 years; and
- 2 LDL cholesterol has not reduced to less than 1.0 mmol/litre with treatment with the maximum tolerated dose of atorvastatin and/or simvastatin.

### SIMVASTATIN

* Tab 10 mg .....	1.68	90	✓ <u>Simvastatin Mylan</u>
* Tab 20 mg .....	2.54	90	✓ <u>Simvastatin Viatris</u>
* Tab 40 mg .....	4.11	90	✓ <u>Simvastatin Viatris</u>
* Tab 80 mg .....	8.81	90	✓ <u>Simvastatin Viatris</u>

## Selective Cholesterol Absorption Inhibitors

### EZETIMIBE

* Tab 10 mg .....	1.76	30	✓ <u>Ezetimibe Sandoz</u>
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	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>EZETIMIBE WITH SIMVASTATIN</b>				
Tab 10 mg with simvastatin 10 mg.....	11.86	30	✓	Zimybe
Tab 10 mg with simvastatin 20 mg.....	12.55	30	✓	Zimybe
Tab 10 mg with simvastatin 40 mg.....	11.55	30	✓	Vytorin <sup>\$29</sup>
			✓	Zimybe
Tab 10 mg with simvastatin 80 mg.....	14.27	30	✓	Vytorin <sup>\$29</sup>
			✓	Zimybe

**Nitrates**

**GLYCERYL TRINITRATE**

* Oral pump spray, 400 mcg per dose – Up to 250 dose available on a PSO.....	7.48	250 dose OP	✓	Nitrolingual Pump Spray
* Patch 25 mg, 5 mg per day.....	15.73	30	✓	Nitroderm TTS
* Patch 50 mg, 10 mg per day.....	18.62	30	✓	Nitroderm TTS

**ISOSORBIDE MONONITRATE**

* Tab 20 mg.....	22.49	100	✓	Ismo 20
* Tab long-acting 40 mg.....	9.80	30	✓	Ismo 40 Retard
* Tab long-acting 60 mg.....	13.50	90	✓	Duride

**Sympathomimetics**

**ADRENALINE**

Inj 1 in 1,000, 1 ml ampoule – Up to 5 inj available on a PSO.....	4.98	5	✓	Aspen Adrenaline
	17.78		✓	DBL Adrenaline

- Note: adrenaline inj 1 in 1,000, 1 ml ampoule can be supplied on BSO to a Vaccinator (other than a Pharmacist) under the provisions in Part I of Section A
- Note: Direct Provision by a pharmacist of Inj 1 in 1,000, 1 ml ampoule permitted under the provisions in Part I of Section A.

Inj 1 in 10,000, 10 ml ampoule – Up to 5 inj available on a PSO.....	36.18	5	✓	DBL Adrenaline
	49.00	10	✓	Aspen Adrenaline

**Vasodilators**

**HYDRALAZINE HYDROCHLORIDE**

* Tab 25 mg – Special Authority see SA1321 below – Retail pharmacy.....	CBS	1	✓	Hydralazine
		56	✓	Onelink <sup>\$29</sup>
		84	✓	AMDIPHARM <sup>\$29</sup>
		100	✓	Camber <sup>\$29</sup>
* Inj 20 mg ampoule.....	25.90	5	✓	Apresoline
			✓	Hydrapres <sup>\$29</sup>
* Inj 20 mg per ml, 1 ml vial.....	283.00	25	✓	Eugia <sup>\$29</sup>

►SA1321 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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continued...

- Either:
- 1 For the treatment of refractory hypertension; or
  - 2 For the treatment of heart failure in combination with a nitrate, in patients who are intolerant or have not responded to ACE inhibitors and/or angiotensin receptor blockers.

## MINOXIDIL

▲ Tab 10 mg	47.04	60	✓	<b>Minoxidil Roma</b> <sup>S29</sup>
	78.40	100	✓	<b>Loniten</b>

## NICORANDIL

▲ Tab 10 mg	27.81	60	✓	<b>Max Health</b>
▲ Tab 20 mg	35.12	60	✓	<b>Max Health</b>

## PAPAVERINE HYDROCHLORIDE

* Inj 12 mg per ml, 10 ml ampoule	257.12	5	✓	<b>Hospira</b>
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## PENTOXIFYLLINE [OXPENTIFYLLINE]

Tab 400 mg	44.37	50	✓	<b>Trental 400</b>
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## Endothelin Receptor Antagonists

AMBRISENTAN – Special Authority see [SA2556 below](#) – Retail pharmacy

Tab 5 mg	200.00	30	✓	<b>Ambrisentan Viatris</b>
Tab 10 mg	200.00	30	✓	<b>Ambrisentan Viatris</b>

### ► [SA2556](#) Special Authority for Subsidy

**Initial application — (PAH monotherapy)** only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has pulmonary arterial hypertension (PAH); and
- 2 PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications; and
- 3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV; and
- 4 Any of the following:
  - 4.1 All of the following:
    - 4.1.1 PAH has been confirmed by right heart catheterisation; and
    - 4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
    - 4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
    - 4.1.4 Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm<sup>-5</sup>); and
    - 4.1.5 Any of the following:
      - 4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH; or
      - 4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool<sup>\*\*</sup>; or
      - 4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
  - 4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease; or
  - 4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures; and

5 Both:

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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continued...

- 5.1 Ambrisentan is to be used as PAH monotherapy; and
- 5.2 Any of the following:
  - 5.2.1 Patient has experienced intolerable side effects with both sildenafil and bosentan; or
  - 5.2.2 Patient has an absolute contraindication to sildenafil and an absolute or relative contraindication to bosentan (e.g. due to current use of a combined oral contraceptive or liver disease); or
  - 5.2.3 Patient is a child with idiopathic PAH or PAH secondary to congenital heart disease.

**Initial application — (PAH dual therapy)** only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has pulmonary arterial hypertension (PAH); and
- 2 PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications; and
- 3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV; and
- 4 Any of the following:
  - 4.1 All of the following:
    - 4.1.1 PAH has been confirmed by right heart catheterisation; and
    - 4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
    - 4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
    - 4.1.4 Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm<sup>-5</sup>); and
    - 4.1.5 Any of the following:
      - 4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH; or
      - 4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool\*\*; or
      - 4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
  - 4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease; and
  - 4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures; and

5 Both:

- 5.1 Ambrisentan is to be used as PAH dual therapy; and
- 5.2 Any of the following:
  - 5.2.1 Patient has tried bosentan (either as PAH monotherapy, or PAH dual therapy with sildenafil) for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool\*\*; or
  - 5.2.2 Patient has experienced intolerable side effects on bosentan; or
  - 5.2.3 Patient has an absolute or relative contraindication to bosentan (e.g. due to current use of a combined oral contraceptive or liver disease); or
  - 5.2.4 Patient is presenting in NYHA/WHO functional class III or IV, and would benefit from initial dual therapy in the opinion of the treating clinician and has an absolute or relative contraindication to bosentan (eg. due to current liver disease or use of a combined oral contraceptive).

**Initial application — (PAH triple therapy)** only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has pulmonary arterial hypertension (PAH); and

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

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continued...

- 2 PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications; and
- 3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV; and
- 4 Any of the following:
  - 4.1 All of the following:
    - 4.1.1 PAH has been confirmed by right heart catheterisation; and
    - 4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
    - 4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
    - 4.1.4 Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm<sup>-5</sup>); and
    - 4.1.5 Any of the following:
      - 4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH; or
      - 4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool\*\*; or
      - 4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
  - 4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease; or
  - 4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures; and
- 5 Both:
  - 5.1 Ambrisentan is to be used as PAH triple therapy; and
  - 5.2 Any of the following:
    - 5.2.1 Patient is on the lung transplant list; or
    - 5.2.2 Both:
      - 5.2.2.1 Patient is presenting in NYHA/WHO functional class IV; and
      - 5.2.2.2 Patient has an absolute or relative contraindication to bosentan (e.g. due to current use of a combined oral contraceptive or liver disease); or
    - 5.2.3 Both:
      - 5.2.3.1 Patient has tried PAH dual therapy for at least three months and remains in an unacceptable risk category according to a validated risk stratification tool\*\*; and
      - 5.2.3.2 Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario.

**Renewal** only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist. Approvals valid for 2 years where the patient is continuing to derive benefit from ambrisentan treatment according to a validated PAH risk stratification tool\*\*.

Note: \*\* the requirement to use a validated risk stratification tool to determine insufficient response applies to adults.

Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

BOSENTAN – Special Authority see [SA2557 below](#) – Retail pharmacy

Tab 62.5 mg .....	100.00	60	✓ <b>Bosentan Dr Reddy's</b>
Tab 125 mg .....	100.00	60	✓ <b>Bosentan Dr Reddy's</b>

### ►SA2557 Special Authority for Subsidy

**Initial application — (PAH monotherapy)** only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist. Approvals valid for 6 months for

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continued...

applications meeting the following criteria:

All of the following:

- 1 Patient has pulmonary arterial hypertension (PAH)\*; and
- 2 PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications; and
- 3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV; and
- 4 Any of the following:
  - 4.1 All of the following:
    - 4.1.1 PAH has been confirmed by right heart catheterisation; and
    - 4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
    - 4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
    - 4.1.4 Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm<sup>-5</sup>); and
    - 4.1.5 Any of the following:
      - 4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH; or
      - 4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool\*\*; or
      - 4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
  - 4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease; or
  - 4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures; and
- 5 Both:
  - 5.1 Bosentan is to be used as PAH monotherapy; and
  - 5.2 Any of the following:
    - 5.2.1 Patient has experienced intolerable side effects on sildenafil; or
    - 5.2.2 Patient has an absolute contraindication to sildenafil; or
    - 5.2.3 Patient is a child with idiopathic PAH or PAH secondary to congenital heart disease.

**Initial application — (PAH dual therapy)** only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has pulmonary arterial hypertension (PAH)\*; and
- 2 PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications; and
- 3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV; and
- 4 Any of the following:
  - 4.1 All of the following:
    - 4.1.1 PAH has been confirmed by right heart catheterisation; and
    - 4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
    - 4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
    - 4.1.4 Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm<sup>-5</sup>); and
    - 4.1.5 Any of the following:
      - 4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH; or
      - 4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool\*\*; or

continued...

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

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- 4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
- 4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease; or
- 4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures; and
- 5 Bosentan is to be used as part of PAH dual therapy; and
- 6 Either:
  - 6.1 Patient has tried a PAH monotherapy (sildenafil) for at least three months and has experienced an inadequate therapeutic response to treatment according to a validated risk stratification tool\*\*; or
  - 6.2 Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would likely benefit from initial dual therapy.

**Initial application — (PAH triple therapy)** only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has pulmonary arterial hypertension (PAH)\*; and
- 2 PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications; and
- 3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV; and
- 4 Any of the following:
  - 4.1 All of the following:
    - 4.1.1 PAH has been confirmed by right heart catheterisation; and
    - 4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
    - 4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
    - 4.1.4 Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn  $\text{cm}^{-5}$ ); and
    - 4.1.5 Any of the following:
      - 4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH; or
      - 4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool\*\*; or
      - 4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
  - 4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease; or
  - 4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures; and
- 5 Both:
  - 5.1 Bosentan is to be used as part of PAH triple therapy; and
  - 5.2 Any of the following:
    - 5.2.1 Patient is on the lung transplant list; or
    - 5.2.2 Patient is presenting in NYHA/WHO functional class IV; or
    - 5.2.3 Both:
      - 5.2.3.1 Patient has tried PAH dual therapy for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool\*\*; and
      - 5.2.3.2 Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario.

**Renewal** only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist. Approvals valid for 2 years where patient is continuing to derive benefit from

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bosentan treatment according to a validated PAH risk stratification tool\*\*.

Note: \*\* the requirement to use a validated risk stratification tool to determine insufficient response applies to adults.

Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

### Phosphodiesterase Type 5 Inhibitors

SILDENAFIL – Special Authority see SA2558 below – Retail pharmacy

Tab 25 mg .....	0.72	4	✓ <b>Vedafil</b>
Tab 50 mg .....	1.45	4	✓ <b>Vedafil</b>
Tab 100 mg .....	11.22	12	✓ <b>Vedafil</b>

#### ►SA2558 Special Authority for Subsidy

**Initial application — (Raynaud's Phenomenon\*)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Patient has Raynaud's Phenomenon\*; and
- 2 Patient has severe digital ischaemia (defined as severe pain requiring hospital admission or with a high likelihood of digital ulceration; digital ulcers; or gangrene); and
- 3 Patient is following lifestyle management (avoidance of cold exposure, sufficient protection, smoking cessation support, avoidance of sympathomimetic drugs); and
- 4 Patient is being treated with calcium channel blockers and nitrates (or these are contraindicated/not tolerated).

**Initial application — (Pulmonary arterial hypertension\*)** only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Patient has pulmonary arterial hypertension (PAH)\*; and
- 2 PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications; and
- 3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV; and
- 4 Any of the following:
  - 4.1 All of the following:
    - 4.1.1 PAH is confirmed by right heart catheterisation; and
    - 4.1.2 A mean pulmonary artery pressure (PAPm) of greater than 20 mmHg; and
    - 4.1.3 A pulmonary capillary wedge pressure (PCWP) that is less than or equal to 15 mmHg; and
    - 4.1.4 Pulmonary vascular resistance (PVR) of at least 2 Wood Units or greater than 160 International Units (dyn s cm<sup>-5</sup>); and
    - 4.1.5 Any of the following:
      - 4.1.5.1 PAH is non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH; or
      - 4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool\*\*; or
      - 4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
  - 4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including severe chronic neonatal lung disease; or
  - 4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures.

**Initial application — (erectile dysfunction due to spinal cord injury)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

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- 1 Patient has a documented history of traumatic or non-traumatic spinal cord injury; and
- 2 Patient has erectile dysfunction secondary to spinal cord injury requiring pharmacological treatment.

**Renewal — (erectile dysfunction due to spinal cord injury)** from any relevant practitioner. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefiting from treatment.

Notes: Indications marked with \* are Unapproved Indications.

\*\* the requirement to use a validated risk stratification tool to determine insufficient response applies to adults. Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

## Prostacyclin Analogues

EPOPSTENOL – Special Authority see [SA2559 below](#) – Retail pharmacy

Inj 500 mcg vial.....	36.61	1	✓ Veletri
Inj 1.5 mg vial .....	73.21	1	✓ Veletri

### ►SA2559 Special Authority for Subsidy

**Initial application — (PAH dual therapy)** only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has pulmonary arterial hypertension (PAH); and
- 2 PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications; and
- 3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class III or IV; and
- 4 Any of the following:
  - 4.1 All of the following:
    - 4.1.1 PAH has been confirmed by right heart catheterisation; and
    - 4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
    - 4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
    - 4.1.4 A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm<sup>-5</sup>); and
    - 4.1.5 Any of the following:
      - 4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH; or
      - 4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool\*\*; or
      - 4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
  - 4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease; or
  - 4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures ; and
- 5 All of the following:
  - 5.1 Epoprostenol is to be used as part of PAH dual therapy with either sildenafil or an endothelin receptor antagonist; and
  - 5.2 Patient is presenting in NYHA/WHO functional class IV; and
  - 5.3 Patient has tried a PAH monotherapy for at least three months and remains in an unacceptable risk category according to a validated risk stratification tool.

**Initial application — (PAH triple therapy)** only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist. Approvals valid for 6 months for

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applications meeting the following criteria:

All of the following:

- 1 Patient has pulmonary arterial hypertension (PAH); and
- 2 PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications; and
- 3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class III or IV; and
- 4 Any of the following:
  - 4.1 All of the following:
    - 4.1.1 PAH has been confirmed by right heart catheterisation; and
    - 4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
    - 4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
    - 4.1.4 A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm<sup>-5</sup>); and
    - 4.1.5 Any of the following:
      - 4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH; or
      - 4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool\*\*; or
      - 4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
  - 4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease; or
  - 4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures ; and
- 5 Both:
  - 5.1 Epoprostenol is to be used as PAH triple therapy; and
  - 5.2 Any of the following:
    - 5.2.1 Patient is on the lung transplant list; or
    - 5.2.2 Patient is presenting in NYHA/WHO functional class IV; or
    - 5.2.3 Both:
      - 5.2.3.1 Patient has tried PAH dual therapy for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool; and
      - 5.2.3.2 Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario.

**Renewal** only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist. Approvals valid for 2 years where patient is continuing to derive benefit from epoprostenol treatment according to a validated PAH risk stratification tool\*\*.

Note: \*\* the requirement to use a validated risk stratification tool to determine insufficient response applies to adults.

Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

ILOPROST – Special Authority see [SA2560 below](#) – Retail pharmacy

Nebuliser soln 10 mcg per ml, 2 ml.....	166.53	30	✓ <b>Veblis</b>
			✓ <b>Veblis S29</b> <small>S29</small>

**SA2560 Special Authority for Subsidy**

**Initial application — (PAH monotherapy)** only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

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continued...

- 1 Patient has pulmonary arterial hypertension (PAH); and
- 2 PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications; and
- 3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV; and
- 4 Any of the following:
  - 4.1 All of the following:
    - 4.1.1 PAH has been confirmed by right heart catheterisation; and
    - 4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
    - 4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
    - 4.1.4 A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn cm<sup>-5</sup>); and
    - 4.1.5 Any of the following:
      - 4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH; or
      - 4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool\*\*; or
      - 4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
  - 4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease; or
  - 4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures ; and
- 5 Both:
  - 5.1 Iloprost is to be used as PAH monotherapy; and
  - 5.2 Either:
    - 5.2.1 Patient has experienced intolerable side effects on sildenafil and both the funded endothelin receptor antagonists (i.e. both bosentan and ambrisentan); or
    - 5.2.2 Patient has an absolute contraindication to sildenafil and an absolute or relative contraindication to endothelin receptor antagonists.

**Initial application — (PAH dual therapy)** only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has pulmonary arterial hypertension (PAH); and
- 2 PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications; and
- 3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV; and
- 4 Any of the following:
  - 4.1 All of the following:
    - 4.1.1 PAH has been confirmed by right heart catheterisation; and
    - 4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
    - 4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
    - 4.1.4 A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn cm<sup>-5</sup>); and
    - 4.1.5 Any of the following:
      - 4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH; or
      - 4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool\*\*; or
      - 4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or

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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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- 4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease; or
- 4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures ; and
- 5 All of the following:
  - 5.1 Iloprost is to be used as PAH dual therapy with either sildenafil or an endothelin receptor antagonist; and
  - 5.2 Either:
    - 5.2.1 Patient has an absolute contraindication to or has experienced intolerable side effects on sildenafil; or
    - 5.2.2 Patient has an absolute or relative contraindication to or experienced intolerable side effects with a funded endothelin receptor antagonist; and
  - 5.3 Either:
    - 5.3.1 Patient has tried a PAH monotherapy for at least three months and remains in an unacceptable risk category according to a validated risk stratification tool\*\*; or
    - 5.3.2 Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would benefit from initial dual therapy.

**Initial application — (PAH triple therapy)** only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has pulmonary arterial hypertension (PAH); and
- 2 PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications; and
- 3 PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or IV; and
- 4 Any of the following:
  - 4.1 All of the following:
    - 4.1.1 PAH has been confirmed by right heart catheterisation; and
    - 4.1.2 A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair); and
    - 4.1.3 A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg; and
    - 4.1.4 A pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Units (dyn s cm<sup>-5</sup>); and
    - 4.1.5 Any of the following:
      - 4.1.5.1 PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric oxide, as defined in the 2022 ECS/ERS Guidelines for PAH; or
      - 4.1.5.2 Patient has not experienced an acceptable response to calcium antagonist treatment, according to a validated risk stratification tool\*\*; or
      - 4.1.5.3 Patient has PAH other than idiopathic / heritable or drug-associated type; or
  - 4.2 Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital or developmental lung disorders including chronic neonatal lung disease; or
  - 4.3 Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures or a major complication of the Fontan circulation requiring the minimising of pulmonary/venous filling pressures ; and
- 5 Both:
  - 5.1 Iloprost is to be used as PAH triple therapy; and
  - 5.2 Any of the following:
    - 5.2.1 Patient is on the lung transplant list; or
    - 5.2.2 Patient is presenting in NYHA/WHO functional class IV; or
    - 5.2.3 Both:
      - 5.2.3.1 Patient has tried PAH dual therapy for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool\*\*; and

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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continued...

5.2.3.2 Patient does not have major life-threatening comorbidities and triple therapy is not being used in a palliative scenario.

**Renewal** only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist. Approvals valid for 2 years where patient is continuing to derive benefit from iloprost treatment according to a validated PAH risk stratification tool\*\*.

Note: \*\* the requirement to use a validated risk stratification tool to determine insufficient response applies to adults. Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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## Antiacne Preparations

For systemic antibacterials, refer to INFECTIONS, Antibacterials, [page 95](#)

ADAPALENE – Only on a prescription  
Maximum of 30 g per three months

Gel 0.1%.....	22.89	30 g OP	✓ Differin
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ISOTRETINOIN – Special Authority see [SA2584 below](#) – Retail pharmacy

Cap 5 mg.....	11.26	60	✓ Oratane
Cap 10 mg.....	18.75	120	✓ Oratane
Cap 20 mg.....	26.73	120	✓ Oratane

► [SA2584](#) **Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:  
All of the following:

- 1 Applicant is a vocationally registered dermatologist, paediatrician, vocationally registered general practitioner, or nurse practitioner working in a relevant scope of practice; and
- 2 Applicant has an up to date knowledge of the safety issues around isotretinoin and is competent to prescribe isotretinoin; and
- 3 Any of the following:
  - 3.1 Patient is of child bearing potential and the possibility of pregnancy has been excluded prior to commencement of treatment and patient has been counselled and understands the risk of teratogenicity if isotretinoin is used during pregnancy and that they must not become pregnant during treatment and for a period of one month after the completion of treatment; or
  - 3.2 Patient is not of child bearing potential; or
  - 3.3 Patient is a child and it is considered not appropriate to exclude pregnancy or start contraceptives or undertake pregnancy-related isotretinoin counselling.

**Renewal** from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:  
Any of the following:

- 1 Patient is of child bearing potential and the possibility of pregnancy has been excluded prior to commencement of treatment and patient has been counselled and understands the risk of teratogenicity if isotretinoin is used during pregnancy and that they must not become pregnant during treatment and for a period of one month after the completion of treatment; or
- 2 Patient is not of child bearing potential; or
- 3 Patient is a child and it is considered not appropriate to exclude pregnancy or start contraceptives or undertake pregnancy-related isotretinoin counselling.

**Initial application — (Neuroblastoma)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

- Both:
- 1 The patient has neuroblastoma; and
  - 2 Any of the following:
    - 2.1 Patient is of child bearing potential and the possibility of pregnancy has been excluded prior to commencement of treatment and patient has been counselled and understands the risk of teratogenicity if isotretinoin is used during pregnancy and that they must not become pregnant during treatment and for a period of one month after the completion of treatment; or
    - 2.2 Patient is not of child bearing potential; or
    - 2.3 Patient is a child and it is considered not appropriate to exclude pregnancy or start contraceptives or undertake pregnancy-related isotretinoin counselling.

**Renewal — (Neuroblastoma)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the

continued...

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

## DERMATOLOGICALS

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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continued...

following criteria:

Both:

- 1 The patient has neuroblastoma; and
- 2 Any of the following:
  - 2.1 Patient is of child bearing potential and the possibility of pregnancy has been excluded prior to commencement of treatment and patient has been counselled and understands the risk of teratogenicity if isotretinoin is used during pregnancy and that they must not become pregnant during treatment and for a period of one month after the completion of treatment; or
  - 2.2 Patient is not of child bearing potential; or
  - 2.3 Patient is a child and it is considered not appropriate to exclude pregnancy or start contraceptives or undertake pregnancy-related isotretinoin counselling.

### TRETINOIN

Crm 0.5 mg per g.....	16.82	50 g OP	✓ <u>ReTrieve</u>
Maximum of 50 g per three months			

## Antibacterials Topical

For systemic antibacterials, refer to INFECTIONS, Antibacterials, [page 95](#)

### HYDROGEN PEROXIDE

* Crm 1%.....	4.89	15 g OP	✓ <u>Crystaderm</u>
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### MUPIROCIN

Oint 2%.....	6.60 (13.00)	15 g OP	Bactroban
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- a) Only on a prescription
- b) Not in combination

### SODIUM FUSIDATE [FUSIDIC ACID]

Crm 2%.....	1.69	5 g OP	✓ <u>Foban</u>
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- a) Maximum of 5 g per prescription
- b) Only on a prescription
- c) Not in combination

Oint 2%.....	1.69	5 g OP	✓ <u>Foban</u>
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- a) Maximum of 5 g per prescription
- b) Only on a prescription
- c) Not in combination

### SULFADIAZINE SILVER

Crm 1%.....	10.80	50 g OP	✓ <u>Flamazine</u>
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- a) Up to 250 g available on a PSO
- b) Not in combination

## Antifungals Topical

For systemic antifungals, refer to INFECTIONS, Antifungals, [page 102](#)

### AMOROLFINE

- a) Only on a prescription
- b) Not in combination

Nail soln 5%.....	21.87	5 ml OP	✓ <u>MycoNail</u>
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Subsidy (Manufacturer's Price) \$ Fully Subsidised Per ✓ Brand or Generic Manufacturer

**Corticosteroids Topical**

For systemic corticosteroids, refer to CORTICOSTEROIDS AND RELATED AGENTS, page 86

**Corticosteroids - Plain**

**BETAMETHASONE DIPROPIONATE**

Crm 0.05%.....	2.96	15 g OP	✓ <b>Diprosone</b>
	36.00	50 g OP	✓ <b>Diprosone</b>
Oint 0.05%.....	2.96	15 g OP	✓ <b>Diprosone</b>
	36.00	50 g OP	✓ <b>Diprosone</b>
Oint 0.05% in propylene glycol base .....	4.33	30 g OP	✓ <b>Diprosone OV</b>

**BETAMETHASONE VALERATE**

* Crm 0.1%.....	5.85	50 g OP	✓ <b>Beta Cream</b>
* Oint 0.1%.....	7.90	50 g OP	✓ <b>Beta Ointment</b>
* Lotn 0.1% .....	30.00	50 ml OP	✓ <b>Betnovate</b>

**CLOBETASOL PROPIONATE**

* Crm 0.05%.....	3.75	30 g OP	✓ <b>Dermol</b>
* Oint 0.05%.....	3.68	30 g OP	✓ <b>Dermol</b>

**CLOBETASONE BUTYRATE**

Crm 0.05%.....	5.38	30 g OP	
	(10.00)		Eumovate

**HYDROCORTISONE**

* Crm 1% – Only on a prescription.....	1.75	30 g OP	✓ <b>Ethics</b>
	20.40	500 g	✓ <b>Noumed</b>
Ethics to be Principal Supply on 1 July 2026			
* Powder – Only in combination.....	49.95	25 g	✓ <b>ABM</b>
Up to 5% in a dermatological base (not proprietary Topical Corticosteroid – Plain) with or without other dermatological galenicals			

**HYDROCORTISONE AND PARAFFIN LIQUID AND LANOLIN**

Lotn 1% with paraffin liquid 15.9% and lanolin 0.6% – Only on a prescription .....	12.83	250 ml	✓ <b>DP Lotn HC</b>
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**HYDROCORTISONE BUTYRATE**

Lipocream 0.1%.....	4.85	100 g OP	✓ <b>Locoid Lipocream</b>
Oint 0.1%.....	10.28	100 g OP	✓ <b>Locoid</b>
Milky emul 0.1% .....	12.33	100 ml OP	✓ <b>Locoid Crelo</b>

**METHYLPREDNISOLONE ACEPONATE**

Crm 0.1%.....	4.95	15 g OP	✓ <b>Advantan</b>
Oint 0.1%.....	4.95	15 g OP	✓ <b>Advantan</b>

**MOMETASONE FUROATE**

Crm 0.1%.....	2.25	15 g OP	✓ <b>Elocon Alcohol Free</b>
	3.50	50 g OP	✓ <b>Elocon Alcohol Free</b>
Oint 0.1%.....	2.25	15 g OP	✓ <b>Elocon</b>
	3.50	50 g OP	✓ <b>Elocon</b>
Lotn 0.1% .....	4.99	30 ml OP	✓ <b>Elocon</b>

**TRIAMCINOLONE ACETONIDE**

Crm 0.02%.....	6.49	100 g OP	✓ <b>Aristocort</b>
Oint 0.02%.....	6.54	100 g OP	✓ <b>Aristocort</b>

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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**Corticosteroids - Combination**

BETAMETHASONE VALERATE WITH SODIUM FUSIDATE [FUSIDIC ACID] Crm 0.1% with sodium fusidate (fusidic acid) 2%.....	3.49 (10.45)	15 g OP		Fucicort
a) Maximum of 15 g per prescription b) Only on a prescription				
HYDROCORTISONE WITH MICONAZOLE – Only on a prescription * Crm 1% with miconazole nitrate 2%.....	2.85	15 g OP	✓	<u>Micreme H</u>
HYDROCORTISONE WITH NATAMYCIN AND NEOMYCIN – Only on a prescription Oint 1% with natamycin 1% and neomycin sulphate 0.5%.....	4.34	15 g OP	✓	<u>Pimafucort</u>
TRIAMCINOLONE ACETONIDE WITH GRAMICIDIN, NEOMYCIN AND NYSTATIN Crm 1 mg with nystatin 100,000 u, neomycin sulphate 2.5 mg and gramicidin 250 mcg per g – Only on a prescription .....	3.49 (9.28)	15 g OP		Viaderm KC

**Barrier Creams and Emollients**

**Barrier Creams**

DIMETHICONE				
* Crm 5% pump bottle.....	4.14	460 g OP	✓	<u>Hydralock</u>
* Crm 10% pump bottle.....	4.52	460 g OP	✓	<u>healthE</u> Dimethicone 10%
ZINC AND CASTOR OIL				
* Oint.....	4.25	500 g	✓	<u>Evara</u>

**Emollients**

AQUEOUS CREAM				
* Crm.....	1.65	500 g	✓	<u>Evara</u>
CETOMACROGOL				
* Crm BP.....	2.29	500 g	✓	<u>Cetomacrogol-AFT</u>
CETOMACROGOL WITH GLYCEROL				
Crm 90% with glycerol 10%.....	1.92	460 g OP	✓	<u>Evara</u>
	3.25	920 g OP	✓	<u>Evara</u>
EMULSIFYING OINTMENT				
* Oint BP.....	3.13	500 g	✓	<u>Evara Emulsifying Ointment</u>
OIL IN WATER EMULSION				
* Crm.....	2.10	500 g	✓	<u>Fatty Emulsion Cream (Evara)</u>
PARAFFIN				
Oint liquid paraffin 50% with white soft paraffin 50%.....	4.45	500 g OP	✓	<u>EVARA Paraffin Ointment 50/50</u>
UREA				
* Crm 10%.....	1.37	100 g OP	✓	<u>healthE Urea Cream</u>

## DERMATOLOGICALS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>WOOL FAT WITH MINERAL OIL – Only on a prescription</b>				
* Lotn hydrous 3% with mineral oil.....	5.60	1,000 ml		
	(14.96)			DP Lotion
	(20.53)			Alpha-Keri Lotion
	1.40	250 ml OP		
	(5.87)			DP Lotion
	5.60	1,000 ml		
	(23.91)			BK Lotion
	1.40	250 ml OP		
	(7.73)			BK Lotion

### Other Dermatological Bases

<b>PARAFFIN</b>				
White soft – Only in combination.....	4.74	450 g	✓	<b><u>EVARA White Soft Paraffin</u></b>
	19.00	2,500 g	✓	<b><u>EVARA White Soft Paraffin</u></b>

Only in combination with a dermatological galenical or as a diluent for a proprietary Topical Corticosteroid – Plain.

### Minor Skin Infections

<b>POVIDONE IODINE</b>				
Oint 10%.....	7.40	65 g OP	✓	<b>Betadine</b>
a) Maximum of 130 g per prescription				
b) Only on a prescription				
Antiseptic Solution 10%.....	4.99	100 ml	✓	<b>Riodine</b>
Antiseptic soln 10%.....	3.83	15 ml	✓	<b>Riodine</b>
	6.99	500 ml	✓	<b>Riodine</b>
Skin preparation, povidone iodine 10% with 30% alcohol.....	1.63	100 ml		
	(3.48)			Betadine Skin Prep

### Parasiticial Preparations

<b>DIMETHICONE</b>				
Note: Direct Provision by a pharmacist permitted under the provisions in Part I of Section A in accordance with the Integrated Community Pharmaceuticals Agreement (ICPSA) – Extended Pharmacy Services.				
* Lotn 4%.....	4.60	200 ml OP	✓	<b>healthE <u>Dimethicone 4% Lotion</u></b>
<b>IVERMECTIN – Special Authority see SA2511 on the next page – Retail pharmacy</b>				
Tab 3 mg – Up to 100 tab available on a PSO.....	17.20	4	✓	<b>Stromectol</b>
1) PSO for institutional use only. Must be endorsed with the name of the institution for which the PSO is required and a valid Special Authority for patient of that institution.				
2) Ivermectin available on BSO provided the BSO includes a valid Special Authority for a patient of the institution.				
3) For the purposes of subsidy of ivermectin, institution means age related residential care facilities, disability care facilities or prisons.				

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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►SA2511 **Special Authority for Subsidy**

**Initial application — (Scabies)** from any relevant practitioner. Approvals valid for 1 month for applications meeting the following criteria:

Either:

- 1 The person has a severe scabies hyperinfestation (Crusted/ Norwegian scabies); or
- 2 Both:
  - 2.1 The person has a confirmed diagnosis of scabies or is a close contact of a scabies case; and
  - 2.2 Either:
    - 2.2.1 The person is unable to complete topical therapy; or
    - 2.2.2 Previous treatment with topical therapy has been tried and not cleared the infestation.

**Initial application — (Other parasitic infections)** from any relevant practitioner. Approvals valid for 1 month for applications meeting the following criteria:

Any of the following:

- 1 filariasis; or
- 2 cutaneous larva migrans (creeping eruption); or
- 3 strongyloidiasis; or
- 4 The individual has a travel or residence history that requires presumptive parasite treatment.

**Renewal — (Scabies)** from any relevant practitioner. Approvals valid for 1 month for applications meeting the following criteria:

Either:

- 1 The person has a severe scabies hyperinfestation (Crusted/ Norwegian scabies); or
- 2 Both:
  - 2.1 The person has a confirmed diagnosis of scabies or is a close contact of a scabies case; and
  - 2.2 Either:
    - 2.2.1 The person is unable to complete topical therapy; or
    - 2.2.2 Previous treatment with topical therapy has been tried and not cleared the infestation.

**Renewal — (Other parasitic infections)** from any relevant practitioner. Approvals valid for 1 month for applications meeting the following criteria:

Any of the following:

- 1 filariasis; or
- 2 cutaneous larva migrans (creeping eruption); or
- 3 strongyloidiasis.

PERMETHRIN

Note: Direct Provision by a pharmacist permitted under the provisions in Part I of Section A in accordance with the Integrated Community Pharmaceuticals Agreement (ICPSA) – Extended Pharmacy Services.

Lotn 5% .....	4.28	30 ml OP	✓ <b>A-Scabies</b>
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**Psoriasis and Eczema Preparations**

ACITRETIN – Special Authority see SA2024 below – Retail pharmacy

Cap 10 mg .....	26.20	60	✓ <b>Novatretin</b>
Cap 25 mg .....	57.37	60	✓ <b>Novatretin</b>

►SA2024 **Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

All of the following:

- 1 Applicant is a vocationally registered dermatologist, vocationally registered general practitioner, or nurse practitioner working in a relevant scope of practice; and

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# DERMATOLOGICALS

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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continued...

2 Applicant has an up to date knowledge of the safety issues around acitretin and is competent to prescribe acitretin; and

3 Either:

3.1 Patient is of child bearing potential and the possibility of pregnancy has been excluded prior to commencement of treatment and patient has been counselled and understands the risk of teratogenicity if acitretin is used during pregnancy and that they must not become pregnant during treatment and for a period of three years after the completion of treatment; or

3.2 Patient is not of child bearing potential.

**Renewal** from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Either:

1 Patient is of child bearing potential and the possibility of pregnancy has been excluded prior to commencement of treatment and patient has been counselled and understands the risk of teratogenicity if acitretin is used during pregnancy and that they must not become pregnant during treatment and for a period of three years after the completion of treatment; or

2 Patient is not of child bearing potential.

## BETAMETHASONE DIPPROPIONATE WITH CALCIPOTRIOL

Foam spray 500 mcg with calcipotriol 50 mcg per g .....	59.95	60 g OP	✓ <b>Enstilar</b>
Gel 500 mcg with calcipotriol 50 mcg per g .....	40.92	60 g OP	✓ <b>Daivobet</b>
Oint 500 mcg with calcipotriol 50 mcg per g .....	14.31	30 g OP	✓ <b>Daivobet</b>

## CALCIPOTRIOL

Oint 50 mcg per g .....	40.00	120 g OP	✓ <b>Daivonex</b>
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## COAL TAR

Soln BP – Only in combination .....	46.00	200 ml	✓ <b>Midwest</b>
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1) Up to 10% only in combination with a dermatological base or proprietary Topical Corticosteroid – Plain

2) With or without other dermatological galenicals.

## COAL TAR WITH ALLANTOIN, MENTHOL, PHENOL AND SULPHUR

Soln 5% with sulphur 0.5%, menthol 0.75%, phenol 0.5% and allantoin crm 2.5% .....	6.59	75 g OP	
	(8.00)		Egopsoryl TA
	3.43	30 g OP	
	(4.35)		Egopsoryl TA

## COAL TAR WITH SALICYLIC ACID AND SULPHUR

Soln 12% with salicylic acid 2% and sulphur 4% oint.....	7.95	40 g OP	✓ <b>Coco-Scalp</b>
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## PIMECROLIMUS – Special Authority see SA1970 below – Retail pharmacy

a) Maximum of 15 g per prescription

b) Note: a maximum of 15 g per prescription and no more than one prescription per 12 weeks.

Cream 1% .....	33.00	15 g OP	✓ <b>Elidel</b>
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### ►SA1970 Special Authority for Subsidy

**Initial application** only from a dermatologist, paediatrician, ophthalmologist or any relevant practitioner on the recommendation of a dermatologist, paediatrician or ophthalmologist. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

1 Patient has atopic dermatitis on the eyelid; and

2 Patient has at least one of the following contraindications to topical corticosteroids: periorificial dermatitis, rosacea, documented epidermal atrophy, documented allergy to topical corticosteroids, cataracts, glaucoma, or raised intraocular pressure.

## PINE TAR WITH TROLAMINE LAURILSULFATE AND FLUORESCIN – Only on a prescription

* Soln 2.3% with trolamine laurilsulfate and fluorescein sodium.....	5.41	500 ml	✓ <b>Pinetarol</b>
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	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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**SALICYLIC ACID**

Powder – Only in combination.....	29.00	250 g	✓	<b>Midwest</b>
1) Only in combination with a dermatological base or proprietary Topical Corticosteroid – Plain or collodion flexible				
2) With or without other dermatological galenicals.				

**SULPHUR**

Precipitated – Only in combination.....	6.35	100 g	✓	<b>Midwest</b>
1) Only in combination with a dermatological base or proprietary Topical Corticosteroid – Plain				
2) With or without other dermatological galenicals.				

(Midwest Precipitated to be delisted 1 October 2028)

**TACROLIMUS**

Oint 0.1% – Special Authority see SA2074 below – Retail pharmacy.....	33.00	30 g OP	✓	<b>Zematom</b>
a) Maximum of 30 g per prescription				
b) Note: a maximum of 30 g per prescription and no more than one prescription per 12 weeks.				

►SA2074 **Special Authority for Subsidy**

**Initial application** only from a dermatologist, paediatrician or any relevant practitioner on the recommendation of a dermatologist, paediatrician, . Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 Patient has atopic dermatitis on the face; and
- 2 Patient has at least one of the following contraindications to topical corticosteroids: periorificial dermatitis, rosacea, documented epidermal atrophy or documented allergy to topical corticosteroids.

**Scalp Preparations**

<b>BETAMETHASONE VALERATE</b>				
* Scalp app 0.1% .....	12.95	100 ml OP	✓	<b>Beta Scalp</b>
<b>CLOBETASOL PROPIONATE</b>				
* Scalp app 0.05% .....	6.90	30 ml OP	✓	<b>Dermol</b>
<b>HYDROCORTISONE BUTYRATE</b>				
Scalp lotn 0.1%.....	6.57	100 ml OP	✓	<b>Locoid</b>
<b>KETOCONAZOLE</b>				
Shampoo 2%.....	4.09	100 ml OP	✓	<b>Sebizole</b>
a) Maximum of 100 ml per prescription				
b) Only on a prescription				

**Sunscreens**

**SUNSCREENS, PROPRIETARY – Subsidy by endorsement**

Only if prescribed for a patient with severe photosensitivity secondary to a defined clinical condition and the prescription is endorsed accordingly.

Lotn.....	6.50	200 g OP	✓	<b>Marine Blue Lotion SPF 50+</b>
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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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## Wart Preparations

For salicylic acid preparations refer to PSORIASIS AND ECZEMA PREPARATIONS, page 75

### PODOPHYLLOTOXIN

Soln 0.5% .....	33.60	3.5 ml OP	✓ <b>Condyline</b> ✓ <b>Condyline S29</b> <sup>S29</sup>
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- a) Maximum of 3.5 ml per prescription
- b) Only on a prescription

## Other Skin Preparations

### Antineoplastics

#### FLUOROURACIL SODIUM

Crn 5% .....	5.56	20 g OP	✓ <b>Efudix</b>
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#### IMIQUIMOD

Crn 5%, 250 mg sachet .....	21.72	24	✓ <b>Padagis</b> ✓ <b>Perrigo</b>
	34.50	12	✓ <b>Aldara</b> <sup>S29</sup>

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# GENITO-URINARY SYSTEM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>Contraceptives - Non-hormonal</b>				
<b>Condoms</b>				
CONDOMS				
* 49 mm – Up to 144 dev available on a PSO .....	14.25	144	✓	Moments
* 53 mm.....	1.15	10	✓	Moments
	14.25	144	✓	Moments
a) Maximum of 60 dev per prescription				
b) Up to 60 dev available on a PSO				
* 53 mm, 0.05 mm thickness.....	1.15	10	✓	Moments
	14.25	144	✓	Moments
a) Up to 60 dev available on a PSO				
b) Maximum of 60 dev per prescription				
* 53 mm, chocolate, brown .....	1.15	10	✓	Moments
	14.25	144	✓	Moments
a) Up to 60 dev available on a PSO				
b) Maximum of 60 dev per prescription				
* 53 mm, strawberry, red.....	1.15	10	✓	Moments
	14.25	144	✓	Moments
a) Up to 60 dev available on a PSO				
b) Maximum of 60 dev per prescription				
* 56 mm.....	1.15	10	✓	Moments
	14.50	144	✓	Moments
a) Maximum of 60 dev per prescription				
b) Up to 60 dev available on a PSO				
* 56 mm, 0.05 mm thickness.....	2.00	12	✓	Gold Knight
	24.10	144	✓	Gold Knight
a) Up to 60 dev available on a PSO				
b) Maximum of 60 dev per prescription				
* 56 mm, 0.05mm thickness (bulk pack) .....	20.17	144	✓	Gold Knight
a) Maximum of 60 dev per prescription				
b) Up to 60 dev available on a PSO				
* 56 mm, 0.08 mm thickness.....	1.15	10	✓	Moments
	14.25	144	✓	Moments
a) Up to 60 dev available on a PSO				
b) Maximum of 60 dev per prescription				
* 56 mm, 0.08 mm thickness, red .....	1.15	10	✓	Moments
	14.25	144	✓	Moments
a) Up to 60 dev available on a PSO				
b) Maximum of 60 dev per prescription				
* 56 mm, chocolate .....	1.79	12	✓	Gold Knight
	21.45	144	✓	Gold Knight
a) Up to 60 dev available on a PSO				
b) Maximum of 60 dev per prescription				
* 56 mm, strawberry.....	1.79	12	✓	Gold Knight
	21.45	144	✓	Gold Knight
a) Up to 60 dev available on a PSO				
b) Maximum of 60 dev per prescription				
* 60 mm.....	1.82	12	✓	Gold Knight XL
	21.89	144	✓	Gold Knight XL
a) Maximum of 60 dev per prescription				
b) Up to 60 dev available on a PSO				
* 60 mm (bulk pack).....	17.38	144	✓	Gold Knight XL

\$29 Unapproved medicine supplied under Section 29

Principal Supply Sole Subsidised Supply

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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- a) Maximum of 60 dev per prescription
- b) Up to 60 dev available on a PSO

### Contraceptive Devices

#### INTRA-UTERINE DEVICE

a) Up to 40 dev available on a PSO				
b) Only on a PSO				
* IUD 29.1 mm length x 23.2 mm width .....	29.80	1	✓	<b>Choice 380 7med Nsha Silver/ copper Short</b>
* IUD 33.6 mm length x 29.9 mm width .....	26.80	1	✓	<b>TCu 380 Plus Normal</b>
* IUD 35.5 mm length x 19.6 mm width .....	33.00	1	✓	<b>Cu 375 Standard</b>

### Contraceptives - Hormonal

#### Combined Oral Contraceptives

##### ETHINYLOESTRADIOL WITH DESOGESTREL

* Tab 20 mcg with desogestrel 150 mcg and 7 inert tab – Up to 84 tab available on a PSO .....	10.00	84	✓	<b>Mercilon 28</b>
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##### ETHINYLOESTRADIOL WITH LEVONORGESTREL

* Tab 20 mcg with levonorgestrel 100 mcg and 7 inert tablets – Up to 84 tab available on a PSO .....	2.00	84	✓	<b>Lo-Oralcon 20 ED</b>
* Tab 30 mcg with levonorgestrel 150 mcg and 7 inert tablets – Up to 84 tab available on a PSO .....	2.30	84	✓	<b>Oralcon 30 ED</b>

##### ETHINYLOESTRADIOL WITH NORETHISTERONE

Tab 35 mcg with norethisterone 1 mg and 7 inert tab – Up to 84 tab available on a PSO .....	14.09	84	✓	<b>Brevinor 1/28</b>
Tab 35 mcg with norethisterone 500 mcg and 7 inert tab – Up to 112 tab available on a PSO .....	23.75	84	✓	<b>Norimin</b>
	29.32	112	✓	<b>Norimin</b>

#### Progestogen-only Contraceptives

##### DESOGESTREL

* Tab 75 mcg – Up to 84 tab available on a PSO .....	24.50	84	✓	<b>Cerazette</b>
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##### LEVONORGESTREL

* Tab 30 mcg – Up to 112 tab available on a PSO .....	22.00	112	✓	<b>Microlut</b>
* Intra-uterine device 52 mg – Up to 25 dev available on a PSO .....	269.50	1	✓	<b>Mirena</b>
* Intra-uterine device 13.5 mg – Up to 10 dev available on a PSO .....	215.60	1	✓	<b>Jaydess</b>
* Subdermal implant (2 x 75 mg rods) – Up to 40 impl available on a PSO .....	106.92	2 OP	✓	<b>Jadelle</b>

##### MEDROXYPROGESTERONE ACETATE

Inj 150 mg per ml, 1 ml syringe – Up to 5 inj available on a PSO ....	10.56	1	✓	<b>Depo-Provera</b>
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##### NORETHISTERONE

Tab 350 mcg – Up to 84 tab available on a PSO .....	12.25	84	✓	<b>Noriday</b>
	13.23		✓	<b>Noriday 28</b>

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

## GENITO-URINARY SYSTEM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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### Emergency Contraceptives

#### LEVONORGESTREL

* Tab 1.5 mg .....	1.31	1	✓	<b>Levonorgestrel -1 (Lupin)</b>
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- Maximum of 2 tab per prescription
- Up to 5 tab available on a PSO
- Note: Direct Provision by a pharmacist permitted under the provisions in Part I of Section A.

### Antiandrogen Oral Contraceptives

Prescribers may code prescriptions "contraceptive" (code "O") when used as indicated for contraception. The period of supply and prescription charge will be as per other contraceptives, as follows:

- A maximum \$5.00 prescription charge (patient co-payment) may apply.
- prescription may be written for up to six months supply.

Prescriptions coded in any other way are subject to any non contraceptive prescription charges that apply, and the non-contraceptive period of supply. ie. Prescriptions may be written for up to three months supply.

#### CYPROTERONE ACETATE WITH ETHINYLOESTRADIOL

* Tab 2 mg with ethinyloestradiol 35 mcg and 7 inert tabs – Up to 168 tab available on a PSO .....	5.08	168	✓	<b>Ginet</b>
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### Gynaecological Anti-infectives

#### ACETIC ACID WITH HYDROXYQUINOLINE AND RICINOLEIC ACID

Jelly with glacial acetic acid 0.94%, hydroxyquinoline sulphate 0.025%, glycerol 5% and ricinoleic acid 0.75% with applicator ....	8.43 (24.87)	100 g OP		Aci-Jel
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#### CLOTRIMAZOLE

* Vaginal crm 1% with applicators.....	4.20	35 g OP	✓	<b>Clomazol</b>
Clomazol to be Principal Supply on 1 July 2026				
* Vaginal crm 2% with applicators.....	4.60	20 g OP	✓	<b>Clomazol</b>
Clomazol to be Principal Supply on 1 July 2026				

#### MICONAZOLE NITRATE

* Vaginal crm 2% with applicator .....	6.89	40 g OP	✓	<b>Micreme</b>
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#### NYSTATIN

Vaginal crm 100,000 u per 5 g with applicator(s) .....	5.70	75 g OP	✓	<b>Nilstat</b>
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### Myometrial and Vaginal Hormone Preparations

#### ERGOMETRINE MALEATE

Inj 500 mcg per ml, 1 ml ampoule – Up to 5 inj available on a PSO .....	160.00	5	✓	<b>DBL Ergometrine</b>
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#### OESTRIOL

* Crm 1 mg per g with applicator.....	6.95	15 g OP	✓	<b>Ovestin</b>
* Pessaries 500 mcg .....	7.55	15	✓	<b>Ovestin</b>

#### OXYTOCIN – Up to 5 inj available on a PSO

Inj 5 iu per ml, 1 ml ampoule .....	5.98	5	✓	<b>Oxytocin BNM</b>
Inj 10 iu per ml, 1 ml ampoule .....	7.18	5	✓	<b>Oxytocin BNM</b>

#### OXYTOCIN WITH ERGOMETRINE MALEATE – Up to 5 inj available on a PSO

Inj 5 iu with ergometrine maleate 500 mcg per ml, 1 ml ampoule .....	41.47	5	✓	<b>Syntometrine</b>
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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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### Pregnancy Tests - hCG Urine

BETA-HCG LOW SENSITIVITY URINE TEST KIT – Up to 15 test available on a PSO

Note: For use in abortion services only.

Midstream.....17.47      1 test OP      ✓ **CheckTop**

PREGNANCY TESTS - HCG URINE

a) Up to 200 test available on a PSO

b) Only on a PSO

Cassette .....16.00      40 test OP      ✓ **David One Step  
Cassette  
Pregnancy Test**

### Urinary Agents

For urinary tract infections refer to INFECTIONS, Antibacterials, [page 115](#)

#### 5-Alpha Reductase Inhibitors

FINASTERIDE – Special Authority see [SA0928 below](#) – Retail pharmacy

\* Tab 5 mg .....4.79      100      ✓ **Ricit**

► [SA0928](#) **Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 Patient has symptomatic benign prostatic hyperplasia; and
- 2 Either:
  - 2.1 The patient is intolerant of non-selective alpha blockers or these are contraindicated; or
  - 2.2 Symptoms are not adequately controlled with non-selective alpha blockers.

#### Alpha-1A Adrenoreceptor Blockers

TAMSULOSIN HYDROCHLORIDE – Special Authority see [SA1032 below](#) – Retail pharmacy

\* Cap 400 mcg .....28.56      100      ✓ **Tamsulosin-Rex**

► [SA1032](#) **Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 Patient has symptomatic benign prostatic hyperplasia; and
- 2 The patient is intolerant of non-selective alpha blockers or these are contraindicated.

#### Other Urinary Agents

OXYBUTYNIN

\* Tab 5 mg .....5.42      100      ✓ **Alchemy  
Oxybutynin**

POTASSIUM CITRATE

Oral liq 3 mmol per ml – Special Authority see [SA1083 on the next page](#) – Retail pharmacy.....37.49      200 ml OP      ✓ **Biomed**

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

## GENITO-URINARY SYSTEM

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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### ►SA1083 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:  
Both:

- 1 The patient has recurrent calcium oxalate urolithiasis; and
- 2 The patient has had more than two renal calculi in the two years prior to the application.

**Renewal** from any relevant practitioner. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefitting from the treatment.

#### SODIUM CITRO-TARTRATE

\* Grans eff 4 g sachets .....3.50 28 ✓ **Ural**

#### SOLIFENACIN SUCCINATE

Tab 5 mg ..... 1.95 30 ✓ **Solifenacin succinate Max Health**

Tab 10 mg .....3.53 30 ✓ **Solifenacin succinate Max Health**

## Detection of Substances in Urine

#### ORTHO-TOLIDINE

\* Compound diagnostic sticks .....7.50 50 test OP  
(8.25) Hemastix

#### TETRABROMOPHENOL

\* Blue diagnostic strips ..... 13.92 100 test OP ✓ **Albustix**

## Obstetric Preparations

### Antiprogesterones

#### MIFEPRISTONE

Tab 200 mg – Up to 15 tab available on a PSO .....90.02 1 ✓ **Mifegyne**  
270.06 3 ✓ **Mifegyne**

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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## Calcium Homeostasis

### CALCITONIN

* Inj 100 iu per ml, 1 ml ampoule .....	121.00	5	✓ Miacalcic ✓ Miacalcic S29 <sup>S29</sup>
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CINACALCET – Special Authority see [SA2170 below](#) – Retail pharmacy

Tab 30 mg – Wastage claimable .....	25.24	28	✓ Cinacalcet Devatis
Tab 60 mg – Wastage claimable .....	50.47	28	✓ Cinacalcet Devatis

### ▶SA2170 Special Authority for Subsidy

**Initial application — (parathyroid carcinoma or calciphylaxis)** only from a nephrologist or endocrinologist. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 All of the following:
  - 1.1 The patient has been diagnosed with a parathyroid carcinoma (see Note); and
  - 1.2 The patient has persistent hypercalcaemia (serum calcium greater than or equal to 3 mmol/L) despite previous first-line treatments including sodium thiosulfate (where appropriate) and bisphosphonates; and
  - 1.3 The patient is symptomatic; or
- 2 All of the following:
  - 2.1 The patient has been diagnosed with calciphylaxis (calcific uraemic arteriopathy); and
  - 2.2 The patient has symptomatic (e.g. painful skin ulcers) hypercalcaemia (serum calcium greater than or equal to 3 mmol/L); and
  - 2.3 The patient's condition has not responded to previous first-line treatments including bisphosphonates and sodium thiosulfate.

**Renewal — (parathyroid carcinoma or calciphylaxis)** only from a nephrologist or endocrinologist. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 The patient's serum calcium level has fallen to < 3mmol/L; and
- 2 The patient has experienced clinically significant symptom improvement.

Note: This does not include parathyroid adenomas unless these have become malignant.

**Initial application — (primary hyperparathyroidism)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Patient has primary hyperparathyroidism; and
- 2 Either:
  - 2.1 Patient has hypercalcaemia of more than 3 mmol/L with or without symptoms; or
  - 2.2 Patient has hypercalcaemia of more than 2.85 mmol/L with symptoms; and
- 3 Surgery is not feasible or has failed; and
- 4 Patient has other comorbidities, severe bone pain, or calciphylaxis.

**Initial application — (secondary or tertiary hyperparathyroidism)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Either:
  - 1.1 Patient has tertiary hyperparathyroidism and markedly elevated parathyroid hormone (PTH) with hypercalcaemia; or
  - 1.2 Patient has symptomatic secondary hyperparathyroidism and elevated PTH; and
- 2 Patient is on renal replacement therapy; and
- 3 Any of the following:

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# HORMONE PREPARATIONS - SYSTEMIC EXCLUDING CONTRACEPTIVE HORMONES

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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continued...

- 3.1 Residual parathyroid tissue has not been localised despite repeat unsuccessful parathyroid explorations; or
- 3.2 Parathyroid tissue is surgically inaccessible; or
- 3.3 Parathyroid surgery is not feasible.

**Renewal** — (secondary or tertiary hyperparathyroidism) from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

- Either:
- 1 The patient has had a kidney transplant, and following a treatment free interval of at least 12 weeks a clinically acceptable parathyroid hormone (PTH) level to support ongoing cessation of treatment has not been reached; or
  - 2 The patient has not received a kidney transplant and trial of withdrawal of cinacalcet is clinically inappropriate.

## ZOLEDRONIC ACID

Inj 4 mg per 5 ml, vial .....	15.65	1	✓ <b>Zoledronic acid Injection</b> <b>Mylan</b> <sup>S29</sup>
			✓ <b>Zoledronic acid</b> <b>Viatris</b>

(Zoledronic acid Injection Mylan <sup>S29</sup> Inj 4 mg per 5 ml, vial to be delisted 1 November 2026)

## Corticosteroids and Related Agents for Systemic Use

### BETAMETHASONE SODIUM PHOSPHATE WITH BETAMETHASONE ACETATE

* Inj 3.9 mg with betamethasone acetate 3 mg per ml, 1 ml .....	19.20	5	
	(36.96)		Celestone Chronodose

### DEXAMETHASONE

* Tab 0.5 mg – Up to 60 tab available on a PSO .....	1.80	30	✓ <b>Dexamethasone</b>
* Tab 4 mg – Up to 30 tab available on a PSO .....	3.18	30	✓ <b>Dexamethasone</b>
Oral liq 1 mg per ml .....	53.86	25 ml OP	✓ <b>Biomed</b>

### DEXAMETHASONE PHOSPHATE

Dexamethasone phosphate injection will not be funded for oral use.

* Inj 4 mg per ml, 1 ml ampoule – Up to 5 inj available on a PSO .....	6.88	10	✓ <b>Dexamethasone</b> <b>Medsurge</b>
* Inj 4 mg per ml, 2 ml ampoule – Up to 5 inj available on a PSO .....	10.98	10	✓ <b>Dexamethasone</b> <b>Medsurge</b>

### FLUDROCORTISONE ACETATE

* Tab 100 mcg .....	8.05	100	✓ <b>Florinef</b>
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### HYDROCORTISONE

* Tab 5 mg .....	8.10	100	✓ <b>Douglas</b>
* Tab 20 mg .....	20.32	100	✓ <b>Douglas</b>
* Inj 100 mg vial .....	3.96	1	✓ <b>Solu-Cortef</b>
a) Not on a BSO			
b) Up to 5 inj available on a PSO			

### METHYLPREDNISOLONE

* Tab 4 mg .....	112.00	100	✓ <b>Medrol</b>
* Tab 100 mg .....	223.10	20	✓ <b>Medrol</b>

# HORMONE PREPARATIONS - SYSTEMIC EXCLUDING CONTRACEPTIVE HORMONES

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>METHYLPREDNISOLONE (AS SODIUM SUCCINATE)</b>				
Inj 40 mg vial .....	22.30	1	✓	<b>Solu-Medrol-Act-O-Vial</b>
Inj 125 mg vial .....	34.10	1	✓	<b>Solu-Medrol-Act-O-Vial</b>
Inj 500 mg vial .....	43.01	1	✓	<b>Solu-Medrol-Act-O-Vial</b>
Inj 1 g vial .....	52.54	1	✓	<b>Solu-Medrol</b>
<b>METHYLPREDNISOLONE ACETATE</b>				
Inj 40 mg per ml, 1 ml vial.....	47.06	5	✓	<b>Depo-Medrol</b>
<b>PREDNISOLONE</b>				
* Oral liq 5 mg per ml – Up to 30 ml available on a PSO Restricted to children under 12 years of age. ....	6.00	30 ml OP	✓	<b>Redipred</b>
<b>PREDNISONE</b>				
* Tab 1 mg .....	18.58	500	✓	<b>Prednisone Clinect</b>
* Tab 2.5 mg .....	21.04	500	✓	<b>Prednisone Clinect</b>
* Tab 5 mg – Up to 30 tab available on a PSO .....	19.30	500	✓	<b>Prednisone Clinect</b>
* Tab 20 mg – Up to 30 tab available on a PSO .....	50.51	500	✓	<b>Prednisone Clinect</b>
<b>TETRACOSACTRIN</b>				
* Inj 250 mcg per ml, 1 ml ampoule .....	86.25	1	✓	<b>Synacthen</b> ✓ <b>UK Synacthen</b>
* Inj 1 mg per ml, 1 ml ampoule .....	690.00	1	✓	<b>Synacthen Depot</b> ✓ <b>Synacthene Retard</b> <sup>S29</sup>
<b>TRIAMCINOLONE ACETONIDE</b>				
Inj 10 mg per ml, 1 ml ampoule .....	21.42	5	✓	<b>Kenacort-A 10</b>
Inj 40 mg per ml, 1 ml ampoule .....	52.63	5	✓	<b>Kenacort-A 40</b>
<b>Sex Hormones Non Contraceptive</b>				
<b>Androgen Agonists and Antagonists</b>				
<b>CYPROTERONE ACETATE</b>				
Tab 50 mg .....	17.05	50	✓	<b>Siterone</b>
Tab 100 mg .....	31.00	50	✓	<b>Siterone</b>
<b>TESTOSTERONE</b>				
Gel (transdermal) 16.2 mg per g, 88 g .....	52.00	60 OP	✓	<b>Testogel</b>
<b>TESTOSTERONE CIPIONATE</b>				
Inj 100 mg per ml, 10 ml vial.....	97.75	1	✓	<b>Depo-Testosterone</b>
<b>TESTOSTERONE ESTERS</b>				
Inj 250 mg per ml, 1 ml.....	12.98	1	✓	<b>Sustanon Ampoules</b>
<b>TESTOSTERONE UNDECANOATE</b>				
Cap 40 mg – Subsidy by endorsement .....	36.00	100	✓	<b>Steril-Gene</b> <sup>S29</sup>
Subsidy by endorsement – subsidised for patients who were taking testosterone undecanoate cap 40mg prior to 1 November 2021 and the prescription is endorsed accordingly. Pharmacists may annotate the prescription as endorsed where there exists a record of prior dispensing of testosterone undecanoate cap 40 mg in the preceding 12 months.				
Inj 250 mg per ml, 4 ml vial.....	86.00	1	✓	<b>Reandron 1000</b>

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# HORMONE PREPARATIONS - SYSTEMIC EXCLUDING CONTRACEPTIVE HORMONES

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
<b>Hormone Replacement Therapy - Systemic</b>			
<b>Oestrogens</b>			
OESTRADIOL			
* Tab 1 mg .....	4.12 (11.10)	28 OP	Estrofem
* Tab 2 mg .....	4.12 (11.10)	28 OP	Estrofem
* Gel (transdermal) 0.06% (750 mcg/actuation).....	14.25	80 g OP	✓ <b>Estrojel</b>
Patch 25 mcg per day.....	8.89	8	✓ <b>Estradiol TDP Mylan</b>
	16.23		✓ <b>Estradot</b>
a) No more than 2 patch per week			
b) Only on a prescription			
Patch 50 mcg per day.....	9.26	8	✓ <b>Estradiol TDP Mylan</b>
	15.79		✓ <b>Estradot</b>
a) No more than 2 patch per week			
b) Only on a prescription			
Patch 75 mcg per day.....	10.33	8	✓ <b>Estradiol TDP Mylan</b>
	16.53		✓ <b>Estradot</b>
a) No more than 2 patch per week			
b) Only on a prescription			
Patch 100 mcg per day.....	10.59	8	✓ <b>Estradiol TDP Mylan</b>
	16.18		✓ <b>Estradot</b>
a) No more than 2 patch per week			
b) Only on a prescription			
OESTRADIOL VALERATE			
* Tab 1 mg .....	12.36	84	✓ <b>Progynova</b>
* Tab 2 mg .....	8.24	56	✓ <b>Progynova</b>
	12.36	84	✓ <b>Progynova</b>
OESTROGENS			
* Conjugated, equine tab 300 mcg.....	3.01 (19.25)	28	Premarin
* Conjugated, equine tab 625 mcg.....	4.12 (19.25)	28	Premarin
<b>Progestogens</b>			
MEDROXYPROGESTERONE ACETATE			
* Tab 2.5 mg .....	7.54	30	✓ <b>Provera</b>
	8.75	56	✓ <b>Provera</b>
* Tab 5 mg .....	9.80	56	✓ <b>Provera</b>
	23.15	100	✓ <b>Provera</b>
* Tab 10 mg .....	11.10	30	✓ <b>Provera</b>

# HORMONE PREPARATIONS - SYSTEMIC EXCLUDING CONTRACEPTIVE HORMONES

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>Progestogen and Oestrogen Combined Preparations</b>				
OESTRADIOL WITH NORETHISTERONE				
* Tab 1 mg with 0.5 mg norethisterone acetate .....	5.40	28 OP		
	(18.10)			Kliovance
* Tab 2 mg with 1 mg norethisterone acetate .....	5.40	28 OP		
	(18.10)			Kliogest
* Tab 2 mg with 1 mg norethisterone acetate (10), and 2 mg oestradiol tab (12) and 1 mg oestradiol tab (6).....	5.40	28 OP		
	(18.10)			Trisequens

## Other Oestrogen Preparations

OESTRIOL				
* Tab 2 mg .....	7.70	30	✓	<b>Ovestin</b>

## Other Progestogen Preparations

MEDROXYPROGESTERONE ACETATE				
Tab 100 mg .....	153.60	100	✓	<b>Provera HD</b>
NORETHISTERONE				
* Tab 5 mg – Up to 30 tab available on a PSO .....	5.49	30	✓	<b>Primolut N</b>
PROGESTERONE				
Cap 100 mg .....	14.85	30	✓	<b>Utrogestan</b>

## Thyroid and Antithyroid Agents

CARBIMAZOLE				
* Tab 5 mg .....	7.56	100	✓	<b>Neo-Mercazole</b>
LEVOTHYROXINE				
* Tab 25 mcg.....	5.55	90	✓	<b>Synthroid</b>
* Tab 50 mcg.....	1.71	28	✓	<b>Mercury Pharma</b>
	5.79	90	✓	<b>Synthroid</b>
	64.28	1,000	✓	<b>Eltroxin</b>
* Tablet 50 mcg.....	12.86	200	✓	<b>Eltroxin</b>
* Tab 100 mcg.....	1.78	28	✓	<b>Mercury Pharma</b>
	6.01	90	✓	<b>Synthroid</b>
	66.78	1,000	✓	<b>Eltroxin</b>
* Tablet 100 mcg.....	13.36	200	✓	<b>Eltroxin</b>
PROPYLTHIOURACIL – Special Authority see SA1199 below – Retail pharmacy				
Tab 50 mg .....	35.00	100	✓	<b>PTU</b> <small>S29</small>

### ►SA1199 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 The patient has hyperthyroidism; and
- 2 The patient is intolerant of carbimazole or carbimazole is contraindicated.

**Renewal** from any relevant practitioner. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefitting from the treatment.

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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## Trophic Hormones

### Growth Hormones

SOMATROPIN (OMNITROPE) – Special Authority see [SA2032 below](#) – Retail pharmacy

* Inj 5 mg cartridge.....	80.21	1	✓ <b>Omnitrope</b> ✓ <b>Omnitrope AU</b> <sup>\$29</sup> ✓ <b>Omnitrope</b> ✓ <b>Omnitrope</b>
* Inj 10 mg cartridge.....	80.21	1	
* Inj 15 mg cartridge.....	139.50	1	

#### ➔SA2032 Special Authority for Subsidy

**Initial application — (growth hormone deficiency in children)** only from a paediatric endocrinologist or endocrinologist.

Approvals valid for 9 months for applications meeting the following criteria:

Either:

- 1 Growth hormone deficiency causing symptomatic hypoglycaemia, or with other significant growth hormone deficient sequelae (e.g. cardiomyopathy, hepatic dysfunction) and diagnosed with GH < 5 mcg/l on at least two random blood samples in the first 2 weeks of life, or from samples during established hypoglycaemia (whole blood glucose < 2 mmol/l using a laboratory device); or
- 2 All of the following:
  - 2.1 Height velocity < 25th percentile for age adjusted for bone age/pubertal status if appropriate over 6 or 12 months using the standards of Tanner and Davies (1985); and
  - 2.2 A current bone age is < 14 years (female patients) or < 16 years (male patients); and
  - 2.3 Peak growth hormone value of < 5.0 mcg per litre in response to two different growth hormone stimulation tests. In children who are 5 years or older, GH testing with sex steroid priming is required; and
  - 2.4 If the patient has been treated for a malignancy, they should be disease free for at least one year based upon follow-up laboratory and radiological imaging appropriate for the malignancy, unless there are strong medical reasons why this is either not necessary or appropriate; and
  - 2.5 Appropriate imaging of the pituitary gland has been obtained.

**Renewal — (growth hormone deficiency in children)** only from a paediatric endocrinologist or endocrinologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 A current bone age is 14 years or under (female patients) or 16 years or under (male patients); and
- 2 Height velocity is greater than or equal to 25th percentile for age (adjusted for bone age/pubertal status if appropriate) while on growth hormone treatment, as calculated over six months using the standards of Tanner and Davis (1985); and
- 3 Height velocity is greater than or equal to 2.0 cm per year, as calculated over 6 months; and
- 4 No serious adverse effect that the patients specialist considers is likely to be attributable to growth hormone treatment has occurred; and
- 5 No malignancy has developed since starting growth hormone.

**Initial application — (Turner syndrome)** only from a paediatric endocrinologist or endocrinologist. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 The patient has a post-natal genotype confirming Turner Syndrome; and
- 2 Height velocity is < 25th percentile over 6-12 months using the standards of Tanner and Davies (1985); and
- 3 A current bone age is < 14 years.

**Renewal — (Turner syndrome)** only from a paediatric endocrinologist or endocrinologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Height velocity is greater than or equal to 50th percentile for age (while on growth hormone calculated over 6 to 12 months using the Ranke's Turner Syndrome growth velocity charts); and

continued...

# HORMONE PREPARATIONS - SYSTEMIC EXCLUDING CONTRACEPTIVE HORMONES

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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continued...

- 2 Height velocity is greater than or equal to 2 cm per year, calculated over six months; and
- 3 A current bone age is 14 years or under ; and
- 4 No serious adverse effect that the specialist considers is likely to be attributable to growth hormone treatment has occurred; and
- 5 No malignancy has developed since starting growth hormone.

**Initial application — (short stature without growth hormone deficiency)** only from a paediatric endocrinologist or endocrinologist. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 The patient's height is more than 3 standard deviations below the mean for age or for bone age if there is marked growth acceleration or delay; and
- 2 Height velocity is < 25th percentile for age (adjusted for bone age/pubertal status if appropriate), as calculated over 6 to 12 months using the standards of Tanner and Davies(1985); and
- 3 A current bone age is < 14 years or under (female patients) or < 16 years (male patients); and
- 4 The patient does not have severe chronic disease (including malignancy or recognized severe skeletal dysplasia) and is not receiving medications known to impair height velocity.

**Renewal — (short stature without growth hormone deficiency)** only from a paediatric endocrinologist or endocrinologist.

Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Height velocity is greater than or equal to 50th percentile (adjusted for bone age/pubertal status if appropriate) as calculated over 6 to 12 months using the standards of Tanner and Davies (1985); and
- 2 Height velocity is greater than or equal to 2 cm per year as calculated over six months; and
- 3 A current bone age is 14 years or under (female patients) or 16 years or under (male patients); and
- 4 No serious adverse effect that the patient's specialist considers is likely to be attributable to growth hormone treatment has occurred.

**Initial application — (short stature due to chronic renal insufficiency)** only from a paediatric endocrinologist, endocrinologist or renal physician on the recommendation of a paediatric endocrinologist or endocrinologist. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 The patient's height is more than 2 standard deviations below the mean; and
- 2 Height velocity is < 25th percentile (adjusted for bone age/pubertal status if appropriate) as calculated over 6 to 12 months using the standards of Tanner and Davies (1985); and
- 3 A current bone age is to 14 years or under (female patients) or to 16 years or under (male patients); and
- 4 The patient is metabolically stable, has no evidence of metabolic bone disease and absence of any other severe chronic disease; and
- 5 The patient is under the supervision of a specialist with expertise in renal medicine; and
- 6 Either:
  - 6.1 The patient has a GFR less than or equal to 30 ml/min/1.73m<sup>2</sup> as measured by the Schwartz method (Height(cm)/plasma creatinine (umol/l)) × 40 = corrected GFR (ml/min/1.73m<sup>2</sup>) in a child who may or may not be receiving dialysis; or
  - 6.2 The patient has received a renal transplant and has received < 5mg/ m<sup>2</sup>/day of prednisone or equivalent for at least 6 months..

**Renewal — (short stature due to chronic renal insufficiency)** only from a paediatric endocrinologist, endocrinologist or renal physician on the recommendation of a paediatric endocrinologist or endocrinologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Height velocity is greater than or equal to 50th percentile (adjusted for bone age/pubertal status if appropriate) as calculated over 6 to 12 months using the standards of Tanner and Davies (1985); and

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

## HORMONE PREPARATIONS - SYSTEMIC EXCLUDING CONTRACEPTIVE HORMONES

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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continued...

- 2 Height velocity is greater than or equal to 2 cm per year as calculated over six months; and
- 3 A current bone age is 14 years or under (female patients) or 16 years or under (male patients); and
- 4 No serious adverse effect that the patients specialist considers is likely to be attributable to growth hormone has occurred; and
- 5 No malignancy has developed after growth hormone therapy was commenced; and
- 6 The patient has not experienced significant biochemical or metabolic deterioration confirmed by diagnostic results; and
- 7 The patient has not received renal transplantation since starting growth hormone treatment; and
- 8 If the patient requires transplantation, growth hormone prescription should cease before transplantation and a new application should be made after transplantation based on the above criteria.

**Initial application — (Prader-Willi syndrome)** only from a paediatric endocrinologist or endocrinologist. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 The patient has a diagnosis of Prader-Willi syndrome that has been confirmed by genetic testing or clinical scoring criteria; and
- 2 The patient is aged six months or older; and
- 3 A current bone age is < 14 years (female patients) or < 16 years (male patients); and
- 4 Sleep studies or overnight oximetry have been performed and there is no obstructive sleep disorder requiring treatment, or if an obstructive sleep disorder is found, it has been adequately treated under the care of a paediatric respiratory physician and/or ENT surgeon; and
- 5 Either:
  - 5.1 Both:
    - 5.1.1 The patient is aged two years or older; and
    - 5.1.2 There is no evidence of type II diabetes or uncontrolled obesity defined by BMI that has increased by greater than or equal to 0.5 standard deviations in the preceding 12 months; or
  - 5.2 The patient is aged between six months and two years and a thorough upper airway assessment is planned to be undertaken prior to treatment commencement and at six to 12 weeks following treatment initiation.

**Renewal — (Prader-Willi syndrome)** only from a paediatric endocrinologist or endocrinologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Height velocity is greater than or equal to 50th percentile (adjusted for bone age/pubertal status if appropriate) as calculated over 6 to 12 months using the standards of Tanner and Davies (1985); and
- 2 Height velocity is greater than or equal to 2 cm per year as calculated over six months; and
- 3 A current bone age is 14 years or under (female patients) or 16 years or under (male patients); and
- 4 No serious adverse effect that the patient's specialist considers is likely to be attributable to growth hormone treatment has occurred; and
- 5 No malignancy has developed after growth hormone therapy was commenced; and
- 6 The patient has not developed type II diabetes or uncontrolled obesity as defined by BMI that has increased by greater than or equal to 0.5 standard deviations in the preceding 12 months.

**Initial application — (adults and adolescents)** only from a paediatric endocrinologist or endocrinologist. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 The patient has a medical condition that is known to cause growth hormone deficiency (e.g. surgical removal of the pituitary for treatment of a pituitary tumour); and
- 2 The patient has undergone appropriate treatment of other hormonal deficiencies and psychological illnesses; and
- 3 The patient has severe growth hormone deficiency (see notes); and
- 4 The patient's serum IGF-I is more than 1 standard deviation below the mean for age and sex; and
- 5 The patient has poor quality of life, as defined by a score of 16 or more using the disease-specific quality of life

continued...

# HORMONE PREPARATIONS - SYSTEMIC EXCLUDING CONTRACEPTIVE HORMONES

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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questionnaire for adult growth hormone deficiency (QoL-AGHDA®).

Notes: For the purposes of adults and adolescents, severe growth hormone deficiency is defined as a peak serum growth hormone level of less than or equal to 3 mcg per litre during an adequately performed insulin tolerance test (ITT) or glucagon stimulation test.

Patients with one or more additional anterior pituitary hormone deficiencies and a known structural pituitary lesion only require one test. Patients with isolated growth hormone deficiency require two growth hormone stimulation tests, of which, one should be ITT unless otherwise contraindicated. Where an additional test is required, an arginine provocation test can be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre.

The dose of somatropin should be started at 0.2 mg daily and be titrated by 0.1 mg monthly until the serum IGF-I is within 1 standard deviation of the mean normal value for age and sex; and

Dose of somatropin not to exceed 0.7 mg per day for male patients, or 1 mg per day for female patients.

At the commencement of treatment for hypopituitarism, patients must be monitored for any required adjustment in replacement doses of corticosteroid and levothyroxine.

**Renewal — (adults and adolescents)** only from a paediatric endocrinologist or endocrinologist. Approvals valid for 12 months for applications meeting the following criteria:

Any of the following:

- 1 All of the following:
  - 1.1 The patient has been treated with somatropin for < 12 months; and
  - 1.2 There has been an improvement in Quality of Life defined as a reduction of at least 8 points on the Quality of Life Assessment of Growth Hormone Deficiency in Adults (QoL-AGHDA®) score from baseline; and
  - 1.3 Serum IGF-I levels have been increased within  $\pm 1SD$  of the mean of the normal range for age and sex; and
  - 1.4 The dose of somatropin has not exceeded 0.7 mg per day for male patients, or 1 mg per day for female patients; or
- 2 All of the following:
  - 2.1 The patient has been treated with somatropin for more than 12 months; and
  - 2.2 The patient has not had a deterioration in Quality of Life defined as a 6 point or greater increase from their lowest QoL-AGHDA® score on treatment (other than due to obvious external factors such as external stressors); and
  - 2.3 Serum IGF-I levels have continued to be maintained within  $\pm 1SD$  of the mean of the normal range for age and sex (other than for obvious external factors); and
  - 2.4 The dose of somatropin has not exceeded 0.7 mg per day for male patients or 1 mg per day for female patients; or
- 3 All of the following:
  - 3.1 The patient has had a Special Authority approval for somatropin for childhood deficiency in children and no longer meets the renewal criteria under this indication; and
  - 3.2 The patient has undergone appropriate treatment of other hormonal deficiencies and psychological illnesses; and
  - 3.3 The patient has severe growth hormone deficiency (see notes); and
  - 3.4 The patient's serum IGF-I is more than 1 standard deviation below the mean for age and sex; and
  - 3.5 The patient has poor quality of life, as defined by a score of 16 or more using the disease-specific quality of life questionnaire for adult growth hormone deficiency (QoL-AGHDA®).

Notes: For the purposes of adults and adolescents, severe growth hormone deficiency is defined as a peak serum growth hormone level of less than or equal to 3 mcg per litre during an adequately performed insulin tolerance test (ITT) or glucagon stimulation test.

Patients with one or more additional anterior pituitary hormone deficiencies and a known structural pituitary lesion only require one test. Patients with isolated growth hormone deficiency require two growth hormone stimulation tests, of which, one should be ITT unless otherwise contraindicated. Where an additional test is required, an arginine provocation test can be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre.

The dose of somatropin should be started at 0.2 mg daily and be titrated by 0.1 mg monthly until the serum IGF-I is within 1 standard deviation of the mean normal value for age and sex; and

Dose of somatropin not to exceed 0.7 mg per day for male patients, or 1 mg per day for female patients.

At the commencement of treatment for hypopituitarism, patients must be monitored for any required adjustment in replacement

continued...

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# HORMONE PREPARATIONS - SYSTEMIC EXCLUDING CONTRACEPTIVE HORMONES

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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continued...

doses of corticosteroid and levothyroxine.

## GnRH Analogues

### GOSERELIN

Implant 3.6 mg, syringe .....	66.48	1	✓	<b>Zoladex</b>
Implant 10.8 mg, syringe .....	138.23	1	✓	<b>Zoladex</b>

### LEUPRORELIN

Additional subsidy by endorsement where the patient is a child or adolescent and is unable to tolerate administration of goserelin and the prescription is endorsed accordingly.

Inj 3.75 mg prefilled dual chamber syringe – Higher subsidy of \$221.60 per 1 inj with Endorsement .....	66.48 (221.60)	1		Lucrin Depot 1-month
Inj 11.25 mg prefilled dual chamber syringe – Higher subsidy of \$591.68 per 1 inj with Endorsement .....	177.50 (591.68)	1		Lucrin Depot 3-month

## Vasopressin Agonists

### DESMOPRESSIN

Wafer 120 mcg .....	47.00	30	✓	<b>Minirin Melt</b>
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### DESMOPRESSIN ACETATE

Tab 100 mcg .....	25.00	30	✓	<b>Minirin</b>
Tab 200 mcg .....	54.45	30	✓	<b>Minirin</b>
Inj 4 mcg per ml, 1 ml .....	67.18	10	✓	<b>Minirin</b>
▲ Nasal spray 10 mcg per dose, 6 ml .....	34.95	60 OP	✓	<b>Desmopressin- PH&amp;T</b>

## Other Endocrine Agents

### CABERGOLINE

Tab 0.5 mg – Maximum of 2 tab per prescription; can be waived by Special Authority see <a href="#">SA2070 below</a> .....	4.43 17.94	2 8	✓ ✓	<b>Dostinex</b> <b>Dostinex</b>
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#### ► [SA2070](#) Special Authority for Waiver of Rule

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Any of the following:

- 1 Hyperprolactinemia; or
- 2 Acromegaly\*; or
- 3 Inhibition of lactation.

**Renewal** — (for patients who have previously been funded under Special Authority form SA1031) from any relevant practitioner. Approvals valid without further renewal unless notified where the patient has previously held a valid Special Authority which has expired and the treatment remains appropriate and the patient is benefiting from treatment.

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

### CLOMIFENE CITRATE

Tab 50 mg .....	29.84	10	✓	<b>Mylan</b> <b>Clomiphen</b> <sup>S29</sup>
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### METYRAPONE

Cap 250 mg .....	558.00	50	✓	<b>Metopirone</b>
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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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## Anthelmintics

ALBENDAZOLE – Special Authority see [SA2512 below](#) – Retail pharmacy

Tab 400 mg .....	469.20	60	✓ Eskazole <sup>S29</sup>
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### ►SA2512 Special Authority for Subsidy

**Initial application** only from a relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:  
Either:

- 1 The individual has hydatids; or
- 2 The individual has a travel or residence history that requires presumptive parasite treatment.

**Renewal** only from an infectious disease specialist or clinical microbiologist. Approvals valid for 6 months where the treatment remains appropriate and the patient is benefitting from the treatment.

MEBENDAZOLE – Only on a prescription

Tab 100 mg .....	5.18	6	✓ <b>Vermox</b>
Oral liq 100 mg per 5 ml .....	2.18	15 ml	Vermox
	(7.83)		

PRAZIQUANTEL

Tab 600 mg .....	87.68	8	✓ <b>Distoside</b> <sup>S29</sup>
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## Antibacterials

- a) For topical antibacterials, refer to DERMATOLOGICALS, [page 70](#)
- b) For anti-infective eye preparations, refer to SENSORY ORGANS, [page 278](#)

## Cephalosporins and Cephamecins

CEFACLOR MONOHYDRATE

Cap 250 mg .....	29.73	100	✓ <b>Ranbaxy-Cefaclor</b>
Grans for oral liq 125 mg per 5 ml – Wastage claimable.....	5.83	100 ml	✓ <b>Ranbaxy-Cefaclor</b>

CEFALEXIN

Cap 250 mg .....	3.85	20	✓ <b>Cephalexin ABM</b>
	3.90		✓ <b>Cefalexin Lupin</b>
Cefalexin Lupin to be Principal Supply on 1 July 2026			
Cap 500 mg .....	3.33	20	✓ <b>Cefalexin Sandoz</b>
	5.85		✓ <b>Cephalexin ABM</b>
Cefalexin Sandoz to be Principal Supply on 1 July 2026			
Grans for oral liq 25 mg per ml – Wastage claimable.....	5.41	100 ml	✓ <b>Cefalexin Sandoz</b>
	7.88		✓ <b>Flynn</b>
Grans for oral liq 50 mg per ml – Wastage claimable.....	7.54	100 ml	✓ <b>Cefalexin Sandoz</b>
	10.38		✓ <b>Flynn</b>

*(Cephalexin ABM Cap 250 mg to be delisted 1 July 2026)*

*(Cephalexin ABM Cap 500 mg to be delisted 1 July 2026)*

*(Flynn Grans for oral liq 25 mg per ml to be delisted 1 December 2026)*

*(Flynn Grans for oral liq 50 mg per ml to be delisted 1 December 2026)*

CEFAZOLIN – Subsidy by endorsement

Only if prescribed for dialysis or cellulitis in accordance with a Health NZ Hospital approved protocol and the prescription is endorsed accordingly.

Inj 500 mg vial .....	3.39	5	✓ <b>Cefazolin-AFT</b>
Inj 1 g vial .....	3.59	5	✓ <b>Cefazolin-AFT</b>
Inj 2 g vial .....	7.09	5	✓ <b>Cefazolin-AFT</b>

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# INFECTIONS - AGENTS FOR SYSTEMIC USE

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>CEFTRIAXONE – Subsidy by endorsement</b>				
a) Up to 10 inj available on a PSO				
b) Subsidised only if prescribed for a dialysis or cystic fibrosis patient, or the treatment of gonorrhoea, or the treatment of pelvic inflammatory disease, or the treatment of suspected meningococcal disease, and the prescription or PSO is endorsed accordingly.				
Inj 500 mg vial .....	0.94	1	✓	<b>Ceftriaxone-AFT</b>
Inj 1 g vial .....	3.49	5	✓	<b>Ceftriaxone-AFT</b>
<b>CEFUROXIME AXETIL – Subsidy by endorsement</b>				
Only if prescribed for prophylaxis of endocarditis and the prescription is endorsed accordingly.				
Tab 250 mg .....	CBS	20	✓	<b>Ascend- Cefuroxime <sup>S29</sup></b>

## Macrolides

<b>AZITHROMYCIN – Maximum of 5 days treatment per prescription; can be waived by Special Authority see SA1683 below</b>				
A maximum of 24 months of azithromycin treatment for non-cystic fibrosis bronchiectasis will be subsidised on Special Authority.				
Tab 250 mg .....	8.19	30	✓	<b>Apo-Azithromycin</b>
Tab 500 mg – Up to 8 tab available on a PSO .....	2.80	2	✓	<b>Zithromax</b>
Grans for oral liq 200 mg per 5 ml (40 mg per ml) – Wastage claimable .....				
	16.97	15 ml	✓	<b>Zithromax</b>

### ➔SA1683 Special Authority for Waiver of Rule

**Initial application — (bronchiolitis obliterans syndrome, cystic fibrosis and atypical Mycobacterium infections)** only from a relevant specialist. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Any of the following:

- 1 Patient has received a lung transplant, stem cell transplant, or bone marrow transplant and requires treatment for bronchiolitis obliterans syndrome\*; or
- 2 Patient has received a lung transplant and requires prophylaxis for bronchiolitis obliterans syndrome\*; or
- 3 Patient has cystic fibrosis and has chronic infection with *Pseudomonas aeruginosa* or *Pseudomonas*-related gram negative organisms\*; or
- 4 Patient has an atypical *Mycobacterium* infection.

Note: Indications marked with \* are unapproved indications.

**Initial application — (non-cystic fibrosis bronchiectasis\*)** only from a respiratory specialist or paediatrician. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 For prophylaxis of exacerbations of non-cystic fibrosis bronchiectasis\*; and
- 2 Patient is aged 18 and under; and
- 3 Either:
  - 3.1 Patient has had 3 or more exacerbations of their bronchiectasis, within a 12 month period; or
  - 3.2 Patient has had 3 acute admissions to hospital for treatment of infective respiratory exacerbations within a 12 month period.

Note: Indications marked with \* are unapproved indications.

**Renewal — (non-cystic fibrosis bronchiectasis\*)** only from a respiratory specialist or paediatrician. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has completed 12 months of azithromycin treatment for non-cystic fibrosis bronchiectasis; and
- 2 Following initial 12 months of treatment, the patient has not received any further azithromycin treatment for non-cystic fibrosis bronchiectasis for a further 12 months, unless considered clinically inappropriate to stop treatment; and

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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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3 The patient will not receive more than a total of 24 months' azithromycin cumulative treatment (see note).

The patient must not have had more than 1 prior approval.

Note: No further renewals will be subsidised. A maximum of 24 months of azithromycin treatment for non-cystic fibrosis bronchiectasis will be subsidised. Indications marked with \* are unapproved indications

CLARITHROMYCIN – Maximum of 500 mg per prescription; can be waived by Special Authority see SA1857 below

Tab 250 mg .....	7.31	12	✓ Klaricid <sup>S29</sup>
	8.53	14	✓ Klacid
Grans for oral liq 250 mg per 5 ml – Wastage claimable.....	192.00	50 ml	✓ Klacid

►SA1857 Special Authority for Waiver of Rule

**Initial application — (Mycobacterial infections)** only from a respiratory specialist, infectious disease specialist or paediatrician.

Approvals valid for 2 years for applications meeting the following criteria:

Either:

- 1 Atypical mycobacterial infection; or
- 2 Mycobacterium tuberculosis infection where there is drug-resistance or intolerance to standard pharmaceutical agents.

**Initial application — (Helicobacter pylori eradication)** from any relevant practitioner. Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 For the eradication of helicobacter pylori in a patient unable to swallow tablets; and
- 2 For use only in combination with omeprazole and amoxicillin as part of a triple therapy regimen.

**Initial application — (Prophylaxis of infective endocarditis)** from any relevant practitioner. Approvals valid for 3 months where prophylaxis of infective endocarditis associated with surgical or dental procedures if amoxicillin is contra-indicated.

**Renewal — (Mycobacterial infections)** only from a respiratory specialist, infectious disease specialist or paediatrician.

Approvals valid for 2 years where the treatment remains appropriate and the patient is benefiting from treatment.

ERYTHROMYCIN (AS LACTOBIONATE)

Inj 1 g vial .....	10.00	1	✓ Erythrocin IV
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ERYTHROMYCIN ETHYL SUCCINATE

Tab 400 mg .....	35.82	100	✓ E-Mycin
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- a) Up to 20 tab available on a PSO
- b) Up to 2 x the maximum PSO quantity for RFPP

Grans for oral liq 200 mg per 5 ml .....	6.53	100 ml	✓ E-Mycin
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- a) Up to 300 ml available on a PSO
- b) Up to 2 x the maximum PSO quantity for RFPP
- c) Wastage claimable

Grans for oral liq 400 mg per 5 ml .....	9.41	100 ml	✓ E-Mycin
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- a) Up to 200 ml available on a PSO
- b) Wastage claimable

ROXITHROMYCIN

Tab 150 mg .....	13.19	50	✓ Arrow-Roxithromycin
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Tab 300 mg .....	25.00	50	✓ Arrow-Roxithromycin
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▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# INFECTIONS - AGENTS FOR SYSTEMIC USE

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>Penicillins</b>				
<b>AMOXICILLIN</b>				
Cap 250 mg.....	54.00	500	✓	<b>Miro-Amoxicillin</b>
a) Up to 30 cap available on a PSO				
b) Up to 10 x the maximum PSO quantity for RFPF				
Cap 500 mg.....	1.14	20	✓	<b>Amoxycillin Sandoz</b>
	41.00	500	✓	<b>Miro-Amoxicillin</b>
a) Up to 30 cap available on a PSO				
b) Up to 10 x the maximum PSO quantity for RFPF				
Grans for oral liq 125 mg per 5 ml.....	2.22	100 ml	✓	<b>Alphamox 125</b>
a) Up to 200 ml available on a PSO				
b) Wastage claimable				
Grans for oral liq 250 mg per 5 ml.....	2.81	100 ml	✓	<b>Alphamox 250</b>
a) Up to 300 ml available on a PSO				
b) Up to 10 x the maximum PSO quantity for RFPF				
c) Wastage claimable				
Inj 250 mg vial .....	15.97	10	✓	<b>Ibiamox</b>
Inj 500 mg vial .....	17.43	10	✓	<b>Ibiamox</b>
Inj 1 g vial – Up to 5 inj available on a PSO .....	21.64	10	✓	<b>Ibiamox</b>
<i>(Miro-Amoxicillin Cap 500 mg to be delisted 1 November 2026)</i>				
<b>AMOXICILLIN WITH CLAVULANIC ACID</b>				
Tab 500 mg with clavulanic acid 125 mg – Up to 30 tab available on a PSO.....	1.59	10	✓	<b>Curam Duo 500/125</b>
Grans for oral liq amoxicillin 25 mg with clavulanic acid 6.25 mg per ml.....	8.50	100 ml	✓	<b>Augmentin</b>
a) Up to 200 ml available on a PSO				
b) Wastage claimable				
Grans for oral liq amoxicillin 50 mg with clavulanic acid 12.5 mg per ml – Up to 200 ml available on a PSO .....	5.61	100 ml OP	✓	<b>Amoxiclav Devatis Forte</b>
<b>BENZATHINE BENZYL PENICILLIN</b>				
Inj 900 mg (1.2 million units) vial .....	43.24	1	✓	<b>Benzetacil</b> <sup>S29</sup>
Inj 900 mg (1.2 million units) in 2.3 ml syringe – Up to 5 inj available on a PSO.....	432.37	10	✓	<b>Bicillin LA</b>
<b>BENZYL PENICILLIN SODIUM [PENICILLIN G]</b>				
Inj 600 mg (1 million units) vial – Up to 5 inj available on a PSO .....	16.50	10	✓	<b>Sandoz</b>
<b>FLUCLOXACILLIN</b>				
Cap 250 mg – Up to 30 cap available on a PSO.....	22.58	250	✓	<b>Staphlex</b>
Cap 500 mg – Up to 30 cap available on a PSO.....	72.71	500	✓	<b>Staphlex</b>
Grans for oral liq 25 mg per ml.....	4.89	100 ml	✓	<b>AFT</b>
a) Up to 200 ml available on a PSO				
b) Wastage claimable				
Grans for oral liq 50 mg per ml.....	5.89	100 ml	✓	<b>AFT</b>
a) Up to 200 ml available on a PSO				
b) Wastage claimable				
Inj 250 mg vial .....	42.60	10	✓	<b>Flucloxin</b>
Inj 500 mg vial .....	45.63	10	✓	<b>Flucloxin</b>
Inj 1 g vial – Up to 5 inj available on a PSO .....	6.00	5	✓	<b>Flucil</b>

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>PHENOXYMETHYLPENICILLIN (PENICILLIN V)</b>				
Cap 250 mg – Up to 30 cap available on a PSO.....	7.68	50	✓	<b>Cilicaine VK</b>
Cap 500 mg.....	13.72	50	✓	<b>Cilicaine VK</b>
a) Up to 20 cap available on a PSO				
b) Up to 2 x the maximum PSO quantity for RFPP				
Grans for oral liq 125 mg per 5 ml.....	5.75	100 ml	✓	<b>AFT</b>
a) Up to 200 ml available on a PSO				
b) Wastage claimable				
Grans for oral liq 250 mg per 5 ml.....	5.89	100 ml	✓	<b>AFT</b>
a) Up to 300 ml available on a PSO				
b) Up to 2 x the maximum PSO quantity for RFPP				
c) Wastage claimable				

**Tetracyclines**

<b>DOXYCYCLINE</b>				
* Tab 100 mg – Up to 30 tab available on a PSO.....	64.43	500	✓	<b>Doxine</b>
<b>MINOCYCLINE HYDROCHLORIDE</b>				
* Tab 50 mg – Additional subsidy by Special Authority see SA1355 below – Retail pharmacy .....				
	5.79 (12.05)	60		Mino-tabs
* Cap 100 mg.....	19.32 (52.04)	100		Minomycin

►SA1355 **Special Authority for Manufacturers Price**

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified where the patient has rosacea.

TETRACYCLINE – Special Authority see SA2513 below – Retail pharmacy

Tab 250 mg.....	68.44	28	✓	<b>Accord</b> S29
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►SA2513 **Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 For the eradication of helicobacter pylori following unsuccessful treatment with appropriate first-line therapy; and
- 2 For use only in combination with bismuth as part of a quadruple therapy regimen.

**Renewal** from any relevant practitioner. Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 For the eradication of helicobacter pylori following unsuccessful treatment with, or noncompletion of second line therapy; and
- 2 For use only in combination with bismuth as part of a quadruple therapy regimen.

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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## Other Antibiotics

For topical antibiotics, refer to DERMATOLOGICALS, page 70

### CIPROFLOXACIN

Recommended for patients with any of the following:

- i) microbiologically confirmed and clinically significant pseudomonas infection; or
- ii) prostatitis; or
- iii) pyelonephritis; or
- iv) gonorrhoea.

Tab 250 mg – Up to 5 tab available on a PSO .....	1.95	28	✓ <b>Ipca-Ciprofloxacin</b>
Tab 500 mg – Up to 5 tab available on a PSO .....	3.10	28	✓ <b>Ipca-Ciprofloxacin</b>
Tab 750 mg .....	4.80	28	✓ <b>Ipca-Ciprofloxacin</b>

### CLINDAMYCIN

Cap hydrochloride 150 mg .....	4.94	24	✓ <b>Dalacin C</b>
Inj 150 mg per ml, 4 ml ampoule .....	48.78	10	✓ <b>Dalacin C</b>

### COLISTIN SULPHOMETHATE – Retail pharmacy-Specialist – Subsidy by endorsement

Only if prescribed for dialysis or cystic fibrosis patient and the prescription is endorsed accordingly.

Inj 2 million iu, 10 ml vial.....	216.67	10	✓ <b>Colomycin</b> <sup>S29</sup>
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### GENTAMICIN SULPHATE

Inj 40 mg per ml, 2 ml vial – Subsidy by endorsement.....	36.70	5	✓ <b>Cidomycin</b> P/Free <sup>S29</sup>
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Only if prescribed for a dialysis or cystic fibrosis patient or complicated urinary tract infection and the prescription is endorsed accordingly.

Inj 10 mg per ml, 1 ml ampoule – Subsidy by endorsement.....	102.60	5	✓ <b>DBL Gentamicin</b>
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Only if prescribed for a dialysis or cystic fibrosis patient or complicated urinary tract infection and the prescription is endorsed accordingly.

Inj 40 mg per ml, 2 ml ampoule – Subsidy by endorsement.....	18.38	10	✓ <b>Pfizer</b>
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Only if prescribed for a dialysis or cystic fibrosis patient or complicated urinary tract infection and the prescription is endorsed accordingly.

### MOXIFLOXACIN – Special Authority see SA1740 below – Retail pharmacy

No patient co-payment payable

Tab 400 mg .....	42.00	5	✓ <b>Avelox</b>
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### ►SA1740 Special Authority for Subsidy

**Initial application — (Tuberculosis)** only from a respiratory specialist or infectious disease specialist. Approvals valid for 1 year for applications meeting the following criteria:

Any of the following:

1 Both:

1.1 Active tuberculosis\*; and

1.2 Any of the following:

1.2.1 Documented resistance to one or more first-line medications; or

1.2.2 Suspected resistance to one or more first-line medications (tuberculosis assumed to be contracted in an area with known resistance), as part of regimen containing other second-line agents; or

1.2.3 Impaired visual acuity (considered to preclude ethambutol use); or

1.2.4 Significant pre-existing liver disease or hepatotoxicity from tuberculosis medications; or

1.2.5 Significant documented intolerance and/or side effects following a reasonable trial of first-line medications; or

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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continued...

- 2 Mycobacterium avium-intracellulare complex not responding to other therapy or where such therapy is contraindicated.\*; or
- 3 Patient is under five years of age and has had close contact with a confirmed multi-drug resistant tuberculosis case.

Note: Indications marked with \* are unapproved indications.

**Renewal** only from a respiratory specialist or infectious disease specialist. Approvals valid for 1 year where the treatment remains appropriate and the patient is benefiting from treatment.

**Initial application — (Mycoplasma genitalium)** only from a sexual health specialist or Practitioner on the recommendation of a sexual health specialist. Approvals valid for 1 month for applications meeting the following criteria:

All of the following:

- 1 Has nucleic acid amplification test (NAAT) confirmed Mycoplasma genitalium\* and is symptomatic; and
- 2 Either:
  - 2.1 Has tried and failed to clear infection using azithromycin; or
  - 2.2 Has laboratory confirmed azithromycin resistance; and
- 3 Treatment is only for 7 days.

**Initial application — (Penetrating eye injury)** only from an ophthalmologist. Approvals valid for 1 month where the patient requires prophylaxis following a penetrating eye injury and treatment is for 5 days only.

Note: Indications marked with \* are unapproved indications.

PAROMOMYCIN – Special Authority see [SA1689 below](#) – Retail pharmacy

Cap 250 mg .....	126.00	16	✓ <b>Humatin</b> <small>S29</small>
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**▶SA1689 Special Authority for Subsidy**

**Initial application** only from an infectious disease specialist, clinical microbiologist or gastroenterologist. Approvals valid for 1 month for applications meeting the following criteria:

Either:

- 1 Patient has confirmed cryptosporidium infection; or
- 2 For the eradication of Entamoeba histolytica carriage.

**Renewal** only from an infectious disease specialist, clinical microbiologist or gastroenterologist. Approvals valid for 1 month for applications meeting the following criteria:

Either:

- 1 Patient has confirmed cryptosporidium infection; or
- 2 For the eradication of Entamoeba histolytica carriage.

SODIUM FUSIDATE [FUSIDIC ACID]

Tab 250 mg .....	135.70	36	✓ <b>Fucidin</b>
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SULFADIAZINE SODIUM – Special Authority see [SA1331 below](#) – Retail pharmacy

Tab 500 mg .....	150.70	100	✓ <b>Sulfadiazin-Heyl</b> <small>S29</small>
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**▶SA1331 Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Any of the following:

- 1 For the treatment of toxoplasmosis in patients with HIV for a period of 3 months; or
- 2 For pregnant patients for the term of the pregnancy; or
- 3 For infants with congenital toxoplasmosis until 12 months of age.

TOBRAMYCIN

Inj 40 mg per ml, 2 ml vial – Subsidy by endorsement .....	15.50	5	✓ <b>Tobramycin (Viatris)</b>
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Only if prescribed for dialysis or cystic fibrosis patient and the prescription is endorsed accordingly.

Solution for inhalation 60 mg per ml, 5 ml – Subsidy by

endorsement.....	395.00	56 dose	✓ <b>Tobramycin BNM</b>
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a) Wastage claimable

b) Only if prescribed for a cystic fibrosis patient and the prescription is endorsed accordingly.

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# INFECTIONS - AGENTS FOR SYSTEMIC USE

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>TRIMETHOPRIM</b>				
Note: Direct Provision by a pharmacist permitted under the provisions in Part I of Section A in accordance with the Integrated Community Pharmaceuticals Agreement (ICPSA) – Extended Pharmacy Services.				
* Tab 300 mg – Up to 30 tab available on a PSO .....	27.83	50	✓	<b>TMP</b>
<b>TRIMETHOPRIM WITH SULPHAMETHOXAZOLE [CO-TRIMOXAZOLE]</b>				
* Tab trimethoprim 80 mg and sulphamethoxazole 400 mg – Up to 30 tab available on a PSO .....	115.74	500	✓	<b>Trisul</b>
* Oral liq 8 mg sulphamethoxazole 40 mg per ml – Up to 200 ml available on a PSO .....	4.95	100 ml	✓	<b>Deprim</b>
<b>VANCOMYCIN – Subsidy by endorsement</b>				
Only if prescribed for a dialysis or cystic fibrosis patient or for prophylaxis of endocarditis or for treatment of Clostridium difficile following metronidazole failure and the prescription is endorsed accordingly.				
Inj 500 mg vial .....	3.38	1	✓	<b>Vancomycin Viatrix</b>

## Antifungals

- a) For topical antifungals refer to DERMATOLOGICALS, [page 70](#)  
 b) For topical antifungals refer to GENITO URINARY, [page 82](#)

<b>FLUCONAZOLE</b>				
Cap 50 mg .....	4.10	28	✓	<b>Mylan</b>
Cap 150 mg .....	0.45	1	✓	<b>Flucazole</b>
Cap 200 mg .....	8.90	28	✓	<b>Mylan</b>
Powder for oral suspension 10 mg per ml – Special Authority see <a href="#">SA1359 below</a> – Retail pharmacy .....	129.02	35 ml	✓	<b>Diflucan</b>
Wastage claimable				

### ► [SA1359](#) Special Authority for Subsidy

**Initial application — (Systemic candidiasis)** from any relevant practitioner. Approvals valid for 6 weeks for applications meeting the following criteria:

Both:

- 1 Patient requires prophylaxis for, or treatment of systemic candidiasis; and
- 2 Patient is unable to swallow capsules.

**Initial application — (Immunocompromised)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient is immunocompromised; and
- 2 Patient is at moderate to high risk of invasive fungal infection; and
- 3 Patient is unable to swallow capsules.

**Renewal — (Systemic candidiasis)** from any relevant practitioner. Approvals valid for 6 weeks for applications meeting the following criteria:

Both:

- 1 Patient requires prophylaxis for, or treatment of systemic candidiasis; and
- 2 Patient is unable to swallow capsules.

**Renewal — (Immunocompromised)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient remains immunocompromised; and
- 2 Patient remains at moderate to high risk of invasive fungal infection; and
- 3 Patient is unable to swallow capsules.

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>ITRACONAZOLE</b>				
Cap 100 mg .....	6.83	15	✓	<b>Itraconazole</b> <b>Crescent</b> <sup>S29</sup>
Oral liq 10 mg per ml – Special Authority see <a href="#">SA1322 below</a> –				
Retail pharmacy.....	141.80	150 ml OP	✓	<b>Itraconazole</b> <b>Kent</b> <sup>S29</sup>

►**SA1322** **Special Authority for Subsidy**

**Initial application** only from an infectious disease specialist, clinical microbiologist, clinical immunologist or any relevant practitioner on the recommendation of a infectious disease physician, clinical microbiologist or clinical immunologist. Approvals valid for 6 months where the patient has a congenital immune deficiency.

**Renewal** from any relevant practitioner. Approvals valid for 6 months where the treatment remains appropriate and the patient is benefitting from the treatment.

**KETOCONAZOLE**

Tab 200 mg – PCT .....	CBS	30	✓	<b>Burel</b> <sup>S29</sup>
		100	✓	<b>Strides Shasun</b> <sup>S29</sup>
			✓	<b>Taro</b> <sup>S29</sup>
			✓	<b>Teva-</b> <b>Ketoconazole</b> <sup>S29</sup>

**NYSTATIN**

Tab 500,000 u .....	14.16	50		
	(17.09)			Nilstat
Cap 500,000 u .....	12.81	50		
	(15.47)			Nilstat

**POSACONAZOLE** – Special Authority see [SA2383 below](#) – Retail pharmacy

Tab modified-release 100 mg.....	123.60	24	✓	<b>Posaconazole Juno</b>
Oral liq 40 mg per ml .....	308.26	105 ml OP	✓	<b>Devatis</b>

►**SA2383** **Special Authority for Subsidy**

**Initial application** only from a haematologist or infectious disease specialist. Approvals valid for 6 weeks for applications meeting the following criteria:

Either:

- 1 Patient has acute myeloid leukaemia and is to be treated with high dose remission induction, re-induction or consolidation chemotherapy; or
- 2 Patient has received a stem cell transplant and has graft versus host disease and is on significant immunosuppressive therapy\*.

**Renewal** only from a haematologist or infectious disease specialist. Approvals valid for 6 weeks for applications meeting the following criteria:

Either:

- 1 Patient has acute myeloid leukaemia and is to be treated with high dose remission induction, re-induction or consolidation therapy; or
- 2 Patient has received a stem cell transplant and has graft versus host disease and is on significant immunosuppression\* and requires on going posaconazole treatment.

Note: \* Graft versus host disease (GVHD) on significant immunosuppression is defined as acute GVHD, grade II to IV, or extensive chronic GVHD, or if they were being treated with intensive immunosuppressive therapy consisting of either high-dose corticosteroids (1 mg or greater per kilogram of body weight per day for patients with acute GVHD or 0.8 mg or greater per kilogram every other day for patients with chronic GVHD), antithymocyte globulin, or a combination of two or more

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time



Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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continued...

- 3.2 Patient continues to require treatment for possible invasive aspergillus infection; or
- 3.3 Patient has fluconazole resistant candidiasis; or
- 3.4 Patient has mould strain such as *Fusarium* spp. and *Scedosporium* spp.

**Initial application — (Invasive fungal infection prophylaxis)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

- Both:
- 1 The patient is at risk of invasive fungal infection; and
  - 2 Either:
    - 2.1 Voriconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist; or
    - 2.2 Prescribing voriconazole is in accordance with a protocol or guideline that has been endorsed by the Health New Zealand - Te Whatu Ora Hospital in the specific settings where there is a greater than 10% risk of invasive fungal infection (IFI).

**Renewal — (Invasive fungal infection prophylaxis)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

- Both:
- 1 The patient is at risk of invasive fungal infection; and
  - 2 Either:
    - 2.1 Voriconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist; or
    - 2.2 Prescribing voriconazole is in accordance with a protocol or guideline that has been endorsed by the Health New Zealand - Te Whatu Ora Hospital in the specific settings where there is a greater than 10% risk of invasive fungal infection (IFI).

## Antimalarials

PRIMAQUINE – Special Authority see SA1684 below – Retail pharmacy

Tab 15 mg .....	395.00	100	✓ Bayshore S29
	550.00		✓ Sanofi
			Primaquine S29

»SA1684 Special Authority for Subsidy

**Initial application** only from an infectious disease specialist or clinical microbiologist. Approvals valid for 1 month for applications meeting the following criteria:

- Both:
- 1 The patient has vivax or ovale malaria; and
  - 2 Primaquine is to be given for a maximum of 21 days.

**Renewal** only from an infectious disease specialist or clinical microbiologist. Approvals valid for 1 month for applications meeting the following criteria:

- Both:
- 1 The patient has relapsed vivax or ovale malaria; and
  - 2 Primaquine is to be given for a maximum of 21 days.

## Antitrichomonal Agents

METRONIDAZOLE

Tab 200 mg – Up to 30 tab available on a PSO .....	25.86	250	✓ Metronidamed
Tab 400 mg – Up to 15 tab available on a PSO .....	4.29	21	✓ Metronidamed
Oral liq benzoate 200 mg per 5 ml .....	25.00	100 ml	✓ Flagyl-S
Suppos 500 mg .....	24.48	10	✓ Flagyl

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# INFECTIONS - AGENTS FOR SYSTEMIC USE

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
ORNIDAZOLE				
Tab 500 mg .....	36.52	10	✓	<b>Arrow-Ornidazole</b>

## Antituberculotics and Antileptotics

Note: There is no co-payment charge for all pharmaceuticals listed in the Antituberculotics and Antileptotics group regardless of immigration status.

BEDAQUILINE – Special Authority see [SA2244 below](#) – Retail pharmacy

No patient co-payment payable

Tab 100mg ..... 3,084.51      24 OP      ✓ **Sirturo**

➔ **SA2244** Special Authority for Subsidy

**Initial application — (multi-drug resistant tuberculosis)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 The person has multi-drug resistant tuberculosis (MDR-TB); and
- 2 Ministry of Health's Tuberculosis Clinical Network has reviewed the individual case and recommends bedaquiline as part of the treatment regimen.

CLOFAZIMINE – Retail pharmacy-Specialist

a) No patient co-payment payable

b) Prescriptions must be written by, or on the recommendation of, an infectious disease physician, clinical microbiologist or dermatologist.

\* Cap 50 mg ..... 442.00      100      ✓ **Lamprene** <sup>S29</sup>

CYCLOSERINE – Retail pharmacy-Specialist

a) No patient co-payment payable

b) Prescriptions must be written by, or on the recommendation of, an infectious disease physician, clinical microbiologist or respiratory physician.

Cap 250 mg ..... 344.00      60      ✓ **Cyclorin** <sup>S29</sup>

DAPSONE – Retail pharmacy-Specialist

a) No patient co-payment payable

b) Prescriptions must be written by, or on the recommendation of, an infectious disease physician, clinical microbiologist or dermatologist

Tab 25 mg ..... 268.50      100      ✓ **Dapsone**

Tab 100 mg ..... 329.50      100      ✓ **Dapsone**

ETHAMBUTOL HYDROCHLORIDE – Retail pharmacy-Specialist

a) No patient co-payment payable

b) Prescriptions must be written by, or on the recommendation of, an infectious disease physician, clinical microbiologist or respiratory physician

Tab 100 mg ..... 85.73      100      ✓ **EMB Fatol** <sup>S29</sup>

Tab 400 mg ..... 49.34      56      ✓ **Myambutol** <sup>S29</sup>

ISONIAZID – Retail pharmacy-Specialist

a) No patient co-payment payable

b) Prescriptions must be written by, or on the recommendation of, an internal medicine physician, paediatrician, clinical microbiologist, dermatologist or public health physician

\* Tab 100 mg ..... 94.50      100      ✓ **Isoniazid Teva** <sup>S29</sup>

327.41      ✓ **Noumed Isoniazid**

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
<b>ISONIAZID WITH RIFAMPICIN – Retail pharmacy-Specialist</b>			
a) No patient co-payment payable			
b) Prescriptions must be written by, or on the recommendation of, an internal medicine physician, paediatrician, clinical microbiologist, dermatologist or public health physician			
* Tab 100 mg with rifampicin 150 mg.....	89.82	100	✓ <b>Rifinah</b>
* Tab 150 mg with rifampicin 300 mg.....	179.13	100	✓ <b>Rifinah</b>
* Cap 100 mg with rifampicin 150 mg.....	199.00	100	✓ <b>Rifamazid</b> §29
<b>LINEZOLID – Special Authority see SA2234 below – Retail pharmacy</b>			
No patient co-payment payable			
Tab 600 mg .....	194.60	10	✓ <b>Zyvox</b>
Oral liq 20 mg per ml .....	1,879.00	150 ml	✓ <b>Zyvox</b>
▶ <b>SA2234</b> <b>Special Authority for Subsidy</b>			
<b>Initial application — (multi-drug resistant tuberculosis)</b> from any relevant practitioner. Approvals valid for 18 months for applications meeting the following criteria:			
Both:			
1 The person has multi-drug resistant tuberculosis (MDR-TB); and			
2 Ministry of Health's Tuberculosis Clinical Network has reviewed the individual case and recommends linezolid as part of the treatment regimen.			
<b>PARA-AMINO SALICYLIC ACID – Retail pharmacy-Specialist</b>			
a) No patient co-payment payable			
b) Prescriptions must be written by, or on the recommendation of, an infectious disease specialist, clinical microbiologist or respiratory physician			
Grans for oral liq 4 g sachet .....	280.00	30	✓ <b>Paser</b> §29
<b>PROTIONAMIDE – Retail pharmacy-Specialist</b>			
a) No patient co-payment payable			
b) Prescriptions must be written by, or on the recommendation of, an infectious disease specialist, clinical microbiologist or respiratory physician			
Tab 250 mg .....	305.00	100	✓ <b>Peteha</b> §29
<b>PYRAZINAMIDE – Retail pharmacy-Specialist</b>			
a) No patient co-payment payable			
b) Prescriptions must be written by, or on the recommendation of, an infectious disease physician, clinical microbiologist or respiratory physician			
* Tab 500 mg .....	64.95	100	✓ <b>AFT-Pyrazinamide</b>
<b>RIFABUTIN – Retail pharmacy-Specialist</b>			
a) No patient co-payment payable			
b) Prescriptions must be written by, or on the recommendation of, an infectious disease physician, respiratory physician or gastroenterologist			
* Cap 150 mg .....	353.71	30	✓ <b>Mycobutin</b>
<b>RIFAMPICIN – Subsidy by endorsement</b>			
a) No patient co-payment payable			
b) For confirmed recurrent Staphylococcus aureus infection in combination with other effective anti-staphylococcal antimicrobial based on susceptibilities and the prescription is endorsed accordingly; can be waived by endorsement - Retail pharmacy - Specialist. Specialist must be an internal medicine physician, clinical microbiologist, dermatologist, paediatrician, or public health physician.			
* Cap 150 mg .....	58.54	100	✓ <b>Rifadin</b>
* Cap 300 mg .....	122.06	100	✓ <b>Rifadin</b>
* Oral liq 100 mg per 5 ml .....	12.60	60 ml	✓ <b>Rifadin Sanofi</b> ✓ <b>Rifadin</b>

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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## Antivirals

For eye preparations refer to Eye Preparations, Anti-Infective Preparations, [page 278](#)

### Hepatitis B Treatment

#### ENTECAVIR

* Tab 0.5 mg .....	12.04	30	✓ <b>Entecavir (Rex)</b>
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LAMIVUDINE – Special Authority see [SA1685 below](#) – Retail pharmacy

* Tab 100 mg .....	12.06	28	✓ <b>Zetlam</b>
* Oral liq 5 mg per ml .....	270.00	240 ml OP	✓ <b>Zeffix</b>

➔ [SA1685](#) Special Authority for Subsidy

**Initial application** only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist.

Approvals valid for 1 year where used for the treatment or prevention of hepatitis B.

**Renewal** from any relevant practitioner. Approvals valid for 2 years where used for the treatment or prevention of hepatitis B.

#### TENOFOVIR DISOPROXIL

Tenofovir disoproxil prescribed under endorsement for the treatment of HIV is included in the count of up to 4 subsidised antiretrovirals for the purposes of Special Authority SA2139., [page 113](#)

* Tab 245 mg (300 mg as a maleate) .....	13.80	30	✓ <b>Tenofovir Disoproxil Viartis</b>
* Tab 245 mg (300 mg as a fumarate) .....	13.80	30	✓ <b>Ricovir</b> <sup>S29</sup>

### Herpesvirus Treatments

#### ACICLOVIR

* Tab dispersible 200 mg .....	2.05	25	✓ <b>Lovir</b>
* Tab dispersible 400 mg .....	7.55	56	✓ <b>Lovir</b>
* Tab dispersible 800 mg .....	7.43	35	✓ <b>Lovir</b>

LETERMOVIR – Special Authority see [SA2635 below](#) – Retail pharmacy

Wastage claimable

Tab 240 mg .....	6,664.00	28	✓ <b>Prevymis</b>
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➔ [SA2635](#) Special Authority for Subsidy

**Initial application** — (CMV prophylaxis - post HSCT) from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Patient has undergone an allogeneic haematopoietic stem cell transplant; and
- 2 The patient has confirmed presence of cytomegalovirus-specific antibodies; and
- 3 Treatment to commence within 28 days of an allogeneic haematopoietic stem cell transplant; and
- 4 Maximum treatment duration of 100 days post-transplant.

**Renewal** — (CMV prophylaxis – second or subsequent HSCT) from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Patient has undergone an allogeneic haematopoietic stem cell transplant; and
- 2 The patient has confirmed presence of cytomegalovirus-specific antibodies; and
- 3 Treatment to commence within 28 days of an allogeneic haematopoietic stem cell transplant; and
- 4 Maximum treatment duration of 100 days post-transplant.

**Initial application** — (CMV prophylaxis - severe immunosuppression\*) only from an infectious disease specialist, clinical microbiologist or any relevant practitioner on the recommendation of a infectious disease specialist or clinical microbiologist.

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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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continued...

Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Patient has severe immunosuppression requiring prophylaxis of CMV; and
- 2 Either:
  - 2.1 Patient is contraindicated to all other funded CMV active oral antiviral agents; or
  - 2.2 Patient's CMV is resistant to all other funded CMV active oral antiviral agents.

**Renewal — (CMV prophylaxis - severe immunosuppression\*)** only from an infectious disease specialist, clinical microbiologist or any relevant practitioner on the recommendation of a infectious disease specialist or clinical microbiologist.

Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Patient has severe immunosuppression requiring prophylaxis of CMV; and
- 2 Either:
  - 2.1 Patient is contraindicated to all other funded CMV active oral antiviral agents; or
  - 2.2 Patient's CMV is resistant to all other funded CMV active oral antiviral agents.

Note: Indications marked with \* are unapproved indications.

**VALACICLOVIR**

Tab 500 mg .....	9.64	30	✓ <b>Vaclovir</b>
Tab 1,000 mg .....	12.45	21	✓ <b>Valaciclovir</b> Mylan <sup>§29</sup>
			✓ <b>Valaciclovir</b> Viatris <sup>§29</sup>
	17.78	30	✓ <b>Vaclovir</b>

**VALGANCICLOVIR – Special Authority see SA2514 below – Retail pharmacy**

Tab 450 mg .....	140.89	60	✓ <b>Valganciclovir</b> Viatris
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**►SA2514 Special Authority for Subsidy**

**Initial application — (transplant cytomegalovirus prophylaxis)** only from a relevant specialist. Approvals valid for 3 months where the patient has undergone a solid organ transplant and requires valganciclovir for CMV prophylaxis.

**Renewal — (transplant cytomegalovirus prophylaxis)** only from a relevant specialist. Approvals valid for 3 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 Patient has undergone a solid organ transplant and received anti-thymocyte globulin and requires valganciclovir therapy for CMV prophylaxis; and
  - 1.2 Patient is to receive a maximum of 90 days of valganciclovir prophylaxis following anti-thymocyte globulin; or
- 2 Both:
  - 2.1 Patient has received pulse methylprednisolone for acute rejection and requires further valganciclovir therapy for CMV prophylaxis; and
  - 2.2 Patient is to receive a maximum of 90 days of valganciclovir prophylaxis following pulse methylprednisolone.

**Initial application — (cytomegalovirus prophylaxis following anti-thymocyte globulin)** only from a relevant specialist.

Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 Patient has undergone a solid organ transplant and received valganciclovir under Special Authority more than 2 years ago (27 months); and
- 2 Patient has received anti-thymocyte globulin and requires valganciclovir for CMV prophylaxis.

**Renewal — (cytomegalovirus prophylaxis following anti-thymocyte globulin)** only from a relevant specialist. Approvals

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

continued...

valid for 3 months where the patient has received a further course of anti-thymocyte globulin and requires valganciclovir for CMV prophylaxis.

**Initial application — (Lung transplant cytomegalovirus prophylaxis)** only from a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient has undergone a lung transplant; and
- 2 Either:
  - 2.1 The donor was cytomegalovirus positive and the patient is cytomegalovirus negative; or
  - 2.2 The recipient is cytomegalovirus positive; and
- 3 Patient has a high risk of CMV disease.

**Renewal — (Lung transplant cytomegalovirus prophylaxis)** only from a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient has undergone a lung re-transplant; and
- 2 Either:
  - 2.1 The donor was cytomegalovirus positive and the patient is cytomegalovirus negative; or
  - 2.2 The recipient is cytomegalovirus positive; and
- 3 Patient has a high risk of CMV disease.

**Initial application — (Cytomegalovirus in immunocompromised patients)** only from a relevant specialist. Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 Patient is immunocompromised; and
- 2 Any of the following:
  - 2.1 Patient has cytomegalovirus syndrome or tissue invasive disease; or
  - 2.2 Patient has rapidly rising plasma CMV DNA in absence of disease; or
  - 2.3 Patient has cytomegalovirus retinitis.

**Renewal — (Cytomegalovirus in immunocompromised patients)** only from a relevant specialist. Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 Patient is immunocompromised; and
- 2 Any of the following:
  - 2.1 Patient has cytomegalovirus syndrome or tissue invasive disease; or
  - 2.2 Patient has rapidly rising plasma CMV DNA in absence of disease; or
  - 2.3 Patient has cytomegalovirus retinitis.

Note: for the purpose of this Special Authority "immunocompromised" includes transplant recipients, patients with immunosuppressive diseases (e.g. HIV) or those receiving immunosuppressive treatment for other conditions.

## Hepatitis C Treatment

GLECAPREVIR WITH PIBRENTASVIR – [Xpharm]

Note the supply of treatment is via Pharmac's approved direct distribution supply. Further details can be found on Pharmac's website <https://pharmac.govt.nz/maviret>

Tab 100 mg with pibrentasvir 40 mg .....	24,750.00	84 OP	✓ Maviret
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LEDIPASVIR WITH SOFOSBUVIR – [Xpharm] – Special Authority see [SA1605 on the next page](#)

No patient co-payment payable

Tab 90 mg with sofosbuvir 400 mg.....	24,363.46	28	✓ Harvoni
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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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►SA1605 Special Authority for Subsidy

Special Authority approved by the Hepatitis C Treatment Panel (HepCTP)

Notes: By application to the Hepatitis C Treatment Panel (HepCTP).

Applications will be considered by HepCTP and approved subject to confirmation of eligibility.

Application details may be obtained from Pharmac's website <http://www.pharmac.govt.nz/harvoni> or:

The Coordinator, Hepatitis C Treatment Panel

Pharmac, PO Box 10-254, WELLINGTON Tel: (04) 460 4990,

Email: [hepcpanel@pharmac.govt.nz](mailto:hepcpanel@pharmac.govt.nz)

**HIV Prophylaxis and Treatment**

EMTRICITABINE WITH TENOFOVIR DISOPROXIL – Subsidy by endorsement; can be waived by Special Authority see SA2520 below

- a) Funding for emtricitabine with tenofovir disoproxil for use as PrEP or PEP, should be applied using Special Authority SA2520.
- b) Endorsement for treatment of conditions approved via Special Authority SA2139 (antiretrovirals for confirmed HIV, prevention of maternal transmission, post-exposure prophylaxis following exposure to HIV (when co-prescribed with other antiretrovirals) and percutaneous exposure): Prescription is deemed to be endorsed if emtricitabine with tenofovir disoproxil is co-prescribed with another antiretroviral subsidised under Special Authority SA2139 and the prescription is annotated accordingly by the Pharmacist or endorsed by the prescriber.

Note: Emtricitabine with tenofovir disoproxil prescribed under endorsement, for treatment of conditions approved via Special Authority SA2139 (antiretrovirals for confirmed HIV, prevention of maternal transmission, post-exposure prophylaxis following exposure to HIV and percutaneous exposure), is included in the count of up to 4 subsidised antiretrovirals, and counts as two antiretroviral medications, for the purposes of Special Authority SA2139, page 113

There is an approval process to become a named specialist to prescribe antiretroviral therapy in New Zealand. Further information is available on the Pharmac website.

* Tab 200 mg with tenofovir disoproxil 245 mg (300 mg as a fumarate).....	13.45	30	✓ Tenofovir Disoproxil Emtricitabine Mylan <sup>S29</sup>
* Tab 200 mg with tenofovir disoproxil 245 mg (300 mg as a maleate).....	13.45	30	✓ Tenofovir Disoproxil Emtricitabine Viatr

►SA2520 Special Authority for Subsidy

Initial application — (Pre-exposure prophylaxis) from any relevant practitioner. Approvals valid for 24 months for applications meeting the following criteria:

Both:

- 1 Patient has tested HIV negative, does not have signs or symptoms of acute HIV infection and has been assessed for HIV seroconversion; and
- 2 The Practitioner considers the patient is at elevated risk of HIV exposure and use of PrEP is clinically appropriate.

Notes: Refer to local health pathways or the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine clinical guidelines:

<https://ashm.org.au/HIV/PrEP/>

Renewal — (Pre-exposure prophylaxis) from any relevant practitioner. Approvals valid for 24 months for applications meeting the following criteria:

Both:

- 1 Patient has tested HIV negative, does not have signs or symptoms of acute HIV infection and has been assessed for HIV seroconversion; and

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

continued...

2 The Practitioner considers the patient is at elevated risk of HIV exposure and use of PrEP is clinically appropriate.

Notes: Refer to local health pathways or the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine clinical guidelines:

<https://ashm.org.au/HIV/PrEP/>

**Initial application — (post-exposure prophylaxis following exposure to HIV)** from any relevant practitioner. Approvals valid for 4 weeks for applications meeting the following criteria:

Both:

- 1 Treatment course to be initiated within 72 hours post exposure; and
- 2 Any of the following:
  - 2.1 Patient has had condomless anal intercourse or receptive vaginal intercourse with a known HIV positive person with an unknown or detectable viral load greater than 200 copies per ml; or
  - 2.2 Patient has shared intravenous injecting equipment with a known HIV positive person; or
  - 2.3 Patient has had non-consensual intercourse and the clinician considers that the risk assessment indicates prophylaxis is appropriate; or
  - 2.4 Patient has had condomless anal intercourse with a person from a high HIV prevalence country or risk group whose HIV status is unknown.

Notes: Tenofvir disoproxil prescribed under endorsement for HIV is included in the count of up to 4 subsidised antiretrovirals. Subsidies apply for a combination of up to four antiretroviral medications. The combination of a protease inhibitor and low-dose ritonavir given as a booster (either as part of a combination product or separately) will be counted as one protease inhibitor for the purpose of accessing funding to antiretrovirals.

Refer to local health pathways or the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine clinical guidelines for PEP (<https://www.ashm.org.au/hiv/hiv-management/pep/>).

**Renewal — (second or subsequent post-exposure prophylaxis)** from any relevant practitioner. Approvals valid for 4 weeks for applications meeting the following criteria:

Both:

- 1 Treatment course to be initiated within 72 hours post exposure; and
- 2 Any of the following:
  - 2.1 Patient has had condomless anal intercourse or receptive vaginal intercourse with a known HIV positive person with an unknown or detectable viral load greater than 200 copies per ml; or
  - 2.2 Patient has shared intravenous injecting equipment with a known HIV positive person; or
  - 2.3 Patient has had non-consensual intercourse and the clinician considers that the risk assessment indicates prophylaxis is appropriate; or
  - 2.4 Patient has had condomless anal intercourse with a person from a high HIV prevalence country or risk group whose HIV status is unknown.

## COVID-19 Treatments

**NIRMATRELVIR WITH RITONAVIR – PCT – Subsidy by endorsement**

Subsidised for patients meeting access criteria for oral COVID-19 antiviral treatments (as on [Pharmac's website](#)) and where the prescription is endorsed accordingly. Pharmacists may annotate the prescription as endorsed when supplying by Direct Provision under the provisions in Part I of Section A of the Pharmaceutical Schedule.

Tab 150 mg with ritonavir 100 mg .....1,274.00      30 OP      ✓ **Paxlovid**

**REMDESIVIR – PCT only**

Note: Subsidised for patients meeting access criteria for oral antiviral treatments (as on [Pharmac's website](#)).

Inj 100 mg vial .....615.23      1      ✓ **Veklury**

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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## Antiretrovirals

### ►SA2139 Special Authority for Subsidy

**Initial application — (Confirmed HIV)** only from a named specialist. Approvals valid without further renewal unless notified where the patient has confirmed HIV infection.

Notes: Tenofovir disoproxil prescribed under endorsement for HIV is included in the count of up to 4 subsidised antiretrovirals. Subsidies apply for a combination of up to four antiretroviral medications. The combination of a protease inhibitor and low-dose ritonavir given as a booster (either as part of a combination product or separately) will be counted as one protease inhibitor for the purpose of accessing funding to antiretrovirals.

**Renewal — (Confirmed HIV)** only from a named specialist. Approvals valid without further renewal unless notified where the treatment remains appropriate and the patient is benefiting from treatment.

**Initial application — (Prevention of maternal transmission)** only from a named specialist. Approvals valid for 1 year for applications meeting the following criteria:

Either:

- 1 Prevention of maternal foetal transmission; or
- 2 Treatment of the newborn for up to eight weeks.

Notes: Tenofovir disoproxil prescribed under endorsement for HIV is included in the count of up to 4 subsidised antiretrovirals. Subsidies apply for a combination of up to four antiretroviral medications. The combination of a protease inhibitor and low-dose ritonavir given as a booster (either as part of a combination product or separately) will be counted as one protease inhibitor for the purpose of accessing funding to antiretrovirals.

Some antiretrovirals are unapproved or contraindicated for this indication. Practitioners prescribing these medications should exercise their own skill, judgement, expertise and discretion, and make their own prescribing decisions with respect to the use of a Pharmaceutical for an indication for which it is not approved or contraindicated.

**Initial application — (post-exposure prophylaxis following exposure to HIV)** from any relevant practitioner. Approvals valid for 4 weeks for applications meeting the following criteria:

Both:

- 1 Treatment course to be initiated within 72 hours post exposure; and
- 2 Any of the following:
  - 2.1 Patient has had condomless anal intercourse or receptive vaginal intercourse with a known HIV positive person with an unknown or detectable viral load greater than 200 copies per ml; or
  - 2.2 Patient has shared intravenous injecting equipment with a known HIV positive person; or
  - 2.3 Patient has had non-consensual intercourse and the clinician considers that the risk assessment indicates prophylaxis is required; or
  - 2.4 Patient has had condomless anal intercourse with a person from a high HIV prevalence country or risk group whose HIV status is unknown.

Notes: Tenofovir disoproxil prescribed under endorsement for HIV is included in the count of up to 4 subsidised antiretrovirals. Subsidies apply for a combination of up to four antiretroviral medications. The combination of a protease inhibitor and low-dose ritonavir given as a booster (either as part of a combination product or separately) will be counted as one protease inhibitor for the purpose of accessing funding to antiretrovirals.

Refer to local health pathways or the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine clinical guidelines for PEP (<https://www.ashm.org.au/hiv/hiv-management/pep/>).

**Renewal — (second or subsequent post-exposure prophylaxis)** from any relevant practitioner. Approvals valid for 4 weeks for applications meeting the following criteria:

Both:

- 1 Treatment course to be initiated within 72 hours post exposure; and
- 2 Any of the following:
  - 2.1 Patient has had condomless anal intercourse or receptive vaginal intercourse with a known HIV positive person

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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continued...

- with an unknown or detectable viral load greater than 200 copies per ml; or
- 2.2 Patient has shared intravenous injecting equipment with a known HIV positive person; or
- 2.3 Patient has had non-consensual intercourse and the clinician considers that the risk assessment indicates prophylaxis is required; or
- 2.4 Patient has had condomless anal intercourse with a person from a high HIV prevalence country or risk group whose HIV status is unknown.

**Initial application — (Percutaneous exposure)** only from a named specialist. Approvals valid for 6 weeks where the patient has percutaneous exposure to blood known to be HIV positive.

Notes: Tenofovir disoproxil prescribed under endorsement for HIV is included in the count of up to 4 subsidised antiretrovirals. Subsidies apply for a combination of up to four antiretroviral medications. The combination of a protease inhibitor and low-dose ritonavir given as a booster (either as part of a combination product or separately) will be counted as one protease inhibitor for the purpose of accessing funding to antiretrovirals.

**Renewal — (Second or subsequent percutaneous exposure)** only from a named specialist. Approvals valid for 6 weeks where the patient has percutaneous exposure to blood known to be HIV positive.

## Non-nucleosides Reverse Transcriptase Inhibitors

EFAVIRENZ – Special Authority see [SA2139 on the previous page](#) – Retail pharmacy

Note: No new patients to be initiated on efavirenz.

* Tab 600 mg	65.38	30	✓ Efavirenz Milpharm <sup>§29</sup>
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(Efavirenz Milpharm <sup>§29</sup> Tab 600 mg to be delisted 1 November 2026)

ETRAVIRINE – Special Authority see [SA2139 on the previous page](#) – Retail pharmacy

* Tab 200 mg	770.00	60	✓ Intence
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NEVIRAPINE – Special Authority see [SA2139 on the previous page](#) – Retail pharmacy

* Tab 200 mg	198.25	60	✓ Nevirapine Viatris
* Oral suspension 10 mg per ml	203.55	240 ml OP	✓ Viramune Suspension

## Nucleosides Reverse Transcriptase Inhibitors

ABACAVIR SULPHATE – Special Authority see [SA2139 on the previous page](#) – Retail pharmacy

* Tab 300 mg	180.00	60	✓ Ziagen
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ABACAVIR SULPHATE WITH LAMIVUDINE – Special Authority see [SA2139 on the previous page](#) – Retail pharmacy

Note: abacavir with lamivudine (combination tablets) counts as two anti-retroviral medications for the purposes of the anti-retroviral Special Authority.

* Tab 600 mg with lamivudine 300 mg	35.00	30	✓ Abacavir/ Lamivudine Viatris
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EFAVIRENZ WITH EMTRICITABINE AND TENOFOVIR DISOPROXIL – Special Authority see [SA2139 on the previous page](#) – Retail pharmacy

Note: Efavirenz with emtricitabine and tenofovir disoproxil counts as three anti-retroviral medications for the purposes of the anti-retroviral Special Authority

* Tab 600 mg with emtricitabine 200 mg and tenofovir disoproxil 245 mg (300 mg as a fumarate)	106.88	30	✓ TEEVIR <sup>§29</sup> ✓ TEEVIR (India) <sup>§29</sup>
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* Tab 600 mg with emtricitabine 200 mg and tenofovir disoproxil 245 mg (300 mg as a maleate)	106.88	30	✓ Viatris
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EMTRICITABINE – Special Authority see [SA2139 on the previous page](#) – Retail pharmacy

* Cap 200 mg	307.20	30	✓ Emtriva
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	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>LAMIVUDINE – Special Authority see SA2139 on page 113 – Retail pharmacy</b>				
* Tab 150 mg .....	98.00	60	✓	<b>Lamivudine Viatris</b>
* Oral liq 10 mg per ml .....	102.50	240 ml OP	✓	<b>3TC</b>
<b>ZIDOVUDINE – Special Authority see SA2139 on page 113 – Retail pharmacy</b>				
* Cap 100 mg .....	152.25	100	✓	<b>Retrovir</b>
* Oral liq 10 mg per ml .....	30.45	200 ml OP	✓	<b>Retrovir</b>
<b>ZIDOVUDINE WITH LAMIVUDINE – Special Authority see SA2139 on page 113 – Retail pharmacy</b>				
Note: zidovudine [AZT] with lamivudine (combination tablets) counts as two anti-retroviral medications for the purposes of the anti-retroviral Special Authority.				
* Tab 300 mg with lamivudine 150 mg .....	92.40	60	✓	<b>Lamivudine/ Zidovudine Viatris</b>

### Protease Inhibitors

<b>ATAZANAVIR SULPHATE – Special Authority see SA2139 on page 113 – Retail pharmacy</b>				
* Cap 150 mg .....	102.50	60	✓	<b>Atazanavir Viatris</b>
* Cap 200 mg .....	152.30	60	✓	<b>Atazanavir Viatris</b>
<b>DARUNAVIR – Special Authority see SA2139 on page 113 – Retail pharmacy</b>				
* Tab 400 mg .....	150.00	60	✓	<b>Darunavir Viatris</b>
* Tab 600 mg .....	225.00	60	✓	<b>Darunavir Viatris</b>
<b>LOPINAVIR WITH RITONAVIR – Special Authority see SA2139 on page 113 – Retail pharmacy</b>				
* Tab 200 mg with ritonavir 50 mg .....	875.00	120	✓	<b>Lopinavir/Ritonavir Mylan</b>
<b>RITONAVIR – Special Authority see SA2139 on page 113 – Retail pharmacy</b>				
* Tab 100 mg .....	43.31	30	✓	<b>Norvir</b>

### Strand Transfer Inhibitors

<b>DOLUTEGRAVIR – Special Authority see SA2139 on page 113 – Retail pharmacy</b>				
* Tab 50 mg .....	1,090.00	30	✓	<b>Tivicay</b>
<b>DOLUTEGRAVIR WITH LAMIVUDINE – Special Authority see SA2139 on page 113 – Retail pharmacy</b>				
* Tab 50 mg with lamivudine 300 mg .....	1,090.00	30	✓	<b>Dovato</b>
<b>RALTEGRAVIR POTASSIUM – Special Authority see SA2139 on page 113 – Retail pharmacy</b>				
* Tab 400 mg .....	1,090.00	60	✓	<b>Isentress</b>
* Tab 600 mg .....	1,090.00	60	✓	<b>Isentress HD</b>

### Immune Modulators

<b>PEGYLATED INTERFERON ALFA-2A – Special Authority see SA2034 below – Retail pharmacy</b>				
Note: Pharmac will consider funding ribavirin for the small group of patients who have a clinical need for ribavirin and meet Special Authority criteria. Please contact the Hepatitis C Coordinator at Pharmac on 0800-023-588 option 4.				
Inj 135 mcg prefilled syringe .....	887.35	1	✓	<b>Pegasys (S29) S29</b>
Inj 180 mcg prefilled syringe .....	1,074.79	4	✓	<b>Pegasys</b>
	1,355.71		✓	<b>Pegasys S29 S29</b>

#### ►SA2034 Special Authority for Subsidy

**Initial application — (chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver transplant)** from any specialist. Approvals valid for 18 months for applications meeting the following criteria:

Both:

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

continued...

- 1 Any of the following:
  - 1.1 Patient has chronic hepatitis C, genotype 1, 4, 5 or 6 infection; or
  - 1.2 Patient has chronic hepatitis C and is co-infected with HIV; or
  - 1.3 Patient has chronic hepatitis C genotype 2 or 3 and has received a liver transplant; and
- 2 Maximum of 48 weeks therapy.

**Renewal — (Chronic hepatitis C - genotype 1 infection)** only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months for applications meeting the following criteria:

All of the following:

- 1 Patient has chronic hepatitis C, genotype 1; and
- 2 Patient has had previous treatment with pegylated interferon and ribavirin; and
- 3 Either:
  - 3.1 Patient has responder relapsed; or
  - 3.2 Patient was a partial responder; and
- 4 Patient is to be treated in combination with boceprevir; and
- 5 Maximum of 48 weeks therapy.

**Initial application — (Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior)** only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months for applications meeting the following criteria:

All of the following:

- 1 Patient has chronic hepatitis C, genotype 1; and
- 2 Patient has had previous treatment with pegylated interferon and ribavirin; and
- 3 Any of the following:
  - 3.1 Patient has responder relapsed; or
  - 3.2 Patient was a partial responder; or
  - 3.3 Patient received interferon treatment prior to 2004; and
- 4 Patient is to be treated in combination with boceprevir; and
- 5 Maximum of 48 weeks therapy.

**Initial application — (chronic hepatitis C - genotype 2 or 3 infection without co-infection with HIV)** from any specialist.

Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 Patient has chronic hepatitis C, genotype 2 or 3 infection; and
- 2 Maximum of 6 months therapy.

**Initial application — (Hepatitis B)** only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months for applications meeting the following criteria:

All of the following:

- 1 Patient has confirmed Hepatitis B infection (HBsAg positive for more than 6 months); and
- 2 Patient is Hepatitis B treatment-naive; and
- 3 ALT > 2 times Upper Limit of Normal; and
- 4 HBV DNA < 10 log<sub>10</sub> IU/ml; and
- 5 Either:
  - 5.1 HBsAg positive; or
  - 5.2 serum HBV DNA greater than or equal to 2,000 units/ml and significant fibrosis (Metavir Stage F2 or greater or moderate fibrosis); and
- 6 Compensated liver disease; and
- 7 No continuing alcohol abuse or intravenous drug use; and
- 8 Not co-infected with HCV, HIV or HDV; and
- 9 Neither ALT nor AST > 10 times upper limit of normal; and

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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continued...

- 10 No history of hypersensitivity or contraindications to pegylated interferon; and
- 11 Maximum of 48 weeks therapy.

**Initial application — (myeloproliferative disorder or cutaneous T cell lymphoma)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Any of the following:

- 1 Patient has a cutaneous T cell lymphoma\*; or
- 2 All of the following:
  - 2.1 Patient has a myeloproliferative disorder\*; and
  - 2.2 Patient is intolerant of hydroxyurea; and
  - 2.3 Treatment with anagrelide and busulfan is not clinically appropriate; or
- 3 Both:
  - 3.1 Patient has a myeloproliferative disorder; and
  - 3.2 Patient is pregnant, planning pregnancy or lactating.

**Renewal — (myeloproliferative disorder or cutaneous T cell lymphoma)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 No evidence of disease progression; and
- 2 The treatment remains appropriate and patient is benefitting from treatment; and
- 3 Either:
  - 3.1 Patient has a cutaneous T cell lymphoma\*; or
  - 3.2 Both:
    - 3.2.1 Patient has a myeloproliferative disorder\*; and
    - 3.2.2 Either:
      - 3.2.2.1 Remains intolerant of hydroxyurea and treatment with anagrelide and busulfan remains clinically inappropriate; or
      - 3.2.2.2 Patient is pregnant, planning pregnancy or lactating.

Note: Indications marked with \* are unapproved indications.

**Initial application — (post-allogenic bone marrow transplant)** from any relevant practitioner. Approvals valid for 3 months where patient has received an allogenic bone marrow transplant\* and has evidence of disease relapse.

**Renewal — (post-allogenic bone marrow transplant)** from any relevant practitioner. Approvals valid for 3 months where patient is responding and ongoing treatment remains appropriate.

Note: Indications marked with \* are unapproved indications.

## Urinary Tract Infections

FOSFOMYCIN – Special Authority see SA2406 below – Retail pharmacy

Powder for oral solution, 3 g sachet ..... 18.70      1      ✓ **UroFos**

►SA2406 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid for 2 months for applications meeting the following criteria:

- Both:
- 1 Patient has an acute, symptomatic, bacteriologically-proven uncomplicated urinary tract infection (UTI)/cystitis with Escherichia Coli; and
  - 2 Either:
    - 2.1 Microbiological testing confirms the pathogen is resistant to all of: trimethoprim, nitrofurantoin, amoxicillin, cefaclor, cefalexin, amoxicillin with clavulanic acid, and norfloxacin; or
    - 2.2 The patient has a contraindication or intolerance to all of: trimethoprim, nitrofurantoin, amoxicillin, cefaclor, cefalexin, amoxicillin with clavulanic acid, and norfloxacin that the pathogen is susceptible to.

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# INFECTIONS - AGENTS FOR SYSTEMIC USE

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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continued...

**Renewal** from any relevant practitioner. Approvals valid for 2 months for applications meeting the following criteria:

Both:

- 1 Patient has an acute, symptomatic, bacteriologically-proven uncomplicated urinary tract infection (UTI)/cystitis with Escherichia Coli; and
- 2 Either:
  - 2.1 Microbiological testing confirms the pathogen is resistant to all of: trimethoprim, nitrofurantoin, amoxicillin, cefaclor, cefalexin, amoxicillin with clavulanic acid, and norfloxacin; or
  - 2.2 The patient has a contraindication or intolerance to all of: trimethoprim, nitrofurantoin, amoxicillin, cefaclor, cefalexin, amoxicillin with clavulanic acid, and norfloxacin that the pathogen is susceptible to.

## METHENAMINE (HEXAMINE) HIPPURATE

* Tab 1 g .....	19.95	100	✓ Hiprex
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## NITROFURANTOIN

* Tab 50 mg – Up to 30 tab available on a PSO .....	22.20	100	✓ Nifuran ✓ Nitrofurantoin Clinect
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* Tab 100 mg .....	37.50	100	✓ Nifuran
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* Cap modified-release 100 mg – Up to 15 cap available on a PSO .....	81.20	100	✓ Macrobid
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Note: Direct Provision of Nitrofurantoin cap modified-release 100 mg by a pharmacist permitted under the provisions in Part I of Section A in accordance with the Integrated Community Pharmaceuticals Agreement (ICPSA) – Extended Pharmacy Services.

*(Nifuran Tab 50 mg to be delisted 1 November 2026)*

*(Nifuran Tab 100 mg to be delisted 1 November 2026)*

## NORFLOXACIN

Tab 400 mg – Subsidy by endorsement.....	245.00	100	✓ Arrow-Norfloxacin
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Only if prescribed for a patient with an uncomplicated urinary tract infection that is unresponsive to a first line agent or with proven resistance to first line agents and the prescription is endorsed accordingly.

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>Anticholinesterases</b>				
<b>NEOSTIGMINE METILSULFATE</b>				
Inj 2.5 mg per ml, 1 ml ampoule .....	48.25	10	✓	<b>Max Health</b>
<b>PYRIDOSTIGMINE BROMIDE</b>				
▲ Tab 60 mg .....	50.28	100	✓	<b>Mestinon</b>
<b>Non-Steroidal Anti-Inflammatory Drugs</b>				
<b>DICLOFENAC SODIUM</b>				
* Tab EC 25 mg .....	2.19	50	✓	<b>Diclofenac Sandoz</b>
* Tab 50 mg dispersible .....	1.50	20	✓	<b>Voltaren D</b>
* Tab EC 50 mg .....	2.19	50	✓	<b>Diclofenac Sandoz</b>
* Tab long-acting 75 mg.....	10.00	100	✓	<b>Voltaren SR</b>
* Inj 25 mg per ml, 3 ml ampoule – Up to 5 inj available on a PSO ....	13.20	5	✓	<b>Voltaren</b>
* Suppos 12.5 mg .....	2.04	10	✓	<b>Voltaren</b>
* Suppos 25 mg .....	2.44	10	✓	<b>Voltaren</b>
* Suppos 50 mg – Up to 10 supp available on a PSO .....	4.22	10	✓	<b>Voltaren</b>
* Suppos 100 mg .....	7.00	10	✓	<b>Voltaren</b>
<b>IBUPROFEN</b>				
* Tab 200 mg .....	21.40	1,000	✓	<b>Relieve</b>
* Tab long-acting 800 mg.....	3.65	30	✓	<b>Ibuprofen SR BNM</b>
* Oral liq 20 mg per ml .....	2.85	200 ml	✓	<b>Ethics</b>
Note: Direct Provision of Ibuprofen oral liq 20 mg per ml by a pharmacist permitted under the provisions in Part I of Section A in accordance with the Integrated Community Pharmaceuticals Agreement (ICPSA) – Extended Pharmacy Services.				
<b>KETOPROFEN</b>				
* Cap long-acting 200 mg .....	12.07	28	✓	<b>Oruvail SR</b>
<i>(Oruvail SR Cap long-acting 200 mg to be delisted 1 October 2026)</i>				
<b>MEFENAMIC ACID</b>				
* Cap 250 mg.....	1.25	50		
	(10.82)			Ponstan
	0.50	20		
	(7.50)			Ponstan
<b>NAPROXEN</b>				
* Tab 250 mg .....	3.92	50	✓	<b>Inza</b>
	7.06	90	✓	<b>Noflam 250</b>
	39.23	500	✓	<b>Noflam 250</b>
* Tab 500 mg .....	6.89	50	✓	<b>Inza</b>
	34.45	250	✓	<b>Noflam 500</b>
* Tab long-acting 750 mg.....	10.40	28	✓	<b>Naprosyn SR 750</b>
* Tab long-acting 1 g.....	11.50	28	✓	<b>Naprosyn SR 1000</b>
<b>TENOXCAM</b>				
* Tab 20 mg .....	23.50	100	✓	<b>Tilcotil</b>
* Inj 20 mg vial .....	9.95	1	✓	<b>AFT</b>

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# MUSCULOSKELETAL SYSTEM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>NSAIDs Other</b>				
CELECOXIB				
Cap 100 mg .....	3.60	60	✓	<b>Celebrex</b>
Cap 200 mg .....	2.55	30	✓	<b>Celostea</b>
	3.20		✓	<b>Celebrex</b>
			✓	<b>Celecoxib Pfizer</b>
<p>Celostea to be Principal Supply on 1 July 2026  <i>(Celebrex Cap 200 mg to be delisted 1 July 2026)</i>  <i>(Celecoxib Pfizer Cap 200 mg to be delisted 1 July 2026)</i></p>				

## Topical Products for Joint and Muscular Pain

CAPSAICIN				
Crm 0.025% – Special Authority see <a href="#">SA1289 below</a> – Retail pharmacy .....				
	9.75	45 g OP	✓	<b>Zo-Rub Osteo</b>
			✓	<b>Zostrix</b>

### ► [SA1289](#) Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified where the patient has osteoarthritis that is not responsive to paracetamol and oral non-steroidal anti-inflammatories are contraindicated.

## Antirheumatoid Agents

HYDROXYCHLOROQUINE SULPHATE				
* Tab 200 mg .....	7.80	100	✓	<b>Ipca-Hydroxychloroquine</b>
LEFLUNOMIDE				
* Tab 10 mg .....	6.00	30	✓	<b>Arava</b>
* Tab 20 mg .....	6.00	30	✓	<b>Arava</b>
PENICILLAMINE				
Tab 125 mg .....	67.23	100	✓	<b>D-Penaminate</b>
Tab 250 mg .....	110.12	100	✓	<b>D-Penaminate</b>

## Drugs Affecting Bone Metabolism

### Alendronate for Osteoporosis

ALENDRONATE SODIUM				
* Tab 70 mg .....	3.10	4	✓	<b>Fosamax</b>
ALENDRONATE SODIUM WITH COLECALCIFEROL				
* Tab 70 mg with colecalciferol 5,600 iu .....	1.99	4	✓	<b>Fosamax Plus</b>

### Other Treatments

DENOSUMAB – Special Authority see [SA2441 on the next page](#) – Retail pharmacy

Note: Denosumab inj 60 mg per 1 ml pre-filled syringe is Medsafe approved for use in osteoporosis. Denosumab inj 120 mg per 1.7 ml vial is Medsafe approved for use in hypercalcaemia of malignancy.

Inj 120 mg per 1.7 ml vial .....	375.00	1	✓	<b>Xgeva</b>
Inj 60 mg per 1 ml prefilled syringe .....	187.50	1	✓	<b>Prolia</b>

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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►SA2441 Special Authority for Subsidy

**Initial application — (Osteoporosis)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 The patient has established osteoporosis; and
- 2 Any of the following:
  - 2.1 History of one significant osteoporotic fracture demonstrated radiologically, with a documented T-Score less than or equal to -2.5, that incorporates BMD measured using dual-energy x-ray absorptiometry (DEXA); or
  - 2.2 History of one significant osteoporotic fracture, demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of logistical, technical or pathophysiological reasons; or
  - 2.3 History of two significant osteoporotic fractures demonstrated radiologically; or
  - 2.4 Documented T-Score less than or equal to -3.0; or
  - 2.5 A 10-year risk of hip fracture greater than or equal to 3%, calculated using a published risk assessment algorithm that incorporates BMD measured using DEXA; and
- 3 Any of the following:
  - 3.1 Bisphosphonates are contraindicated because the patient's creatinine clearance or eGFR is less than 35 mL/min; or
  - 3.2 The patient has experienced at least two symptomatic new fractures or a BMD loss greater than 2% per year, after at least 12 months' continuous therapy with a funded antiresorptive agent; or
  - 3.3 Bisphosphonates result in intolerable side effects; or
  - 3.4 Intravenous bisphosphonates cannot be administered due to logistical or technical reasons.

**Initial application — (Hypercalcaemia)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 Patient has hypercalcaemia of malignancy; and
- 2 Patient has severe renal impairment.

PAMIDRONATE DISODIUM

Inj 3 mg per ml, 10 ml vial.....	32.49	1	✓ Pamisol
Inj 6 mg per ml, 10 ml vial.....	88.11	1	✓ Pamisol
Inj 9 mg per ml, 10 ml vial.....	94.34	1	✓ Pamisol

RISEDRONATE SODIUM

Tab 35 mg .....	3.00	4	✓ Risedronate Sandoz
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TERIPARATIDE – Special Authority see SA1139 below – Retail pharmacy

Inj 250 mcg per ml, 2.4 ml .....	200.27	1	✓ Teriparatide - Teva
	490.00		✓ Forteo \$29

►SA1139 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid for 18 months for applications meeting the following criteria:

All of the following:

- 1 The patient has severe, established osteoporosis; and
- 2 The patient has a documented T-score less than or equal to -3.0 (see Notes); and
- 3 The patient has had two or more fractures due to minimal trauma; and
- 4 The patient has experienced at least one symptomatic new fracture after at least 12 months' continuous therapy with a funded antiresorptive agent at adequate doses (see Notes).

Notes:

- a) The bone mineral density (BMD) measurement used to derive the T-score must be made using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# MUSCULOSKELETAL SYSTEM

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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continued...

- b) Antiresorptive agents and their adequate doses for the purposes of this Special Authority are defined as: alendronate sodium tab 70 mg or tab 70 mg with colecalciferol 5,600 iu once weekly; raloxifene hydrochloride tab 60 mg once daily; zoledronic acid 5 mg per year. If an intolerance of a severity necessitating permanent treatment withdrawal develops during the use of one antiresorptive agent, an alternate antiresorptive agent must be trialled so that the patient achieves the minimum requirement of 12 months' continuous therapy.
- c) A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.
- d) A maximum of 18 months of treatment (18 cartridges) will be subsidised.

## ZOLEDRONIC ACID

Inj 0.05 mg per ml, 100 ml, bag.....	19.45	1	✓ <b>Zoledronic Acid</b> <b>Viatris</b>
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## Hyperuricaemia and Antigout

### ALLOPURINOL

* Tab 100 mg .....	17.99	1,000	✓ <b>Ipca-Allopurinol</b>
* Tab 300 mg .....	22.50	500	✓ <b>Ipca-Allopurinol</b>

### BENZBROMARONE – Special Authority see SA1963 below – Retail pharmacy

Tab 50 mg .....	32.00	100	✓ <b>Narcaricin mite</b> <sup>S29</sup>
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#### ►SA1963 Special Authority for Subsidy

**Renewal** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefitting from the treatment; and
- 2 There is no evidence of liver toxicity and patient is continuing to receive regular (at least every three months) liver function tests.

### COLCHICINE

* Tab 500 mcg.....	6.30	100	✓ <b>Colgout</b>
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### FEBUXOSTAT – Special Authority see SA2555 below – Retail pharmacy

Tab 80 mg .....	4.73	28	✓ <b>Febuxostat (Teva)</b>
Tab 120 mg .....	11.78	28	✓ <b>Febuxostat (Teva)</b>

#### ►SA2555 Special Authority for Subsidy

**Initial application — (Gout)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 Patient has been diagnosed with gout; and
- 2 Any of the following:
  - 2.1 The patient has a serum urate level greater than 0.36 mmol/l despite treatment with allopurinol at doses of at least 600 mg/day and addition of probenecid at doses of up to 2 g per day or maximum tolerated dose; or
  - 2.2 The patient has experienced intolerable side effects from allopurinol such that treatment discontinuation is required and serum urate remains greater than 0.36 mmol/l despite use of probenecid at doses of up to 2 g per day or maximum tolerated dose; or
  - 2.3 The patient has renal impairment such that probenecid is contraindicated or likely to be ineffective and serum urate remains greater than 0.36 mmol/l despite optimal treatment with allopurinol ; or
  - 2.4 The patient has previously had an initial Special Authority approval for benzbromarone for treatment of gout..

**Initial application — (Tumour lysis syndrome)** only from a haematologist or oncologist. Approvals valid for 6 weeks for

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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continued...

applications meeting the following criteria:

Both:

- 1 Patient is scheduled to receive cancer therapy carrying an intermediate or high risk of tumour lysis syndrome; and
- 2 Patient has a documented history of allopurinol intolerance.

**Renewal — (Tumour lysis syndrome)** only from a haematologist or oncologist. Approvals valid for 6 weeks where the treatment remains appropriate and the patient is benefitting from treatment.

PROBENECID

* Tab 500 mg .....	66.95	100	✓ <b>Probenecid-AFT</b>
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**Muscle Relaxants**

BACLOFEN

* Tab 10 mg .....	3.70	100	✓ <b>Pacifen</b>
Inj 0.05 mg per ml, 1 ml ampoule – Subsidy by endorsement.....	11.55	1	✓ <b>Lioresal Intrathecal</b>
Subsidised only for use in a programmable pump in patients where oral antispastic agents have been ineffective or have caused intolerable side effects and the prescription is endorsed accordingly.			
Inj 2 mg per ml, 5 ml ampoule – Subsidy by endorsement.....	490.91	10	✓ <b>Sintetica Baclofen Intrathecal</b>
Subsidised only for use in a programmable pump in patients where oral antispastic agents have been ineffective or have caused intolerable side effects and the prescription is endorsed accordingly.			

DANTROLENE

Cap 25 mg .....	145.77	100	✓ <b>Dantrium S29</b> <small>S29</small>
Cap 50 mg .....	77.00	100	✓ <b>Dantrium</b>

ORPHENADRINE CITRATE

Tab 100 mg .....	23.25	100	✓ <b>Norflex</b>
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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

## Agents for Parkinsonism and Related Disorders

### Dopamine Agonists and Related Agents

<b>AMANTADINE HYDROCHLORIDE</b>			
▲ Cap 100 mg	38.24	60	✓ Symmetrel
	63.73	100	✓ Symmetrel
<b>APOMORPHINE HYDROCHLORIDE</b>			
▲ Inj 10 mg per ml, 2 ml ampoule	59.50	5	✓ Movapo
▲ Inj 10 mg per ml, 5 ml ampoule	121.84	5	✓ Movapo
<b>ENTACAPONE</b>			
▲ Tab 200 mg	13.73	100	✓ Entacapone Viatrix
<b>LEVODOPA WITH BENSERAZIDE</b>			
* Tab dispersible 50 mg with benserazide 12.5 mg	13.25	100	✓ Madopar Rapid
* Cap 50 mg with benserazide 12.5 mg	13.75	100	✓ Madopar 62.5
* Cap 100 mg with benserazide 25 mg	15.80	100	✓ Madopar 125
* Cap long-acting 100 mg with benserazide 25 mg	22.85	100	✓ Madopar HBS
* Cap 200 mg with benserazide 50 mg	26.25	100	✓ Madopar 250
<b>LEVODOPA WITH CARBIDOPA</b>			
* Tab 100 mg with carbidopa 25 mg	26.49	100	✓ Sinemet
* Tab long-acting 200 mg with carbidopa 50 mg	44.99	100	✓ Sinemet CR
* Tab 250 mg with carbidopa 25 mg	39.49	100	✓ Sinemet
<b>LEVODOPA WITH CARBIDOPA AND ENTACAPONE</b>			
* Tab 50 mg with carbidopa 12.5 mg and entacapone 200 mg	27.01	100	✓ Stalevo
* Tab 100 mg with carbidopa 25 mg and entacapone 200 mg	34.18	100	✓ Stalevo
* Tab 150 mg with carbidopa 37.5 mg and entacapone 200 mg	44.96	100	✓ Stalevo
* Tab 200 mg with carbidopa 50 mg and entacapone 200 mg	51.23	100	✓ Stalevo
<b>PRAMIPEXOLE HYDROCHLORIDE</b>			
▲ Tab 0.25 mg	5.23	100	✓ Ramipex
▲ Tab 1 mg	17.73	100	✓ Ramipex
<b>RASAGILINE</b>			
* Tab 1 mg	53.50	30	✓ Azilect <sup>S29</sup>
<b>ROPINIROLE HYDROCHLORIDE</b>			
▲ Tab 0.25 mg	8.83	84	✓ Ropin
▲ Tab 1 mg	10.09	84	✓ Ropin
▲ Tab 2 mg	12.29	84	✓ Ropin
▲ Tab 5 mg	25.94	84	✓ Ropin
<b>TOLCAPONE</b>			
▲ Tab 100 mg	152.38	100	✓ Tasmar

### Anticholinergics

<b>BENZATROPINE MESYLATE</b>			
Tab 2 mg	10.99	60	✓ Bantrop
Inj 1 mg per ml, 2 ml	95.00	5	✓ Phebra
a) Up to 10 inj available on a PSO			
b) Only on a PSO			
<b>PROCYCLIDINE HYDROCHLORIDE</b>			
Tab 5 mg	15.00	100	✓ Kemadrin

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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### Agents for Essential Tremor, Chorea and Related Disorders

RILUZOLE – Special Authority see SA1403 below – Retail pharmacy

Wastage claimable

Tab 50 mg .....	117.00	56	✓ <b>Rilutek</b>
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»SA1403 **Special Authority for Subsidy**

**Initial application** only from a neurologist or respiratory specialist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 The patient has amyotrophic lateral sclerosis with disease duration of 5 years or less; and
- 2 The patient has at least 60 percent of predicted forced vital capacity within 2 months prior to the initial application; and
- 3 The patient has not undergone a tracheostomy; and
- 4 The patient has not experienced respiratory failure; and
- 5 Any of the following:
  - 5.1 The patient is ambulatory; or
  - 5.2 The patient is able to use upper limbs; or
  - 5.3 The patient is able to swallow.

**Renewal** from any relevant practitioner. Approvals valid for 18 months for applications meeting the following criteria:

All of the following:

- 1 The patient has not undergone a tracheostomy; and
- 2 The patient has not experienced respiratory failure; and
- 3 Any of the following:
  - 3.1 The patient is ambulatory; or
  - 3.2 The patient is able to use upper limbs; or
  - 3.3 The patient is able to swallow.

TETRABENAZINE

Tab 25 mg .....	126.02	112	✓ <b>Motetis</b>
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### Anaesthetics

#### Local

LIDOCAINE [LIGNOCAINE]

Gel 2%, tube – Subsidy by endorsement .....	14.50	30 ml	✓ <b>Xylocaine 2% Jelly</b>
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a) Up to 150 ml available on a PSO

b) Subsidised only if prescribed for urethral or cervical administration and the prescription is endorsed accordingly.

Gel 2%, 11 ml urethral syringe – Subsidy by endorsement.....	65.45	10	✓ <b>Instillagel Lido</b>
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a) Up to 5 each available on a PSO

b) Subsidised only if prescribed for urethral, cervical or rectal administration and the prescription is endorsed accordingly.

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

## NERVOUS SYSTEM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>LIDOCAINE [LIGNOCAINE] HYDROCHLORIDE</b>				
Oral (gel) soln 2%.....	30.80	200 ml	✓	<b>Xylocaine Viscous</b>
Inj 1%, 5 ml ampoule – Up to 25 inj available on a PSO.....	15.00	25	✓	<b>Lidocaine-Baxter</b>
	17.50	50		
	(35.00)			Xylocaine
Inj 2%, 5 ml ampoule – Up to 5 inj available on a PSO.....	27.50	25	✓	<b>Lidocaine-Baxter</b>
Inj 1%, 20 ml ampoule – Up to 5 inj available on a PSO.....	12.00	5		
	(20.00)			Xylocaine
Inj 1%, 20 ml vial – Up to 5 inj available on a PSO.....	19.50	5	✓	<b>Lidocaine-Baxter</b>
Inj 2%, 20 ml vial – Up to 5 inj available on a PSO.....	14.00	5	✓	<b>Lidocaine-Baxter</b>
Inj 10%, 5 ml ampoule – Subsidy by endorsement.....	CBS	10	✓	<b>Xylocard 500</b> <sup>S29</sup>
Subsidised only for people receiving palliative care services where other analgesic agents haven't been effective.				

### Topical Local Anaesthetics

#### ➔SA0906 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid for 2 years where the patient is a child with a chronic medical condition requiring frequent injections or venepuncture.

**Renewal** from any relevant practitioner. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefiting from treatment.

LIDOCAINE [LIGNOCAINE] – Special Authority see [SA0906 above](#) – Retail pharmacy

Crm 4%.....	7.60	5 g OP	✓	<b>LMX4</b>
	30.00	30 g OP	✓	<b>LMX4</b>

LIDOCAINE [LIGNOCAINE] WITH PRILOCAINE – Special Authority see [SA0906 above](#) – Retail pharmacy

Crm 2.5% with prilocaine 2.5%.....	45.00	30 g OP	✓	<b>EMLA</b>
Crm 2.5% with prilocaine 2.5% (5 g tubes).....	45.00	5	✓	<b>EMLA</b>

### General Anaesthetics

KETAMINE – Subsidy by endorsement

- Up to 5 inj available on a PSO
- Subsidised only for use within a Primary Response in Medical Emergencies (PRIME) service or to treat intractable pain in palliative care\* and the prescription or PSO is endorsed accordingly. Note: Indication marked with \* is an unapproved indication.

Inj 100 mg per ml, 2 ml vial.....	91.98	5	✓	<b>Ketalar</b>
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### Analgesics

For Anti-inflammatory NSAIDs refer to MUSCULOSKELETAL, [page 119](#)

### Non-opioid Analgesics

ASPIRIN

* Tab dispersible 300 mg – Up to 30 tab available on a PSO.....	5.65	100	✓	<b>Ethics Aspirin</b>
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CAPSAICIN – Subsidy by endorsement

Subsidised only if prescribed for post-herpetic neuralgia or diabetic peripheral neuropathy and the prescription is endorsed accordingly.

Crm 0.075%.....	11.95	45 g OP	✓	<b>Zo-Rub HP</b>
			✓	<b>Zostrix HP</b>

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer ✓
<b>METHOXYFLURANE – Subsidy by endorsement</b>			
a) Only on a PSO			
b) Subsidised only for use within a Primary Response in Medical Emergencies (PRIME) service and the PSO is endorsed accordingly.			
Soln for inhalation 999.9 mg per g, 3 ml bottle – Up to 10 btl available on a PSO .....	276.00	10	✓ <b>Pentrox</b>
Soln for inhalation 999.9 mg per g, 3 ml bottle with inhaler device and activated carbon chamber – Up to 2 pack available on a PSO .....	54.00	1 OP	✓ <b>Pentrox</b>
<b>NEFOPAM HYDROCHLORIDE</b>			
Tab 30 mg .....	23.40	90	✓ <b>Acupan</b>

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# NERVOUS SYSTEM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>PARACETAMOL</b>				
Tab 500 mg - blister pack .....	19.75	1,000	✓	<b><u>Pacimol</u></b>
a) Maximum of 300 tab per prescription; can be waived by endorsement				
b) Up to 30 tab available on a PSO				
c)				
1) Subsidy by endorsement for higher quantities is available for patients with long term conditions who require regular daily dosing for one month or greater, and the prescription is annotated accordingly. Pharmacists may annotate the prescription as endorsed where dispensing history supports a long-term condition.				
2) Maximum of 100 tab per dispensing for non-endorsed patients. If quantities prescribed for more than 100 tabs (for non-endorsed patients), then dispense in repeat dispensings not exceeding 100 tab per dispensing.				
3) Note: Direct Provision by a pharmacist permitted under the provisions in Part I of Section A in accordance with the Integrated Community Pharmaceuticals Agreement (ICPSA) – Extended Pharmacy Services.				
Tab 500 mg - bottle pack – Maximum of 300 tab per prescription; can be waived by endorsement .....	17.92	1,000	✓	<b><u>Noumed Paracetamol</u></b>
1) Subsidy by endorsement for higher quantities is available for patients with long term conditions who require regular daily dosing for one month or greater, and the prescription is annotated accordingly. Pharmacists may annotate the prescription as endorsed where dispensing history supports a long-term condition.				
2) Maximum of 100 tab per dispensing for non-endorsed patients. If quantities prescribed for more than 100 tabs (for non-endorsed patients), then dispense in repeat dispensings not exceeding 100 tab per dispensing.				
Oral liq 120 mg per 5 ml .....	3.18 3.98	200 ml	✓ ✓	<b><u>Noumed Paracetamol (Ethics)</u></b>
a) Maximum of 600 ml per prescription; can be waived by endorsement				
b) Up to 200 ml available on a PSO				
c) Not in combination				
d)				
1) Maximum of 200 ml per dispensing for non-endorsed patients. If quantities prescribed exceed 200 ml (for non-endorsed patients), then dispense in repeat dispensing not exceeding 200 ml per dispensing.				
2) Subsidy by endorsement for higher quantities is available for patients with long term conditions who require regular daily dosing for one month or greater and the prescription is endorsed or annotated accordingly. Pharmacists may annotate the prescription as endorsed where dispensing history supports a long-term condition.				
3) Note: 200 ml presentations of paracetamol oral liquid may be supplied on BSO to a Vaccinator (other than a Pharmacist) under the provisions in Part I of Section A				
4) Note: Direct Provision by a pharmacist of up to 200 ml permitted under the provisions in Part I of Section A in conjunction with immunisation of a child under 2 years of age with meningococcal B multicomponent vaccine, and otherwise in accordance with the Integrated Community Pharmaceuticals Agreement (ICPSA) – Extended Pharmacy Services.				
Oral liq 250 mg per 5 ml .....	3.18	200 ml	✓	<b><u>Pamol</u></b>

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
a) Maximum of 600 ml per prescription; can be waived by endorsement			
b) Up to 200 ml available on a PSO			
c) Not in combination			
d)			
1) Maximum of 200 ml per dispensing for non-endorsed patients. If quantities prescribed exceed 200 ml (for non-endorsed patients), then dispense in repeat dispensing not exceeding 200 ml per dispensing.			
2) Subsidy by endorsement for higher quantities is available for patients with long term conditions who require regular daily dosing for one month or greater and the prescription is endorsed or annotated accordingly. Pharmacists may annotate the prescription as endorsed where dispensing history supports a long-term condition.			
3) Note: 200 ml presentations of paracetamol oral liquid may be supplied on BSO to a Vaccinator (other than a Pharmacist) under the provisions in Part I of Section A			
4) Note: Direct Provision by a pharmacist of up to 200 ml permitted under the provisions in Part I of Section A in conjunction with immunisation of a child under 2 years of age with meningococcal B multicomponent vaccine, and otherwise in accordance with the Integrated Community Pharmaceuticals Agreement (ICPSA) – Extended Pharmacy Services.			
e) Pamol to be Principal Supply on 1 July 2026			
* Suppos 125 mg .....	4.29	10	✓ <b>Gacet</b>
* Suppos 250 mg .....	5.39	10	✓ <b>Gacet</b>
* Suppos 500 mg .....	16.55	50	✓ <b>Gacet</b>

*(Paracetamol (Ethics) Oral liq 120 mg per 5 ml to be delisted 1 November 2026)*

**Opioid Analgesics**

<b>CODEINE PHOSPHATE – Safety medicine; prescriber may determine dispensing frequency</b>			
Tab 15 mg .....	5.82	100	✓ <b>Noumed</b>
Tab 30 mg .....	6.88	100	✓ <b>Noumed</b>
Tab 60 mg .....	13.89	100	✓ <b>Noumed</b>
<b>DIHYDROCODEINE TARTRATE</b>			
Tab long-acting 60 mg .....	9.20	60	✓ <b>DHC Continus</b>
<b>FENTANYL</b>			
a) Only on a controlled drug form			
b) No patient co-payment payable			
c) Safety medicine; prescriber may determine dispensing frequency			
Inj 50 mcg per ml, 2 ml ampoule .....	4.25	10	✓ <b>Boucher and Muir</b>
Inj 50 mcg per ml, 10 ml ampoule .....	9.41	10	✓ <b>Boucher and Muir</b>
Patch 12 mcg per hour .....	6.02	5	✓ <b>Fentanyl Sandoz</b>
Patch 25 mcg per hour .....	6.91	5	✓ <b>Fentanyl Sandoz</b>
Patch 50 mcg per hour .....	9.28	5	✓ <b>Fentanyl Sandoz</b>
Patch 75 mcg per hour .....	15.50	5	✓ <b>Fentanyl Sandoz</b>
Patch 100 mcg per hour .....	16.37	5	✓ <b>Fentanyl Sandoz</b>
<b>METHADONE HYDROCHLORIDE</b>			
a) Only on a controlled drug form			
b) No patient co-payment payable			
c) Safety medicine; prescriber may determine dispensing frequency			
Tab 5 mg .....	1.38	10	✓ <b>Methadone BNM</b>
Methadone BNM to be Principal Supply on 1 September 2026			
Oral liq 2 mg per ml .....	7.80	200 ml	✓ <b>Biodone</b>
Oral liq 5 mg per ml .....	7.80	200 ml	✓ <b>Biodone Forte</b>
Oral liq 10 mg per ml .....	9.65	200 ml	✓ <b>Biodone Extra Forte</b>
Inj 10 mg per ml, 1 ml .....	72.99	10	✓ <b>AFT</b>

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.  
 \* Three months or six months, as applicable, dispensed at one time

# NERVOUS SYSTEM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>MORPHINE HYDROCHLORIDE</b>				
a) Only on a controlled drug form				
b) No patient co-payment payable				
c) Safety medicine; prescriber may determine dispensing frequency				
Oral liq 1 mg per ml .....	19.00	200 ml	✓	<b>RA-Morph</b>
Oral liq 2 mg per ml .....	23.55	200 ml	✓	<b>RA-Morph</b>
Oral liq 5 mg per ml .....	28.20	200 ml	✓	<b>RA-Morph</b>
Oral liq 10 mg per ml .....	40.25	200 ml	✓	<b>RA-Morph</b>
<b>MORPHINE SULPHATE</b>				
a) Only on a controlled drug form				
b) No patient co-payment payable				
c) Safety medicine; prescriber may determine dispensing frequency				
Tab immediate-release 10 mg .....	2.80	10	✓	<b>Sevredol</b>
Tab immediate-release 20 mg .....	5.52	10	✓	<b>Sevredol</b>
Cap long-acting 10 mg .....	4.10	10	✓	<b>m-Eslon</b>
m-Eslon to be Principal Supply on 1 July 2026				
Cap long-acting 30 mg .....	6.05	10	✓	<b>m-Eslon</b>
m-Eslon to be Principal Supply on 1 July 2026				
Cap long-acting 60 mg .....	12.10	10	✓	<b>m-Eslon</b>
m-Eslon to be Principal Supply on 1 July 2026				
Cap long-acting 100 mg .....	14.50	10	✓	<b>m-Eslon</b>
m-Eslon to be Principal Supply on 1 July 2026				
Oral liq 2 mg per ml .....	16.31	100 ml	✓	<b>Wockhardt</b> <sup>S29</sup>
	29.80		✓	<b>Oramorph</b>
			✓	<b>Oramorph CDC</b>
				<b>S29</b> <sup>S29</sup>
Inj 5 mg per ml, 1 ml ampoule – Up to 5 inj available on a PSO .....	5.96	5	✓	<b>Medsurge</b>
Inj 10 mg per ml, 1 ml ampoule – Up to 5 inj available on a PSO .....	4.99	5	✓	<b>Medsurge</b>
Inj 15 mg per ml, 1 ml ampoule – Up to 5 inj available on a PSO .....	6.93	5	✓	<b>Medsurge</b>
Inj 30 mg per ml, 1 ml ampoule – Up to 5 inj available on a PSO .....	7.28	5	✓	<b>Medsurge</b>
<b>OXYCODONE HYDROCHLORIDE</b>				
a) Only on a controlled drug form				
b) No patient co-payment payable				
c) Safety medicine; prescriber may determine dispensing frequency				
Tab controlled-release 5 mg .....	2.49	20	✓	<b>Oxycodone Sandoz</b>
Tab immediate-release 5 mg .....	13.77	100	✓	<b>Oxycodone Amneal</b>
Tab controlled-release 10 mg .....	2.49	20	✓	<b>Oxycodone Sandoz</b>
Tab immediate-release 10 mg .....	18.77	100	✓	<b>Oxycodone Amneal</b>
Tab controlled-release 20 mg .....	3.41	20	✓	<b>Oxycodone Sandoz</b>
Tab immediate-release 20 mg .....	26.77	100	✓	<b>Oxycodone Amneal</b>
Tab controlled-release 40 mg .....	6.67	20	✓	<b>Oxycodone Sandoz</b>
Tab controlled-release 80 mg .....	12.99	20	✓	<b>Oxycodone Sandoz</b>
Oral liq 1 mg per ml .....	37.08	250 ml	✓	<b>Rosemont</b>
Inj 10 mg per ml, 1 ml ampoule .....	4.37	5	✓	<b>Hameln</b>
Inj 10 mg per ml, 2 ml ampoule .....	8.62	5	✓	<b>Hameln</b>
Inj 50 mg per ml, 1 ml ampoule .....	14.90	5	✓	<b>Hameln</b>
<b>PARACETAMOL WITH CODEINE – Safety medicine; prescriber may determine dispensing frequency</b>				
* Tab paracetamol 500 mg with codeine phosphate 8 mg .....	31.95	1,000	✓	<b>Paracetamol + Codeine (Relieve)</b>

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>PETHIDINE HYDROCHLORIDE</b>				
a) Only on a controlled drug form				
b) No patient co-payment payable				
c) Safety medicine; prescriber may determine dispensing frequency				
Tab 50 mg .....	8.68	10	✓	<b>Noumed Pethidine</b>
Inj 50 mg per ml, 1 ml ampoule – Up to 5 inj available on a PSO ....	29.88	5	✓	<b>DBL Pethidine Hydrochloride</b>
Inj 50 mg per ml, 2 ml ampoule – Up to 5 inj available on a PSO ....	30.72	5	✓	<b>DBL Pethidine Hydrochloride</b>
<b>TRAMADOL HYDROCHLORIDE</b>				
Tab sustained-release 100 mg .....	1.95	20	✓	<b>Tramal SR 100</b>
Tab sustained-release 150 mg .....	2.95	20	✓	<b>Tramal SR 150</b>
Tab sustained-release 200 mg .....	3.80	20	✓	<b>Tramal SR 200</b>
Cap 50 mg .....	3.33	100	✓	<b>Arrow-Tramadol</b>

**Antidepressants**

**Cyclic and Related Agents**

<b>AMITRIPTYLINE – Safety medicine; prescriber may determine dispensing frequency</b>				
Tab 10 mg .....	2.99	100	✓	<b>Arrow-Amitriptyline</b>
Tab 25 mg .....	1.99	100	✓	<b>Arrow-Amitriptyline</b>
Tab 50 mg .....	3.14	100	✓	<b>Arrow-Amitriptyline</b>
<b>CLOMIPRAMINE HYDROCHLORIDE – Safety medicine; prescriber may determine dispensing frequency</b>				
Tab 25 mg .....	16.99	50	✓	<b>APC Clomipramine</b>
<b>DOSULEPIN [DOTHIEPIN] HYDROCHLORIDE – Subsidy by endorsement</b>				
a) Safety medicine; prescriber may determine dispensing frequency				
b) Subsidy by endorsement – Subsidised for patients who were taking dosulepin [dothiepin] hydrochloride prior to 1 June 2019 and the prescription is endorsed accordingly. Pharmacists may annotate the prescription as endorsed where there exists a record of prior dispensing of dosulepin [dothiepin] hydrochloride.				
Tab 75 mg .....	3.85	30	✓	<b>Dosulepin Viatris</b>
Cap 25 mg .....	7.83	50	✓	<b>Dosulepin Viatris</b> <sup>S29</sup>
<b>IMIPRAMINE HYDROCHLORIDE – Safety medicine; prescriber may determine dispensing frequency</b>				
Tab 10 mg .....	5.48	50	✓	<b>Tofranil</b>
	10.96	100	✓	<b>Tofranil</b>
Tab 25 mg .....	4.93	28	✓	<b>Imipramine Crescent</b> <sup>S29</sup>
	8.80	50	✓	<b>Tofranil</b>
<b>NORTRIPTYLINE HYDROCHLORIDE – Safety medicine; prescriber may determine dispensing frequency</b>				
Tab 10 mg .....	2.24	50	✓	<b>Allegron</b>
Tab 25 mg .....	2.95	50	✓	<b>Allegron</b>

**Monoamine-Oxidase Inhibitors (MAOIs) - Non Selective**

<b>TRANLYCPROMINE SULPHATE</b>				
* Tab 10 mg .....	22.94	50	✓	<b>Parnate</b>

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.  
 \* Three months or six months, as applicable, dispensed at one time

# NERVOUS SYSTEM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>Monoamine-Oxidase Type A Inhibitors</b>				
MOCLOBEMIDE				
* Tab 150 mg .....	23.60	60	✓	<b>Aurorix</b>
* Tab 300 mg .....	38.50	60	✓	<b>Aurorix</b>
<b>Selective Serotonin Reuptake Inhibitors</b>				
CITALOPRAM HYDROBROMIDE				
* Tab 20 mg .....	3.55	84	✓	<b>Celapram</b>
ESCITALOPRAM				
* Tab 10 mg .....	0.79	28	✓	<b>Ipca-Escitalopram</b>
	1.07		✓	<b>Escitalopram (Ethics)</b>
* Tab 20 mg .....	1.49	28	✓	<b>Ipca-Escitalopram</b>
FLUOXETINE HYDROCHLORIDE				
* Tab dispersible 20 mg, scored – Subsidy by endorsement.....	2.37	28	✓	<b>Fluox</b>
Subsidised by endorsement				
1) When prescribed for a patient who cannot swallow whole tablets or capsules and the prescription is endorsed accordingly; or				
2) When prescribed in a daily dose that is not a multiple of 20 mg in which case the prescription is deemed to be endorsed. Note: Tablets should be combined with capsules to facilitate incremental 10 mg doses.				
* Cap 20 mg .....	3.50	90	✓	<b>Arrow-Fluoxetine</b>
PAROXETINE				
* Tab 20 mg .....	4.98	90	✓	<b>Loxamine</b>
SERTRALINE				
* Tab 50 mg .....	1.24	30	✓	<b>Setrona</b>
* Tab 100 mg .....	2.00	30	✓	<b>Setrona</b>
<b>Other Antidepressants</b>				
MIRTAZAPINE				
Tab 30 mg .....	2.34	30	✓	<b>Noumed</b>
Tab 45 mg .....	3.10	30	✓	<b>Noumed</b>
VENLAFAXINE				
* Cap 37.5 mg .....	8.29	84	✓	<b>Enlafax XR</b>
* Cap 75 mg .....	10.32	84	✓	<b>Enlafax XR</b>
* Cap 150 mg .....	13.95	84	✓	<b>Enlafax XR</b>
<b>Antiepilepsy Drugs</b>				
<b>Agents for Control of Status Epilepticus</b>				
DIAZEPAM – Safety medicine; prescriber may determine dispensing frequency				
Inj 5 mg per ml, 2 ml ampoule – Subsidy by endorsement.....	27.92	5	✓	<b>Hospira</b>
a) Up to 5 inj available on a PSO				
b) Only on a PSO				
c) PSO must be endorsed “not for anaesthetic procedures”.				
Rectal tubes 5 mg – Up to 5 tube available on a PSO .....	54.58	5	✓	<b>Stesolid</b>

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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**PHENYTOIN SODIUM**

* Inj 50 mg per ml, 5 ml ampoule – Up to 5 inj available on a PSO .....	154.01	5	✓	Hospira
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**Control of Epilepsy**

**CARBAMAZEPINE**

* Tab 200 mg .....	14.53	100	✓	Tegretol
* Tab long-acting 200 mg.....	16.98	100	✓	Tegretol CR
	33.96	200	✓	Tegretol CR
* Tab 400 mg .....	34.58	100	✓	Tegretol
* Tab long-acting 400 mg.....	39.17	100	✓	Tegretol CR
* Oral liq 20 mg per ml .....	26.37	250 ml	✓	Tegretol

**CLOBAZAM – Safety medicine; prescriber may determine dispensing frequency**

Tab 10 mg .....	9.12	50	✓	Frisium
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**CLONAZEPAM – Safety medicine; prescriber may determine dispensing frequency**

Oral drops 2.5 mg per ml.....	7.38	10 ml OP	✓	Rivotril
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**ETHOSUXIMIDE**

Cap 250 mg.....	140.88	100	✓	Zarontin
Oral liq 250 mg per 5 ml.....	56.35	200 ml	✓	Zarontin

**GABAPENTIN**

Note: Not subsidised in combination with subsidised pregabalin

* Cap 100 mg.....	6.45	100	✓	Nupentin
* Cap 300 mg.....	8.45	100	✓	Nupentin
* Cap 400 mg.....	10.26	100	✓	Nupentin

**LACOSAMIDE – Special Authority see SA2267 below – Retail pharmacy**

▲ Tab 50 mg .....	25.04	14	✓	Vimpat
▲ Tab 100 mg .....	50.06	14	✓	Vimpat
	200.24	56	✓	Vimpat
▲ Tab 150 mg .....	75.10	14	✓	Vimpat
	300.40	56	✓	Vimpat
▲ Tab 200 mg .....	400.55	56	✓	Vimpat

**►SA2267 Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid for 15 months for applications meeting the following criteria:  
Both:

- 1 Patient has focal epilepsy; and
- 2 Seizures are not adequately controlled by, or patient has experienced unacceptable side effects from, optimal treatment with all of the following: sodium valproate, topiramate, levetiracetam and any two of carbamazepine, lamotrigine and phenytoin sodium (see Note).

Note: Those of childbearing potential are not required to trial phenytoin sodium, sodium valproate, or topiramate. Those who can father children are not required to trial sodium valproate.

**Renewal** from any relevant practitioner. Approvals valid for 24 months where the patient has demonstrated a significant and sustained improvement in seizure rate or severity and/or quality of life compared with that prior to starting lacosamide treatment.

**LAMOTRIGINE**

▲ Tab dispersible 2 mg .....	55.00	30	✓	Lamictal
▲ Tab dispersible 5 mg .....	50.00	30	✓	Lamictal
* Tab dispersible 25 mg .....	4.20	56	✓	Logem
* Tab dispersible 50 mg .....	5.11	56	✓	Logem
* Tab dispersible 100 mg .....	6.75	56	✓	Logem

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# NERVOUS SYSTEM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>LEVETIRACETAM</b>				
Tab 250 mg .....	5.84	60	✓	Everet
Tab 500 mg .....	10.51	60	✓	Everet
Tab 750 mg .....	16.71	60	✓	Everet
Tab 1,000 mg .....	21.82	60	✓	Everet
Oral liq 100 mg per ml .....	44.78	300 ml OP	✓	Levetiracetam-AFT
Inj 100 mg per ml, 5 ml vial.....	38.95	10	✓	Levetiracetam-AFT
<b>PHENOBARBITONE</b>				
For phenobarbitone oral liquid refer Standard Formulae, <a href="#">page 285</a>				
Tab 15 mg .....	248.50	500	✓	Noumed Phenobarbitone
Tab 30 mg .....	398.50	500	✓	Noumed Phenobarbitone
<b>PHENYTOIN SODIUM</b>				
* Tab 50 mg .....	75.00	200	✓	Dilantin Infatab
Cap 30 mg .....	74.00	200	✓	Dilantin
Cap 100 mg .....	37.00	200	✓	Dilantin
* Oral liq 30 mg per 5 ml .....	22.03	500 ml	✓	Dilantin Paediatric
<b>PREGABALIN – Brand switch fee payable (Pharmacode 2723727) - see <a href="#">page 283</a> for details</b>				
Note: Not subsidised in combination with subsidised gabapentin				
* Cap 25 mg .....	2.25	56	✓	Lyrica
			✓	Pregabalin Pfizer
* Cap 75 mg .....	2.65	56	✓	Lyrica
			✓	Pregabalin Pfizer
* Cap 150 mg .....	4.01	56	✓	Lyrica
			✓	Pregabalin Pfizer
* Cap 300 mg .....	7.38	56	✓	Lyrica
			✓	Pregabalin Pfizer
<b>PRIMIDONE</b>				
* Tab 250 mg .....	37.35	100	✓	Primidone Clinect
<b>SODIUM VALPROATE</b>				
Tab 100 mg .....	13.65	100	✓	Epilim Crushable
Tab 200 mg EC .....	27.44	100	✓	Epilim
Tab 500 mg EC .....	52.24	100	✓	Epilim
* Oral liq 200 mg per 5 ml .....	20.48	300 ml	✓	Epilim S/F Liquid
			✓	Epilim Syrup
* Inj 100 mg per ml, 4 ml .....	41.50	1	✓	Epilim IV
<b>STIRIPENTOL – Special Authority see <a href="#">SA2268 below</a> – Retail pharmacy</b>				
Cap 250 mg .....	509.29	60	✓	Diacomit
Powder for oral liq 250 mg sachet.....	509.29	60	✓	Diacomit

## ➔SA2268 Special Authority for Subsidy

**Initial application** only from a paediatric neurologist or Practitioner on the recommendation of a paediatric neurologist.

Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Patient has confirmed diagnosis of Dravet syndrome; and
- 2 Seizures have been inadequately controlled by appropriate courses of sodium valproate, clobazam and at least two of the following: topiramate, levetiracetam, ketogenic diet.

continued...

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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continued...

Note: Those of childbearing potential are not required to trial sodium valproate or topiramate. Those who can father children are not required to trial sodium valproate.

**Renewal** from any relevant practitioner. Approvals valid without further renewal unless notified where the patient continues to benefit from treatment as measured by reduced seizure frequency from baseline.

**TOPIRAMATE**

▲ Tab 25 mg	11.07	60	✓ Arrow-Topiramate ✓ Topiramate Actavis
	26.04		✓ Topamax
▲ Tab 50 mg	18.81	60	✓ Arrow-Topiramate ✓ Topiramate Actavis
	44.26		✓ Topamax
▲ Tab 100 mg	31.99	60	✓ Arrow-Topiramate ✓ Topiramate Actavis
	75.25		✓ Topamax
▲ Tab 200 mg	55.19	60	✓ Arrow-Topiramate ✓ Topiramate Actavis
	129.85		✓ Topamax
▲ Sprinkle cap 15 mg	20.84	60	✓ Topamax
▲ Sprinkle cap 25 mg	26.04	60	✓ Topamax
VIGABATRIN – Special Authority see SA2088 below – Retail pharmacy			
▲ Tab 500 mg	119.30	100	✓ Sabril

**►SA2088 Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid for 15 months for applications meeting the following criteria:

Both:

- 1 Any of the following:
  - 1.1 Patient has infantile spasms; or
  - 1.2 Both:
    - 1.2.1 Patient has epilepsy; and
    - 1.2.2 Either:
      - 1.2.2.1 Seizures are not adequately controlled with optimal treatment with other antiepilepsy agents; or
      - 1.2.2.2 Seizures are controlled adequately but the patient has experienced unacceptable side effects from optimal treatment with other antiepilepsy agents; or
  - 1.3 Patient has tuberous sclerosis complex; and
- 2 Either:
  - 2.1 Patient is, or will be, receiving regular automated visual field testing (ideally before starting therapy and on a 6-monthly basis thereafter); or
  - 2.2 It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields..

**Renewal** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 The patient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality of life; and
- 2 Either:
  - 2.1 Patient is receiving regular automated visual field testing (ideally every 6 months) on an ongoing basis for duration of treatment with vigabatrin; or
  - 2.2 It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields..

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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## Antimigraine Preparations

For Anti-inflammatory NSAIDS refer to MUSCULOSKELETAL, [page 119](#)

### Acute Migraine Treatment

<b>RIZATRIPTAN</b>			
Tab orodispersible 10 mg .....	4.84	30	✓ <b>Rizamelt</b> ✓ <b>Rizatriptan</b> <b>Viatrix</b> <small>S29</small>
<b>SUMATRIPTAN</b>			
Tab 50 mg .....	14.41	90	✓ <b>Sumagran</b>
Tab 100 mg .....	22.68	90	✓ <b>Sumagran</b>
Inj 12 mg per ml, 0.5 ml prefilled pen – Maximum of 10 inj per prescription .....	29.80	2 OP	✓ <b>Clustran</b>

### Prophylaxis of Migraine

For Beta Adrenoceptor Blockers refer to CARDIOVASCULAR SYSTEM, [page 50](#)

<b>PIZOTIFEN</b>			
* Tab 500 mcg .....	23.21	100	✓ <b>Sandomigran</b>

## Antinausea and Vertigo Agents

For Antispasmodics refer to ALIMENTARY TRACT, [page 8](#)

<b>APREPITANT</b> – Special Authority see <a href="#">SA0987 below</a> – Retail pharmacy			
Cap 2 x 80 mg and 1 x 125 mg .....	21.90	3 OP	✓ <b>Emend Tri-Pack</b>

#### ► [SA0987](#) Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid for 12 months where the patient is undergoing highly emetogenic chemotherapy and/or anthracycline-based chemotherapy for the treatment of malignancy.

**Renewal** from any relevant practitioner. Approvals valid for 12 months where the patient is undergoing highly emetogenic chemotherapy and/or anthracycline-based chemotherapy for the treatment of malignancy.

<b>BETAHISTINE DIHYDROCHLORIDE</b>			
* Tab 16 mg .....	3.70	100	✓ <b>Serc</b>
<b>CYCLIZINE HYDROCHLORIDE</b>			
Tab 50 mg .....	0.66	10	✓ <b>Nausicalm</b>
<b>CYCLIZINE LACTATE</b>			
Inj 50 mg per ml, 1 ml ampoule – Up to 10 inj available on a PSO .....	17.86	10	✓ <b>Hameln</b>
<b>DOMPERIDONE</b>			
* Tab 10 mg .....	3.80	100	✓ <b>Domperidone</b> <b>Viatrix</b>

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>DROPERIDOL – Subsidy by endorsement</b>				
a) Up to 10 inj available on a PSO				
b) Only on a PSO				
c) Subsidised only for use within a Primary Response in Medical Emergencies (PRIME) service and the PSO is endorsed accordingly.				
Inj 2.5 mg per ml, 1 ml ampoule .....	28.68	10	✓	<b>Droperidol Medsurge</b>
	43.85		✓	<b>Droperidol Panpharma</b>
<b>HYOSCINE HYDROBROMIDE</b>				
* Inj 400 mcg per ml, 1 ml ampoule .....	93.00	10	✓	<b>Martindale</b> <small>S29</small>
Patch 1 mg per 72 hours – Special Authority see <a href="#">SA1998</a> below – Retail pharmacy .....	88.50	10	✓	<b>Scopolamine Transdermal System Viatrix</b>
<b>▶SA1998 Special Authority for Subsidy</b>				
<b>Initial application</b> from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria: Either:				
1 Control of intractable nausea, vomiting, or inability to swallow saliva in the treatment of malignancy or chronic disease where the patient cannot tolerate or does not adequately respond to oral anti-nausea agents; or				
2 Control of clozapine-induced hypersalivation where trials of at least two other alternative treatments have proven ineffective.				
<b>Renewal</b> from any relevant practitioner. Approvals valid for 1 year where the treatment remains appropriate and the patient is benefiting from treatment.				
<b>METOCLOPRAMIDE HYDROCHLORIDE</b>				
* Tab 10 mg – Up to 30 tab available on a PSO .....	1.57	100	✓	<b>Metoclopramide Actavis 10</b>
* Inj 5 mg per ml, 2 ml ampoule – Up to 5 inj available on a PSO .....	5.48	10	✓	<b>Medsurge</b>
<b>ONDANSETRON</b>				
* Tab 4 mg .....	1.95	50	✓	<b>Periset</b>
Tab disp 4 mg – Up to 10 tab available on a PSO .....	0.56	10	✓	<b>Periset ODT</b>
* Tab 8 mg .....	3.50	50	✓	<b>Periset</b>
Tab disp 8 mg – Up to 10 tab available on a PSO .....	0.90	10	✓	<b>Periset ODT</b>
<b>PROCHLORPERAZINE</b>				
* Tab 3 mg buccal .....	5.97 (30.00)	50		Prochlorperazine maleate (Brown & Burk)
* Tab 5 mg – Up to 30 tab available on a PSO .....	25.00	250	✓	<b>Nausafix</b>
* Inj 12.5 mg per ml, 1 ml – Up to 5 inj available on a PSO .....	25.81	10	✓	<b>Stemetil</b>

**Antipsychotics**

**General**

**AMISULPRIDE – Safety medicine; prescriber may determine dispensing frequency**

Tab 100 mg .....	5.84	30	✓	<b>Sulprix</b>
Tab 200 mg .....	14.47	60	✓	<b>Sulprix</b>
Tab 400 mg .....	35.06	60	✓	<b>Sulprix</b>

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# NERVOUS SYSTEM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>ARIPIPRAZOLE – Safety medicine; prescriber may determine dispensing frequency</b>				
Tab 5 mg .....	10.50	30	✓	<b>Aripiprazole Sandoz</b>
Tab 10 mg .....	10.50	30	✓	<b>Aripiprazole Sandoz</b>
Tab 15 mg .....	10.50	30	✓	<b>Aripiprazole Sandoz</b>
Tab 20 mg .....	10.50	30	✓	<b>Aripiprazole Sandoz</b>
Tab 30 mg .....	10.50	30	✓	<b>Aripiprazole Sandoz</b>
<b>CHLORPROMAZINE HYDROCHLORIDE – Safety medicine; prescriber may determine dispensing frequency</b>				
Tab 25 mg – Up to 30 tab available on a PSO .....	15.62	100	✓	<b>Largactil</b>
Tab 100 mg – Up to 30 tab available on a PSO .....	36.73	100	✓	<b>Largactil</b>
Inj 25 mg per ml, 2 ml – Up to 5 inj available on a PSO .....	30.79	10	✓	<b>Largactil</b>
<b>CLOZAPINE – Hospital pharmacy [HP4]</b>				
Safety medicine; prescriber may determine dispensing frequency				
Tab 25 mg .....	6.69	50	✓	<b>Clopine</b>
	13.37	100	✓	<b>Clozaril</b>
			✓	<b>Clopine</b>
			✓	<b>Clozaril</b>
Tab 50 mg .....	8.67	50	✓	<b>Clopine</b>
	17.33	100	✓	<b>Clopine</b>
Tab 100 mg .....	17.33	50	✓	<b>Clopine</b>
			✓	<b>Clozaril</b>
	34.65	100	✓	<b>Clopine</b>
			✓	<b>Clozaril</b>
Tab 200 mg .....	34.65	50	✓	<b>Clopine</b>
	69.30	100	✓	<b>Clopine</b>
Suspension 50 mg per ml .....	173.30	100 ml	✓	<b>Versacloz</b>
<b>HALOPERIDOL – Safety medicine; prescriber may determine dispensing frequency</b>				
Tab 500 mcg – Up to 30 tab available on a PSO .....	6.23	100	✓	<b>Serenace</b>
Tab 1.5 mg – Up to 30 tab available on a PSO .....	9.43	100	✓	<b>Serenace</b>
Tab 5 mg – Up to 30 tab available on a PSO .....	14.86	50	✓	<b>Serenace</b>
	29.72	100	✓	<b>Serenace</b>
Oral liq 2 mg per ml – Up to 200 ml available on a PSO .....	23.84	100 ml	✓	<b>Serenace</b>
Inj 5 mg per ml, 1 ml ampoule – Up to 5 inj available on a PSO .....	12.93	10	✓	<b>Serenace</b>
Serenace to be Principal Supply on 1 August 2026				
<b>LEVOMEPRMAZINE – Safety medicine; prescriber may determine dispensing frequency</b>				
Tab 25 mg (33.8 mg as a maleate) .....	16.10	100	✓	<b>Nozinan (Swiss)</b>
Tab 25 mg as a maleate .....	16.10	100	✓	<b>Nozinan</b>
Tab 100 mg (135 mg as a maleate) .....	41.75	100	✓	<b>Nozinan (Swiss)</b>
Tab 100 mg as a maleate .....	41.75	100	✓	<b>Nozinan</b>
<b>LEVOMEPRMAZINE HYDROCHLORIDE – Safety medicine; prescriber may determine dispensing frequency</b>				
Inj 25 mg per ml, 1 ml ampoule .....	23.26	10	✓	<b>Wockhardt</b>
<b>LITHIUM CARBONATE – Safety medicine; prescriber may determine dispensing frequency</b>				
Tab long-acting 400 mg .....	82.80	100	✓	<b>Priadel</b>
Cap 250 mg .....	35.78	100	✓	<b>Douglas</b>

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>OLANZAPINE – Safety medicine; prescriber may determine dispensing frequency</b>				
Tab 2.5 mg .....	1.40	30	✓	<b>Zypine</b>
Tab 5 mg .....	1.93	30	✓	<b>Zypine</b>
Tab orodispersible 5 mg .....	2.42	28	✓	<b>Zypine ODT</b>
	3.93		✓	<b>APO- Olanzapine</b> <sup>S29</sup>
	8.64	100	✓	<b>Olanzapine ODT</b> <b>Viatris</b> <sup>S29</sup>
Tab 10 mg .....	1.80	28	✓	<b>Zypine</b>
	1.93	30	✓	<b>Zypine</b>
Tab orodispersible 10 mg .....	2.89	28	✓	<b>Olanzapina</b> <b>Mylan</b> <sup>S29</sup>
	4.49		✓	<b>Olanzapina Mylan</b> <b>Pharma</b> <sup>S29</sup>
			✓	<b>Zypine ODT</b>
			✓	<b>APO- Olanzapine</b> <sup>S29</sup>
	10.32	100	✓	<b>Olanzapine ODT</b> <b>Viatris</b> <sup>S29</sup>
<b>PERICYAZINE – Safety medicine; prescriber may determine dispensing frequency</b>				
Tab 2.5 mg .....	13.61	100	✓	<b>Neulactil</b>
Tab 10 mg .....	48.45	100	✓	<b>Neulactil</b>
<b>QUETIAPINE – Safety medicine; prescriber may determine dispensing frequency</b>				
Tab 25 mg .....	0.79	30	✓	<b>Quetiapine</b> <b>Viatris</b> <sup>S29</sup>
	2.36	90	✓	<b>Quetapel</b>
	13.11	500	✓	<b>Quetiapine</b> <b>Viatris</b> <sup>S29</sup>
Tab 100 mg .....	6.40	90	✓	<b>Quetapel</b>
Tab 200 mg .....	10.97	90	✓	<b>Quetapel</b>
Tab 300 mg .....	15.83	90	✓	<b>Quetapel</b>
<b>RISPERIDONE – Safety medicine; prescriber may determine dispensing frequency</b>				
Tab 0.5 mg .....	2.17	60	✓	<b>Risperidone (Teva)</b>
	4.01		✓	<b>Risperidone</b> <b>Sandoz</b> <sup>S29</sup>
Tab 1 mg .....	2.44	60	✓	<b>Risperidone (Teva)</b>
Tab 2 mg .....	2.72	60	✓	<b>Risperidone (Teva)</b>
	5.38		✓	<b>Risperidone</b> <b>Sandoz</b> <sup>S29</sup>
Tab 3 mg .....	4.50	60	✓	<b>Risperidone (Teva)</b>
Tab 4 mg .....	6.25	60	✓	<b>Risperdal</b>
			✓	<b>Risperidone (Teva)</b>
Oral liq 1 mg per ml .....	10.29	30 ml	✓	<b>Risperon</b>
	34.30	100 ml	✓	<b>Risperon</b>

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>ZIPRASIDONE – Safety medicine; prescriber may determine dispensing frequency</b>				
Cap 20 mg .....	17.90	60	✓	<b>Zusdone</b>
Cap 40 mg .....	27.41	60	✓	<b>Zusdone</b>
Cap 60 mg .....	38.39	60	✓	<b>Zusdone</b>
Cap 80 mg .....	46.55	60	✓	<b>Zusdone</b>
<b>ZUCLOPENTHIXOL HYDROCHLORIDE – Safety medicine; prescriber may determine dispensing frequency</b>				
Tab 10 mg .....	31.45	100	✓	<b>Clopixol</b>

## Depot Injections

**ARIPRAZOLE – Special Authority see SA2395 below – Retail pharmacy**

Safety medicine; prescriber may determine dispensing frequency

Inj 300 mg vial .....	273.56	1	✓	<b>Abilify Maintena</b>
Inj 400 mg vial .....	341.96	1	✓	<b>Abilify Maintena</b>

### ►SA2395 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

1 Either:

- 1.1 The patient has had an initial Special Authority approval for risperidone depot injection, paliperidone depot injection or olanzapine depot injection; or
- 1.2 All of the following:
  - 1.2.1 The patient has schizophrenia or other psychotic disorder; and
  - 1.2.2 The patient has received treatment with oral atypical antipsychotic agents but has been unable to adhere; and
  - 1.2.3 The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in last 12 months; or

2 Patient has been unable to access olanzapine depot injection due to supply issues with olanzapine depot injection, or otherwise would have been started on olanzapine depot injection but has been unable to due to supply issues with olanzapine depot injection.

**Notes:** The Olanzapine depot injection Special Authority criteria that apply to criterion 2 in this Aripiprazole Special Authority application are as follows:

- The patient has had an initial Special Authority approval for paliperidone depot injection or risperidone depot injection; or
- All of the following:
  - The patient has schizophrenia; and
  - The patient has not been able to adhere with treatment using oral atypical antipsychotic agents; and
  - The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last 12 months.

**FLUPENTHIXOL DECANOATE – Safety medicine; prescriber may determine dispensing frequency**

Inj 20 mg per ml, 1 ml – Up to 5 inj available on a PSO .....	13.14	5	✓	<b>Fluanxol</b>
Inj 20 mg per ml, 2 ml – Up to 5 inj available on a PSO .....	20.90	5	✓	<b>Fluanxol</b>
Inj 100 mg per ml, 1 ml – Up to 5 inj available on a PSO .....	40.87	5	✓	<b>Fluanxol</b>

**HALOPERIDOL DECANOATE – Safety medicine; prescriber may determine dispensing frequency**

Inj 50 mg per ml, 1 ml – Up to 5 inj available on a PSO .....	28.39	5	✓	<b>Haldol</b>
Inj 100 mg per ml, 1 ml – Up to 5 inj available on a PSO .....	55.90	5	✓	<b>Haldol Concentrate</b>
			✓	<b>Haldol</b>

**Decanoates** <sup>S29</sup>

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>OLANZAPINE – Special Authority see SA2586 below – Retail pharmacy</b>				
Safety medicine; prescriber may determine dispensing frequency				
Inj 210 mg vial .....	252.00	1	✓	Zyprexa Relprevv
Inj 300 mg vial .....	414.00	1	✓	Zyprexa Relprevv
Inj 405 mg vial .....	504.00	1	✓	Zyprexa Relprevv

► **SA2586 Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Either:
  - 1.1 The patient has had an initial Special Authority approval for paliperidone depot injection or risperidone depot injection; or
  - 1.2 All of the following:
    - 1.2.1 The patient has schizophrenia or other psychotic disorder; and
    - 1.2.2 The patient has tried but failed to comply with treatment using oral atypical antipsychotic agents; and
    - 1.2.3 The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last 12 months; and
- 2 The patient has trialled other funded depot antipsychotics (aripiprazole, risperidone, and paliperidone) unless it is considered clinically inappropriate to use these; and
- 3 The patient continues to have difficulties with adherence on oral antipsychotic treatments; and
- 4 Prescribing clinician has relevant Clinical Director (Mental Health and Addiction services) approval.

**Renewal** from any relevant practitioner. Approvals valid for 12 months where the initiation of olanzapine depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection.

**PALIPERIDONE – Special Authority see SA2396 below – Retail pharmacy**

Safety medicine; prescriber may determine dispensing frequency				
Inj 25 mg syringe .....	194.25	1	✓	Invega Sustenna
Inj 50 mg syringe .....	271.95	1	✓	Invega Sustenna
Inj 75 mg syringe .....	357.42	1	✓	Invega Sustenna
Inj 100 mg syringe .....	435.12	1	✓	Invega Sustenna
Inj 150 mg syringe .....	435.12	1	✓	Invega Sustenna

► **SA2396 Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Either:

- 1 The patient has had an initial Special Authority approval for risperidone depot injection or olanzapine depot injection or aripiprazole depot injection; or
- 2 All of the following:
  - 2.1 The patient has schizophrenia or other psychotic disorder; and
  - 2.2 Has been unable to adhere to treatment using oral atypical antipsychotic agents; and
  - 2.3 Has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in last 12 months.

**Renewal** from any relevant practitioner. Approvals valid for 12 months where the initiation of paliperidone depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection.

**PALIPERIDONE PALMITATE – Special Authority see SA2167 on the next page – Retail pharmacy**

Inj 175 mg syringe .....	815.85	1	✓	Invega Trinza
Inj 263 mg syringe .....	1,072.26	1	✓	Invega Trinza
Inj 350 mg syringe .....	1,305.36	1	✓	Invega Trinza
Inj 525 mg syringe .....	1,305.36	1	✓	Invega Trinza

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# NERVOUS SYSTEM

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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## ►SA2167 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:  
Both:

- 1 The patient has schizophrenia; and
- 2 The patient has had an initial Special Authority approval for paliperidone once-monthly depot injection.

**Renewal** from any relevant practitioner. Approvals valid for 12 months where the initiation of paliperidone depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection.

RISPERIDONE – Special Authority see SA2397 below – Retail pharmacy

Safety medicine; prescriber may determine dispensing frequency

Inj 25 mg vial .....	135.98	1	✓ Risperdal Consta
Inj 37.5 mg vial .....	178.71	1	✓ Risperdal Consta
Inj 50 mg vial .....	217.56	1	✓ Risperdal Consta

## ►SA2397 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:  
Either:

- 1 The patient has had an initial Special Authority approval for paliperidone depot injection or olanzapine depot injection or aripiprazole depot injection; or
- 2 All of the following:
  - 2.1 The patient has schizophrenia or other psychotic disorder; and
  - 2.2 Has not been able to adhere with treatment using oral atypical antipsychotic agents; and
  - 2.3 Has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in last 12 months.

**Renewal** from any relevant practitioner. Approvals valid for 12 months where the initiation of risperidone depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection.

ZUCLOPENTHIXOL DECANOATE – Safety medicine; prescriber may determine dispensing frequency

Inj 200 mg per ml, 1 ml – Up to 5 inj available on a PSO .....	19.80	5	✓ Clopixol
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## Anxiolytics

BUSPIRONE HYDROCHLORIDE

* Tab 5 mg .....	13.95	100	✓ Buspirone Viatrix
* Tab 10 mg .....	12.50	100	✓ Buspirone Viatrix

CLONAZEPAM – Safety medicine; prescriber may determine dispensing frequency

Tab 500 mcg .....	5.64	100	✓ Paxam
Tab 2 mg .....	10.78	100	✓ Paxam

DIAZEPAM – Safety medicine; prescriber may determine dispensing frequency

Tab 2 mg .....	95.00	500	✓ Arrow-Diazepam
Tab 5 mg .....	115.00	500	✓ Arrow-Diazepam

LORAZEPAM – Safety medicine; prescriber may determine dispensing frequency

Tab 1 mg .....	10.20	250	✓ Ativan
Tab 2.5 mg .....	13.13	100	✓ Ativan

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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**Multiple Sclerosis Treatments**

►SA2274 Special Authority for Subsidy

**Initial application — (Multiple Sclerosis - dimethyl fumarate, fingolimod, glatiramer acetate, interferon beta-1-alpha, interferon beta-1-beta, natalizumab and teriflunomide)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Either:

- 1 All of the following:
  - 1.1 Diagnosis of multiple sclerosis (MS) meets the McDonald 2017 diagnostic criteria for MS and has been confirmed by a neurologist; and
  - 1.2 Patient has an EDSS score between 0 – 6.0; and
  - 1.3 Patient has had at least one significant attack of MS in the previous 12 months or two significant attacks in the past 24 months; and
  - 1.4 All of the following:
    - 1.4.1 Each significant attack must be confirmed by the applying neurologist or general physician (the patient may not necessarily have been seen by them during the attack, but the neurologist/physician must be satisfied that the clinical features were characteristic); and
    - 1.4.2 Each significant attack is associated with characteristic new symptom(s)/sign(s) or substantially worsening of previously experienced symptoms(s)/sign(s); and
    - 1.4.3 Each significant attack has lasted at least one week and has started at least one month after the onset of a previous attack (where relevant); and
    - 1.4.4 Each significant attack can be distinguished from the effects of general fatigue; and is not associated with a fever (T> 37.5°C); and
    - 1.4.5 Either:
      - 1.4.5.1 Each significant attack is severe enough to change either the EDSS or at least one of the Kurtze Functional System scores by at least 1 point; or
      - 1.4.5.2 Each significant attack is a recurrent paroxysmal symptom of multiple sclerosis (tonic seizures/spasms, trigeminal neuralgia, Lhermitte’s symptom); and
  - 1.5 Evidence of new inflammatory activity on an MRI scan within the past 24 months; and
  - 1.6 Any of the following:
    - 1.6.1 A sign of that new inflammatory activity on MRI scanning (in criterion 5 immediately above) is a gadolinium enhancing lesion; or
    - 1.6.2 A sign of that new inflammatory activity is a lesion showing diffusion restriction; or
    - 1.6.3 A sign of that new inflammatory is a T2 lesion with associated local swelling; or
    - 1.6.4 A sign of that new inflammatory activity is a prominent T2 lesion that clearly is responsible for the clinical features of a recent attack that occurred within the last 2 years; or
    - 1.6.5 A sign of that new inflammatory activity is new T2 lesions compared with a previous MRI scan; or
- 2 Patient has an active approval for ocrelizumab and does not have primary progressive MS.

Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.

**Renewal — (Multiple Sclerosis - dimethyl fumarate, fingolimod, glatiramer acetate, interferon beta-1-alpha, interferon beta-1-beta, natalizumab and teriflunomide)** from any relevant practitioner. Approvals valid for 12 months where patient has had an EDSS score of 0 to 6.0 (inclusive) with or without the use of unilateral or bilateral aids at any time in the last six months (ie the patient has walked 100 metres or more with or without aids in the last six months).

Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.

DIMETHYL FUMARATE – Special Authority see SA2274 above – Retail pharmacy

a) Wastage claimable

b) Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.

Cap 120 mg.....	520.00	14	✓ Tecfidera
Cap 240 mg.....	2,000.00	56	✓ Tecfidera

▲Three months supply may be dispensed at one time if endorsed “certified exemption” by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>FINGOLIMOD</b> – Special Authority see <a href="#">SA2274 on the previous page</a> – Retail pharmacy				
a) Wastage claimable				
b) Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.				
Cap 0.5 mg .....	2,200.00	28	✓	<b>Gilenya</b>
<b>GLATIRAMER ACETATE</b> – Special Authority see <a href="#">SA2274 on the previous page</a> – Retail pharmacy				
Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.				
Inj 40 mg prefilled syringe.....	1,500.00	12	✓	<b>Copaxone</b>
<b>INTERFERON BETA-1-ALPHA</b> – Special Authority see <a href="#">SA2274 on the previous page</a> – Retail pharmacy				
Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.				
Inj 6 million iu prefilled syringe.....	1,170.00	4	✓	<b>Avonex</b>
<b>INTERFERON BETA-1-BETA</b> – Special Authority see <a href="#">SA2274 on the previous page</a> – Retail pharmacy				
Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.				
Inj 8 million iu per 1 ml.....	1,322.89	15	✓	<b>Betaferon</b>
<b>NATALIZUMAB</b> – Special Authority see <a href="#">SA2274 on the previous page</a> – Retail pharmacy				
Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.				
Inj 20 mg per ml, 15 ml vial.....	1,750.00	1	✓	<b>Tysabri</b>
<b>TERIFLUNOMIDE</b> – Special Authority see <a href="#">SA2274 on the previous page</a> – Retail pharmacy				
a) Wastage claimable				
b) Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.				
Tab 14 mg .....	263.96	28	✓	<b>Teriflunomide</b> <b>Sandoz</b>

## Multiple Sclerosis Treatments - Other

<b>OCRELIZUMAB</b> – Special Authority see <a href="#">SA2273 below</a> – Retail pharmacy				
Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.				
Inj 30 mg per ml, 10 ml vial.....	8,450.00	1	✓	<b>Ocrevus</b>
Inj 40 mg per ml, 23 ml vial.....	16,900.00	1	✓	<b>Ocrevus SC</b>

### ►SA2273 Special Authority for Subsidy

**Initial application** — (**Multiple Sclerosis - ocrelizumab**) from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

- Either:
- 1 All of the following:
    - 1.1 Diagnosis of multiple sclerosis (MS) meets the McDonald 2017 diagnostic criteria for MS and has been confirmed by a neurologist; and
    - 1.2 Patient has an EDSS score between 0 – 6.0; and
    - 1.3 Patient has had at least one significant attack of MS in the previous 12 months or two significant attacks in the past 24 months; and
    - 1.4 All of the following:
      - 1.4.1 Each significant attack must be confirmed by the applying neurologist or general physician (the patient may not necessarily have been seen by them during the attack, but the neurologist/physician must be satisfied that the clinical features were characteristic); and
      - 1.4.2 Each significant attack is associated with characteristic new symptom(s)/sign(s) or substantially worsening of previously experienced symptoms(s)/sign(s); and
      - 1.4.3 Each significant attack has lasted at least one week and has started at least one month after the onset of a previous attack (where relevant); and
      - 1.4.4 Each significant attack can be distinguished from the effects of general fatigue; and is not associated with a fever (T> 37.5°C); and

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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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continued...

1.4.5 Either:

- 1.4.5.1 Each significant attack is severe enough to change either the EDSS or at least one of the Kurtzke Functional System scores by at least 1 point; or
- 1.4.5.2 Each significant attack is a recurrent paroxysmal symptom of multiple sclerosis (tonic seizures/spasms, trigeminal neuralgia, Lhermitte's symptom); and

1.5 Evidence of new inflammatory activity on an MRI scan within the past 24 months; and

1.6 Any of the following:

- 1.6.1 A sign of that new inflammatory activity on MRI scanning (in criterion 5 immediately above) is a gadolinium enhancing lesion; or
- 1.6.2 A sign of that new inflammatory activity is a lesion showing diffusion restriction; or
- 1.6.3 A sign of that new inflammatory is a T2 lesion with associated local swelling; or
- 1.6.4 A sign of that new inflammatory activity is a prominent T2 lesion that clearly is responsible for the clinical features of a recent attack that occurred within the last 2 years; or
- 1.6.5 A sign of that new inflammatory activity is new T2 lesions compared with a previous MRI scan; or

2 Patient has an active Special Authority approval for either dimethyl fumarate, fingolimod, glatiramer acetate, interferon beta-1-alpha, interferon beta-1-beta, natalizumab or teriflunomide.

Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.

**Renewal — (Multiple Sclerosis - ocrelizumab)** from any relevant practitioner. Approvals valid for 12 months where patient has had an EDSS score of 0 to 6.0 (inclusive) with or without the use of unilateral or bilateral aids at any time in the last six months (ie the patient has walked 100 metres or more with or without aids in the last six months).

Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.

**Initial application — (Primary Progressive Multiple Sclerosis)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Diagnosis of primary progressive multiple sclerosis (PPMS) meets the 2017 McDonald criteria and has been confirmed by a neurologist; and
- 2 Patient has an EDSS 2.0 (score equal to or greater than 2 on pyramidal functions) to EDSS 6.5; and
- 3 Patient has no history of relapsing remitting multiple sclerosis.

**Renewal — (Primary Progressive Multiple Sclerosis)** from any relevant practitioner. Approvals valid for 12 months where patient has had an EDSS score of less than or equal to 6.5 at any time in the last six months (ie patient has walked 20 metres with bilateral assistance/aids, without rest in the last six months).

## Sedatives and Hypnotics

MELATONIN – Special Authority see [SA2523 below](#) – Retail pharmacy

Tab modified-release 2 mg – No more than 5 tab per day.....5.80	30	✓ <b>Vigisom</b>
Restricted to patients aged 18 years or under.		

➔ **SA2523** **Special Authority for Subsidy**

**Initial application** only from a psychiatrist, paediatrician, neurologist, respiratory specialist or any relevant practitioner on the recommendation of a psychiatrist, paediatrician, neurologist or respiratory specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient has been diagnosed with persistent and distressing insomnia secondary to a neurodevelopmental disorder (including, but not limited to, autism spectrum disorder or attention deficit hyperactivity disorder)\*; and
- 2 Behavioural and environmental approaches have been tried and were unsuccessful, or are inappropriate; and
- 3 Funded modified-release melatonin is to be given at doses no greater than 10 mg per day; and
- 4 Patient is aged 18 years or under\*.

continued...

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# NERVOUS SYSTEM

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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continued...

**Renewal** only from a psychiatrist, paediatrician, neurologist, respiratory specialist or any relevant practitioner on the recommendation of a psychiatrist, paediatrician, neurologist or respiratory specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient is aged 18 years or under\*; and
- 2 Patient has demonstrated clinically meaningful benefit from funded modified-release melatonin (clinician determined); and
- 3 Patient has had a trial of funded modified-release melatonin discontinuation within the past 12 months and has had a recurrence of persistent and distressing insomnia; and
- 4 Funded modified-release melatonin is to be given at doses no greater than 10 mg per day.

Note: Indications marked with \* are unapproved indications.

MIDAZOLAM – Safety medicine; prescriber may determine dispensing frequency

Inj 1 mg per ml, 5 ml ampoule .....	7.80	10	✓ Midazolam-Baxter
Inj 1 mg per ml, 5 ml plastic ampoule – Up to 10 inj available on a PSO .....	46.65	10	✓ Midazolam-Pfizer
On a PSO for status epilepticus use only. PSO must be endorsed for status epilepticus use only.			
Inj 5 mg per ml, 1 ml plastic ampoule – Up to 10 inj available on a PSO .....	22.50	10	✓ Midazolam-Pfizer
On a PSO for status epilepticus use only. PSO must be endorsed for status epilepticus use only.			
Inj 5 mg per ml, 3 ml ampoule .....	4.75	5	✓ Midazolam-Baxter
Inj 5 mg per ml, 3 ml plastic ampoule – Up to 5 inj available on a PSO .....	35.10	5	✓ Midazolam-Pfizer
On a PSO for status epilepticus use only. PSO must be endorsed for status epilepticus use only.			

PHENOBARBITONE SODIUM – Special Authority see [SA1386 below](#) – Retail pharmacy

Inj 200 mg per ml, 1 ml ampoule .....	113.37	10	✓ Max Health <sup>S29</sup>
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## ➔SA1386 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 For the treatment of terminal agitation that is unresponsive to other agents; and
- 2 The applicant is part of a multidisciplinary team working in palliative care.

TEMAZEPAM – Safety medicine; prescriber may determine dispensing frequency

Tab 10 mg .....	1.40	25	✓ Normison
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ZOPICLONE – Safety medicine; prescriber may determine dispensing frequency

Tab 7.5 mg .....	21.85	500	✓ Zopiclone Actavis
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## Spinal Muscular Atrophy

NUSINERSEN – PCT only – Special Authority see [SA2174 below](#)

Inj 12 mg per 5 ml vial .....	120,000.00	1	✓ Spinraza
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## ➔SA2174 Special Authority for Subsidy

**Initial application** — (spinal muscular atrophy (SMA)) from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient has genetic documentation of homozygous SMN1 gene deletion, homozygous SMN1 point mutation, or compound heterozygous mutation; and

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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continued...

- 2 Patient is 18 years of age or under; and
- 3 Either:
  - 3.1 Patient has experienced the defined signs and symptoms of SMA type I, II or IIIa prior to three years of age; or
  - 3.2 Both:
    - 3.2.1 Patient is pre-symptomatic; and
    - 3.2.2 Patient has three or less copies of SMN2.

**Renewal — (spinal muscular atrophy (SMA))** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 There has been demonstrated maintenance of motor milestone function since treatment initiation; and
- 2 Patient does not require invasive permanent ventilation (at least 16 hours per day) in the absence of a potentially reversible cause while being treated with nusinersen; and
- 3 Nusinersen not to be administered in combination other SMA disease modifying treatments or gene therapy.

RISDIPLAM – [Xpharm] – Special Authority see [SA2203 below](#)

Note: the supply of risdiplam is via Pharmac's approved direct distribution supply. Further details can be found on Pharmac's website <https://pharmac.govt.nz/risdiplam>

Powder for oral soln 750 mcg per ml, 60 mg per bottle..... 14,100.00      80 ml OP      ✓ **Evrysdi**

► **SA2203 Special Authority for Subsidy**

**Initial application — (spinal muscular atrophy (SMA))** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient has genetic documentation of homozygous SMN1 gene deletion, homozygous SMN1 point mutation, or compound heterozygous mutation; and
- 2 Patient is 18 years of age or under; and
- 3 Either:
  - 3.1 Patient has experienced the defined signs and symptoms of SMA type I, II or IIIa prior to three years of age; or
  - 3.2 Both:
    - 3.2.1 Patient is pre-symptomatic; and
    - 3.2.2 Patient has three or less copies of SMN2.

**Renewal — (spinal muscular atrophy (SMA))** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 There has been demonstrated maintenance of motor milestone function since treatment initiation; and
- 2 Patient does not require invasive permanent ventilation (at least 16 hours per day) in the absence of a potentially reversible cause while being treated with risdiplam; and
- 3 Risdiplam not to be administered in combination other SMA disease modifying treatments or gene therapy.

**Stimulants/ADHD Treatments**

**ATOMOXETINE**

Cap 10 mg.....	43.02	28	✓ <b>APO-Atomoxetine</b>
Cap 18 mg.....	45.57	28	✓ <b>APO-Atomoxetine</b>
Cap 25 mg.....	44.30	28	✓ <b>APO-Atomoxetine</b>
Cap 40 mg.....	46.21	28	✓ <b>APO-Atomoxetine</b>
Cap 60 mg.....	51.31	28	✓ <b>APO-Atomoxetine</b>
Cap 80 mg.....	65.20	28	✓ <b>APO-Atomoxetine</b>
Cap 100 mg.....	65.71	28	✓ <b>APO-Atomoxetine</b>

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# NERVOUS SYSTEM

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
<b>DEXAMFETAMINE SULFATE</b> – Special Authority see <a href="#">SA2587 below</a> – Retail pharmacy			
a) Only on a controlled drug form			
b) Safety medicine; prescriber may determine dispensing frequency			
Tab 5 mg .....	29.80	100	✓ <b>Dexamfetamine Aspen</b> ✓ <b>Noumed Dexamfetamine</b>

## ►SA2587 Special Authority for Subsidy

**Initial application** — (ADHD in patients aged 5 years or over) from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 ADHD (Attention Deficit and Hyperactivity Disorder) in patients aged 5 years or over; and
- 2 Diagnosed according to DSM-IV or ICD 10 criteria; and
- 3 Applicant is a health practitioner authorised to prescribe treatment consistent with the approval notice gazetted for dexamfetamine (see note).

Note: Prescribing practitioner detail is in the relevant approval notice published in the New Zealand Gazette. Approval notices are located through the 'Medicines (controlled drugs) with restrictions under regulation 22 of the Misuse of Drugs Regulations 1977' section of the Medsafe 'Restrictions on the Supply, Prescribing or Administration of Medicines under the Medicines Act 1981 and Misuse of Drugs Regulations 1977' webpage (<https://www.medsafe.govt.nz/profs/riss/restrict.asp#MedicinesReg22> as of April 2025).

**Initial application** — (ADHD in patients aged under 5 years) from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 ADHD (Attention Deficit and Hyperactivity Disorder) in patients under 5 years of age; and
- 2 Diagnosed according to DSM-IV or ICD 10 criteria; and
- 3 Applicant is a health practitioner authorised to prescribe treatment consistent with the approval notice gazetted for dexamfetamine (see note).

Note: Prescribing practitioner detail is in the relevant approval notice published in the New Zealand Gazette. Approval notices are located through the 'Medicines (controlled drugs) with restrictions under regulation 22 of the Misuse of Drugs Regulations 1977' section of the Medsafe 'Restrictions on the Supply, Prescribing or Administration of Medicines under the Medicines Act 1981 and Misuse of Drugs Regulations 1977' webpage (<https://www.medsafe.govt.nz/profs/riss/restrict.asp#MedicinesReg22> as of April 2025).

**Initial application** — (Narcolepsy) only from a neurologist or respiratory specialist. Approvals valid without further renewal unless notified where the patient suffers from narcolepsy.

**LISDEXAMFETAMINE DIMESILATE** – Special Authority see [SA2588 below](#) – Retail pharmacy

- |   |       |    |                  |
|---|-------|----|------------------|
| a) Only on a controlled drug form                                 |       |    |                  |
| b) Safety medicine; prescriber may determine dispensing frequency |       |    |                  |
| Cap 30 mg – No more than 1 cap per day .....                      | 60.00 | 30 | ✓ <b>Vyvanse</b> |
| Cap 50 mg .....   | 60.00 | 30 | ✓ <b>Vyvanse</b> |
| Cap 70 mg .....   | 60.00 | 30 | ✓ <b>Vyvanse</b> |

## ►SA2588 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 Patient is currently on treatment with lisdexamfetamine dimesilate and met all the following criteria prior to commencing treatment; or
- 2 All of the following:
  - 2.1 ADHD (Attention Deficit and Hyperactivity Disorder); and

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Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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continued...

- 2.2 Diagnosed according to DSM-5 or ICD 11 criteria; and
- 2.3 Applicant is a health practitioner authorised to prescribe treatment consistent with the approval notice gazetted for lisdexamfetamine (see note); and
- 2.4 Any of the following:
  - 2.4.1 Patient is taking a currently subsidised formulation of atomoxetine or methylphenidate hydrochloride (extended-release) for ADHD and has not received sufficient clinical benefit or has experienced intolerable side effects; or
  - 2.4.2 Patient is taking a currently subsidised formulation of dexamfetamine sulfate (immediate-release) which has not been effective due to significant administration and/or treatment adherence difficulties; or
  - 2.4.3 There is significant concern regarding the risk of diversion or abuse of immediate release dexamfetamine sulfate; or
  - 2.4.4 Patient is taking a currently subsidised formulation of methylphenidate hydrochloride (immediate-release or sustained release) which has not been effective due to significant administration and/or treatment adherence difficulties; or
  - 2.4.5 There is significant concern regarding the risk of diversion or abuse of immediate release methylphenidate hydrochloride; or
  - 2.4.6 Both:
    - 2.4.6.1 Patient would have been prescribed a subsidised formulation of methylphenidate hydrochloride (extended-release) but has been unable to access due to supply issues with methylphenidate hydrochloride (extended-release); and
    - 2.4.6.2 Other alternative stimulant presentations (methylphenidate or dexamfetamine) are not appropriate; and
- 2.5 Lisdexamfetamine dimesilate is not to be used in combination with another funded methylphenidate presentation.

Note: Prescribing practitioner detail is in the relevant approval notice published in the New Zealand Gazette. Approval notices are located through the 'Medicines (controlled drugs) with restrictions under regulation 22 of the Misuse of Drugs Regulations 1977' section of the Medsafe 'Restrictions on the Supply, Prescribing or Administration of Medicines under the Medicines Act 1981 and Misuse of Drugs Regulations 1977' webpage (<https://www.medsafe.govt.nz/profs/riss/restrict.asp#MedicinesReg22> as of April 2025).

# NERVOUS SYSTEM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
METHYLPHENIDATE HYDROCHLORIDE – Special Authority see <a href="#">SA2590 below</a> – Retail pharmacy				
a) Only on a controlled drug form				
b) Safety medicine; prescriber may determine dispensing frequency				
Tab modified-release 18 mg.....	15.25	30	✓	Methylphenidate Sandoz XR
Tab modified-release 27 mg.....	16.25	30	✓	Methylphenidate Sandoz XR
Tab modified-release 36 mg.....	21.25	30	✓	Methylphenidate Sandoz XR
Tab modified-release 54 mg.....	24.25	30	✓	Methylphenidate Sandoz XR
Tab immediate-release 5 mg.....	3.20	30	✓	Rubifen
Tab immediate-release 10 mg.....	3.00	30	✓	Rubifen
	4.00		✓	Ritalin
Tab extended-release 18 mg.....	15.25	30	✓	Methylphenidate ER - Teva
Tab immediate-release 20 mg.....	7.85	30	✓	Rubifen
Tab sustained-release 20 mg.....	10.95	30	✓	Rubifen SR
Tab extended-release 27 mg.....	16.25	30	✓	Methylphenidate ER - Teva
Tab extended-release 36 mg.....	21.25	30	✓	Methylphenidate ER - Teva
Tab extended-release 54 mg.....	24.25	30	✓	Methylphenidate ER - Teva

## ➔SA2590 Special Authority for Subsidy

**Initial application — (ADHD in patients aged 5 years or over)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 ADHD (Attention Deficit and Hyperactivity Disorder) in patients aged 5 years or over; and
- 2 Diagnosed according to DSM-IV or ICD 10 criteria; and
- 3 Applicant is a health practitioner authorised to prescribe treatment consistent with the approval notice gazetted for methylphenidate (see note).

Note: Prescribing practitioner detail is in the relevant approval notice published in the New Zealand Gazette. Approval notices are located through the 'Medicines (controlled drugs) with restrictions under regulation 22 of the Misuse of Drugs Regulations 1977' section of the Medsafe 'Restrictions on the Supply, Prescribing or Administration of Medicines under the Medicines Act 1981 and Misuse of Drugs Regulations 1977' webpage (<https://www.medsafe.govt.nz/profs/riss/restrict.asp#MedicinesReg22> as of April 2025).

**Initial application — (ADHD in patients aged under 5 years)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 ADHD (Attention Deficit and Hyperactivity Disorder) in patients under 5 years of age; and
- 2 Diagnosed according to DSM-IV or ICD 10 criteria; and
- 3 Applicant is a health practitioner authorised to prescribe treatment consistent with the approval notice gazetted for methylphenidate (see note).

Note: Prescribing practitioner detail is in the relevant approval notice published in the New Zealand Gazette. Approval notices are located through the 'Medicines (controlled drugs) with restrictions under regulation 22 of the Misuse of Drugs Regulations 1977' section of the Medsafe 'Restrictions on the Supply, Prescribing or Administration of Medicines under the Medicines Act 1981 and Misuse of Drugs Regulations 1977' webpage (<https://www.medsafe.govt.nz/profs/riss/restrict.asp#MedicinesReg22> as of April 2025).

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Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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continued...  
of April 2025).

**Initial application — (Narcolepsy\*)** only from a neurologist or respiratory specialist. Approvals valid without further renewal unless notified where the patient suffers from narcolepsy.

Note: \*narcolepsy is not a registered indication for Methylphenidate ER – Teva or Methylphenidate Sandoz XR.

**METHYLPHENIDATE HYDROCHLORIDE EXTENDED-RELEASE** – Special Authority see [SA2591 below](#) – Retail pharmacy

a) Only on a controlled drug form			
b) Safety medicine; prescriber may determine dispensing frequency			
Tab extended-release 18 mg.....	58.96	30	✓ <b>Concerta</b>
Tab extended-release 27 mg.....	65.44	30	✓ <b>Concerta</b>
Tab extended-release 36 mg.....	71.93	30	✓ <b>Concerta</b>
Tab extended-release 54 mg.....	86.24	30	✓ <b>Concerta</b>
Cap modified-release 10 mg.....	19.41	30	✓ <b>Ritalin LA</b>
Cap modified-release 20 mg.....	27.72	30	✓ <b>Ritalin LA</b>
Cap modified-release 30 mg.....	34.39	30	✓ <b>Ritalin LA</b>
Cap modified-release 40 mg.....	38.67	30	✓ <b>Ritalin LA</b>

➔**SA2591** **Special Authority for Subsidy**

**Initial application — (ADHD)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 All of the following:
  - 1.1 ADHD (Attention Deficit and Hyperactivity Disorder); and
  - 1.2 Diagnosed according to DSM-IV or ICD 10 criteria; and
  - 1.3 Applicant is a health practitioner authorised to prescribe treatment consistent with the approval notice gazetted for methylphenidate (see note); and
  - 1.4 Either:
    - 1.4.1 Patient is taking a currently subsidised formulation of methylphenidate hydrochloride (immediate-release or sustained-release) which has not been effective due to significant administration and/or difficulties with adherence; or
    - 1.4.2 There is significant concern regarding the risk of diversion or abuse of immediate-release methylphenidate hydrochloride; or
- 2 Both:
  - 2.1 Patient meets the Special Authority criteria for SA2590 methylphenidate hydrochloride; and
  - 2.2 Patient is unable to access other methylphenidate hydrochloride presentations under Special Authority criteria SA2590 due to an out of stock (see note).

Notes: Criterion 2 is to permit short-term funding to cover an out-of-stock on tab extended-release Methylphenidate ER – Teva and tab sustained-release 20 mg Rubifen SR subsidised under SA2590 (<https://schedule.pharmac.govt.nz/latest/SA2590.pdf>). Prescribing practitioner detail is in the relevant approval notice published in the New Zealand Gazette. Approval notices are located through the 'Medicines (controlled drugs) with restrictions under regulation 22 of the Misuse of Drugs Regulations 1977' section of the Medsafe 'Restrictions on the Supply, Prescribing or Administration of Medicines under the Medicines Act 1981 and Misuse of Drugs Regulations 1977' webpage (<https://www.medsafe.govt.nz/profs/riss/restrict.asp#MedicinesReg22> as of April 2025).

**Initial application — (Narcolepsy\*)** only from a neurologist or respiratory specialist. Approvals valid without further renewal unless notified where the patient suffers from narcolepsy.

Note: \*narcolepsy is not a registered indication for Concerta or Ritalin LA.

**MODAFINIL** – Special Authority see [SA2451 on the next page](#) – Retail pharmacy

Tab 100 mg.....	14.27	30	✓ <b>Modafinil Max Health</b>
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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

## ►SA2451 Special Authority for Subsidy

**Initial application** only from a neurologist or respiratory specialist. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 All of the following:
  - 1.1 The patient has a diagnosis of narcolepsy and has excessive daytime sleepiness associated with narcolepsy occurring almost daily for three months or more; and
  - 1.2 Either:
    - 1.2.1 The patient has a multiple sleep latency test with a mean sleep latency of less than or equal to 10 minutes and 2 or more sleep onset rapid eye movement periods; or
    - 1.2.2 The patient has at least one of: cataplexy, sleep paralysis or hypnagogic hallucinations; and
  - 1.3 Either:
    - 1.3.1 An effective dose of a subsidised formulation of methylphenidate or dexamfetamine has been trialed and discontinued because of intolerable side effects; or
    - 1.3.2 Methylphenidate and dexamfetamine are contraindicated; or
- 2 Both:
  - 2.1 Patient meets the Special Authority criteria for methylphenidate hydrochloride or methylphenidate hydrochloride extended-release for narcolepsy; and
  - 2.2 Patient is unable to access methylphenidate hydrochloride presentations due to an out of stock (see note).

Note: Criterion 2 is to permit short-term funding to cover an out-of-stock of methylphenidate hydrochloride or methylphenidate hydrochloride extended release.

## Treatments for Dementia

### DONEPEZIL HYDROCHLORIDE

* Tab 5 mg .....	3.70	84	✓ <u>Ipca-Donepezil</u>
* Tab 10 mg .....	5.50	84	✓ <u>Ipca-Donepezil</u>
RIVASTIGMINE – Special Authority see <a href="#">SA2524 below</a> – Retail pharmacy			
Patch 4.6 mg per 24 hour .....	49.40	30	✓ <u>Rivastigmine Patch</u> <u>BNM 5</u>
Patch 9.5 mg per 24 hour .....	49.40	30	✓ <u>Rivastigmine Patch</u> <u>BNM 10</u>

## ►SA2524 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 The patient has been diagnosed with dementia; and
- 2 The patient is contraindicated to or has experienced intolerable side effects from donepezil tablets.

**Renewal** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate; and
- 2 The patient has demonstrated a significant and sustained benefit from treatment.

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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## Treatments for Substance Dependence

BUPRENORPHINE WITH NALOXONE – Special Authority see [SA2592 below](#) – Retail pharmacy

a) No patient co-payment payable			
b) Safety medicine; prescriber may determine dispensing frequency			
Tab sublingual 2 mg with naloxone 0.5 mg .....	11.76	28	✓ <b>Buprenorphine Naloxone BNM</b>
Tab sublingual 8 mg with naloxone 2 mg .....	26.86	28	✓ <b>Buprenorphine Naloxone BNM</b>

► **SA2592** Special Authority for Subsidy

**Initial application — (Detoxification)** from any medical practitioner. Approvals valid for 6 weeks for applications meeting the following criteria:

All of the following:

- 1 Patient is opioid dependent; and
- 2 Patient is currently engaged with an opioid treatment service approved by the Ministry of Health; and
- 3 Applicant works in an opioid treatment service approved by the Ministry of Health..

**Initial application — (Maintenance treatment)** from any medical practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient is opioid dependent; and
- 2 Patient will not be receiving methadone; and
- 3 Patient is currently enrolled in an opioid substitution treatment program in a service approved by the Ministry of Health; and
- 4 Applicant works in an opioid treatment service approved by the Ministry of Health.

**Renewal — (Detoxification)** from any medical practitioner. Approvals valid for 6 weeks for applications meeting the following criteria:

All of the following:

- 1 Patient is opioid dependent; and
- 2 Patient has previously trialled but failed detoxification with buprenorphine with naloxone with relapse back to opioid use and another attempt is planned; and
- 3 Patient is currently engaged with an opioid treatment service approved by the Ministry of Health; and
- 4 Applicant works in an opioid treatment service approved by the Ministry of Health.

**Renewal — (Maintenance treatment)** from any medical practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient is or has been receiving maintenance therapy with buprenorphine with naloxone (and is not receiving methadone); and
- 2 Patient is currently enrolled in an opioid substitution program in a service approved by the Ministry of Health; and
- 3 Applicant works in an opioid treatment service approved by the Ministry of Health or is a medical practitioner authorised by the service to manage treatment in this patient.

**Renewal — (Maintenance treatment where the patient has previously had an initial application for detoxification)** from any medical practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient received but failed detoxification with buprenorphine with naloxone; and
- 2 Maintenance therapy with buprenorphine with naloxone is planned (and patient will not be receiving methadone); and
- 3 Patient is currently enrolled in an opioid substitution program in a service approved by the Ministry of Health; and
- 4 Applicant works in an opioid treatment service approved by the Ministry of Health.

BUPROPION HYDROCHLORIDE

Tab modified-release 150 mg .....	15.00	30	✓ <b>Zyban</b>
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▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# NERVOUS SYSTEM

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
DISULFIRAM				
Tab 200 mg .....	236.40	100	✓	<b>Antabuse</b>
NALTREXONE HYDROCHLORIDE – Special Authority see <a href="#">SA1408 below</a> – Retail pharmacy				
Tab 50 mg .....	83.33	30	✓	<b>Naltracord</b>

## ►SA1408 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Patient is currently enrolled in a recognised comprehensive treatment programme for alcohol dependence; and
- 2 Applicant works in or with a community Alcohol and Drug Service contracted to Health NZ or accredited against the New Zealand Alcohol and Other Drug Sector Standard or the National Mental Health Sector Standard.

**Renewal** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Compliance with the medication (prescriber determined); and
- 2 Any of the following:
  - 2.1 Patient is still unstable and requires further treatment; or
  - 2.2 Patient achieved significant improvement but requires further treatment; or
  - 2.3 Patient is well controlled but requires maintenance therapy.

## NICOTINE

a) Nicotine will not be funded in amounts less than 4 weeks of treatment.

b) Note: Direct Provision by a pharmacist permitted under the provisions in Part I of Section A.

Patch 7 mg – Up to 28 patch available on a PSO .....	19.62	28	✓	<b>Habitrol</b>
Patch 14 mg – Up to 28 patch available on a PSO .....	21.57	28	✓	<b>Habitrol</b>
Patch 14 mg for direct distribution only – [Xpharm].....	12.49	7	✓	<b>Habitrol</b>
Patch 21 mg – Up to 28 patch available on a PSO .....	24.72	28	✓	<b>Habitrol</b>
Patch 21 mg for direct distribution only – [Xpharm].....	13.19	7	✓	<b>Habitrol</b>
Lozenge 1 mg – Up to 216 loz available on a PSO.....	22.53	216	✓	<b>Habitrol</b>
Lozenge 1 mg for direct distribution only – [Xpharm].....	12.89	36	✓	<b>Habitrol</b>
Lozenge 2 mg – Up to 216 loz available on a PSO.....	24.68	216	✓	<b>Habitrol</b>
Lozenge 2 mg for direct distribution only – [Xpharm].....	13.25	36	✓	<b>Habitrol</b>
Gum 2 mg (Fruit) – Up to 204 piece available on a PSO .....	23.02	204	✓	<b>Habitrol</b>
Gum 2 mg (Fruit) for direct distribution only – [Xpharm].....	17.57	96	✓	<b>Habitrol</b>
Gum 2 mg (Mint) – Up to 204 piece available on a PSO.....	23.02	204	✓	<b>Habitrol</b>
Gum 2 mg (Mint) for direct distribution only – [Xpharm].....	17.57	96	✓	<b>Habitrol</b>
Gum 4 mg (Fruit) – Up to 204 piece available on a PSO .....	25.98	204	✓	<b>Habitrol</b>
Gum 4 mg (Fruit) for direct distribution only – [Xpharm].....	23.87	96	✓	<b>Habitrol</b>
Gum 4 mg (Mint) – Up to 204 piece available on a PSO.....	25.98	204	✓	<b>Habitrol</b>
Gum 4 mg (Mint) for direct distribution only – [Xpharm].....	23.87	96	✓	<b>Habitrol</b>

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>VARENICLINE TARTRATE – Special Authority see SA1845 below – Retail pharmacy</b>				
a) A maximum of 12 weeks' varenicline will be subsidised on each Special Authority approval, including the starter pack				
b) Varenicline will not be funded in amounts less than 4 weeks of treatment.				
c) The 6-month time period in which a patient can receive a funded 12-week course of varenicline tartrate starts from the date the Special Authority is approved.				
Tab 0.5 mg x 11 and 1 mg x 42 .....	15.99	53 OP	✓	Pharmacor Varenicline
	16.67		✓	Champix
Pharmacor Varenicline to be Principal Supply on 1 September 2026				
Tab 1 mg .....	10.99	56	✓	Pharmacor Varenicline
	17.62		✓	Champix
Pharmacor Varenicline to be Principal Supply on 1 September 2026				
<i>(Champix Tab 0.5 mg x 11 and 1 mg x 42 to be delisted 1 September 2026)</i>				
<i>(Champix Tab 1 mg to be delisted 1 September 2026)</i>				

►SA1845 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid for 5 months for applications meeting the following criteria:  
All of the following:

- 1 Short-term therapy as an aid to achieving abstinence in a patient who has indicated that they are ready to cease smoking; and
- 2 The patient is part of, or is about to enrol in, a comprehensive support and counselling smoking cessation programme, which includes prescriber or nurse monitoring; and
- 3 Either:
  - 3.1 The patient has tried but failed to quit smoking after at least two separate trials of nicotine replacement therapy, at least one of which included the patient receiving comprehensive advice on the optimal use of nicotine replacement therapy; or
  - 3.2 The patient has tried but failed to quit smoking using bupropion or nortriptyline; and
- 4 The patient has not had a Special Authority for varenicline approved in the last 6 months; and
- 5 Varenicline is not to be used in combination with other pharmacological smoking cessation treatments and the patient has agreed to this; and
- 6 The patient is not pregnant; and
- 7 The patient will not be prescribed more than 12 weeks' funded varenicline (see note).

**Renewal** from any relevant practitioner. Approvals valid for 5 months for applications meeting the following criteria:  
All of the following:

- 1 Short-term therapy as an aid to achieving abstinence in a patient who has indicated that they are ready to cease smoking; and
- 2 The patient is part of, or is about to enrol in, a comprehensive support and counselling smoking cessation programme, which includes prescriber or nurse monitoring; and
- 3 It has been 6 months since the patient's previous Special Authority was approved; and
- 4 Varenicline is not to be used in combination with other pharmacological smoking cessation treatments and the patient has agreed to this; and
- 5 The patient is not pregnant; and
- 6 The patient will not be prescribed more than 12 weeks' funded varenicline (see note).

The patient must not have had an approval in the past 6 months.

Notes: a maximum of 12 weeks' varenicline will be subsidised on each Special Authority approval.  
This includes the 4-week 'starter' pack.

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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## Chemotherapeutic Agents

### Alkylating Agents

BENDAMUSTINE HYDROCHLORIDE – PCT only – Specialist – Special Authority see SA2398 below			
Inj 25 mg vial .....	50.05	1	✓ Bendamustine Sandoz
	77.00		✓ Ribomustin
Inj 100 mg vial .....	200.20	1	✓ Bendamustine Sandoz
	308.00		✓ Ribomustin
Inj 1 mg for ECP .....	2.11	1 mg	✓ Baxter

#### ►SA2398 Special Authority for Subsidy

**Initial application — (CLL\*)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has chronic lymphocytic leukaemia requiring treatment; and
- 2 Patient has ECOG performance status of 0-2; and
- 3 Bendamustine is to be administered at a maximum dose of 100 mg/m<sup>2</sup> on days 1 and 2 every 4 weeks for a maximum of 6 cycles.

Note: Indication marked with a \* includes indications that are unapproved. 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL).

**Initial application — (Indolent, Low-grade lymphomas)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 The patient has indolent low grade NHL requiring treatment; and
- 2 The patient has ECOG performance status of 0-2; and
- 3 Any of the following:
  - 3.1 Both:
    - 3.1.1 Patient is treatment naive; and
    - 3.1.2 Bendamustine is to be administered for a maximum of 6 cycles (in combination with rituximab when CD20+); or
  - 3.2 Both:
    - 3.2.1 Patient is refractory to or has relapsed within 12 months of a rituximab containing combined chemo-immunotherapy regimen; and
    - 3.2.2 Bendamustine is to be administered in combination with obinutuzumab for a maximum of 6 cycles; or
  - 3.3 All of the following:
    - 3.3.1 The patient has not received prior bendamustine therapy; and
    - 3.3.2 Bendamustine is to be administered for a maximum of 6 cycles in relapsed patients (in combination with rituximab when CD20+); and
    - 3.3.3 Patient has had a rituximab treatment-free interval of 12 months or more; or
  - 3.4 Bendamustine is to be administered as monotherapy for a maximum of 6 cycles in rituximab refractory patients.

**Renewal — (Indolent, Low-grade lymphomas)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 9 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 Patient is refractory to or has relapsed within 12 months of rituximab in combination with bendamustine; and

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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continued...

1.2 Bendamustine is to be administered in combination with obinutuzumab for a maximum of 6 cycles; or

2 Both:

2.1 Patients have not received a bendamustine regimen within the last 12 months; and

2.2 Either:

2.2.1 Both:

2.2.1.1 Bendamustine is to be administered for a maximum of 6 cycles in relapsed patients (in combination with rituximab when CD20+); and

2.2.1.2 Patient has had a rituximab treatment-free interval of 12 months or more; or

2.2.2 Bendamustine is to be administered as a monotherapy for a maximum of 6 cycles in rituximab refractory patients.

Note: 'indolent, low-grade lymphomas' includes follicular, mantle cell, marginal zone and lymphoplasmacytic/ Waldenstrom's macroglobulinaemia.

**Initial application — (Hodgkin's lymphoma\*)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has Hodgkin's lymphoma requiring treatment; and
- 2 Patient has a ECOG performance status of 0-2; and
- 3 Patient has received one prior line of chemotherapy; and
- 4 Patient's disease relapsed or was refractory following prior chemotherapy; and
- 5 Bendamustine is to be administered in combination with gemcitabine and vinorelbine (BeGeV) at a maximum dose of no greater than 90 mg/m<sup>2</sup> twice per cycle, for a maximum of four cycles.

Note: Indications marked with \* are unapproved indications.

**BUSULFAN – PCT – Retail pharmacy-Specialist**

Tab 2 mg .....	89.25	100		✓ Myleran
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**CARBOPLATIN – PCT only – Specialist**

Inj 10 mg per ml, 45 ml vial.....	25.73	1		✓ Carboplatin Accord
	32.59			✓ DBL Carboplatin
	48.50			✓ Carbaccord
Inj 1 mg for ECP .....	0.06	1 mg		✓ Baxter

**CARMUSTINE – PCT only – Specialist**

Inj 100 mg vial .....	710.00	1		✓ BICNU
Inj 100 mg for ECP .....	710.00	100 mg OP		✓ Baxter

**CHLORAMBUCIL – PCT – Retail pharmacy-Specialist**

Tab 2 mg .....	29.06	25		✓ Leukeran FC
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**CISPLATIN – PCT only – Specialist**

Inj 1 mg per ml, 50 ml vial.....	9.45	1		✓ Cisplatin Accord
	15.00			✓ Cisplatin Ebewe
Inj 1 mg per ml, 100 ml vial.....	18.90	1		✓ Cisplatin Accord
	21.00			✓ Cisplatin Ebewe
	29.66			✓ DBL Cisplatin
Inj 1 mg for ECP .....	0.19	1 mg		✓ Baxter

**CYCLOPHOSPHAMIDE**

Tab 50 mg – PCT – Retail pharmacy-Specialist.....	145.00	50		✓ Cyclonex
Inj 1 g vial – PCT – Retail pharmacy-Specialist.....	47.46	1		✓ Endoxan
	127.80	6		✓ Cytoxan
Inj 2 g vial – PCT only – Specialist .....	95.06	1		✓ Cyclophosphamide Seacross
				✓ Endoxan
Inj 1 mg for ECP – PCT only – Specialist.....	0.05	1 mg		✓ Baxter

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>IFOSFAMIDE – PCT only – Specialist</b>				
Inj 1 g.....	96.00	1	✓	<b>Holoxan</b>
Inj 2 g.....	180.00	1	✓	<b>Holoxan</b>
Inj 1 mg for ECP.....	0.10	1 mg	✓	<b>Baxter</b>
<b>LOMUSTINE – PCT – Retail pharmacy-Specialist</b>				
Cap 40 mg.....	880.00	20	✓	<b>Medac</b> <sup>S29</sup>
<b>MELPHALAN</b>				
Tab 2 mg – PCT – Retail pharmacy-Specialist.....	40.70	25	✓	<b>Alkeran</b>
Inj 50 mg – PCT only – Specialist.....	48.25	1	✓	<b>Melpha</b>
	67.80		✓	<b>Alkeran</b>
<b>OXALIPLATIN – PCT only – Specialist</b>				
Inj 100 mg vial.....	25.01	1	✓	<b>Oxaliplatin Actavis 100</b>
	110.00		✓	<b>Oxaliplatin Ebewe</b>
Inj 5 mg per ml, 20 ml vial.....	33.35	1	✓	<b>Alchemy Oxaliplatin</b>
	46.32		✓	<b>Oxaliplatin Accord</b>
Inj 1 mg for ECP.....	0.35	1 mg	✓	<b>Baxter</b>
<b>THIOTEPA – PCT only – Specialist</b>				
Inj 15 mg vial.....	CBS	1	✓	<b>Bedford</b> <sup>S29</sup>
			✓	<b>Max Health</b> <sup>S29</sup>
			✓	<b>THIO-TEPA</b> <sup>S29</sup>
	398.00		✓	<b>Tepadina</b>
Inj 100 mg vial.....	CBS	1	✓	<b>Max Health</b> <sup>S29</sup>
	1,800.00		✓	<b>Tepadina</b>
			✓	<b>Thiotepa-Reach</b>

## Antimetabolites

**AZACITIDINE – PCT only – Specialist – Special Authority see SA2479 below**

Inj 100 mg vial.....	50.00	1	✓	<b>Azacitidine Dr Reddy's</b>
Inj 1 mg for ECP.....	0.54	1 mg	✓	<b>Baxter</b>

► **SA2479** **Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 Any of the following:
  - 1.1 The individual has intermediate or high risk MDS based on an internationally recognised scoring system; or
  - 1.2 The individual has chronic myelomonocytic leukaemia (based on an intermediate or high risk score from an internationally recognised scoring system or 10%-29% marrow blasts without myeloproliferative disorder); or
  - 1.3 The individual has acute myeloid leukaemia according to World Health Organisation Classification (WHO); and
- 2 The individual has an estimated life expectancy of at least 3 months.

**Renewal** from any relevant practitioner. Approvals valid for 12 months where there is no evidence of disease progression.

# ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>CALCIUM FOLINATE</b>				
Tab 15 mg – PCT – Retail pharmacy-Specialist.....	135.33	10	✓	<b>DBL Leucovorin Calcium</b>
Inj 3 mg per ml, 1 ml – PCT – Retail pharmacy-Specialist.....	17.10	5	✓	<b>Hospira</b>
Inj 10 mg per ml, 5 ml vial – PCT – Retail pharmacy-Specialist.....	112.20	5	✓	<b>Eurofolic</b>
Inj 50 mg – PCT – Retail pharmacy-Specialist.....	72.80	10	✓	<b>Leucovorin Pharmacia</b> <sup>S29</sup>
Inj 10 mg per ml, 10 ml vial – PCT only – Specialist.....	163.35	5	✓	<b>Eurofolic</b>
Inj 100 mg – PCT only – Specialist.....	94.90	10	✓	<b>Leucovorin Pharmacia</b> <sup>S29</sup>
Inj 300 mg – PCT only – Specialist.....	21.55	1	✓	<b>Leucovorin DBL</b> <sup>S29</sup>
Inj 10 mg per ml, 100 ml vial – PCT only – Specialist.....	139.48	1	✓	<b>Eurofolic</b>
Inj 1 mg for ECP – PCT only – Specialist.....	0.14	1 mg	✓	<b>Baxter</b>
<b>CAPECITABINE – Retail pharmacy-Specialist</b>				
Tab 150 mg.....	10.92	60	✓	<b>Capecitabine Viatris</b>
Tab 500 mg.....	50.96	120	✓	<b>Capecitabine Viatris</b>
<b>CLADRIBINE – PCT only – Specialist</b>				
Inj 1 mg per ml, 10 ml.....	749.96	1	✓	<b>Leustatin</b>
Inj 10 mg for ECP.....	749.96	10 mg OP	✓	<b>Baxter</b>
<b>CYTARABINE</b>				
Inj 20 mg per ml, 5 ml vial – PCT – Retail pharmacy-Specialist.....	472.00	5	✓	<b>Pfizer</b>
Inj 100 mg per ml, 20 ml vial – PCT – Retail pharmacy-Specialist.....	48.80	1	✓	<b>Cytarabine DBL</b>
Inj 1 mg for ECP – PCT only – Specialist.....	0.29	10 mg	✓	<b>Pfizer</b>
Inj 100 mg intrathecal syringe for ECP – PCT only – Specialist.....	94.40	100 mg OP	✓	<b>Baxter</b>
<b>FLUDARABINE PHOSPHATE</b>				
Tab 10 mg – PCT – Retail pharmacy-Specialist.....	412.00	20	✓	<b>Fludara Oral</b>
Inj 50 mg vial – PCT only – Specialist.....	744.95	5	✓	<b>Fludarabine Ebewe</b>
Inj 50 mg for ECP – PCT only – Specialist.....	148.99	50 mg OP	✓	<b>Baxter</b>
<b>FLUOROURACIL</b>				
Inj 50 mg per ml, 20 ml vial – PCT only – Specialist.....	10.51	1	✓	<b>Fluorouracil Accord</b>
Inj 50 mg per ml, 50 ml vial – PCT only – Specialist.....	14.72	1	✓	<b>Fluorouracil Accord</b>
Inj 50 mg per ml, 100 ml vial – PCT only – Specialist.....	19.36	1	✓	<b>Fluorouracil Accord</b>
Inj 1 mg for ECP – PCT only – Specialist.....	0.41	100 mg	✓	<b>Baxter</b>
<b>GEMCITABINE HYDROCHLORIDE – PCT only – Specialist</b>				
Inj 43.3 mg per ml (equivalent to 38 mg per ml gemcitabine), 26.3 ml vial.....	18.94	1	✓	<b>DBL Gemcitabine</b>
Inj 1 g.....	15.89	1	✓	<b>Gemcitabine Ebewe</b>
Inj 1 mg for ECP.....	0.02	1 mg	✓	<b>Baxter</b>
<b>IRINOTECAN HYDROCHLORIDE – PCT only – Specialist</b>				
Inj 20 mg per ml, 5 ml vial.....	52.57	1	✓	<b>Accord</b>
	71.44		✓	<b>Irinotecan Actavis 100</b>
	100.00		✓	<b>Irinotecan-Rex</b>
Inj 20 mg per ml, 25 ml vial.....	262.85	1	✓	<b>Accord</b> <sup>S29</sup>
Inj 1 mg for ECP.....	0.54	1 mg	✓	<b>Baxter</b>

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>MERCAPTOPYRINE</b>				
Tab 50 mg – PCT – Retail pharmacy-Specialist.....	19.50	25	✓	<b>Puri-nethol</b>
Oral suspension 20 mg per ml – Retail pharmacy-Specialist – Special Authority see SA1725 below.....	428.00	100 ml OP	✓	<b>Allmercap</b> <b>Xaluprine</b> <sup>S29</sup>
<b>►SA1725 Special Authority for Subsidy</b>				
<b>Initial application</b> only from a paediatric haematologist or paediatric oncologist. Approvals valid for 12 months where the patient requires a total dose of less than one full 50 mg tablet per day.				
<b>Renewal</b> only from a paediatric haematologist or paediatric oncologist. Approvals valid for 12 months where patient still requires a total dose of less than one full 50 mg tablet per day.				
<b>METHOTREXATE</b>				
* Tab 2.5 mg – PCT.....	7.80	90	✓	<b>Trexate</b>
* Tab 10 mg – PCT.....	26.40	90	✓	<b>Trexate</b>
* Inj 2.5 mg per ml, 2 ml – PCT.....	95.29	5	✓	<b>Methotrexate DBL</b>
* Inj 7.5 mg prefilled syringe.....	29.17	1	✓	<b>Methotrexate</b> <b>Sandoz</b>
* Inj 10 mg prefilled syringe.....	19.09	1	✓	<b>Methotrexate</b> <b>Sandoz</b>
* Inj 15 mg prefilled syringe.....	24.53	1	✓	<b>Methotrexate</b> <b>Sandoz</b>
* Inj 20 mg prefilled syringe.....	16.64	1	✓	<b>Methotrexate</b> <b>Sandoz</b>
* Inj 25 mg prefilled syringe.....	20.72	1	✓	<b>Methotrexate</b> <b>Sandoz</b>
* Inj 30 mg prefilled syringe.....	55.00	1	✓	<b>Methotrexate</b> <b>Sandoz</b>
* Inj 25 mg per ml, 2 ml vial – PCT.....	30.00	5	✓	<b>Methotrexate DBL</b> <b>Onco-Vial</b>
* Inj 25 mg per ml, 20 ml vial – PCT.....	45.00	1	✓	<b>DBL Methotrexate</b> <b>Onco-Vial</b>
* Inj 100 mg per ml, 10 ml – PCT.....	25.00	1	✓	<b>Methotrexate Ebewe</b>
* Inj 100 mg per ml, 50 ml vial – PCT.....	67.99	1	✓	<b>Methotrexate Ebewe</b>
* Inj 1 mg for ECP – PCT only – Specialist.....	0.06	1 mg	✓	<b>Baxter</b>
* Inj 5 mg intrathecal syringe for ECP – PCT only – Specialist.....	19.06	5 mg OP	✓	<b>Baxter</b>
<b>PEMETREXED – PCT only – Specialist</b>				
Inj 100 mg vial.....	8.99	1	✓	<b>Pemetrexed-AFT</b>
	60.89		✓	<b>Juno Pemetrexed</b>
Inj 500 mg vial.....	29.99	1	✓	<b>Pemetrexed-AFT</b>
	217.77		✓	<b>Juno Pemetrexed</b>
Inj 1 mg for ECP.....	0.11	1 mg	✓	<b>Baxter</b>
<b>THIOGUANINE – PCT – Retail pharmacy-Specialist</b>				
Tab 40 mg.....	126.31	25	✓	<b>Lanvis</b>
<b>Other Cytotoxic Agents</b>				
<b>AMSACRINE – PCT only – Specialist</b>				
Inj 50 mg per ml, 1.5 ml ampoule.....	4,736.00	6	✓	<b>Amsidine</b> <sup>S29</sup>
Inj 75 mg.....	6,218.00	5	✓	<b>AmsaLyO</b> <sup>S29</sup>
<b>ANAGRELIDE HYDROCHLORIDE – PCT – Retail pharmacy-Specialist</b>				
Cap 0.5 mg.....	1,175.87	100	✓	<b>Agrylin</b>

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
<b>ARSENIC TRIOXIDE – PCT only – Specialist</b>			
Inj 1 mg per ml, 10 ml vial.....	4,817.00	10	✓ <b>Phenasen</b>
Inj 10 mg for ECP.....	481.70	10 mg OP	✓ <b>Baxter</b>
<b>BLEOMYCIN SULPHATE – PCT only – Specialist</b>			
Inj 15,000 iu, vial.....	185.16	1	✓ <b>DBL Bleomycin Sulfate</b>
Inj 1,000 iu for ECP.....	14.32	1,000 iu	✓ <b>Baxter</b>
<b>BORTEZOMIB – PCT only – Specialist – Special Authority see SA2593 below</b>			
Inj 3.5 mg vial.....	23.99	1	✓ <b>Bortezomib Eugia</b>
	74.93		✓ <b>DBL Bortezomib</b>
Inj 1 mg for ECP.....	22.26	1 mg	✓ <b>Baxter</b>
<b>▶SA2593 Special Authority for Subsidy</b>			
<b>Initial application — (plasma cell dyscrasia)</b> from any relevant practitioner. Approvals valid without further renewal unless notified where the patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment.			
<b>Initial application — (Waldenström Macroglobulinaemia)</b> from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:			
Both:			
1 The patient has Waldenström Macroglobulinaemia/Lymphoplasmacytic Lymphoma requiring treatment; and			
2 The patient has not received prior bortezomib treatment.			
<b>Renewal — (Waldenström Macroglobulinaemia)</b> from any relevant practitioner. Approvals valid for 12 months where there is no evidence of clinical disease progression during bortezomib use.			
<b>DACARBAZINE – PCT only – Specialist</b>			
Inj 200 mg vial.....	72.11	1	✓ <b>DBL Dacarbazine</b>
Inj 200 mg for ECP.....	72.11	200 mg OP	✓ <b>Baxter</b>
<b>DACTINOMYCIN [ACTINOMYCIN D] – PCT only – Specialist</b>			
Inj 0.5 mg vial.....	255.00	1	✓ <b>Cosmegen</b>
Inj 0.5 mg for ECP.....	255.00	0.5 mg OP	✓ <b>Baxter</b>
<b>DAUNORUBICIN – PCT only – Specialist</b>			
Inj 20 mg vial.....	171.93	1	✓ <b>Cerubidine</b>
Inj 18.7 mg for ECP.....	160.75	18.7 mg OP	✓ <b>Baxter</b>
Inj 20 mg for ECP.....	171.93	20 mg OP	✓ <b>Baxter</b>
Inj 18.7 mg vial.....	160.75	1	✓ <b>Pfizer</b>
<b>DOCETAXEL – PCT only – Specialist</b>			
Inj 20 mg.....	48.75	1	✓ <b>Docetaxel Sandoz</b>
Inj 10 mg per ml, 8 ml vial.....	24.91	1	✓ <b>DBL Docetaxel</b>
Inj 20 mg per ml, 4 ml vial.....	26.95	1	✓ <b>Docetaxel Accord</b> <sup>S29</sup>
Inj 80 mg.....	195.00	1	✓ <b>Docetaxel Sandoz</b>
Inj 1 mg for ECP.....	0.35	1 mg	✓ <b>Baxter</b>
<b>DOXORUBICIN HYDROCHLORIDE – PCT only – Specialist</b>			
Inj 2 mg per ml, 5 ml vial.....	10.00	1	✓ <b>Doxorubicin Ebewe</b>
Inj 2 mg per ml, 25 ml vial.....	17.00	1	✓ <b>Arrow-Doxorubicin</b>
	75.55		✓ <b>Doxorubicin Ebewe</b>
Inj 2 mg per ml, 100 ml vial.....	65.00	1	✓ <b>Arrow-Doxorubicin</b>
	164.50		✓ <b>Adriamycin</b>
			✓ <b>Doxorubicin Ebewe</b>
Inj 1 mg for ECP.....	0.84	1 mg	✓ <b>Baxter</b>

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>EPIRUBICIN HYDROCHLORIDE – PCT only – Specialist</b>				
Inj 2 mg per ml, 25 ml vial.....	284.36	1	✓	<b>Epirubicin Ebewe</b>
Inj 2 mg per ml, 100 ml vial.....	284.36	1	✓	<b>Epirubicin Ebewe</b>
Inj 1 mg for ECP.....	1.42	1 mg	✓	<b>Baxter</b>
<b>ETOPOSIDE</b>				
Cap 50 mg – PCT – Retail pharmacy-Specialist.....	340.73	20	✓	<b>Vepesid</b>
Wastage claimable				
Cap 100 mg – PCT – Retail pharmacy-Specialist.....	340.73	10	✓	<b>Vepesid</b>
Wastage claimable				
Inj 20 mg per ml, 5 ml vial – PCT – Retail pharmacy-Specialist.....	7.90	1	✓	<b>Rex Medical</b>
Inj 1 mg for ECP – PCT only – Specialist.....	0.09	1 mg	✓	<b>Baxter</b>
<b>ETOPOSIDE PHOSPHATE – PCT only – Specialist</b>				
Inj 100 mg (of etoposide base).....	40.00	1	✓	<b>Etopophos</b>
Inj 1 mg (of etoposide base) for ECP.....	0.47	1 mg	✓	<b>Baxter</b>
<b>HYDROXYUREA [HYDROXYCARBAMIDE] – PCT – Retail pharmacy-Specialist</b>				
Cap 500 mg.....	20.72	100	✓	<b>Devatis</b>
<b>IBRUTINIB – Special Authority see SA2637 below – Retail pharmacy</b>				
Tab 140 mg.....	3,217.00	30	✓	<b>Imbruvica</b>
Tab 420 mg.....	9,652.00	30	✓	<b>Imbruvica</b>
<b>SA2637 Special Authority for Subsidy</b>				
<b>Initial application — (previously untreated chronic lymphocytic leukaemia in combination with venetoclax) from any relevant practitioner. Approvals valid for 15 months for applications meeting the following criteria:</b>				
Either:				
1 Individual is currently on treatment with ibrutinib and/or venetoclax and met all of the following criteria prior to commencing treatment; or				
2 Both:				
2.1 Individual has previously untreated CLL; and				
2.2 Ibrutinib is to be administered at a maximum dose of 420 mg daily for 3 (28 day) cycles as monotherapy, followed by a maximum of 12 (28 day) cycles in combination with venetoclax.				
<b>Initial application — (chronic lymphocytic leukaemia (CLL)) from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:</b>				
All of the following:				
1 Individual has chronic lymphocytic leukaemia (CLL) requiring therapy; and				
2 Ibrutinib is to be used as monotherapy; and				
3 Individual has experienced intolerable side effects, or their disease has relapsed or is refractory following at least one prior line of therapy; and				
4 Individual has not received ibrutinib monotherapy previously.				
<b>Renewal — (chronic lymphocytic leukaemia (CLL)) from any relevant practitioner. Approvals valid for 12 months where there is no evidence of disease progression.</b>				
Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) and B-cell prolymphocytic leukaemia (B-PLL)*. Indications marked with * are Unapproved indications.				
<b>IDARUBICIN HYDROCHLORIDE</b>				
Inj 5 mg vial – PCT only – Specialist.....	109.74	1	✓	<b>Zavedos</b>
Inj 10 mg vial – PCT only – Specialist.....	233.64	1	✓	<b>Zavedos</b>
Inj 1 mg for ECP – PCT only – Specialist.....	25.77	1 mg	✓	<b>Baxter</b>

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>LENALIDOMIDE (VIATRIS) – Special Authority see SA2353 below – Retail pharmacy</b>				
Cap 5 mg.....	76.92	21	✓	<b>Lenalidomide Viatris</b>
Cap 10 mg.....	50.30	21	✓	<b>Lenalidomide Viatris</b>
Cap 15 mg.....	62.13	21	✓	<b>Lenalidomide Viatris</b>
Cap 25 mg.....	65.09	21	✓	<b>Lenalidomide Viatris</b>
<b>►SA2353 Special Authority for Subsidy</b>				
<b>Initial application — (Plasma cell dyscrasia)</b> from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:				
Both:				
1 Patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment; and				
2 Patient is not refractory to prior lenalidomide use.				
<b>Initial application — (Myelodysplastic syndrome)</b> from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:				
Both:				
1 Patient has low or intermediate-1 risk myelodysplastic syndrome (based on IPSS or an IPSS-R score of less than 3.5) associated with a deletion 5q cytogenetic abnormality; and				
2 Patient has transfusion-dependent anaemia.				
<b>Renewal — (Myelodysplastic syndrome)</b> from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:				
Both:				
1 Patient has not needed a transfusion in the last 4 months; and				
2 No evidence of disease progression.				
<b>MESNA</b>				
Tab 400 mg – PCT – Retail pharmacy-Specialist.....	314.00	50	✓	<b>Uromitexan</b>
Tab 600 mg – PCT – Retail pharmacy-Specialist.....	448.50	50	✓	<b>Uromitexan</b>
Inj 100 mg per ml, 4 ml ampoule – PCT only – Specialist.....	177.45	15	✓	<b>Uromitexan</b>
Inj 100 mg per ml, 10 ml ampoule – PCT only – Specialist.....	407.40	15	✓	<b>Uromitexan</b>
Inj 1 mg for ECP – PCT only – Specialist.....	2.96	100 mg	✓	<b>Baxter</b>
<b>MITOMYCIN C – PCT only – Specialist</b>				
Inj 5 mg vial.....	517.65	1	✓	<b>Accord</b> §29
			✓	<b>Mitomycin (Fresenius Kabi)</b> §29
	526.00		✓	<b>Mitomycin (Sagent)</b> §29
Inj 20 mg vial.....	1,129.94	1	✓	<b>Teva</b>
Inj 1 mg for ECP.....	119.67	1 mg	✓	<b>Baxter</b>
<b>MITOZANTRONE – PCT only – Specialist</b>				
Inj 2 mg per ml, 10 ml vial.....	170.63	1	✓	<b>Mitozantrone Ebewe</b>
Inj 1 mg for ECP.....	9.64	1 mg	✓	<b>Baxter</b>
<b>NIRAPARIB – Special Authority see SA2325 on the next page – Retail pharmacy</b>				
Wastage claimable				
Tab 100 mg.....	8,929.84	56	✓	<b>Zejula</b>
	13,393.50	84	✓	<b>Zejula</b>
Cap 100 mg.....	8,929.84	56	✓	<b>Zejula</b>

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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## ►SA2325 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has advanced high-grade serous\* epithelial ovarian, fallopian tube, or primary peritoneal cancer; and
- 2 Patient has received at least one line\*\* of treatment with platinum-based chemotherapy; and
- 3 Patient has experienced a partial or complete response to the preceding treatment with platinum-based chemotherapy; and
- 4 Patient has not previously received funded treatment with a PARP inhibitor; and
- 5 Either:
  - 5.1 Treatment will be commenced within 12 weeks of the patient's last dose of the preceding platinum-based regimen; or
  - 5.2 Patient commenced treatment with niraparib prior to 1 May 2024; and
- 6 Treatment to be administered as maintenance treatment; and
- 7 Treatment not to be administered in combination with other chemotherapy.

**Renewal** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 No evidence of progressive disease; and
- 2 Treatment to be administered as maintenance treatment; and
- 3 Treatment not to be administered in combination with other chemotherapy; and
- 4 Either:
  - 4.1 Treatment with niraparib to cease after a total duration of 36 months from commencement; or
  - 4.2 Treatment with niraparib is being used in the second-line or later maintenance setting.

Notes: \* "high-grade serous" includes tumours with high-grade serous features or a high-grade serous component.

\*\*A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments

OLAPARIB – Retail pharmacy-Specialist – Special Authority see SA2163 below

Tab 100 mg .....	3,701.00	56	✓ Lynparza
Tab 150 mg .....	3,701.00	56	✓ Lynparza

## ►SA2163 Special Authority for Subsidy

**Initial application — (Ovarian cancer)** only from a medical oncologist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient has a high-grade serous\* epithelial ovarian, fallopian tube, or primary peritoneal cancer; and
- 2 There is documentation confirming pathogenic germline BRCA1 or BRCA2 gene mutation; and
- 3 Either:
  - 3.1 All of the following:
    - 3.1.1 Patient has newly diagnosed, advanced disease; and
    - 3.1.2 Patient has received one line\*\* of previous treatment with platinum-based chemotherapy; and
    - 3.1.3 Patient's disease must have experienced a partial or complete response to the first-line platinum-based regimen; or
  - 3.2 All of the following:
    - 3.2.1 Patient has received at least two lines\*\* of previous treatment with platinum-based chemotherapy; and
    - 3.2.2 Patient has platinum sensitive disease defined as disease progression occurring at least 6 months after the last dose of the penultimate line\*\* of platinum-based chemotherapy; and
    - 3.2.3 Patient's disease must have experienced a partial or complete response to treatment with the immediately preceding platinum-based regimen; and
    - 3.2.4 Patient has not previously received funded olaparib treatment; and

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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continued...

- 4 Treatment will be commenced within 12 weeks of the patient's last dose of the immediately preceding platinum-based regimen; and
- 5 Treatment to be administered as maintenance treatment; and
- 6 Treatment not to be administered in combination with other chemotherapy.

**Renewal — (Ovarian cancer)** only from a medical oncologist or medical practitioner on the recommendation of a medical oncologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Treatment remains clinically appropriate and patient is benefitting from treatment; and
- 2 Either:
  - 2.1 No evidence of progressive disease; or
  - 2.2 Evidence of residual (not progressive) disease and the patient would continue to benefit from treatment in the clinician's opinion; and
- 3 Treatment to be administered as maintenance treatment; and
- 4 Treatment not to be administered in combination with other chemotherapy; and
- 5 Either:
  - 5.1 Both:
    - 5.1.1 Patient has received one line\*\* of previous treatment with platinum-based chemotherapy; and
    - 5.1.2 Documentation confirming that the patient has been informed and acknowledges that the funded treatment period of olaparib will not be continued beyond 2 years if the patient experiences a complete response to treatment and there is no radiological evidence of disease at 2 years; or
  - 5.2 Patient has received at least two lines\*\* of previous treatment with platinum-based chemotherapy.

Notes: \*Note "high-grade serous" includes tumours with high-grade serous features or a high-grade serous component.

\*\*A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments.

**PACLITAXEL – PCT only – Specialist**

Inj 30 mg.....	47.30	5	✓ Paclitaxel Ebewe
Inj 6 mg per ml, 16.7 ml vial.....	19.59	1	✓ Anzatax
	24.00		✓ Paclitaxel Ebewe
	91.67		✓ Paclitaxel Actavis
Inj 150 mg.....	26.69	1	✓ Paclitaxel Ebewe
	137.50		✓ Anzatax
			✓ Paclitaxel Actavis
Inj 6 mg per ml, 50 ml vial.....	37.89	1	✓ Anzatax
	44.00		✓ Paclitaxel Ebewe
	275.00		✓ Paclitaxel Actavis
Inj 1 mg for ECP .....	0.17	1 mg	✓ Baxter

**PEGASPARGASE – PCT only – Special Authority see SA2618 below**

Inj 750 iu per ml, 5 ml vial.....	3,973.25	1	✓ Oncaspar LYO
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► **SA2618** Special Authority for Subsidy

**Initial application — (Acute lymphoblastic leukaemia)** only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 15 months for applications meeting the following criteria:

Both:

- 1 The patient has newly diagnosed acute lymphoblastic leukaemia; and
- 2 Pegaspargase to be used with a contemporary intensive multi-agent chemotherapy treatment protocol.

**Initial application — (Lymphoma)** only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months where the patient has lymphoma requiring L-asparaginase containing protocols (e.g.

continued...

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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**Renewal — (Acute lymphoblastic leukaemia)** only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 The patient has relapsed acute lymphoblastic leukaemia; and
- 2 Pegaspargase to be used with a contemporary intensive multi-agent chemotherapy treatment protocol.

PENTOSTATIN [DEOXYCOFORMYCIN] – PCT only – Specialist

Inj 10 mg.....	CBS	1	✓ <b>Nipent</b> <sup>S29</sup>
POMALIDOMIDE – Special Authority see <a href="#">SA2354 below</a> – Retail pharmacy			
Cap 1 mg.....	47.45	14	✓ <b>Pomalide</b>
	71.18	21	✓ <b>Pomalide</b>
Cap 2 mg.....	94.90	14	✓ <b>Pomalide</b>
	142.35	21	✓ <b>Pomalide</b>
Cap 3 mg.....	142.35	14	✓ <b>Pomalide</b>
	213.53	21	✓ <b>Pomalide</b>
Cap 4 mg.....	189.81	14	✓ <b>Pomalide</b>
	284.71	21	✓ <b>Pomalide</b>

➔ **SA2354** Special Authority for Subsidy

**Initial application — (Relapsed/refractory plasma cell dyscrasia)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Patient has relapsed or refractory plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment; and
- 2 Patient has not received prior funded pomalidomide.

**Renewal — (Relapsed/refractory plasma cell dyscrasia)** from any relevant practitioner. Approvals valid for 12 months where there is no evidence of disease progression.

PROCARBAZINE HYDROCHLORIDE – PCT – Retail pharmacy-Specialist

Cap 50 mg.....	980.00	50	✓ <b>Natulan</b> <sup>S29</sup>
TEMOZOLOMIDE – Special Authority see <a href="#">SA2594 below</a> – Retail pharmacy			
Cap 5 mg.....	9.13	5	✓ <b>Temaccord</b>
			✓ <b>Temozolomide-</b> <b>Taro</b> <sup>S29</sup>

Cap 20 mg.....	16.38	5	✓ <b>Temaccord</b>
	18.30		✓ <b>Apo-Temozolomide</b>
Cap 100 mg.....	35.98	5	✓ <b>Temaccord</b>
	40.20		✓ <b>Apo-Temozolomide</b>
Cap 140 mg.....	50.12	5	✓ <b>Temaccord</b>
Cap 250 mg.....	86.34	5	✓ <b>Temaccord</b>

➔ **SA2594** Special Authority for Subsidy

**Initial application — (gliomas)** only from a relevant specialist. Approvals valid for 12 months where the patient has a glioma.

**Renewal — (gliomas)** only from a relevant specialist. Approvals valid for 12 months where treatment remains appropriate and patient is benefitting from treatment.

**Initial application — (neuroendocrine tumours)** only from a relevant specialist. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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continued...

- 1 Patient has been diagnosed with metastatic or unresectable well-differentiated neuroendocrine tumour\*; and
- 2 Temozolomide is to be given in combination with capecitabine; and
- 3 Temozolomide is to be used in 28 day treatment cycles for a maximum of 5 days treatment per cycle at a maximum dose of 200 mg/m<sup>2</sup> per day; and
- 4 Temozolomide to be discontinued at disease progression.

**Renewal — (neuroendocrine tumours)** only from a relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 No evidence of disease progression; and
- 2 The treatment remains appropriate and the patient is benefitting from treatment.

**Initial application — (ewing's sarcoma)** only from a relevant specialist. Approvals valid for 9 months where the patient has relapsed/refractory Ewing's sarcoma.

**Renewal — (ewing's sarcoma)** only from a relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 No evidence of disease progression; and
- 2 The treatment remains appropriate and the patient is benefitting from treatment.

**Initial application — (Neuroblastoma)** from any relevant practitioner. Approvals valid for 12 months where the patient has neuroblastoma.

**Renewal — (Neuroblastoma)** from any relevant practitioner. Approvals valid for 12 months where there is no evidence of disease progression.

Note: Indication marked with a \* is an unapproved indication. Temozolomide is not subsidised for the treatment of relapsed high grade glioma.

THALIDOMIDE – Retail pharmacy-Specialist – Special Authority see [SA2356 below](#)

Cap 50 mg .....	378.00	28	✓ <b>Thalomid</b>
Cap 100 mg .....	756.00	28	✓ <b>Thalomid</b>

► **SA2356** **Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid for 12 months where the patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment.

**Renewal** from any relevant practitioner. Approvals valid without further renewal unless notified where the patient has obtained a response from treatment during the initial approval period.

Notes: Prescription must be written by a registered prescriber in the thalidomide risk management programme operated by the supplier.

Maximum dose of 400 mg daily as monotherapy or in a combination therapy regimen.

TRETINOIN

Cap 10 mg – PCT – Retail pharmacy-Specialist .....	479.50	100	✓ <b>Vesanoid</b>
Wastage claimable			

VENETOCLAX – Retail pharmacy-Specialist – Special Authority see [SA2678 below](#)

Tab 14 × 10 mg, 7 × 50 mg, 21 × 100 mg .....	1,771.86	42 OP	✓ <b>Venclexta</b>
Tab 10 mg .....	13.68	2 OP	✓ <b>Venclexta</b>
Tab 50 mg .....	239.44	7 OP	✓ <b>Venclexta</b>
Tab 100 mg – Wastage claimable .....	8,209.41	120	✓ <b>Venclexta</b>

► **SA2678** **Special Authority for Subsidy**

**Initial application — (previously untreated chronic lymphocytic leukaemia in combination with obinutuzumab)** from any relevant practitioner. Approvals valid for 15 months for applications meeting the following criteria:

Either:

continued...

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

continued...

- 1 Individual is currently on treatment with venetoclax and obinutuzumab and met all of the following criteria prior to commencing treatment; or
- 2 All of the following:
  - 2.1 Individual has previously untreated chronic lymphocytic leukaemia; and
  - 2.2 Venetoclax is to be administered with obinutuzumab; and
  - 2.3 Venetoclax is to be used to a maximum dose of 400 mg and for a total of 12 (28 day) cycles.

**Initial application — (previously untreated chronic lymphocytic leukaemia in combination with ibrutinib)** from any relevant practitioner. Approvals valid for 15 months for applications meeting the following criteria:

Either:

- 1 Individual is currently on treatment with venetoclax and/or ibrutinib and met all of the following criteria prior to commencing treatment; or
- 2 All of the following:
  - 2.1 Individual has previously untreated chronic lymphocytic leukaemia; and
  - 2.2 Venetoclax is to be administered in combination with ibrutinib; and
  - 2.3 Venetoclax is to be used to a maximum dose of 400 mg and for a total of 12 (28 day) cycles.

**Initial application — (relapsed/refractory chronic lymphocytic leukaemia)** from any relevant practitioner. Approvals valid for 8 months for applications meeting the following criteria:

All of the following:

- 1 Individual has chronic lymphocytic leukaemia requiring treatment; and
- 2 Individual has received at least one prior therapy for chronic lymphocytic leukaemia; and
- 3 The individual's disease has relapsed; and
- 4 Venetoclax to be used in combination with six 28-day cycles of rituximab commencing after the 5-week dose titration schedule with venetoclax; and
- 5 Individual has an ECOG performance status of 0-2.

**Renewal — (relapsed/refractory chronic lymphocytic leukaemia)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Treatment remains clinically appropriate and the individual is benefitting from and tolerating treatment; and
- 2 Venetoclax is to be discontinued after a maximum of 24 months of treatment following the titration schedule unless earlier discontinuation is required due to disease progression or unacceptable toxicity.

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) and B-cell prolymphocytic leukaemia (B-PLL)\*. Indications marked with \* are Unapproved indications.

**Initial application — (previously untreated chronic lymphocytic leukaemia with 17p deletion or TP53 mutation\*)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Individual has previously untreated chronic lymphocytic leukaemia; and
- 2 There is documentation confirming that individual has 17p deletion by FISH testing or TP53 mutation by sequencing; and
- 3 Individual has an ECOG performance status of 0-2.

**Renewal — (previously untreated chronic lymphocytic leukaemia with 17p deletion or TP53 mutation\*)** from any relevant practitioner. Approvals valid for 6 months where the treatment remains clinically appropriate and the patient is benefitting from and tolerating treatment.

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL)\* and B-cell prolymphocytic leukaemia (B-PLL)\*. Indications marked with \* are Unapproved indications

**Initial application — (previously untreated acute myeloid leukaemia)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 The individual is currently on treatment with venetoclax and met all remaining special authority criteria prior to commencing

continued...

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
continued...			
treatment; or			
2 All of the following:			
2.1 Individual has previously untreated acute myeloid leukaemia (see note a), according to World Health Organization (WHO) Classification; and			
2.2 Venetoclax not to be used in combination with standard intensive remission induction chemotherapy; and			
2.3 Venetoclax to be used in combination with azacitidine or low dose cytarabine.			
<b>Renewal</b> — (previously untreated acute myeloid leukaemia) from any relevant practitioner. Approvals valid for 6 months where there is no evidence of disease progression.			
Notes:			
a) 'Acute myeloid leukaemia' includes myeloid sarcoma*			
b) Indications marked with * are Unapproved indications			
<b>VINBLASTINE SULPHATE</b>			
Inj 1 mg per ml, 10 ml vial – PCT – Retail pharmacy-Specialist.....	270.37	5	✓ Hospira
Inj 1 mg for ECP – PCT only – Specialist.....	6.00	1 mg	✓ Baxter
<b>VINCRISTINE SULPHATE</b>			
Inj 1 mg per ml, 1 ml vial – PCT – Retail pharmacy-Specialist.....	74.52	5	✓ DBL Vincristine Sulfate
Inj 1 mg per ml, 2 ml vial – PCT – Retail pharmacy-Specialist.....	102.73	5	✓ DBL Vincristine Sulfate
Inj 1 mg for ECP – PCT only – Specialist.....	12.60	1 mg	✓ Baxter
<b>VINOURELBINE</b>			
Cap 20 mg.....	32.10	1	✓ Vinorelbine Te Arai
Cap 30 mg.....	42.80	1	✓ Vinorelbine Te Arai
Cap 80 mg.....	80.00	1	✓ Vinorelbine Te Arai
Inj 10 mg per ml, 5 ml vial – PCT only – Specialist .....	155.00	1	✓ Vinorelbine Ebewe
	168.00		✓ Navelbine S29 <sup>§29</sup>
Inj 1 mg for ECP – PCT only – Specialist.....	3.51	1 mg	✓ Baxter

### Protein-tyrosine Kinase Inhibitors

ALECTINIB – Retail pharmacy-Specialist – Special Authority see SA1870 below

Wastage claimable			
Cap 150 mg.....	7,935.00	224	✓ Alecensa

#### ►SA1870 Special Authority for Subsidy

**Initial application** only from a medical oncologist or medical practitioner on the recommendation of a relevant specialist.

Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has locally advanced, or metastatic, unresectable, non-small cell lung cancer; and
- 2 There is documentation confirming that the patient has an ALK tyrosine kinase gene rearrangement using an appropriate ALK test; and
- 3 Patient has an ECOG performance score of 0-2.

**Renewal** only from a medical oncologist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 No evidence of progressive disease according to RECIST criteria; and
- 2 The patient is benefitting from and tolerating treatment.

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
AXITINIB – Special Authority see <a href="#">SA2458 below</a> – Retail pharmacy				
Wastage claimable				
Tab 1 mg .....	536.40	28	✓	Inlyta
Tab 5 mg .....	2,682.00	28	✓	Inlyta

## ►SA2458 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 The patient has metastatic renal cell carcinoma; and
- 2 The disease is of predominant clear cell histology; and
- 3 The patient has documented disease progression following one previous line of treatment; and
- 4 The patient has ECOG performance status of 0-2.

**Renewal** from any relevant practitioner. Approvals valid for 4 months where there is no evidence of disease progression..

CRIZOTINIB – Special Authority see [SA2547 below](#) – Retail pharmacy

Cap 200 mg .....	7,250.00	60	✓	Xalkori
Cap 250 mg .....	7,250.00	60	✓	Xalkori

## ►SA2547 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Individual has locally advanced or metastatic, unresectable, non-squamous non-small cell lung cancer; and
- 2 Either:
  - 2.1 The individual has not received entrectinib; or
  - 2.2 Both:
    - 2.2.1 The individual has received an initial Special Authority approval for entrectinib and has discontinued entrectinib due to intolerance; and
    - 2.2.2 The cancer did not progress while the individual was on entrectinib; and
- 3 There is documentation confirming that the patient has a ROS1 rearrangement using an appropriate ROS1 test; and
- 4 Individual has ECOG performance score of 0-3; and
- 5 Baseline measurement of overall tumour burden is documented clinically and radiologically.

**Renewal** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Response to treatment has been determined by comparable radiological assessment following the most recent treatment period; and
- 2 No evidence of disease progression.

DABRAFENIB – Special Authority see [SA2548 below](#) – Retail pharmacy

Cap 50 mg .....	6,320.86	120	✓	Tafinlar
Cap 75 mg .....	9,481.29	120	✓	Tafinlar

## ►SA2548 Special Authority for Subsidy

**Initial application** — (stage III or IV resected melanoma - adjuvant) from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Either:
  - 1.1 The individual has resected stage IIIB, IIIC, IIID or IV melanoma (excluding uveal) (see note a); or
  - 1.2 Both:
    - 1.2.1 The individual has received neoadjuvant treatment with a PD-1/PD-L1 inhibitor; and
    - 1.2.2 Adjuvant treatment with dabrafenib is required; and
- 2 The individual has not received prior funded systemic treatment in the adjuvant setting for stage IIIB, IIIC, IIID or IV

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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continued...

- melanoma; and
- 3 Treatment must be adjuvant to complete surgical resection; and
- 4 Treatment must be initiated within 13 weeks of surgical resection, unless delay is necessary due to post-surgery recovery (see note b); and
- 5 The individual has a confirmed BRAF mutation; and
- 6 Dabrafenib must be administered in combination with trametinib; and
- 7 The individual has ECOG performance score 0-2.

Notes:

- a) Stage IIIB, IIIC, IIID or IV melanoma defined as per American Joint Committee on Cancer (AJCC) 8th Edition
- b) Initiating treatment within 13 weeks of complete surgical resection means 13 weeks after resection (primary or lymphadenectomy)

**Renewal — (stage III or IV resected melanoma - adjuvant)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

Any of the following:

- 1 All of the following:
  - 1.1 No evidence of disease recurrence; and
  - 1.2 Dabrafenib must be administered in combination with trametinib; and
  - 1.3 Treatment to be discontinued at signs of disease recurrence or at completion of 12 months' total treatment course, including any systemic neoadjuvant treatment; or
- 2 All of the following:
  - 2.1 The individual has received adjuvant treatment with a BRAF/MEK inhibitor; and
  - 2.2 The individual has metastatic or unresectable melanoma (excluding uveal) stage III or IV; and
  - 2.3 The individual meets initial application criteria for dabrafenib for unresectable or metastatic melanoma; or
- 3 All of the following:
  - 3.1 The individual has received adjuvant treatment with a BRAF/MEK inhibitor; and
  - 3.2 The individual has received a BRAF/MEK inhibitor for unresectable or metastatic melanoma; and
  - 3.3 The individual meets renewal criteria for dabrafenib for unresectable or metastatic melanoma.

**Initial application — (unresectable or metastatic melanoma)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 The individual has metastatic or unresectable melanoma (excluding uveal) stage III or IV; and
- 2 Baseline measurement of overall tumour burden is documented clinically and radiologically; and
- 3 The individual has ECOG performance score 0-2; and
- 4 The individual has confirmed BRAF mutation; and
- 5 Dabrafenib must be administered in combination with trametinib; and
- 6 Any of the following:
  - 6.1 The individual has been diagnosed in the metastatic or unresectable stage III or IV setting; or
  - 6.2 The individual did not receive treatment in the adjuvant setting with a BRAF/MEK inhibitor; or
  - 6.3 All of the following:
    - 6.3.1 The individual received treatment in the adjuvant setting with a BRAF/MEK inhibitor; and
    - 6.3.2 The individual did not experience disease recurrence while on treatment with that BRAF/MEK inhibitor; and
    - 6.3.3 The individual did not experience disease recurrence within six months of completing adjuvant treatment with a BRAF/MEK inhibitor.

**Renewal — (unresectable or metastatic melanoma)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

Both:

- 1 Any of the following:

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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continued...

- 1.1 The individual's disease has had a complete response to treatment; or
- 1.2 The individual's disease has had a partial response to treatment; or
- 1.3 The individual has stable disease with treatment; and
- 2 Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period.

**DASATINIB** – Special Authority see [SA2385 below](#) – Retail pharmacy

Wastage claimable

Tab 20 mg .....	132.88	60	✓ <b>Dasatinib-Teva</b>
Tab 50 mg .....	304.13	60	✓ <b>Dasatinib-Teva</b>
Tab 70 mg .....	415.75	60	✓ <b>Dasatinib-Teva</b>

## ►SA2385 Special Authority for Subsidy

**Initial application** only from a haematologist or Practitioner on the recommendation of a haematologist. Approvals valid for 6 months for applications meeting the following criteria:

Any of the following:

- 1 The patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis or accelerated phase; or
- 2 The patient has a diagnosis of Philadelphia chromosome-positive acute lymphoid leukaemia (Ph+ ALL); or
- 3 Both:
  - 3.1 The patient has a diagnosis of CML in chronic phase; and
  - 3.2 Any of the following:
    - 3.2.1 Patient has documented treatment failure\* with imatinib; or
    - 3.2.2 Patient has experienced treatment-limiting toxicity with imatinib precluding further treatment with imatinib; or
    - 3.2.3 Patient has high-risk chronic-phase CML defined by the Sokal or EURO scoring system.

**Renewal** only from a haematologist or Practitioner on the recommendation of a haematologist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Lack of treatment failure while on dasatinib\*; and
- 2 Dasatinib treatment remains appropriate and the patient is benefiting from treatment.

Note: \*treatment failure for CML as defined by Leukaemia Net Guidelines.

**ENTRECTINIB** – Special Authority see [SA2532 below](#) – Retail pharmacy

Cap 200 mg.....	9,610.00	90	✓ <b>Rozlytrek</b>
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## ►SA2532 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Individual has locally advanced or metastatic, unresectable, non-squamous non-small cell lung cancer; and
- 2 Either:
  - 2.1 The individual has not received crizotinib; or
  - 2.2 Both:
    - 2.2.1 The individual has received an initial Special Authority approval for crizotinib and has discontinued crizotinib due to intolerance; and
    - 2.2.2 The cancer did not progress while the individual was on crizotinib; and
- 3 There is documentation confirming that the patient has a ROS1 rearrangement using an appropriate ROS1 test; and
- 4 Individual has ECOG performance score of 0-3; and
- 5 Baseline measurement of overall tumour burden is documented clinically and radiologically.

**Renewal** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Response to treatment has been determined by comparable radiological assessment following the most recent treatment period; and
- 2 No evidence of disease progression.

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>ERLOTINIB – Retail pharmacy-Specialist – Special Authority see <a href="#">SA2422 below</a></b>				
Tab 100 mg .....	280.84	30	✓	<b>Alchemy</b>
Tab 150 mg .....	484.24	30	✓	<b>Alchemy</b>

► **SA2422 Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:  
All of the following:

- 1 Patient has locally advanced or metastatic, unresectable, non-squamous Non Small Cell Lung Cancer (NSCLC); and
- 2 There is documentation confirming that the disease expresses activating mutations of EGFR; and
- 3 Any of the following:
  - 3.1 Patient is treatment naive; or
  - 3.2 Patient has received prior treatment in the adjuvant setting and/or while awaiting EGFR results; or
  - 3.3 Both:
    - 3.3.1 The patient has discontinued osimertinib or gefitinib due to intolerance; and
    - 3.3.2 The cancer did not progress while on osimertinib or gefitinib.

**Renewal** from any relevant practitioner. Approvals valid for 6 months where radiological assessment (preferably including CT scan) indicates NSCLC has not progressed.

**GEFITINIB – Retail pharmacy-Specialist – Special Authority see [SA2423 below](#)**

Tab 250 mg .....	918.00	30	✓	<b>Iressa</b>
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► **SA2423 Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:  
All of the following:

- 1 Patient has locally advanced, or metastatic, unresectable, non-squamous Non Small Cell Lung Cancer (NSCLC); and
- 2 Any of the following:
  - 2.1 Patient is treatment naive; or
  - 2.2 Patient has received prior treatment in the adjuvant setting and/or while awaiting EGFR results; or
  - 2.3 Both:
    - 2.3.1 The patient has discontinued osimertinib or erlotinib due to intolerance; and
    - 2.3.2 The cancer did not progress whilst on osimertinib or erlotinib; and
- 3 There is documentation confirming that disease expresses activating mutations of EGFR.

**Renewal** from any relevant practitioner. Approvals valid for 6 months where radiological assessment (preferably including CT scan) indicates NSCLC has not progressed.

**IMATINIB MESILATE**

* Cap 100 mg .....	44.93	60	✓	<b>Imatinib-Rex</b>
* Cap 400 mg .....	69.76	30	✓	<b>Imatinib-Rex</b>

**LENVATINIB – Special Authority see [SA2442 below](#) – Retail pharmacy**

Wastage claimable				
Cap 4 mg .....	3,407.40	30	✓	<b>Lenvima</b>
Cap 10 mg .....	3,407.40	30	✓	<b>Lenvima</b>

► **SA2442 Special Authority for Subsidy**

**Initial application — (thyroid cancer)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Patient is currently on treatment with lenvatinib and met all remaining criteria prior to commencing treatment; or
- 2 All of the following:
  - 2.1 The patient has locally advanced or metastatic differentiated thyroid cancer; and
  - 2.2 Either:

continued...

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

continued...

- 2.2.1 Patient must have symptomatic progressive disease prior to treatment; or
- 2.2.2 Patient must progressive disease at critical anatomical sites with a high risk of morbidity or mortality where local control cannot be achieved by other measures; and
- 2.3 Any of the following:
  - 2.3.1 A lesion without iodine uptake in a RAI scan; or
  - 2.3.2 Receiving cumulative RAI greater than or equal to 600 mCi; or
  - 2.3.3 Experiencing disease progression after a RAI treatment within 12 months; or
  - 2.3.4 Experiencing disease progression after two RAI treatments administered within 12 months of each other; and
- 2.4 Patient has thyroid stimulating hormone (TSH) adequately suppressed; and
- 2.5 Patient is not a candidate for radiotherapy with curative intent; and
- 2.6 Surgery is clinically inappropriate; and
- 2.7 Patient has an ECOG performance status of 0-2.

**Renewal — (thyroid cancer)** from any relevant practitioner. Approvals valid for 6 months where there is no evidence of disease progression.

**Initial application — (unresectable hepatocellular carcinoma)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has unresectable hepatocellular carcinoma; and
- 2 Patient has preserved liver function (Childs-Pugh A); and
- 3 Transarterial chemoembolisation (TACE) is unsuitable; and
- 4 Patient has an ECOG performance status of 0-2; and
- 5 Either:
  - 5.1 Patient has not received prior systemic therapy for their disease in the palliative setting; or
  - 5.2 Both:
    - 5.2.1 Patient has experienced treatment-limiting toxicity from treatment with atezolizumab with bevacizumab; and
    - 5.2.2 No disease progression since initiation of atezolizumab with bevacizumab.

**Renewal — (unresectable hepatocellular carcinoma)** from any relevant practitioner. Approvals valid for 6 months where there is no evidence of disease progression.

**Initial application — (renal cell carcinoma)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 All of the following:
  - 1.1 The patient has metastatic renal cell carcinoma; and
  - 1.2 The disease is of predominant clear-cell histology; and
  - 1.3 The patient has documented disease progression following one previous line of treatment; and
  - 1.4 The patient has an ECOG performance status of 0-2; and
  - 1.5 Lenvatinib is to be used in combination with everolimus; or
- 2 All of the following:
  - 2.1 Patient has received funded treatment with nivolumab for the second line treatment of metastatic renal cell carcinoma; and
  - 2.2 Patient has experienced treatment limiting toxicity from treatment with nivolumab; and
  - 2.3 Lenvatinib is to be used in combination with everolimus; and
  - 2.4 There is no evidence of disease progression.

**Renewal — (renal cell carcinoma)** from any relevant practitioner. Approvals valid for 4 months where there is no evidence of disease progression.

MIDOSTAURIN – PCT only – Special Authority see [SA2342 on the next page](#)

Cap 25 mg .....	10,981.00	56	✓ Rydapt
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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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►►**SA2342** **Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid for 9 months for applications meeting the following criteria:  
All of the following:

- 1 Patient has a diagnosis of acute myeloid leukaemia; and
- 2 Condition must be FMS tyrosine kinase 3 (FLT3) mutation positive; and
- 3 Patient must not have received a prior line of intensive chemotherapy for acute myeloid leukaemia; and
- 4 Patient is to receive standard intensive chemotherapy in combination with midostaurin only; and
- 5 Midostaurin to be funded for a maximum of 4 cycles.

**NILOTINIB** – Special Authority see [SA2301 below](#) – Retail pharmacy

Wastage claimable			
Cap 150 mg .....	4,680.00	120	✓ <b>Tasigna</b>
Cap 200 mg .....	6,532.00	120	✓ <b>Tasigna</b>

►►**SA2301** **Special Authority for Subsidy**

**Initial application** only from a haematologist. Approvals valid for 6 months for applications meeting the following criteria:  
All of the following:

- 1 Patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis, high risk chronic phase, or in chronic phase; and
- 2 Either:
  - 2.1 Patient has documented CML treatment failure\* with a tyrosine kinase inhibitor (TKI); or
  - 2.2 Patient has experienced treatment limiting toxicity with a tyrosine kinase inhibitor (TKI) precluding further treatment; and
- 3 Maximum nilotinib dose of 800 mg/day; and
- 4 Subsidised for use as monotherapy only.

Note: \*treatment failure as defined by Leukaemia Net Guidelines.

**Renewal** only from a haematologist. Approvals valid for 6 months for applications meeting the following criteria:  
All of the following:

- 1 Lack of treatment failure while on nilotinib as defined by Leukaemia Net Guidelines; and
- 2 Nilotinib treatment remains appropriate and the patient is benefiting from treatment; and
- 3 Maximum nilotinib dose of 800 mg/day; and
- 4 Subsidised for use as monotherapy only.

**OSIMERTINIB** – Special Authority see [SA2418 below](#) – Retail pharmacy

Tab 40 mg .....	9,310.00	30	✓ <b>Tagrisso</b>
Tab 80 mg .....	9,310.00	30	✓ <b>Tagrisso</b>

►►**SA2418** **Special Authority for Subsidy**

**Initial application** — (NSCLC – first line) from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 Patient is currently on treatment with osimertinib and met all remaining criteria prior to commencing treatment; or
- 2 All of the following:
  - 2.1 Patient has locally advanced or metastatic, incurable, non-squamous non-small cell lung cancer (NSCLC); and
  - 2.2 Any of the following:
    - 2.2.1 Patient is treatment naïve; or
    - 2.2.2 Patient has received prior chemotherapy in the adjuvant setting and/or while awaiting EGFR results; or
    - 2.2.3 Both:
      - 2.2.3.1 The patient has discontinued gefitinib or erlotinib due to intolerance; and

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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continued...

2.2.3.2 The cancer did not progress while on gefitinib or erlotinib; and

- 2.3 There is documentation confirming that the cancer expresses activating mutations of EGFR; and
- 2.4 Patient has an ECOG performance status 0-3; and
- 2.5 Baseline measurement of overall tumour burden is documented clinically and radiologically.

**Renewal — (NSCLC – first line)** from any relevant practitioner. Approvals valid for 6 months where response to or stable disease with treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period.

**Initial application — (NSCLC – second line)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 Patient is currently on treatment with osimertinib and met all remaining criteria prior to commencing treatment; or
- 2 All of the following:
  - 2.1 Patient has locally advanced or metastatic, incurable, non-squamous non-small cell lung cancer (NSCLC); and
  - 2.2 Patient has an ECOG performance status 0-3; and
  - 2.3 The patient must have received previous treatment with erlotinib or gefitinib; and
  - 2.4 There is documentation confirming that the cancer expresses T790M mutation of EGFR following progression on or after erlotinib or gefitinib; and
  - 2.5 The treatment must be given as monotherapy; and
  - 2.6 Baseline measurement of overall tumour burden is documented clinically and radiologically.

**Renewal — (NSCLC – second line)** from any relevant practitioner. Approvals valid for 6 months where response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period.

PALBOCICLIB – Special Authority see [SA2345 below](#) – Retail pharmacy

Wastage claimable

Tab 75 mg .....	1,200.00	21	✓ Palbociclib Pfizer
Tab 100 mg .....	1,200.00	21	✓ Palbociclib Pfizer
Tab 125 mg .....	1,200.00	21	✓ Palbociclib Pfizer

► [SA2345](#) **Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 All of the following:
  - 1.1 Patient has unresectable locally advanced or metastatic breast cancer; and
  - 1.2 There is documentation confirming disease is hormone-receptor positive and HER2-negative; and
  - 1.3 Patient has an ECOG performance score of 0-2; and
  - 1.4 Either:
    - 1.4.1 Disease has relapsed or progressed during prior endocrine therapy; or
    - 1.4.2 Both:
      - 1.4.2.1 Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state; and
      - 1.4.2.2 Patient has not received prior systemic treatment for metastatic disease; and
  - 1.5 Treatment must be used in combination with an endocrine partner; and
  - 1.6 Patient has not received prior funded treatment with a CDK4/6 inhibitor; or
- 2 All of the following:
  - 2.1 Patient has an active Special Authority approval for ribociclib; and
  - 2.2 Patient has experienced a grade 3 or 4 adverse reaction to ribociclib that cannot be managed by dose reductions and requires treatment discontinuation; and
  - 2.3 Treatment must be used in combination with an endocrine partner; and

continued...

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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continued...

2.4 There is no evidence of progressive disease since initiation of ribociclib.

**Renewal** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:  
Both:

- 1 Treatment must be used in combination with an endocrine partner; and
- 2 There is no evidence of progressive disease since initiation of palbociclib.

PAZOPANIB – Special Authority see [SA2596 below](#) – Retail pharmacy

Tab 200 mg .....	172.88	30	✓ <b>Pazopanib</b> <b>ADVZ S29</b>
Tab 400 mg .....	464.00	30	✓ <b>Pazopanib Teva</b> ✓ <b>Pazopanib Teva</b>

► **SA2596** **Special Authority for Subsidy**

**Initial application** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist.

Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 All of the following:
  - 1.1 The patient has metastatic renal cell carcinoma of predominantly clear cell histology; and
  - 1.2 Either:
    - 1.2.1 The patient is treatment naive; or
    - 1.2.2 The patient has only received prior cytokine treatment; and
  - 1.3 The patient has an ECOG performance score of 0-2; and  
The patient has intermediate or poor prognosis defined as:
  - 1.4 Any of the following:
    - 1.4.1 Lactate dehydrogenase level > 1.5 times upper limit of normal; or
    - 1.4.2 Haemoglobin level < lower limit of normal; or
    - 1.4.3 Corrected serum calcium level > 10 mg/dL (2.5 mmol/L); or
    - 1.4.4 Interval of < 1 year from original diagnosis to the start of systemic therapy; or
    - 1.4.5 Karnofsky performance score of less than or equal to 70; or
    - 1.4.6 2 or more sites of organ metastasis; and
  - 1.5 Pazopanib to be used for a maximum of 3 months; or
- 2 All of the following:
  - 2.1 The patient has metastatic renal cell carcinoma; and
  - 2.2 The patient has discontinued sunitinib within 3 months of starting treatment due to intolerance; and
  - 2.3 The cancer did not progress whilst on sunitinib; and
  - 2.4 Pazopanib to be used for a maximum of 3 months.

**Renewal** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 3 months where there is no evidence of disease progression.

RIBOCICLIB – Special Authority see [SA2495 below](#) – Retail pharmacy

Wastage claimable			
Tab 200 mg .....	1,883.00	21	✓ <b>Kisqali</b>
	3,767.00	42	✓ <b>Kisqali</b>
	5,650.00	63	✓ <b>Kisqali</b>

► **SA2495** **Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 All of the following:

continued...

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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continued...

- 1.1 Patient has unresectable locally advanced or metastatic breast cancer; and
- 1.2 There is documentation confirming disease is hormone-receptor positive and HER2-negative; and
- 1.3 Patient has an ECOG performance score of 0-2; and
- 1.4 Either:
  - 1.4.1 Disease has relapsed or progressed during prior endocrine therapy; or
  - 1.4.2 Both:
    - 1.4.2.1 Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state; and
    - 1.4.2.2 Patient has not received prior systemic endocrine treatment for metastatic disease; and
- 1.5 Treatment to be used in combination with an endocrine partner; and
- 1.6 Patient has not received prior funded treatment with a CDK4/6 inhibitor; or
- 2 All of the following:
  - 2.1 Patient has an active Special Authority approval for palbociclib; and
  - 2.2 Patient has experienced a grade 3 or 4 adverse reaction to palbociclib that cannot be managed by dose reductions and requires treatment discontinuation; and
  - 2.3 Treatment must be used in combination with an endocrine partner; and
  - 2.4 There is no evidence of progressive disease since initiation of palbociclib.

**Renewal** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:  
Both:

- 1 Treatment must be used in combination with an endocrine partner; and
- 2 There is no evidence of progressive disease since initiation of ribociclib.

**RUXOLITINIB** – Special Authority see [SA1890 below](#) – Retail pharmacy

Wastage claimable

Tab 5 mg .....	2,500.00	56	✓ <b>Jakavi</b>
Tab 10mg .....	5,000.00	56	✓ <b>Jakavi</b>
Tab 15 mg .....	5,000.00	56	✓ <b>Jakavi</b>
Tab 20 mg .....	5,000.00	56	✓ <b>Jakavi</b>

► **SA1890** **Special Authority for Subsidy**

**Initial application** only from a haematologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has primary myelofibrosis or post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis; and
- 2 Either:
  - 2.1 A classification of risk of intermediate-2 or high-risk myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS; or
  - 2.2 Both:
    - 2.2.1 A classification of risk of intermediate-1 myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS; and
    - 2.2.2 Patient has severe disease-related symptoms that are resistant, refractory or intolerant to available therapy; and
- 3 A maximum dose of 20 mg twice daily is to be given.

**Renewal** only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 A maximum dose of 20 mg twice daily is to be given.

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>SUNITINIB</b> – Special Authority see <a href="#">SA2452 below</a> – Retail pharmacy				
Cap 12.5 mg .....	103.11	28	✓	<b>Sunitinib Rex</b>
Cap 25 mg .....	203.15	28	✓	<b>Sunitinib Rex</b>
Cap 50 mg .....	343.19	28	✓	<b>Sunitinib Rex</b>

► **SA2452 Special Authority for Subsidy**

**Initial application — (RCC)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

Both:

- 1 The patient has metastatic renal cell carcinoma; and
- 2 The patient has not previously received funded sunitinib.

**Initial application — (GIST)** only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 The patient has unresectable or metastatic malignant gastrointestinal stromal tumour (GIST); and
- 2 Either:
  - 2.1 The patient's disease has progressed following treatment with imatinib; or
  - 2.2 The patient has documented treatment-limiting intolerance, or toxicity to, imatinib.

**Renewal — (RCC)** from any relevant practitioner. Approvals valid for 4 months where there is no evidence of disease progression.

**Renewal — (GIST)** only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

The patient has responded to treatment or has stable disease as determined by Choi's modified CT response evaluation criteria as follows:

- 1 Any of the following:
  - 1.1 The patient has had a complete response (disappearance of all lesions and no new lesions); or
  - 1.2 The patient has had a partial response (a decrease in size of 10% or more or decrease in tumour density in Hounsfield Units (HU) of 15% or more on CT and no new lesions and no obvious progression of non measurable disease); or
  - 1.3 The patient has stable disease (does not meet criteria the two above) and does not have progressive disease and no symptomatic deterioration attributed to tumour progression; and
- 2 The treatment remains appropriate and the patient is benefiting from treatment.

Note: It is recommended that response to treatment be assessed using Choi's modified CT response evaluation criteria (J Clin Oncol, 2007, 25:1753-1759). Progressive disease is defined as either: an increase in tumour size of 10% or more and not meeting criteria of partial response (PR) by tumour density (HU) on CT; or: new lesions, or new intratumoral nodules, or increase in the size of the existing intratumoral nodules.

**Renewal — (GIST pandemic circumstances)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 The patient has unresectable or metastatic malignant gastrointestinal stromal (GIST); and
- 2 The patient is clinically benefiting from treatment and continued treatment remains appropriate; and
- 3 Sunitinib is to be discontinued at progression; and
- 4 The regular Special Authority renewal requirements cannot be met due to COVID-19 constraints on the health sector.

**TRAMETINIB** – Special Authority see [SA2549 on the next page](#) – Retail pharmacy

Tab 0.5 mg .....	2,370.32	30	✓	<b>Mekinist</b>
Tab 2 mg .....	9,481.29	30	✓	<b>Mekinist</b>

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

## ►SA2549 Special Authority for Subsidy

**Initial application — (stage III or IV resected melanoma - adjuvant)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Either:
  - 1.1 The individual has resected stage IIIB, IIIC, IIID or IV melanoma (excluding uveal) (see note a); or
  - 1.2 Both:
    - 1.2.1 The individual has received neoadjuvant treatment with a PD-1/PD-L1 inhibitor; and
    - 1.2.2 Adjuvant treatment with trametinib is required; and
- 2 The individual has not received prior funded systemic treatment in the adjuvant setting for stage IIIB, IIIC, IIID or IV melanoma; and
- 3 Treatment must be adjuvant to complete surgical resection; and
- 4 Treatment must be initiated within 13 weeks of surgical resection, unless delay is necessary due to post-surgery recovery (see note b); and
- 5 The individual has a confirmed BRAF mutation; and
- 6 Trametinib must be administered in combination with dabrafenib; and
- 7 The individual has ECOG performance score 0-2.

Notes:

- a) Stage IIIB, IIIC, IIID or IV melanoma defined as per American Joint Committee on Cancer (AJCC) 8th Edition
- b) Initiating treatment within 13 weeks of complete surgical resection means 13 weeks after resection (primary or lymphadenectomy)

**Renewal — (stage III or IV resected melanoma - adjuvant)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

Any of the following:

- 1 All of the following:
  - 1.1 No evidence of disease recurrence; and
  - 1.2 Trametinib must be administered in combination with dabrafenib; and
  - 1.3 Treatment to be discontinued at signs of disease recurrence or at completion of 12 months' total treatment course, including any systemic neoadjuvant treatment; or
- 2 All of the following:
  - 2.1 The individual has received adjuvant treatment with a BRAF/MEK inhibitor; and
  - 2.2 The individual has metastatic or unresectable melanoma (excluding uveal) stage III or IV; and
  - 2.3 The individual meets initial application criteria for trametinib for unresectable or metastatic melanoma; or
- 3 All of the following:
  - 3.1 The individual has received adjuvant treatment with a BRAF/MEK inhibitor; and
  - 3.2 The individual has received a BRAF/MEK inhibitor for unresectable or metastatic melanoma; and
  - 3.3 The individual meets renewal criteria for trametinib for unresectable or metastatic melanoma.

**Initial application — (unresectable or metastatic melanoma)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 The individual has metastatic or unresectable melanoma (excluding uveal melanoma) stage III or IV; and
- 2 Baseline measurement of overall tumour burden is documented clinically and radiologically; and
- 3 The individual has ECOG performance score 0-2; and
- 4 The individual has confirmed BRAF mutation; and
- 5 Trametinib must be administered in combination with dabrafenib; and
- 6 Any of the following:
  - 6.1 The individual has been diagnosed in the metastatic or unresectable stage III or IV setting; or

continued...

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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continued...

- 6.2 The individual did not receive treatment in the adjuvant setting with a BRAF/MEK inhibitor; or
- 6.3 All of the following:
  - 6.3.1 The individual received treatment in the adjuvant setting with a BRAF/MEK inhibitor; and
  - 6.3.2 The individual did not experience disease recurrence while on treatment with that BRAF/MEK inhibitor; and
  - 6.3.3 The individual did not experience disease recurrence within six months of completing adjuvant treatment with a BRAF/MEK inhibitor.

**Renewal — (unresectable or metastatic melanoma)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

- Both:
- 1 Any of the following:
    - 1.1 The individual's disease has had a complete response to treatment; or
    - 1.2 The individual's disease has had a partial response to treatment; or
    - 1.3 The individual has stable disease with treatment; and
  - 2 Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period.

## Endocrine Therapy

For GnRH ANALOGUES – refer to HORMONE PREPARATIONS, Tropic Hormones, [page 90](#)

ABIRATERONE ACETATE – Retail pharmacy-Specialist – Special Authority see [SA2118 below](#)

Wastage claimable

Tab 250 mg .....4,276.19      120      ✓ Zytiga

### ➔SA2118 Special Authority for Subsidy

**Initial application** only from a medical oncologist, radiation oncologist, urologist or medical practitioner on the recommendation of a medical oncologist, radiation oncologist or urologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has prostate cancer; and
- 2 Patient has metastases; and
- 3 Patient's disease is castration resistant; and
- 4 Either:
  - 4.1 All of the following:
    - 4.1.1 Patient is symptomatic; and
    - 4.1.2 Patient has disease progression (rising serum PSA) after second line anti-androgen therapy; and
    - 4.1.3 Patient has ECOG performance score of 0-1; and
    - 4.1.4 Patient has not had prior treatment with taxane chemotherapy; or
  - 4.2 All of the following:
    - 4.2.1 Patient's disease has progressed following prior chemotherapy containing a taxane; and
    - 4.2.2 Patient has ECOG performance score of 0-2; and
    - 4.2.3 Patient has not had prior treatment with abiraterone.

**Renewal — (abiraterone acetate)** only from a medical oncologist, radiation oncologist, urologist or medical practitioner on the recommendation of a medical oncologist, radiation oncologist or urologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Significant decrease in serum PSA from baseline; and
- 2 No evidence of clinical disease progression; and
- 3 No initiation of taxane chemotherapy with abiraterone; and

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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continued...

4 The treatment remains appropriate and the patient is benefitting from treatment.

**Renewal — (pandemic circumstances)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 The patient is clinically benefitting from treatment and continued treatment remains appropriate; and
- 2 Abiraterone acetate to be discontinued at progression; and
- 3 No initiation of taxane chemotherapy with abiraterone; and
- 4 The regular Special Authority renewal requirements cannot be met due to COVID-19 constraints on the health sector.

## BICALUTAMIDE

Tab 50 mg .....4.18 28 ✓ **Binarex**

## FLUTAMIDE

Tab 250 mg .....107.55 90 ✓ **Prostacur** <sup>§29</sup>  
119.50 100 ✓ **Flutamin**

FULVESTRANT – Retail pharmacy-Specialist – Special Authority see [SA1895 below](#)

Inj 50 mg per ml, 5 ml prefilled syringe.....181.00 2 ✓ **Fulvestrant EVER  
Pharma**

## ►SA1895 Special Authority for Subsidy

**Initial application** only from a medical oncologist or medical practitioner on the recommendation of a medical oncologist.

Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has oestrogen-receptor positive locally advanced or metastatic breast cancer; and
- 2 Patient has disease progression following prior treatment with an aromatase inhibitor or tamoxifen for their locally advanced or metastatic disease; and
- 3 Treatment to be given at a dose of 500 mg monthly following loading doses; and
- 4 Treatment to be discontinued at disease progression.

**Renewal** only from a medical oncologist or medical practitioner on the recommendation of a medical oncologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Treatment remains appropriate and patient is benefitting from treatment; and
- 2 Treatment to be given at a dose of 500 mg monthly; and
- 3 There is no evidence of disease progression.

## OCTREOTIDE

Inj 100 mcg per ml, 1 ml ampoule .....32.71 5 ✓ **Max Health**  
✓ **Octreotide GH** <sup>§29</sup>  
✓ **Sun Pharma** <sup>§29</sup>  
Inj 100 mcg per ml, 1 ml vial.....48.50 5 ✓ **Omega** <sup>§29</sup>  
Inj 50 mcg per ml, 1 ml vial.....27.58 5 ✓ **Omega** <sup>§29</sup>  
Inj 500 mcg per ml, 1 ml vial.....113.10 5 ✓ **Omega** <sup>§29</sup>  
Inj 50 mcg per ml, 1 ml ampoule .....27.58 5 ✓ **Max Health**  
✓ **Octreotide GH** <sup>§29</sup>  
Inj 500 mcg per ml, 1 ml ampoule .....113.10 5 ✓ **Max Health**  
✓ **Octreotide GH** <sup>§29</sup>  
✓ **Sun Pharma** <sup>§29</sup>

## TAMOXIFEN CITRATE

\* Tab 10 mg .....15.00 60 ✓ **Tamoxifen Sandoz**  
\* Tab 20 mg .....5.32 60 ✓ **Tamoxifen Sandoz**

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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## Long-acting Somatostatin Analogues

### ►SA2445 Special Authority for Subsidy

**Initial application — (Malignant Bowel Obstruction)** from any relevant practitioner. Approvals valid for 2 months for applications meeting the following criteria:

All of the following:

- 1 The patient has nausea\* and vomiting\* due to malignant bowel obstruction\*; and
- 2 Treatment with antiemetics, rehydration, antimuscarinic agents, corticosteroids and analgesics for at least 48 hours has not been successful; and
- 3 Treatment to be given for up to 4 weeks.

Note: Indications marked with \* are unapproved indications.

**Renewal — (Malignant Bowel Obstruction)** from any relevant practitioner. Approvals valid for 3 months where the treatment remains appropriate and the patient is benefiting from treatment.

**Initial application — (Acromegaly)** from any relevant practitioner. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 The patient has acromegaly; and
- 2 Either:
  - 2.1 Treatment with surgery and radiotherapy is not suitable or was unsuccessful; or
  - 2.2 Treatment is for an interim period while awaiting the beneficial effects of radiotherapy; and
- 3 Treatment with a dopamine agonist has been unsuccessful.

**Renewal — (Acromegaly)** from any relevant practitioner. Approvals valid for 2 years where IGF1 levels have decreased since starting treatment.

Note: In patients with acromegaly, treatment should be discontinued if IGF1 levels have not decreased 3 months after treatment. In patients treated with radiotherapy treatment should be withdrawn every 2 years, for 1 month, for assessment of remission. Treatment should be stopped where there is biochemical evidence of remission (normal IGF1 levels) following treatment withdrawal for at least 4 weeks

**Initial application — (pre-operative acromegaly)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient has acromegaly; and
- 2 Patient has a large pituitary tumour, greater than 10 mm at its widest; and
- 3 Patient is scheduled to undergo pituitary surgery in the next six months.

**Initial application — (Other Indications)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Any of the following:

- 1 VIPomas and Glucagonomas - for patients who are seriously ill in order to improve their clinical state prior to definitive surgery; or
- 2 Both:
  - 2.1 Gastrinoma; and
  - 2.2 Either:
    - 2.2.1 Surgery has been unsuccessful; or
    - 2.2.2 Patient has metastatic disease after treatment with H2 antagonist or proton pump inhibitors has been unsuccessful; or
- 3 Both:
  - 3.1 Insulinomas; and
  - 3.2 Surgery is contraindicated or has not been successful; or

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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continued...

4 For pre-operative control of hypoglycaemia and for maintenance therapy; or

5 Both:

5.1 Carcinoid syndrome (diagnosed by tissue pathology and/or urinary 5HIAA analysis); and

5.2 Disabling symptoms not controlled by maximal medical therapy.

Note: The use of a long-acting somatostatin analogue in patients with fistulae, oesophageal varices, miscellaneous diarrhoea and hypotension will not be funded under Special Authority

**Renewal — (Other Indications)** from any relevant practitioner. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefiting from treatment.

LANREOTIDE – Special Authority see [SA2445 on the previous page](#) – Retail pharmacy

Inj 60 mg per 0.5 ml, 0.5 ml syringe .....	382.77	1	✓	<b>Mytolac</b>
	1,543.79		✓	<b>Mytolac S29</b> <sup>S29</sup>
Inj 90 mg per 0.5 ml, 0.5 ml syringe .....	562.92	1	✓	<b>Somatuline Autogel</b>
	2,054.40		✓	<b>Mytolac</b>
Inj 120 mg per 0.5 ml, 0.5 ml syringe .....	646.70	1	✓	<b>Somatuline Autogel</b>
	2,570.44		✓	<b>Mytolac</b>
			✓	<b>Somatuline Autogel</b>

OCTREOTIDE LONG-ACTING – Special Authority see [SA2445 on the previous page](#) – Retail pharmacy

Inj depot 10 mg prefilled syringe.....	438.40	1	✓	<b>Sandostatin LAR</b>
Inj depot 20 mg prefilled syringe.....	583.70	1	✓	<b>Sandostatin LAR</b>
Inj depot 30 mg prefilled syringe.....	670.80	1	✓	<b>Sandostatin LAR</b>

## Aromatase Inhibitors

ANASTROZOLE

\* Tab 1 mg ..... 4.39 30 ✓ **Anatrole**

EXEMESTANE

\* Tab 25 mg ..... 9.86 30 ✓ **Pfizer Exemestane**

LETROZOLE

\* Tab 2.5 mg ..... 4.36 28 ✓ **Accord** <sup>S29</sup>

4.67 30 ✓ **Letrole**

(*Accord* <sup>S29</sup> Tab 2.5 mg to be delisted 1 July 2026)

## Immunosuppressants

### Cytotoxic Immunosuppressants

AZATHIOPRINE

\* Tab 25 mg ..... 10.15 60 ✓ **Azamun**

\* Tab 50 mg ..... 10.34 100 ✓ **Azamun**

MYCOPHENOLATE MOFETIL

Tab 500 mg ..... 35.90 50 ✓ **Cellcept**

Cap 250 mg ..... 35.90 100 ✓ **Cellcept**

Powder for oral liq 1 g per 5 ml – Subsidy by endorsement..... 187.25 165 ml OP ✓ **Cellcept**

Mycophenolate powder for oral liquid is subsidised only for patients unable to swallow tablets and capsules, and when the prescription is endorsed accordingly.

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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**Fusion Proteins**

ETANERCEPT – Special Authority see SA2619 below – Retail pharmacy

Inj 25 mg.....	690.00	4	✓ Enbrel
Inj 25 mg autoinjector .....	690.00	4	✓ Enbrel
Inj 50 mg autoinjector .....	1,050.00	4	✓ Enbrel
Inj 50 mg prefilled syringe.....	1,050.00	4	✓ Enbrel

►SA2619 Special Authority for Subsidy

**Initial application — (Stills disease - adult-onset (AOSD))** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 Patient has had a Special Authority approval for adalimumab or tocilizumab for AOSD; and
  - 1.2 Either:
    - 1.2.1 Patient has experienced intolerable side effects; or
    - 1.2.2 Patient has received insufficient benefit to meet the renewal criteria from at least a 3-month trial of adalimumab or tocilizumab; or
- 2 All of the following:
  - 2.1 Patient diagnosed with AOSD according to the Yamaguchi criteria; and
  - 2.2 Patient has tried and received insufficient benefit from at least 6 months of corticosteroids at a dose of at least 0.5 mg/kg prednisone-equivalents, NSAIDs and methotrexate, unless contraindicated; and
  - 2.3 Patient has persistent symptoms of disabling poorly controlled and active disease.

**Initial application — (ankylosing spondylitis)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 Patient has had a Special Authority approval for adalimumab for ankylosing spondylitis; and
  - 1.2 Either:
    - 1.2.1 Patient has experienced intolerable side effects; or
    - 1.2.2 Patient has received insufficient benefit to meet the renewal criteria for ankylosing spondylitis; or
- 2 All of the following:
  - 2.1 Patient has a confirmed diagnosis of ankylosing spondylitis; and
  - 2.2 Patient has low back pain and stiffness that is relieved by exercise but not by rest; and
  - 2.3 Patient has bilateral sacroiliitis demonstrated by radiologic imaging; and
  - 2.4 Disease has not responded adequately to treatment with two or more NSAIDs (unless contraindicated), while patient was undergoing at least 3 months of a regular exercise regimen for ankylosing spondylitis; and
  - 2.5 Either:
    - 2.5.1 Patient has limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by the following BASMI measures: a modified Schober's test of less than or equal to 4 cm and lumbar side flexion measurement of less than or equal to 10 cm (mean of left and right); or
    - 2.5.2 Patient has limitation of chest expansion by at least 2.5 cm below the average normal values corrected for age and gender; and
  - 2.6 BASDAI of at least 6 on a 10-point scale completed after 3-month exercise trial before ceasing any previous pharmacological treatment and not more than 1 month before the application.

**Renewal — (ankylosing spondylitis)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 BASDAI has improved from pre-treatment baseline either by at least 4 points on a 10-point scale, or by at least 50%; and

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

continued...

2 Maximum dose 50 mg every 7 days.

**Initial application — (arthritis - polyarticular course juvenile idiopathic)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Any of the following:

1 Both:

1.1 Patient has had a Special Authority approval for adalimumab for polyarticular course juvenile idiopathic arthritis (JIA); and

1.2 Either:

1.2.1 Patient has experienced intolerable side effects; or

1.2.2 Patient has received insufficient benefit to meet the renewal criteria for polyarticular course JIA; or

2 At least 5 active joints and at least 3 joints with pain, tenderness or a limited range of motion, after a 3-month trial of methotrexate at the maximum tolerated dose, unless contraindicated; or

3 Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate at the maximum tolerated dose, unless contraindicated; or

4 Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate.

**Renewal — (arthritis - polyarticular course juvenile idiopathic)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Either:

1 Following initial treatment, at least a 50% decrease in active joint count from baseline; or

2 On subsequent reapplications, at least a continuing 30% improvement in active joint count from baseline.

**Initial application — (arthritis - oligoarticular course juvenile idiopathic)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Any of the following:

1 Both:

1.1 Patient has had a Special Authority approval for adalimumab for oligoarticular course juvenile idiopathic arthritis (JIA); and

1.2 Either:

1.2.1 Patient has experienced intolerable side effects; or

1.2.2 Patient has received insufficient benefit to meet the renewal criteria for oligoarticular course JIA; or

2 At least 2 active joints with pain, tenderness or a limited range of motion, after a 3-month trial of methotrexate at the maximum tolerated dose, unless contraindicated; or

3 Moderate or high disease activity (cJADAS10 score greater than 1.5) with poor prognostic features after a 3-month trial of methotrexate at the maximum tolerated dose, unless contraindicated.

**Renewal — (arthritis - oligoarticular course juvenile idiopathic)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Either:

1 Following initial treatment, at least a 50% decrease in active joint count from baseline; or

2 On subsequent reapplications, at least a continuing 30% improvement in active joint count from baseline.

**Initial application — (arthritis - psoriatic)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Either:

1 Both:

1.1 Patient has had a Special Authority approval for adalimumab or secukinumab for psoriatic arthritis; and

1.2 Either:

1.2.1 Patient has experienced intolerable side effects; or

1.2.2 Patient has received insufficient benefit to meet the renewal criteria for psoriatic arthritis; or

2 All of the following:

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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continued...

- 2.1 Patient has received insufficient benefit from at least 3 months of methotrexate at maximum tolerated dose unless contraindicated; and
- 2.2 Patient received insufficient benefit from at least 3 months of sulfasalazine or leflunomide at maximum tolerated dose unless contraindicated; and
- 2.3 Either:
  - 2.3.1 Patient has persistent symptoms of poorly controlled and active disease in at least 15 joints; or
  - 2.3.2 Patient has persistent symptoms of poorly controlled and active disease in at least 4 joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip; and
- 2.4 Any of the following:
  - 2.4.1 Patient has a CRP greater than 15 mg/L measured within one month before the application; or
  - 2.4.2 Patient has an ESR greater than 25 mm per hour measured within one month before the application; or
  - 2.4.3 ESR and CRP not measured as patient is receiving prednisone therapy greater than 5 mg per day received for more than 3 months.

**Renewal — (arthritis - psoriatic)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 Either:
  - 1.1 Following initial treatment, at least a 50% decrease in active joint count from baseline; or
  - 1.2 At least a continuing 30% improvement in active joint count from baseline; and
- 2 Maximum dose 50 mg every 7 days.

**Initial application — (pyoderma gangrenosum\*)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 Patient has received insufficient benefit from 3 months of conventional therapy including a minimum of 3 pharmaceuticals (e.g. prednisone, ciclosporine, azathioprine, or methotrexate). Where conventional pharmaceuticals are contraindicated, a 3 month trial has occurred of those that are not contraindicated; and
- 2 Maximum of 8 doses every 4 months.

Note: Indications marked with \* are unapproved indications.

**Initial application — (arthritis - rheumatoid)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 Patient has had a Special Authority approval for adalimumab for rheumatoid arthritis; and
  - 1.2 Either:
    - 1.2.1 Patient has experienced intolerable side effects; or
    - 1.2.2 Patient has received insufficient benefit to meet the renewal criteria for rheumatoid arthritis; or
- 2 All of the following:
  - 2.1 Patient has had rheumatoid arthritis (either confirmed by radiologic imaging, or the patient is cyclic citrullinated peptide (CCP) antibody positive); and
  - 2.2 Patient has received insufficient benefit from at least 3 months of methotrexate at a maximum tolerated dose (unless contraindicated); and
  - 2.3 Patient has received insufficient benefit from at least 3 months of methotrexate in combination with sulfasalazine and hydroxychloroquine sulphate (at maximum tolerated doses unless contraindicated); and
  - 2.4 Either:
    - 2.4.1 Patient has received insufficient benefit from at least 3 months of methotrexate in combination with the maximum tolerated dose of ciclosporin, unless contraindicated; or

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▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

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- 2.4.2 Patient has received insufficient benefit from at least 3 months of therapy at the maximum tolerated dose of leflunomide alone or in combination with methotrexate, unless contraindicated; and
- 2.5 Either:
  - 2.5.1 Patient has persistent symptoms of poorly controlled and active disease in at least 15 joints; or
  - 2.5.2 Patient has persistent symptoms of poorly controlled and active disease in at least 4 joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip.

**Renewal — (arthritis - rheumatoid)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 Either:
  - 1.1 Following initial treatment, at least a 50% decrease in active joint count from baseline; or
  - 1.2 On subsequent reapplications, at least a continuing 30% improvement in active joint count from baseline; and
- 2 Maximum dose 50 mg every 7 days.

**Initial application — (Plaque psoriasis)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 Patient has had a Special Authority approval for adalimumab for plaque psoriasis; and
  - 1.2 Either:
    - 1.2.1 Patient has experienced intolerable side effects; or
    - 1.2.2 Patient has received insufficient benefit to meet the renewal criteria for plaque psoriasis; or
- 2 All of the following:
  - 2.1 Any of the following:
    - 2.1.1 Patient has "whole body" plaque psoriasis with a PASI score of greater than 10; or
    - 2.1.2 Patient has plaque psoriasis of the face, or palm of a hand or sole of a foot; or
    - 2.1.3 Patient has localised genital or flexural plaque psoriasis with a DLQI score greater than 10; and
  - 2.2 Patient has received insufficient benefit from (see Note), or has experienced intolerable side effects from, at least 3 of the following at maximum tolerated doses (unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin; and
  - 2.3 A PASI assessment or DLQI assessment has been completed for the most recent prior treatment course within 1 month of stopping that treatment; and
  - 2.4 The most recent PASI or DLQI assessment is within 1 month before the application.

Note: "Insufficient benefit" is defined as: for whole body plaque psoriasis, a PASI score of greater than 10, for plaque psoriasis of the face, hand, foot, genital or flexural areas at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and for the face, palm of a hand or sole of a foot the skin area affected is 30% or more of the face, palm of a hand or sole of a foot. As assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment.

**Renewal — (Plaque psoriasis)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 Any of the following:
  - 1.1 Both:
    - 1.1.1 Patient had "whole body" plaque psoriasis at the start of treatment; and
    - 1.1.2 Either:
      - 1.1.2.1 Patient has a PASI score which is reduced by 75% or more, or is sustained at this level, compared with the pre-treatment baseline; or
      - 1.1.2.2 Patient has a DLQI improvement of 5 or more, compared with the pre-treatment baseline; or

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1.2 Both:

1.2.1 Patient had plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment; and

1.2.2 Either:

1.2.2.1 Patient has a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, compared to the pre-treatment baseline; or

1.2.2.2 Patient has a reduction of 75% or more in the skin area affected, or sustained at this level, compared to the pre-treatment baseline; or

1.3 Both:

1.3.1 Patient has localised genital or flexural plaque psoriasis at the start of treatment; and

1.3.2 Either:

1.3.2.1 Patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, compared to the pre-treatment baseline; or

1.3.2.2 Patient has a DLQI improvement of 5 or more, compared to the pre-treatment baseline; and

2 Maximum dose 50 mg every 7 days.

**Initial application — (undifferentiated spondyloarthritis\*)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

1 Patient has undifferentiated peripheral spondyloarthritis with active peripheral joint arthritis in at least 4 joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip; and

2 Patient has received insufficient benefit from least 3 months of each of methotrexate, sulfasalazine, and leflunomide at maximum tolerated doses, unless contraindicated; and

3 Any of the following:

3.1 Patient has a CRP level greater than 15 mg/L measured within one month before the application; or

3.2 Patient has an ESR greater than 25 mm per hour measured within one month before the application; or

3.3 ESR and CRP not measured as patient is currently receiving prednisone therapy greater than 5 mg per day received for more than 3 months.

Note: Indications marked with \* are unapproved indications.

**Renewal — (undifferentiated spondyloarthritis\*)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

1 Either:

1.1 Following initial treatment, the patient has experienced at least a 50% decrease in active joint count from baseline; or

1.2 Patient has experienced at least a continuing 30% improvement in active joint count from baseline; and

2 Maximum dose 50 mg every 7 days.

## Immune Modulators

ANTITHYMOCYTE GLOBULIN (EQUINE) – PCT only – Specialist

Inj 50 mg per ml, 5 ml ..... 4,439.17      5      ✓ **ATGAM**

BACILLUS CALMETTE-GUERIN (BCG) VACCINE – PCT only – Specialist

Subsidised only for bladder cancer.

Inj 2-8 x 100 million CFU ..... 149.37      1      ✓ **OncoTICE**

Inj 40 mg per ml, vial ..... 182.45      3      ✓ **SII-Onco-BCG** S29

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

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## Monoclonal Antibodies

ADALIMUMAB (AMGEVITA) – Special Authority see [SA2525 below](#) – Retail pharmacy

Inj 20 mg per 0.4 ml prefilled syringe.....	190.00	1	✓ <b>Amgevita</b>
Inj 40 mg per 0.8 ml prefilled pen .....	375.00	2	✓ <b>Amgevita</b>
Inj 40 mg per 0.8 ml prefilled syringe.....	375.00	2	✓ <b>Amgevita</b>

### ➔SA2525 Special Authority for Subsidy

**Initial application — (Behcet's disease - severe)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 The patient has severe Behcet's disease\* that is significantly impacting the patient's quality of life; and
- 2 Either:
  - 2.1 The patient has severe ocular, neurological, and/or vasculitic symptoms and has not responded adequately to one or more treatment(s) appropriate for the particular symptom(s); or
  - 2.2 The patient has severe gastrointestinal, rheumatological, and/or mucocutaneous symptoms and has not responded adequately to two or more treatments appropriate for the particular symptom(s).

Note: Indications marked with \* are unapproved indications.

**Initial application — (Hidradenitis suppurativa)** only from a dermatologist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Patient has hidradenitis suppurativa Hurley Stage II or Hurley Stage III lesions in distinct anatomic areas; and
- 2 Patient has tried, but had an inadequate response to at least a 90 day trial of systemic antibiotics or has demonstrated intolerance to or has contraindications for systemic antibiotics; and
- 3 Patient has 3 or more active lesions; and
- 4 The patient has a DLQI of 10 or more and the assessment is no more than 1 month old at time of application.

**Renewal — (Hidradenitis suppurativa)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 The patient has a reduction in active lesions (e.g. inflammatory nodules, abscesses, draining fistulae) of 25% or more from baseline; and
- 2 The patient has a DLQI improvement of 4 or more from baseline.

**Initial application — (Plaque psoriasis - severe chronic)** only from a dermatologist or any relevant practitioner on the recommendation of a dermatologist. Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 Patient has had an initial Special Authority approval for etanercept for severe chronic plaque psoriasis; and
  - 1.2 Either:
    - 1.2.1 Patient has experienced intolerable side effects; or
    - 1.2.2 Patient has received insufficient benefit to meet the renewal criteria for etanercept for severe chronic plaque psoriasis; or
- 2 All of the following:
  - 2.1 Any of the following:
    - 2.1.1 Patient has "whole body" severe chronic plaque psoriasis with a PASI score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis; or
    - 2.1.2 Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis; or
    - 2.1.3 Patient has severe chronic localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and with a Dermatology Life Quality

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- Index (DLQI) score greater than 10; and
- 2.2 Patient has tried, but had an inadequate response to, or has experienced intolerable side effects from, at least three of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin; and
  - 2.3 A PASI assessment or DLQI assessment has been completed for at least the most recent prior treatment course but no longer than 1 month following cessation of each prior treatment course and is no more than 1 month old at the time of application.

**Renewal — (Plaque psoriasis - severe chronic)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Any of the following:

- 1 Both:
  - 1.1 Patient had "whole body" severe chronic plaque psoriasis at the start of treatment; and
  - 1.2 Either:
    - 1.2.1 The patient has experienced a 75% or more reduction in PASI score, or is sustained at this level, when compared with the pre-treatment baseline value; or
    - 1.2.2 The patient has a DLQI improvement of 5 or more, when compared with the pre-treatment baseline value; or
- 2 Both:
  - 2.1 Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment; and
  - 2.2 Either:
    - 2.2.1 The patient has experienced reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values; or
    - 2.2.2 The patient has experienced reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre treatment baseline value; or
- 3 Both:
  - 3.1 Patient had severe chronic localised genital or flexural plaque psoriasis at the start of treatment; and
  - 3.2 Either:
    - 3.2.1 The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value; or
    - 3.2.2 Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing adalimumab.

**Initial application — (pyoderma gangrenosum)** only from a dermatologist. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 Patient has pyoderma gangrenosum\*; and
- 2 Patient has received three months of conventional therapy including a minimum of three pharmaceuticals (e.g. prednisone, ciclosporin, azathioprine, or methotrexate) and has not received an adequate response.

Note: Indications marked with \* are unapproved indications.

**Initial application — (Crohn's disease - adults)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has active Crohn's disease; and
- 2 Any of the following:
  - 2.1 Patient has a CDAI score of greater than or equal to 300, or HBI score of greater than or equal to 10; or
  - 2.2 Patient has extensive small intestine disease affecting more than 50 cm of the small intestine; or

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

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- 2.3 Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection; or
- 2.4 Patient has an ileostomy or colostomy and has intestinal inflammation; and
- 3 Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators and corticosteroids.

**Renewal — (Crohn's disease - adults)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Any of the following:

- 1 CDAI score has reduced by 100 points from the CDAI score, or HBI score has reduced by 3 points, from when the patient was initiated on adalimumab; or
- 2 CDAI score is 150 or less, or HBI is 4 or less; or
- 3 The patient has demonstrated an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed.

**Initial application — (Crohn's disease - children)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Paediatric patient has active Crohn's disease; and
- 2 Either:
  - 2.1 Patient has a PCDAI score of greater than or equal to 30; or
  - 2.2 Patient has extensive small intestine disease; and
- 3 Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators and corticosteroids.

**Renewal — (Crohn's disease - children)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Any of the following:

- 1 PCDAI score has reduced by 10 points from the PCDAI score when the patient was initiated on adalimumab; or
- 2 PCDAI score is 15 or less; or
- 3 The patient has demonstrated an adequate response to treatment but PCDAI score cannot be assessed.

**Initial application — (Crohn's disease - fistulising)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has confirmed Crohn's disease; and
- 2 Any of the following:
  - 2.1 Patient has one or more complex externally draining enterocutaneous fistula(e); or
  - 2.2 Patient has one or more rectovaginal fistula(e); or
  - 2.3 Patient has complex peri-anal fistula; and
- 3 A Baseline Fistula Assessment has been completed and is no more than 1 month old at the time of application.

**Renewal — (Crohn's disease - fistulising)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Either:

- 1 The number of open draining fistulae have decreased from baseline by at least 50%; or
- 2 There has been a marked reduction in drainage of all fistula(e) from baseline as demonstrated by a reduction in the Fistula Assessment score, together with less induration and patient-reported pain.

**Initial application — (Ocular inflammation - chronic)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 The patient has had an initial Special Authority approval for infliximab for chronic ocular inflammation; or
- 2 Both:

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- 2.1 Patient has severe uveitis uncontrolled with treatment of steroids and other immunosuppressants with a severe risk of vision loss; and
- 2.2 Any of the following:
  - 2.2.1 Patient is 18 years or older and treatment with at least two other immunomodulatory agents has proven ineffective; or
  - 2.2.2 Patient is under 18 years and treatment with methotrexate has proven ineffective or is not tolerated at a therapeutic dose; or
  - 2.2.3 Patient is under 8 years and treatment with steroids or methotrexate has proven ineffective or is not tolerated at a therapeutic dose; or disease requires control to prevent irreversible vision loss prior to achieving a therapeutic dose of methotrexate.

**Renewal — (Ocular inflammation - chronic)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Any of the following:

- 1 The patient has had a good clinical response following 12 weeks' initial treatment; or
- 2 Following each 2 year treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema); or
- 3 Following each 2 year treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old.

**Initial application — (Ocular inflammation - severe)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 Patient has had an initial Special Authority approval for infliximab for severe ocular inflammation; or
- 2 Both:
  - 2.1 Patient has severe, vision-threatening ocular inflammation requiring rapid control; and
  - 2.2 Any of the following:
    - 2.2.1 Treatment with high-dose steroids (intravenous methylprednisolone) followed by high dose oral steroids has proven ineffective at controlling symptoms; or
    - 2.2.2 Patient developed new inflammatory symptoms while receiving high dose steroids; or
    - 2.2.3 Patient is aged under 8 years and treatment with high dose oral steroids and other immunosuppressants has proven ineffective at controlling symptoms.

**Renewal — (Ocular inflammation - severe)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Any of the following:

- 1 The patient has had a good clinical response following 3 initial doses; or
- 2 Following each 2 year treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema); or
- 3 Following each 2 year treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old.

**Initial application — (ankylosing spondylitis)** only from a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 Patient has had an initial Special Authority approval for etanercept for ankylosing spondylitis; and
  - 1.2 Either:
    - 1.2.1 The patient has experienced intolerable side effects; or

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1.2.2 The patient has received insufficient benefit to meet the renewal criteria for ankylosing spondylitis; or

2 All of the following:

- 2.1 Patient has a confirmed diagnosis of ankylosing spondylitis for more than six months; and
- 2.2 Patient has low back pain and stiffness that is relieved by exercise but not by rest; and
- 2.3 Patient has bilateral sacroiliitis demonstrated by radiology imaging; and
- 2.4 Patient has not responded adequately to treatment with two or more NSAIDs, while patient was undergoing at least 3 months of a regular exercise regimen for ankylosing spondylitis; and
- 2.5 Either:
  - 2.5.1 Patient has limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by the following BASMI measures: a modified Schober's test of less than or equal to 4 cm and lumbar side flexion measurement of less than or equal to 10 cm (mean of left and right); or
  - 2.5.2 Patient has limitation of chest expansion by at least 2.5 cm below the average normal values corrected for age and gender; and
- 2.6 A BASDAI of at least 6 on a 0-10 scale completed after the 3 month exercise trial, but prior to ceasing any previous pharmacological treatment and is no more than 1 month old at the time of application.

**Renewal — (ankylosing spondylitis)** from any relevant practitioner. Approvals valid for 2 years where treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point scale, or an improvement in BASDAI of 50%, whichever is less.

**Initial application — (Arthritis - oligoarticular course juvenile idiopathic)** only from a named specialist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 The patient has had an initial Special Authority approval for etanercept for oligoarticular course juvenile idiopathic arthritis (JIA); and
  - 1.2 Either:
    - 1.2.1 Patient has experienced intolerable side effects; or
    - 1.2.2 Patient has received insufficient benefit to meet the renewal criteria for oligoarticular course JIA; or
- 2 All of the following:
  - 2.1 To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance; and
  - 2.2 Patient has had oligoarticular course JIA for 6 months duration or longer; and
  - 2.3 Either:
    - 2.3.1 At least 2 active joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose); or
    - 2.3.2 Moderate or high disease activity (cJADAS10 score greater than 1.5) with poor prognostic features after a 3-month trial of methotrexate (at the maximum tolerated dose).

**Renewal — (Arthritis - oligoarticular course juvenile idiopathic)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Either:

- 1 Following initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline; or
- 2 On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline.

**Initial application — (Arthritis - polyarticular course juvenile idiopathic)** only from a named specialist or rheumatologist.

Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Both:

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- 1.1 Patient has had an initial Special Authority approval for etanercept for polyarticular course juvenile idiopathic arthritis (JIA); and
- 1.2 Either:
  - 1.2.1 Patient has experienced intolerable side effects; or
  - 1.2.2 Patient has received insufficient benefit to meet the renewal criteria for polyarticular course JIA; or

2 All of the following:

- 2.1 To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance; and
- 2.2 Patient has had polyarticular course JIA for 6 months duration or longer; and
- 2.3 Any of the following:
  - 2.3.1 At least 5 active joints and at least 3 joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose); or
  - 2.3.2 Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the maximum tolerated dose); or
  - 2.3.3 Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate.

**Renewal — (Arthritis - polyarticular course juvenile idiopathic)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Either:

- 1 Following initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline; or
- 2 On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline.

**Initial application — (Arthritis - psoriatic)** only from a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 Patient has had an initial Special Authority approval for etanercept or secukinumab for psoriatic arthritis; and
  - 1.2 Either:
    - 1.2.1 The patient has experienced intolerable side effects; or
    - 1.2.2 The patient has received insufficient benefit from to meet the renewal criteria for psoriatic arthritis; or
- 2 All of the following:
  - 2.1 Patient has had active psoriatic arthritis for six months duration or longer; and
  - 2.2 Patient has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated); and
  - 2.3 Patient has tried and not responded to at least three months of sulfasalazine or leflunomide at maximum tolerated doses (unless contraindicated); and
  - 2.4 Either:
    - 2.4.1 Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen joints; or
    - 2.4.2 Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip; and
  - 2.5 Any of the following:
    - 2.5.1 Patient has a CRP level greater than 15 mg/L measured no more than one month prior to the date of this application; or
    - 2.5.2 Patient has an ESR greater than 25 mm per hour; or
    - 2.5.3 ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months.

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

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**Renewal — (Arthritis - psoriatic)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Either:

- 1 Following initial treatment, the patient has at least a 50% decrease in swollen joint count from baseline and a clinically significant response in the opinion of the physician; or
- 2 Patient demonstrates at least a continuing 30% improvement in swollen joint count from baseline and a clinically significant response in the opinion of the treating physician.

**Initial application — (Arthritis - rheumatoid)** only from a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 The patient has had an initial Special Authority approval for etanercept for rheumatoid arthritis; and
  - 1.2 Either:
    - 1.2.1 The patient has experienced intolerable side effects; or
    - 1.2.2 The patient has received insufficient benefit from etanercept to meet the renewal criteria for rheumatoid arthritis; or
- 2 All of the following:
  - 2.1 Patient has had rheumatoid arthritis (either confirmed by radiology imaging, or the patient is CCP antibody positive) for six months duration or longer; and
  - 2.2 Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance; and
  - 2.3 Patient has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated); and
  - 2.4 Patient has tried and not responded to at least three months of methotrexate in combination with sulfasalazine and hydroxychloroquine sulphate at maximum tolerated doses (unless contraindicated); and
  - 2.5 Either:
    - 2.5.1 Patient has tried and not responded to at least three months of methotrexate in combination with the maximum tolerated dose of ciclosporin (unless contraindicated); or
    - 2.5.2 Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide (unless contraindicated) alone or in combination with methotrexate; and
  - 2.6 Either:
    - 2.6.1 Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen joints; or
    - 2.6.2 Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip.

**Renewal — (Arthritis - rheumatoid)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Either:

- 1 Following initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician; or
- 2 On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician.

**Initial application — (Still's disease - adult-onset (AOSD))** only from a rheumatologist. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 The patient has had an initial Special Authority approval for etanercept and/or tocilizumab for AOSD; and
  - 1.2 Either:

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- 1.2.1 Patient has experienced intolerable side effects from etanercept and/or tocilizumab; or
- 1.2.2 Patient has received insufficient benefit from at least a three-month trial of etanercept and/or tocilizumab; or

2 All of the following:

- 2.1 Patient diagnosed with AOSD according to the Yamaguchi criteria; and
- 2.2 Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, NSAIDs and methotrexate; and
- 2.3 Patient has persistent symptoms of disabling poorly controlled and active disease.

**Initial application — (ulcerative colitis)** from any relevant practitioner. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 Patient has active ulcerative colitis; and
- 2 Either:
  - 2.1 Patient's SCCAI score is greater than or equal to 4; or
  - 2.2 Patient's PUCAI score is greater than or equal to 20; and
- 3 Patient has tried but had an inadequate response to, or has experienced intolerable side effects from prior therapy with immunomodulators and systemic corticosteroids; and
- 4 Surgery (or further surgery) is considered to be clinically inappropriate.

**Renewal — (ulcerative colitis)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Either:

- 1 The SCCAI score has reduced by 2 points or more from the SCCAI score when the patient was initiated on biologic therapy; or
- 2 The PUCAI score has reduced by 10 points or more from the PUCAI score when the patient was initiation on biologic therapy.

**Initial application — (undifferentiated spondyloarthritis)** only from a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has undifferentiated peripheral spondyloarthritis\* with active peripheral joint arthritis in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip; and
- 2 Patient has tried and not responded to at least three months of each of methotrexate, sulfasalazine and leflunomide, at maximum tolerated doses (unless contraindicated); and
- 3 Any of the following:
  - 3.1 Patient has a CRP level greater than 15 mg/L measured no more than one month prior to the date of this application; or
  - 3.2 Patient has an ESR greater than 25 mm per hour measured no more than one month prior to the date of this application; or
  - 3.3 ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months.

Note: Indications marked with \* are unapproved indications

**Renewal — (undifferentiated spondyloarthritis)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Either:

- 1 Following initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician; or
- 2 The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response in the opinion of the treating physician.

**Initial application — (inflammatory bowel arthritis – axial)** only from a rheumatologist. Approvals valid for 6 months for

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

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applications meeting the following criteria:

All of the following:

- 1 Patient has a diagnosis of active ulcerative colitis or active Crohn's disease; and
- 2 Patient has axial inflammatory pain for six months or more; and
- 3 Patient is unable to take NSAIDs; and
- 4 Patient has unequivocal sacroiliitis demonstrated by radiological imaging or MRI; and
- 5 Patient has not responded adequately to prior treatment consisting of at least 3 months of an exercise regime supervised by a physiotherapist; and
- 6 A BASDAI of at least 6 on a 0-10 scale completed after the 3 month exercise trial, but prior to ceasing any previous pharmacological treatment.

**Renewal — (inflammatory bowel arthritis – axial)** from any relevant practitioner. Approvals valid for 2 years where treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point scale, or an improvement in BASDAI of 50%, whichever is less.

**Initial application — (inflammatory bowel arthritis – peripheral)** only from a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has a diagnosis of active ulcerative colitis or active Crohn's disease; and
- 2 Patient has active arthritis in at least four joints from the following: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, sternoclavicular; and
- 3 Patient has tried and not experienced a response to at least three months of methotrexate, or azathioprine at a maximum tolerated dose (unless contraindicated); and
- 4 Patient has tried and not experienced a response to at least three months of sulfasalazine at a maximum tolerated dose (unless contraindicated); and
- 5 Any of the following:
  - 5.1 Patient has a CRP level greater than 15 mg/L measured no more than one month prior to the date of this application; or
  - 5.2 Patient has an ESR greater than 25 mm per hour measured no more than one month prior to the date of this application; or
  - 5.3 ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months.

**Renewal — (inflammatory bowel arthritis – peripheral)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Either:

- 1 Following initial treatment, patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician; or
- 2 Patient has experienced at least a continuing 30% improvement in active joint count from baseline in the opinion of the treating physician.

ADALIMUMAB (HUMIRA - ALTERNATIVE BRAND) – Special Authority see [SA2157 below](#) – Retail pharmacy

Inj 20 mg per 0.2 ml prefilled syringe.....	595.50	2	✓ Humira
Inj 40 mg per 0.4 ml prefilled pen.....	595.50	2	✓ HumiraPen
Inj 40 mg per 0.4 ml prefilled syringe.....	595.50	2	✓ Humira

➔ **SA2157 Special Authority for Subsidy**

**Initial application — (Behcet's disease – severe)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Either:
  - 1.1 The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks

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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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treatment; or

1.2 Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen; and

2 Patient has received a maximum of 6 months treatment with Amgevita; and

3 Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication; and

4 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

**Renewal — (Behcet's disease – severe)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

1 The patient has had a good clinical response to treatment with measurably improved quality of life; and

2 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

**Initial application — (Hidradenitis suppurativa)** only from a dermatologist or Practitioner on the recommendation of a dermatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

1 Either:

1.1 The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment; or

1.2 Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen; and

2 Patient has received a maximum of 6 months treatment with Amgevita; and

3 Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication; and

4 Adalimumab to be administered at doses no greater than 40 mg every 7 days. Fortnightly dosing has been considered.

**Renewal — (Hidradenitis suppurativa)** only from a dermatologist or Practitioner on the recommendation of a dermatologist.

Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

1 The patient has a reduction in active lesions (e.g. inflammatory nodules, abscesses, draining fistulae) of 25% or more from baseline; and

2 The patient has a Dermatology Quality of Life Index improvement of 4 or more from baseline; and

3 Adalimumab is to be administered at doses no greater than 40mg every 7 days. Fortnightly dosing has been considered.

**Initial application — (Psoriasis - severe chronic plaque)** only from a dermatologist or Practitioner on the recommendation of a dermatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

1 Either:

1.1 The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment; or

1.2 Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen; and

2 Patient has received a maximum of 6 months treatment with Amgevita; and

3 Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication; and

4 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

**Renewal — (Psoriasis - severe chronic plaque)** only from a dermatologist or Practitioner on the recommendation of a dermatologist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

1 Either:

1.1 Both:

1.1.1 Patient had "whole body" severe chronic plaque psoriasis at the start of treatment; and

1.1.2 Either:

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

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- 1.1.2.1 Following each prior adalimumab treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-adalimumab treatment baseline value; or
- 1.1.2.2 Following each prior adalimumab treatment course the patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, when compared with the pre-treatment baseline value; or
- 1.2 Both:
  - 1.2.1 Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment; and
  - 1.2.2 Either:
    - 1.2.2.1 Following each prior adalimumab treatment course the patient has a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values; or
    - 1.2.2.2 Following each prior adalimumab treatment course the patient has a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-adalimumab treatment baseline value; and
- 2 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

**Initial application — (Pyoderma gangrenosum)** only from a dermatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Either:
  - 1.1 The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment; or
  - 1.2 Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen; and
- 2 Patient has received a maximum of 6 months treatment with Amgevita; and
- 3 Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication; and
- 4 A maximum of 8 doses.

**Renewal — (Pyoderma gangrenosum)** only from a dermatologist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 The patient has demonstrated clinical improvement and continues to require treatment; and
- 2 A maximum of 8 doses.

**Initial application — (Crohn's disease - adult)** only from a gastroenterologist or Practitioner on the recommendation of a gastroenterologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Any of the following:
  - 1.1 The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita; or
  - 1.2 Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen; or
  - 1.3 Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment; and
- 2 Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication; and
- 3 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

**Renewal — (Crohn's disease - adult)** only from a gastroenterologist or Practitioner on the recommendation of a gastroenterologist. Approvals valid for 6 months for applications meeting the following criteria:

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Both:

- 1 Any of the following:
  - 1.1 CDAI score has reduced by 100 points from the CDAI score when the patient was initiated on adalimumab; or
  - 1.2 CDAI score is 150 or less; or
  - 1.3 The patient has demonstrated an adequate response to treatment, but CDAI score cannot be assessed; and
- 2 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

**Initial application — (Crohn's disease - children)** only from a gastroenterologist or Practitioner on the recommendation of a gastroenterologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Any of the following:
  - 1.1 The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita; or
  - 1.2 Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen; or
  - 1.3 Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment; and
- 2 Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication; and
- 3 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

**Renewal — (Crohn's disease - children)** only from a gastroenterologist or Practitioner on the recommendation of a gastroenterologist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Any of the following:
  - 1.1 PCDAI score has reduced by 10 points from the PCDAI score when the patient was initiated on adalimumab; or
  - 1.2 PCDAI score is 15 or less; or
  - 1.3 The patient has demonstrated an adequate response to treatment, but PCDAI score cannot be assessed; and
- 2 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

**Initial application — (Crohn's disease - fistulising)** only from a gastroenterologist or Practitioner on the recommendation of a gastroenterologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Any of the following:
  - 1.1 The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita; or
  - 1.2 Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen; or
  - 1.3 Patient has Crohn's and is considered to be at risk of disease destabilisation if there were to be a change to current treatment; and
- 2 Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication; and
- 3 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

**Renewal — (Crohn's disease - fistulising)** only from a gastroenterologist or Practitioner on the recommendation of a gastroenterologist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Either:
  - 1.1 The number of open draining fistulae have decreased from baseline by at least 50%; or
  - 1.2 There has been a marked reduction in drainage of all fistula(e) from baseline as demonstrated by a reduction in the Fistula Assessment score, together with less induration and patient-reported pain; and

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

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- 2 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

**Initial application — (Ocular inflammation – chronic)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Any of the following:
  - 1.1 The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita; or
  - 1.2 Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with Amgevita, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen; or
  - 1.3 Patient has uveitis and is considered to be at risk of vision loss if they were to change treatment; and
- 2 Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication; and
- 3 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

**Renewal — (Ocular inflammation – chronic)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 Any of the following:
  - 1.1 The patient has had a good clinical response following 12 weeks' initial treatment; or
  - 1.2 Following each 12-month treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema); or
  - 1.3 Following each 12-month treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old; and
- 2 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

**Initial application — (Ocular inflammation – severe)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Any of the following:
  - 1.1 The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment, and a maximum of 6 months treatment with Amgevita; or
  - 1.2 Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with Amgevita, and a maximum of 6 months treatment with Amgevita and clinician attributes this loss of disease response to a change in treatment regimen; or
  - 1.3 Patient has uveitis and is considered to be at risk of vision loss if they were to change treatment; and
- 2 Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication; and
- 3 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

**Renewal — (Ocular inflammation – severe)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 Any of the following:
  - 1.1 The patient has had a good clinical response following 3 initial doses; or
  - 1.2 Following each 12-month treatment period, the patient has had a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema); or
  - 1.3 Following each 12-month treatment period, the patient has a sustained steroid sparing effect, allowing reduction in prednisone to < 10mg daily, or steroid drops less than twice daily if under 18 years old; and
- 2 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

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**Initial application — (ankylosing spondylitis)** only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Either:
  - 1.1 The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment; or
  - 1.2 Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita); and
- 2 Patient has received a maximum of 6 months treatment with Amgevita; and
- 3 Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication; and
- 4 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

**Renewal — (ankylosing spondylitis)** only from a rheumatologist or Practitioner on the recommendation of a rheumatologist.

Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10 point scale, or an improvement in BASDAI of 50%, whichever is less; and
- 2 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

**Initial application — (Arthritis – oligoarticular course juvenile idiopathic)** only from a named specialist, rheumatologist or Practitioner on the recommendation of a named specialist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Either:
  - 1.1 The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment; or
  - 1.2 Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen; and
- 2 Patient has received a maximum of 6 months treatment with Amgevita; and
- 3 Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication.

**Renewal — (Arthritis – oligoarticular course juvenile idiopathic)** only from a named specialist, rheumatologist or Practitioner on the recommendation of a named specialist or rheumatologist. Approvals valid for 6 months where the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline.

**Initial application — (Arthritis - polyarticular course juvenile idiopathic)** only from a named specialist, rheumatologist or Practitioner on the recommendation of a named specialist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Either:
  - 1.1 The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment; or
  - 1.2 Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen; and
- 2 Patient has received a maximum of 6 months treatment with Amgevita; and
- 3 Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication.

**Renewal — (Arthritis - polyarticular course juvenile idiopathic)** only from a named specialist, rheumatologist or Practitioner on the recommendation of a named specialist or rheumatologist. Approvals valid for 6 months where the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline.

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**Initial application — (Arthritis - psoriatic)** only from a named specialist, rheumatologist or Practitioner on the recommendation of a named specialist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

1 Either:

- 1.1 The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment; or
- 1.2 Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen; and

2 Patient has received a maximum of 6 months treatment with Amgevita; and

3 Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication; and

4 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

**Renewal — (Arthritis - psoriatic)** only from a named specialist, rheumatologist or Practitioner on the recommendation of a named specialist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

1 The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior adalimumab treatment in the opinion of the treating physician; and

2 Adalimumab to be administered at doses no greater than 40 mg every 14 days.

**Initial application — (Arthritis – rheumatoid)** only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

1 Either:

1.1 The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment; or

1.2 Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen; and

2 Patient has received a maximum of 6 months treatment with Amgevita; and

3 Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication; and

4 Either:

4.1 Adalimumab to be administered at doses no greater than 40 mg every 14 days; or

4.2 Patient cannot take concomitant methotrexate and requires doses of adalimumab higher than 40 mg every 14 days to maintain an adequate response.

**Renewal — (Arthritis – rheumatoid)** only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

1 The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior adalimumab treatment in the opinion of the treating physician; and

2 Either:

2.1 Adalimumab to be administered at doses no greater than 40 mg every 14 days; or

2.2 Patient cannot take concomitant methotrexate and requires doses of adalimumab higher than 40 mg every 14 days to maintain an adequate response.

**Initial application — (Still's disease – adult-onset (AOSD))** only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

1 Either:

1.1 The patient has experienced intolerable side effects from adalimumab (Amgevita) following a minimum of 4 weeks treatment; or

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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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- 1.2 Patient has developed symptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab (Amgevita) and clinician attributes this loss of disease response to a change in treatment regimen; and
- 2 Patient has received a maximum of 6 months treatment with Amgevita; and
- 3 Patient has previously had a Special Authority approval for the Humira brand of adalimumab for this indication.

**Renewal — (Still's disease – adult-onset (AOSD))** only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months where the patient has demonstrated a sustained improvement in inflammatory markers and functional status.

AFLIBERCEPT – Special Authority see SA2550 below – Retail pharmacy

Inj 40 mg per ml, 0.1 ml vial..... 1,250.00 1 ✓ Eylea

►SA2550 Special Authority for Subsidy

**Initial application — (diabetic macular oedema)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Patient has centre involving diabetic macular oedema (DMO); and
- 2 Patient's disease is non responsive to 4 doses of intravitreal bevacizumab when administered 4-6 weekly; and
- 3 Patient has reduced visual acuity between 6/9 – 6/36 with functional awareness of reduction in vision; and
- 4 Patient has DMO within central OCT (ocular coherence tomography) subfield > 350 micrometers; and
- 5 There is no centre-involving sub-retinal fibrosis or foveal atrophy; and
- 6 Patient has not previously been treated with faricimab for longer than 3 months.

**Renewal — (diabetic macular oedema)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 There is stability or two lines of Snellen visual acuity gain; and
- 2 There is structural improvement on OCT scan (with reduction in intra-retinal cysts, central retinal thickness, and sub-retinal fluid); and
- 3 Patient's vision is 6/36 or better on the Snellen visual acuity score; and
- 4 There is no centre-involving sub-retinal fibrosis or foveal atrophy.

**Initial application — (wet age related macular degeneration)** from any relevant practitioner. Approvals valid for 3 months for applications meeting the following criteria:

Either:

- 1 All of the following:
  - 1.1 Any of the following:
    - 1.1.1 Wet age-related macular degeneration (wet AMD); or
    - 1.1.2 Polypoidal choroidal vasculopathy; or
    - 1.1.3 Choroidal neovascular membrane from causes other than wet AMD; and
  - 1.2 Either:
    - 1.2.1 The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab; or
    - 1.2.2 There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart; and
  - 1.3 There is no structural damage to the central fovea of the treated eye; and
  - 1.4 Patient has not previously been treated with ranibizumab or faricimab for longer than 3 months; or
- 2 Either:
  - 2.1 Patient has current approval to use ranibizumab or faricimab for treatment of wAMD and was found to be intolerant within 3 months; or
  - 2.2 Patient has previously\* (\*before June 2018) received treatment with ranibizumab for wAMD and disease was stable while on treatment.

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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**Renewal — (wet age related macular degeneration)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Documented benefit must be demonstrated to continue; and
- 2 Patient's vision is 6/36 or better on the Snellen visual acuity score; and
- 3 There is no structural damage to the central fovea of the treated eye.

**BENRALIZUMAB** – Special Authority see [SA2151 below](#) – Retail pharmacy

Inj 30 mg per ml, 1 ml prefilled pen .....	3,539.00	1	✓ <b>Fasenra</b>
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► **SA2151** **Special Authority for Subsidy**

**Initial application — (Severe eosinophilic asthma)** only from a respiratory physician or clinical immunologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient must be aged 12 years or older; and
- 2 Patient must have a diagnosis of severe eosinophilic asthma documented by a respiratory physician or clinical immunologist; and
- 3 Conditions that mimic asthma eg. vocal cord dysfunction, central airway obstruction, bronchiolitis etc. have been excluded; and
- 4 Patient has a blood eosinophil count of greater than  $0.5 \times 10^9$  cells/L in the last 12 months; and
- 5 Patient must be adherent to optimised asthma therapy including inhaled corticosteroids (equivalent to at least 1000 mcg per day of fluticasone propionate) plus long-acting beta-2 agonist, or budesonide/formoterol as part of the anti-inflammatory reliever therapy plus maintenance regimen, unless contraindicated or not tolerated; and
- 6 Either:
  - 6.1 Patient has had at least 4 exacerbations needing systemic corticosteroids in the previous 12 months, where an exacerbation is defined as either documented use of oral corticosteroids for at least 3 days or parenteral corticosteroids; or
  - 6.2 Patient has received continuous oral corticosteroids of at least the equivalent of 10 mg per day over the previous 3 months; and
- 7 Treatment is not to be used in combination with subsidised mepolizumab; and
- 8 Patient has an Asthma Control Test (ACT) score of 10 or less. Baseline measurements of the patient's asthma control using the ACT and oral corticosteroid dose must be made at the time of application, and again at around 52 weeks after the first dose to assess response to treatment; and
- 9 Either:
  - 9.1 Patient has not previously received an anti-IL5 biological therapy for their severe eosinophilic asthma; or
  - 9.2 Both:
    - 9.2.1 Patient was refractory or intolerant to previous anti-IL5 biological therapy; and
    - 9.2.2 Patient was not eligible to continue treatment with previous anti-IL5 biological therapy and discontinued within 12 months of commencing treatment.

**Renewal — (Severe eosinophilic asthma)** only from a respiratory physician or clinical immunologist. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 An increase in the Asthma Control Test (ACT) score of at least 5 from baseline; and
- 2 Either:
  - 2.1 Exacerbations have been reduced from baseline by 50% as a result of treatment with benralizumab; or
  - 2.2 Reduction in continuous oral corticosteroid use by 50% or by 10 mg/day while maintaining or improving asthma control.

**BEVACIZUMAB** – PCT only – Special Authority see [SA2453 on the next page](#)

Inj 25 mg per ml, 4 ml vial.....	69.00	1	✓ <b>Vegzelma</b>
Inj 25 mg per ml, 16 ml vial.....	276.00	1	✓ <b>Vegzelma</b>
Inj 1 mg for ECP .....	0.71	1 mg	✓ <b>Baxter</b>

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

►SA2453 Special Authority for Subsidy

**Initial application — (unresectable hepatocellular carcinoma)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Patient is currently on treatment with bevacizumab, and met all remaining criteria prior to commencing treatment; or
- 2 All of the following:
  - 2.1 Patient has locally advanced or metastatic, unresectable hepatocellular carcinoma; and
  - 2.2 Patient has preserved liver function (Child-Pugh A); and
  - 2.3 Transarterial chemoembolisation (TACE) is unsuitable; and
  - 2.4 Any of the following:
    - 2.4.1 Patient has not received prior systemic therapy for the treatment of hepatocellular carcinoma; or
    - 2.4.2 Patient received funded lenvatinib before 1 March 2025; or
    - 2.4.3 Both:
      - 2.4.3.1 Patient has experienced treatment-limiting toxicity from treatment with lenvatinib; and
      - 2.4.3.2 No disease progression since initiation of lenvatinib; and
  - 2.5 Patient has an ECOG performance status of 0-2; and
  - 2.6 To be given in combination with atezolizumab.

**Renewal — (unresectable hepatocellular carcinoma)** from any relevant practitioner. Approvals valid for 6 months where there is no evidence of disease progression.

**Initial application — (advanced or metastatic ovarian cancer)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Either:
  - 1.1 The patient has FIGO Stage IV epithelial ovarian, fallopian tube, or primary peritoneal cancer; or
  - 1.2 Both:
    - 1.2.1 The patient has previously untreated advanced (FIGO Stage IIIB or IIIC) epithelial ovarian, fallopian tube, or primary peritoneal cancer; and
    - 1.2.2 Either:
      - 1.2.2.1 Debulking surgery is inappropriate; or
      - 1.2.2.2 The cancer is sub-optimally debulked (maximum diameter of any gross residual disease greater than 1cm); and
- 2 Bevacizumab to be administered at a maximum dose of 15 mg/kg every three weeks; and
- 3 18 weeks concurrent treatment with chemotherapy is planned.

**Renewal — (advanced or metastatic ovarian cancer)** from any relevant practitioner. Approvals valid for 4 months where there is no evidence of disease progression.

**Initial application — (Recurrent Respiratory Papillomatosis)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Maximum of 6 doses; and
- 2 The patient has recurrent respiratory papillomatosis; and
- 3 The treatment is for intra-lesional administration.

**Renewal — (Recurrent Respiratory Papillomatosis)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Maximum of 6 doses; and
- 2 The treatment is for intra-lesional administration; and
- 3 There has been a reduction in surgical treatments or disease regrowth as a result of treatment.

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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**Initial application — (Ocular Conditions)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 Ocular neovascularisation; or
- 2 Exudative ocular angiopathy.

BRENTUXIMAB VEDOTIN – PCT only – Special Authority see [SA2629 below](#)

Inj 50 mg vial .....	5,275.18	1	✓ <b>Adcetris</b>
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► [SA2629](#) **Special Authority for Subsidy**

**Initial application — (CD30 positive systemic anaplastic large-cell lymphoma)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Either:

- 1 Patient is currently on treatment with brentuximab vedotin and met all the following criteria prior to commencing treatment; or
- 2 All of the following:
  - 2.1 Patient has CD30 positive systemic anaplastic large-cell lymphoma; and
  - 2.2 Patient must have histological confirmation of CD30 expression; and
  - 2.3 Patient must not have received prior treatment with curative intent chemotherapy for this condition; and
  - 2.4 Treatment must be in combination with cyclophosphamide, anthracycline, and steroids for a maximum of 8 cycles; and
  - 2.5 Brentuximab vedotin is to be administered at doses no greater than 1.8 mg/kg every 3 weeks.

**Initial application — (relapsed/refractory Hodgkin lymphoma)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Either:
  - 1.1 Both:
    - 1.1.1 Patient has relapsed/refractory CD30-positive Hodgkin lymphoma after two or more lines of chemotherapy; and
    - 1.1.2 Patient is ineligible for autologous stem cell transplant; or
  - 1.2 Both:
    - 1.2.1 Patient has relapsed/refractory CD30-positive Hodgkin lymphoma; and
    - 1.2.2 Patient has previously undergone autologous stem cell transplant; and
- 2 Patient has not previously received funded brentuximab vedotin; and
- 3 Response to brentuximab vedotin treatment is to be reviewed after a maximum of 6 treatment cycles; and
- 4 Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks.

**Renewal — (relapsed/refractory Hodgkin lymphoma)** from any relevant practitioner. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 Patient has achieved a partial or complete response to brentuximab vedotin after 6 treatment cycles; and
- 2 Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated; and
- 3 Patient is to receive a maximum of 16 total cycles of brentuximab vedotin treatment.

**Initial application — (relapsed/refractory anaplastic large cell lymphoma)** from any relevant practitioner. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 Patient has relapsed/refractory CD30-positive systemic anaplastic large cell lymphoma; and
- 2 Patient has an ECOG performance status of 0-1; and
- 3 Patient has not previously received brentuximab vedotin; and

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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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continued...

- 4 Response to brentuximab vedotin treatment is to be reviewed after a maximum of 6 treatment cycles; and
- 5 Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks.

**Renewal — (relapsed/refractory anaplastic large cell lymphoma)** from any relevant practitioner. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 Patient has experienced a partial or complete response to brentuximab vedotin after 6 treatment cycles; and
- 2 Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated; and
- 3 Patient is to receive a maximum of 16 total cycles of brentuximab vedotin treatment.

CETUXIMAB – PCT only – Specialist – Special Authority see [SA2401 below](#)

Inj 5 mg per ml, 20 ml vial.....	364.00	1	✓ <b>Erbix</b>
Inj 5 mg per ml, 100 ml vial.....	1,820.00	1	✓ <b>Erbix</b>
Inj 1 mg for ECP .....	3.82	1 mg	✓ <b>Baxter</b>

➔**SA2401** Special Authority for Subsidy

**Initial application — (head and neck cancer, locally advanced)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has locally advanced, non-metastatic, squamous cell cancer of the head and neck; and
- 2 Cisplatin is contraindicated or has resulted in intolerable side effects; and
- 3 Patient has an ECOG performance score of 0-2; and
- 4 To be administered in combination with radiation therapy.

**Initial application — (colorectal cancer, metastatic)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has metastatic colorectal cancer located on the left side of the colon (see Note); and
- 2 There is documentation confirming disease is RAS and BRAF wild-type; and
- 3 Patient has an ECOG performance score of 0-2; and
- 4 Patient has not received prior funded treatment with cetuximab; and
- 5 Either:
  - 5.1 Cetuximab is to be used in combination with chemotherapy; or
  - 5.2 Chemotherapy is determined to not be in the best interest of the patient based on clinician assessment.

**Renewal — (colorectal cancer, metastatic)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months where there is no evidence of disease progression.

Note: Left-sided colorectal cancer comprises of the distal one-third of the transverse colon, the splenic flexure, the descending colon, the sigmoid colon, or the rectum.

FARICIMAB – Special Authority see [SA2533 below](#) – Retail pharmacy

Inj 120 mg per ml, 0.24 ml vial.....	1,565.00	1	✓ <b>Vabysmo</b>
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➔**SA2533** Special Authority for Subsidy

**Initial application — (diabetic macular oedema)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Patient has centre involving diabetic macular oedema (DMO); and
- 2 Patient's disease is nonresponsive to 4 doses of intravitreal bevacizumab when administered 4-6 weekly; and
- 3 Patient has reduced visual acuity between 6/9 – 6/36 with functional awareness of reduction in vision; and
- 4 Patient has DMO within central OCT (ocular coherence tomography) subfield > 350 micrometers; and
- 5 There is no centre-involving sub-retinal fibrosis or foveal atrophy; and
- 6 Patient has not previously been treated with aflibercept for longer than 3 months.

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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**Renewal — (diabetic macular oedema)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 There is stability or two lines of Snellen visual acuity gain; and
- 2 There is structural improvement on OCT scan (with reduction in intra-retinal cysts, central retinal thickness, and sub-retinal fluid); and
- 3 Patient's vision is 6/36 or better on the Snellen visual acuity score; and
- 4 There is no centre-involving sub-retinal fibrosis or foveal atrophy.

**Initial application — (wet age related macular degeneration)** from any relevant practitioner. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 Any of the following:
  - 1.1 Wet age-related macular degeneration (wet AMD); or
  - 1.2 Polypoidal choroidal vasculopathy; or
  - 1.3 Choroidal neovascular membrane from causes other than wet AMD; and
- 2 Either:
  - 2.1 The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab; or
  - 2.2 There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart; and
- 3 There is no structural damage to the central fovea of the treated eye; and
- 4 Patient has not previously been treated with ranibizumab or aflibercept for longer than 3 months.

**Renewal — (wet age related macular degeneration)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 Patient's vision is 6/36 or better on the Snellen visual acuity score; and
- 2 There is no structural damage to the central fovea of the treated eye.

GEMTUZUMAB OZOGAMICIN – PCT only – Specialist – Special Authority see [SA2269 below](#)

Inj 5 mg vial .....	12,973.00	1	✓ Mylotarg
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## ►SA2269 Special Authority for Subsidy

**Initial application** only from a haematologist, paediatric haematologist or paediatric oncologist. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 Patient has not received prior chemotherapy for this condition; and
- 2 Patient has de novo CD33-positive acute myeloid leukaemia; and
- 3 Patient does not have acute promyelocytic leukaemia; and
- 4 Gemtuzumab ozogamicin will be used in combination with standard anthracycline and cytarabine (AraC); and
- 5 Patient is being treated with curative intent; and
- 6 Patient's disease risk has been assessed by cytogenetic testing to be good or intermediate; and
- 7 Patient must be considered eligible for standard intensive remission induction chemotherapy with standard anthracycline and cytarabine (AraC); and
- 8 Gemtuzumab ozogamicin to be funded for one course only (one dose at 3 mg per m<sup>2</sup> body surface area or up to 2 vials of 5 mg as separate doses).

Note: Acute myeloid leukaemia excludes acute promyelocytic leukaemia and acute myeloid leukaemia that is secondary to another haematological disorder (eg myelodysplasia or myeloproliferative disorder).

INFLIXIMAB – PCT only – Special Authority see [SA2620 on the next page](#)

Inj 100 mg.....	428.00	1	✓ Remicade
Inj 1 mg for ECP .....	4.40	1 mg	✓ Baxter

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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►SA2620 Special Authority for Subsidy

**Initial application — (Crohn's disease (adults))** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has active Crohn's disease; and
- 2 Any of the following:
  - 2.1 Patient has a CDAI score of greater than or equal to 300 or HBI score of greater than or equal to 10; or
  - 2.2 Patient has extensive small intestine disease affecting more than 50 cm of the small intestine; or
  - 2.3 Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection; or
  - 2.4 Patient has an ileostomy or colostomy, and has intestinal inflammation; and
- 3 Patient has tried but has experienced an inadequate response to, or intolerable side effects from, prior therapy with immunomodulators and corticosteroids.

**Renewal — (Crohn's disease (adults))** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 Any of the following:
  - 1.1 CDAI score has reduced by 100 points from the CDAI score, or HBI score has reduced by 3 points, from when the patient was initiated on infliximab; or
  - 1.2 CDAI score is 150 or less, or HBI is 4 or less; or
  - 1.3 The patient has demonstrated an adequate response to treatment but CDAI score and/or HBI score cannot be assessed; and
- 2 Infliximab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for up to 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen weeks after completing the last re-induction cycle. Up to 10 mg/kg every 8 weeks (or equivalent) may be used for patients treated with this dose prior to 1 February 2019.

**Initial application — (Crohn's disease (children))** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Paediatric patient has active Crohn's disease; and
- 2 Either:
  - 2.1 Patient has a PCDAI score of greater than or equal to 30; or
  - 2.2 Patient has extensive small intestine disease; and
- 3 Patient has tried but experienced an inadequate response to, or intolerable side effects from, prior therapy with immunomodulators and corticosteroids.

**Renewal — (Crohn's disease (children))** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 Any of the following:
  - 1.1 PCDAI score has reduced by 10 points from the PCDAI score when the patient was initiated on infliximab; or
  - 1.2 PCDAI score is 15 or less; or
  - 1.3 The patient has demonstrated an adequate response to treatment but PCDAI score cannot be assessed; and
- 2 Infliximab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for up to 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen weeks after completing the last re-induction cycle. Up to 10 mg/kg every 8 weeks (or equivalent) may be used for patients treated with this dose prior to 1 February 2019.

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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**Initial application — (Graft vs host disease)** from any relevant practitioner. Approvals valid without further renewal unless notified where patient has steroid-refractory acute graft vs. host disease of the gut.

**Initial application — (Pulmonary sarcoidosis)** from any relevant practitioner. Approvals valid without further renewal unless notified where patient has life-threatening pulmonary sarcoidosis diagnosed by a multidisciplinary team that is refractory to other treatments.

**Initial application — (acute fulminant ulcerative colitis)** only from a gastroenterologist or Practitioner on the recommendation of a gastroenterologist. Approvals valid for 6 weeks for applications meeting the following criteria:

Both:

- 1 Patient has acute, fulminant ulcerative colitis; and
- 2 Treatment with intravenous or high dose oral corticosteroids has not been successful.

**Initial application — (ankylosing spondylitis)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has had a Special Authority approval for adalimumab or etanercept for ankylosing spondylitis; and
- 2 Either:
  - 2.1 Patient has experienced intolerable side effects; or
  - 2.2 Patient has received insufficient benefit to meet the renewal criteria for ankylosing spondylitis; and
- 3 Following initial induction doses, maximum dose 5mg/kg every 6-8 weeks.

**Renewal — (ankylosing spondylitis)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 BASDAI has improved from pre-treatment baseline either by at least 4 points on a 10-point scale, or by at least 50%; and
- 2 Maximum dose 5 mg/kg every 6-8 weeks.

**Initial application — (ocular inflammation - chronic\*)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 Patient has had a Special Authority approval for adalimumab for chronic ocular inflammation; and
  - 1.2 Either:
    - 1.2.1 Patient has experienced intolerable side effects; or
    - 1.2.2 Patient has received insufficient benefit to meet the renewal criteria for chronic ocular inflammation; or

2 Both:

- 2.1 Patient has severe uveitis with a severe risk of vision loss uncontrolled by treatment with corticosteroids and other immunosuppressants; and
- 2.2 Any of the following:
  - 2.2.1 Patient is 18 years or older and treatment with at least two other immunomodulatory agents has been ineffective or are contraindicated; or
  - 2.2.2 Patient is under 18 years and treatment with methotrexate has been ineffective, is contraindicated or is not tolerated at a therapeutic dose; or
  - 2.2.3 Patient is under 8 years and treatment with corticosteroids or methotrexate has been ineffective, is contraindicated or is not tolerated at a therapeutic dose; or disease requires control to prevent irreversible vision loss prior to achieving a therapeutic dose of methotrexate.

Note: Indications marked with \* are unapproved indications

**Renewal — (ocular inflammation - chronic\*)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Any of the following:

- 1 Patient has received a good clinical response following 3 initial doses; or

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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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- 2 Following each 2 year treatment period, the patient has experienced a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema); or
- 3 Following each 2 year treatment period, the patient has a sustained corticosteroid sparing effect, allowing reduction in prednisone to < 10mg daily, or corticosteroid drops less than twice daily if under 18 years old.

Note: A trial withdrawal should be considered after every 24 months of stability, unless the patient is deemed to have extremely high risk of irreversible vision loss if infliximab is withdrawn. Indications marked with \* are unapproved indications

**Initial application — (fistulising Crohn's disease)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Patient has confirmed Crohn's disease; and
- 2 Any of the following:
  - 2.1 Patient has one or more complex externally draining enterocutaneous fistula(e); or
  - 2.2 Patient has one or more rectovaginal fistula(e); or
  - 2.3 Patient has complex peri-anal fistula.

**Renewal — (fistulising Crohn's disease)** only from a gastroenterologist or Practitioner on the recommendation of a gastroenterologist. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 Either:
  - 1.1 The number of open draining fistulae have decreased from baseline by at least 50%; or
  - 1.2 There has been a marked reduction in drainage of all fistula(e) from baseline (in the case of adult patients, as demonstrated by a reduction in the Fistula Assessment score), together with less induration and patient reported pain; and
- 2 Infliximab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for up to 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen weeks after completing the last re-induction cycle. Up to 10 mg/kg every 8 weeks (or equivalent) may be used for patients treated with this dose prior to 1 February 2019.

**Initial application — (neurosarcoidosis)** only from a neurologist or Practitioner on the recommendation of a neurologist.

Approvals valid for 18 months for applications meeting the following criteria:

All of the following:

- 1 Patient has been diagnosed with neurosarcoidosis by a multidisciplinary team; and
- 2 Patient has CNS involvement; and
- 3 Patient has steroid-refractory disease; and
- 4 Either:
  - 4.1 IV cyclophosphamide has been tried; or
  - 4.2 Treatment with IV cyclophosphamide is clinically inappropriate.

**Renewal — (neurosarcoidosis)** only from a neurologist or Practitioner on the recommendation of a neurologist. Approvals valid for 18 months for applications meeting the following criteria:

Either:

- 1 A withdrawal period has been tried and the patient has relapsed; or
- 2 All of the following:
  - 2.1 A withdrawal period has been considered but would not be clinically appropriate; and
  - 2.2 There has been a marked reduction in prednisone dose; and
  - 2.3 Either:
    - 2.3.1 There has been an improvement in MRI appearances; or
    - 2.3.2 Marked improvement in other symptomatology.

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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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**Initial application — (plaque psoriasis)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 Patient had a Special Authority approval for adalimumab, etanercept or secukinumab for plaque psoriasis; and
  - 1.2 Either:
    - 1.2.1 Patient has experienced intolerable side effects; or
    - 1.2.2 Patient has received insufficient benefit to meet the renewal criteria for plaque psoriasis; or
- 2 All of the following:
  - 2.1 Any of the following:
    - 2.1.1 Patient has "whole body" plaque psoriasis with a PASI score of greater than 10; or
    - 2.1.2 Patient has plaque psoriasis of the face, or palm of a hand or sole of a foot; or
    - 2.1.3 Patient has localised genital or flexural plaque psoriasis with a DLQI score greater than 10; and
  - 2.2 Patient has received insufficient benefit (see Note) or has experienced intolerable side effects from at least 3 of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin; and
  - 2.3 A PASI assessment has been completed for the most recent prior treatment course within 1 month of stopping that treatment; and
  - 2.4 The most recent PASI assessment is within 1 month before the application.

Note: "Insufficient benefit" is defined as: for whole body plaque psoriasis, a PASI score of greater than 10; for plaque psoriasis of the face, hand, foot, genital or flexural areas at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and for the face, palm of a hand or sole of a foot the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment.

**Renewal — (plaque psoriasis)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 Any of the following:
  - 1.1 Both:
    - 1.1.1 Patient had "whole body" plaque psoriasis at the start of treatment; and
    - 1.1.2 Patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-infliximab baseline; or
  - 1.2 Both:
    - 1.2.1 Patient had plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment; and
    - 1.2.2 Either:
      - 1.2.2.1 Patient has a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-infliximab baseline; or
      - 1.2.2.2 Patient has a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-infliximab baseline; or
  - 1.3 Both:
    - 1.3.1 Patient had localised genital or flexural plaque psoriasis at the start of treatment; and
    - 1.3.2 Either:
      - 1.3.2.1 Patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline; or
      - 1.3.2.2 Patient has a DLQI improvement of 5 or more, as compared to the pre-infliximab baseline; and
- 2 Maximum dose 5 mg/kg every 8 weeks.

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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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**Initial application — (previous use)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Patient was being treated with infliximab prior to 1 February 2019; and
- 2 Any of the following:
  - 2.1 Rheumatoid arthritis; or
  - 2.2 Ankylosing spondylitis; or
  - 2.3 Psoriatic arthritis; or
  - 2.4 Severe ocular inflammation; or
  - 2.5 Chronic ocular inflammation; or
  - 2.6 Crohn's disease (adults); or
  - 2.7 Crohn's disease (children); or
  - 2.8 Fistulising Crohn's disease; or
  - 2.9 Severe fulminant ulcerative colitis; or
  - 2.10 Severe ulcerative colitis; or
  - 2.11 Plaque psoriasis; or
  - 2.12 Neurosarcoidosis; or
  - 2.13 Severe Behcet's disease.

**Initial application — (arthritis - psoriatic)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has had a Special Authority approval for adalimumab or etanercept or secukinumab for psoriatic arthritis; and
- 2 Either:
  - 2.1 Patient has experienced intolerable side effects; or
  - 2.2 Patient has received insufficient benefit to meet the renewal criteria for psoriatic arthritis; and
- 3 Following initial induction doses, maximum dose 5mg/kg every 8 weeks.

**Renewal — (arthritis - psoriatic)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 Either:
  - 1.1 Following initial treatment, at least a 50% decrease in active joint count from baseline; or
  - 1.2 At least a continuing 30% improvement in active joint count from baseline; and
- 2 Maximum dose 5 mg/kg every 8 weeks.

**Initial application — (arthritis - rheumatoid)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has had a Special Authority approval for adalimumab or etanercept for rheumatoid arthritis; and
- 2 Either:
  - 2.1 Patient has experienced intolerable side effects; or
  - 2.2 Patient has received insufficient benefit to meet the renewal criteria for rheumatoid arthritis; and
- 3 Following initial induction doses, maximum dose 3mg/kg every 8 weeks.

**Renewal — (arthritis - rheumatoid)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 Either:
  - 1.1 Following initial treatment, the patient has experienced at least a 50% decrease in active joint count from baseline; or

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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continued...

- 1.2 Patient has experienced at least a continuing 30% improvement in active joint count from baseline; and
- 2 Maximum dose 3 mg/kg every 8 weeks.

**Initial application — (Behcet disease)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Patient has severe Behcet disease which is significantly impacting their quality of life; and
- 2 Either:
  - 2.1 Patient has severe ocular, neurological and/or vasculitic symptoms and has received insufficient benefit from 1 or more treatment(s) appropriate for the particular symptom(s); or
  - 2.2 Patient has severe gastrointestinal, rheumatologic and/or mucocutaneous symptoms and has received insufficient benefit from 2 or more treatments appropriate for the particular symptom(s); and
- 3 Following initial loading doses, maximum dose 5mg/kg every 8 weeks.

**Renewal — (fulminant ulcerative colitis)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 Where maintenance treatment is considered appropriate, infliximab should be used in combination with immunomodulators and reassessed every 6 months; and
- 2 Infliximab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for up to 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen weeks after completing the last re-induction cycle. Up to 10 mg/kg every 8 weeks (or equivalent) may be used for patients treated with this dose prior to 1 February 2019.

**Initial application — (ocular inflammation - severe\*)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 Patient has had an initial Special Authority approval for adalimumab for severe ocular inflammation; and
  - 1.2 Either:
    - 1.2.1 Patient has experienced intolerable side effects; or
    - 1.2.2 Patient has received insufficient benefit to meet the renewal criteria for severe ocular inflammation; or
- 2 Both:
  - 2.1 Patient has severe, vision-threatening ocular inflammation requiring rapid control; and
  - 2.2 Any of the following:
    - 2.2.1 Treatment with high-dose IV corticosteroids followed by high dose oral corticosteroids has been ineffective at controlling symptoms; or
    - 2.2.2 Patient developed new inflammatory symptoms while receiving high dose corticosteroids; or
    - 2.2.3 Patient is aged under 8 years and treatment with high dose oral corticosteroids and other immunosuppressants has been ineffective at controlling symptoms; or
    - 2.2.4 High dose corticosteroids are contraindicated.

Note: Indications marked with \* are unapproved indications.

**Renewal — (ocular inflammation - severe\*)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Any of the following:

- 1 Patient has received a good clinical response following 3 initial doses; or
- 2 Following each 2 year treatment period, the patient has experienced a sustained reduction in inflammation (Standardisation of Uveitis Nomenclature (SUN) criteria < ½+ anterior chamber or vitreous cells, absence of active vitreous or retinal lesions, or resolution of uveitic cystoid macular oedema); or

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Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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- 3 Following each 2 year treatment period, patient has a sustained corticosteroid sparing effect, allowing reduction in prednisone to < 10mg daily, or corticosteroid drops less than twice daily if under 18 years old.

Note: A trial withdrawal should be considered after every 24 months of stability, unless the patient is deemed to have extremely high risk of irreversible vision loss if infliximab is withdrawn. Indications marked with \* are unapproved indications

**Initial application — (ulcerative colitis)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has active ulcerative colitis; and
- 2 Either:
  - 2.1 Patients SCCAI is greater than or equal to 4; or
  - 2.2 Patients PUCAI score is greater than or equal to 20; and
- 3 Patient has tried but has experienced an inadequate response to, or has experienced intolerable side effects from, prior therapy with immunomodulators and systemic corticosteroids.

**Renewal — (ulcerative colitis)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 Either:
  - 1.1 The SCCAI score has reduced by 2 points or more from the SCCAI score when the patient was initiated on infliximab; or
  - 1.2 The PUCAI score has reduced by 10 points or more from the PUCAI score when the patient was initiated on infliximab; and
- 2 Infliximab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for up to 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen weeks after completing the last re-induction cycle. Up to 10 mg/kg every 8 weeks (or equivalent) may be used for patients treated with this dose prior to 1 February 2019.

**Initial application — (pyoderma gangrenosum\*)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 Patient has received insufficient benefit from 3 months of conventional therapy including a minimum of 3 pharmaceuticals (e.g. prednisone, ciclosporine, azathioprine, or methotrexate). Where conventional pharmaceuticals are contraindicated, a 3-month trial has occurred of those that are not contraindicated; and
- 2 Maximum of 8 doses every 4 months.

Note: Note: Indications marked with \* are unapproved indications.

**Initial application — (inflammatory bowel arthritis – axial)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has a diagnosis of active ulcerative colitis or active Crohn's disease; and
- 2 Patient has had axial inflammatory pain for six months or more; and
- 3 Patient is unable to take NSAIDs; and
- 4 Patient has unequivocal sacroiliitis demonstrated by radiological imaging or MRI; and
- 5 Patient's disease has not responded adequately to prior treatment consisting of at least 3 months of an exercise regime supervised by a physiotherapist; and
- 6 Patient has a BASDAI of at least 6 on a 0 - 10 scale completed after the 3 month exercise trial, but prior to ceasing any previous pharmacological treatment .

**Renewal — (inflammatory bowel arthritis – axial)** from any relevant practitioner. Approvals valid for 2 years where treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10-point scale, or an improvement in BASDAI of 50%, whichever is less.

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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**Initial application — (inflammatory bowel arthritis – peripheral)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has a diagnosis of active ulcerative colitis or active Crohn's disease; and
- 2 Patient has active arthritis in at least four joints from the following: hip, knee, ankle, subtalar, tarsus, forefoot, wrist, elbow, shoulder, sternoclavicular; and
- 3 Patient has tried and not experienced a response to at least three months of methotrexate or azathioprine at a maximum tolerated dose (unless contraindicated); and
- 4 Patient has tried and not experienced a response to at least three months of sulfasalazine at a maximum tolerated dose (unless contraindicated); and
- 5 Any of the following:
  - 5.1 Patient has a CRP level greater than 15 mg/L measured no more than one month prior to the date of this application; or
  - 5.2 Patient has an ESR greater than 25 mm per hour measured no more than one month prior to the date of this application; or
  - 5.3 ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months.

**Renewal — (inflammatory bowel arthritis – peripheral)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Either:

- 1 Following initial treatment, patient has experienced at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician; or
- 2 Patient has experienced at least a continuing 30% improvement in active joint count from baseline in the opinion of the treating physician.

**Initial application — (immune checkpoint inhibitor toxicity in malignancy\*)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 The individual requires treatment for moderate to severe autoimmune toxicity following immune checkpoint inhibitor treatment for malignancy; and
- 2 The individual has received insufficient benefit from use of corticosteroids; and
- 3 Infliximab is to be administered at up to 5mg/kg for up to four doses.

**Renewal — (immune checkpoint inhibitor toxicity in malignancy\*)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

Both:

- 1 The individual has shown clinical improvement and ongoing treatment is required; and
- 2 Infliximab is to be administered at up to 5mg/kg for up to a total of 8 doses.

Note: Indications marked with \* are unapproved indications.

INOTUZUMAB OZOGAMICIN – PCT only – Specialist – Special Authority see [SA2460 below](#)

Inj 1 mg vial .....	14,457.00	1	✓ <b>Besponsa</b>
Inj 1 mg for ECP .....	14,457.00	1 mg	✓ <b>Baxter</b>

► [SA2460](#) **Special Authority for Subsidy**

**Initial application** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist.

Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Patient has relapsed or refractory CD22-positive B-cell acute lymphoblastic leukaemia/lymphoma, including minimal residual disease; and

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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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- 2 Patient has ECOG performance status of 0-2; and
- 3 Either:
  - 3.1 Both:
    - 3.1.1 Patient has Philadelphia chromosome positive B-Cell ALL; and
    - 3.1.2 Patient has previously received a tyrosine kinase inhibitor; or
  - 3.2 Patient has received one prior line of treatment involving intensive chemotherapy; and
- 4 Treatment is to be administered for a maximum of 3 cycles.

**Renewal** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Patient is not proceeding to a stem cell transplant; and
- 2 Either:
  - 2.1 Patient has experienced complete disease response; or
  - 2.2 Patient has experienced complete remission with incomplete haematological recovery; and
- 3 Treatment with inotuzumab ozogamicin is to cease after a total duration of 6 cycles.

MEPOLIZUMAB – Special Authority see [SA2331 below](#) – Retail pharmacy

Inj 100 mg prefilled pen .....	1,638.00	1	✓ Nucala
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**▶SA2331 Special Authority for Subsidy**

**Initial application — (Severe eosinophilic asthma)** only from a respiratory physician or clinical immunologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient must be aged 12 years or older; and
- 2 Patient must have a diagnosis of severe eosinophilic asthma documented by a respiratory physician or clinical immunologist; and
- 3 Conditions that mimic asthma eg. vocal cord dysfunction, central airway obstruction, bronchiolitis etc. have been excluded; and
- 4 Patient has a blood eosinophil count of greater than  $0.5 \times 10^9$  cells/L in the last 12 months; and
- 5 Patient must be adherent to optimised asthma therapy including inhaled corticosteroids (equivalent to at least 1000 mcg per day of fluticasone propionate) plus long acting beta-2 agonist, or budesonide/formoterol as part of the single maintenance and reliever therapy regimen, unless contraindicated or not tolerated; and
- 6 Either:
  - 6.1 Patient has had at least 4 exacerbations needing systemic corticosteroids in the previous 12 months, where an exacerbation is defined as either documented use of oral corticosteroids for at least 3 days or parenteral corticosteroids; or
  - 6.2 Patient has received continuous oral corticosteroids of at least the equivalent of 10 mg per day over the previous 3 months; and
- 7 Treatment is not to be used in combination with subsidised benralizumab; and
- 8 Patient has an Asthma Control Test (ACT) score of 10 or less. Baseline measurements of the patient's asthma control using the ACT and oral corticosteroid dose must be made at the time of application, and again at around 52 weeks after the first dose to assess response to treatment; and
- 9 Either:
  - 9.1 Patient has not previously received an anti-IL5 biological therapy for their severe eosinophilic asthma; or
  - 9.2 Both:
    - 9.2.1 Patient was refractory or intolerant to previous anti-IL5 biological therapy; and
    - 9.2.2 Patient was not eligible to continue treatment with previous anti-IL5 biological therapy and discontinued within 12 months of commencing treatment.

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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**Renewal — (Severe eosinophilic asthma)** only from a respiratory physician or clinical immunologist. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 An increase in the Asthma Control Test (ACT) score of at least 5 from baseline; and
- 2 Either:
  - 2.1 Exacerbations have been reduced from baseline by 50% as a result of treatment with mepolizumab; or
  - 2.2 Reduction in continuous oral corticosteroid use by 50% or by 10 mg/day while maintaining or improving asthma control.

**Initial application — (eosinophilic granulomatosis with polyangiitis)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has eosinophilic granulomatosis with polyangiitis; and
- 2 The patient has trialled and not received adequate benefit from at least one of the following for at least three months (unless contraindicated to all): azathioprine, cyclophosphamide, leflunomide, methotrexate, mycophenolate, or rituximab; and
- 3 Either:
  - 3.1 The patient has trialled prednisone for a minimum of three months and is unable to maintain disease control at doses below 7.5 mg per day; or
  - 3.2 Corticosteroids are contraindicated.

**Renewal — (eosinophilic granulomatosis with polyangiitis)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months where patient has no evidence of clinical disease progression.

OBINUTUZUMAB – PCT only – Specialist – Special Authority see [SA2639 below](#)

Inj 25 mg per ml, 40 ml vial.....	5,910.00	1	✓ Gazyva
Inj 1 mg for ECP.....	6.21	1 mg	✓ Baxter

► [SA2639](#) **Special Authority for Subsidy**

**Initial application — (previously untreated chronic lymphocytic leukaemia in combination with venetoclax)** from any relevant practitioner. Approvals valid for 15 months for applications meeting the following criteria:

Either:

- 1 Individual is currently on treatment with obinutuzumab and venetoclax and met all of the following criteria prior to commencing treatment; or
- 2 Both:
  - 2.1 Individual has previously untreated chronic lymphocytic leukaemia; and
  - 2.2 Obinutuzumab is to be administered at a maximum cumulative dose of 8,000 mg and in combination with venetoclax for a maximum of 6 (28-day) cycles of treatment.

**Initial application — (chronic lymphocytic leukaemia)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has progressive Binet stage A, B or C CD20+ chronic lymphocytic leukaemia requiring treatment; and
- 2 The patient is obinutuzumab treatment naive; and
- 3 The patient is not eligible for full dose FCR due to comorbidities with a score > 6 on the Cumulative Illness Rating Scale (CIRS) or reduced renal function (creatinine clearance < 70mL/min); and
- 4 Patient has adequate neutrophil and platelet counts\* unless the cytopenias are a consequence of marrow infiltration by CLL; and
- 5 Patient has good performance status; and
- 6 Obinutuzumab to be administered at a maximum cumulative dose of 8,000 mg and in combination with chlorambucil for a

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Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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maximum of 6 cycles.

Notes: Chronic lymphocytic leukaemia includes small lymphocytic lymphoma. Comorbidity refers only to illness/impairment other than CLL induced illness/impairment in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL disease symptoms a higher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2.

\* Neutrophil greater than or equal to  $1.5 \times 10^9/L$  and platelets greater than or equal to  $75 \times 10^9/L$ .

**Initial application — (follicular / marginal zone lymphoma)** from any relevant practitioner. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 Either:
  - 1.1 Patient has follicular lymphoma; or
  - 1.2 Patient has marginal zone lymphoma; and
- 2 Patient is refractory to or has relapsed within 12 months of a rituximab containing combined chemo-immunotherapy regimen\*; and
- 3 Patient has an ECOG performance status of 0-2; and
- 4 Patient has been previously treated with no more than four chemotherapy regimens; and
- 5 Obinutuzumab to be administered at a maximum dose of 1000 mg for a maximum of 6 cycles in combination with chemotherapy\*.

Note: \* includes unapproved indications

**Renewal — (follicular / marginal zone lymphoma)** from any relevant practitioner. Approvals valid for 24 months for applications meeting the following criteria:

All of the following:

- 1 Patient has no evidence of disease progression following obinutuzumab induction therapy; and
- 2 Obinutuzumab to be administered at a maximum of 1000 mg every 2 months for a maximum of 2 years; and
- 3 Obinutuzumab to be discontinued at disease progression.

OMALIZUMAB – Special Authority see SA2597 below – Retail pharmacy

Inj 150 mg prefilled syringe.....	450.00	1	✓ Xolair ✓ Xolair AU
Inj 150 mg vial .....	450.00	1	✓ Xolair

►SA2597 **Special Authority for Subsidy**

**Initial application — (severe asthma)** only from a respiratory specialist or clinical immunologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient must be aged 6 years or older; and
- 2 Patient has a diagnosis of severe asthma; and
- 3 Past or current evidence of atopy, documented by skin prick testing or RAST; and
- 4 Total serum human immunoglobulin E (IgE) between 76 IU/mL and 1300 IU/ml at baseline; and
- 5 Proven adherence with optimal inhaled therapy including high dose inhaled corticosteroid (budesonide 1,600 mcg per day or fluticasone propionate 1,000 mcg per day or equivalent), plus long-acting beta-2 agonist therapy (at least salmeterol 50 mcg bd or eformoterol 12 mcg bd) for at least 12 months, unless contraindicated or not tolerated; and
- 6 Either:
  - 6.1 Patient has received courses of systemic corticosteroids equivalent to at least 28 days treatment in the past 12 months, unless contraindicated or not tolerated; or
  - 6.2 Patient has had at least 4 exacerbations needing systemic corticosteroids in the previous 12 months, where an exacerbation is defined as either documented use of oral corticosteroids for at least 3 days or parenteral steroids; and

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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- 7 Patient has an Asthma Control Test (ACT) score of 10 or less; and
- 8 Baseline measurements of the patient's asthma control using the ACT and oral corticosteroid dose must be made at the time of application, and again at around 26 weeks after the first dose to assess response to treatment.

**Initial application — (severe chronic spontaneous urticaria)** only from a clinical immunologist or dermatologist. Approvals valid for 7 months for applications meeting the following criteria:

All of the following:

- 1 Patient must be aged 12 years or older; and
- 2 Either:
  - 2.1 Both:
    - 2.1.1 Patient is symptomatic with Urticaria Activity Score 7 (UAS7) of 20 or above; and
    - 2.1.2 Patient has a Dermatology life quality index (DLQI) of 10 or greater; or
  - 2.2 Patient has a Urticaria Control Test (UCT) of 8 or less; and
- 3 Any of the following:
  - 3.1 Patient has been taking high dose antihistamines (e.g. 4 times standard dose) and ciclosporin (> 3 mg/kg day) for at least 6 weeks; or
  - 3.2 Patient has been taking high dose antihistamines (e.g. 4 times standard dose) and at least 3 courses of systemic corticosteroids (> 20 mg prednisone per day for at least 5 days) in the previous 6 months; or
  - 3.3 Patient has developed significant adverse effects whilst on corticosteroids or ciclosporin; and
- 4 Either:
  - 4.1 Treatment to be stopped if inadequate response\* following 4 doses; or
  - 4.2 Complete response\* to 6 doses of omalizumab.

**Renewal — (severe asthma)** only from a clinical immunologist or respiratory specialist. Approvals valid for 2 years for applications meeting the following criteria:

- Both:
- 1 An increase in the Asthma Control Test (ACT) score of at least 5 from baseline; and
  - 2 A reduction in the maintenance oral corticosteroid dose or number of exacerbations of at least 50% from baseline.

**Renewal — (severe chronic spontaneous urticaria)** only from a clinical immunologist or dermatologist. Approvals valid for 6 months for applications meeting the following criteria:

- Either:
- 1 Patient has previously adequately responded\* to 6 doses of omalizumab; or
  - 2 Both:
    - 2.1 Patient has previously had a complete response\* to 6 doses of omalizumab; and
    - 2.2 Patient has relapsed after cessation of omalizumab therapy.

Note: \*Inadequate response defined as less than 50% reduction in baseline UAS7 and DLQI score, or an increase in Urticaria Control Test (UCT) score of less than 4 from baseline. Patient is to be reassessed for response after 4 doses of omalizumab. Complete response is defined as UAS7 less than or equal to 6 and DLQI less than or equal to 5; or UCT of 16. Relapse of chronic urticaria on stopping prednisone/ciclosporin does not justify the funding of omalizumab.

PALIVIZUMAB – PCT only – Special Authority see [SA2640 below](#)

Inj 100 mg per ml, 1 ml vial.....	1,700.00	1	✓ Synagis
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► **SA2640** Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

- Both:
- 1 Palivizumab to be administered during the annual RSV season; and
  - 2 Either:
    - 2.1 All of the following:
      - 2.1.1 Infant was born in the last 12 months; and

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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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- 2.1.2 Infant was born at less than 32 weeks zero days' gestation; and
- 2.1.3 Infant is to be administered palivizumab within a single calendar year; or
- 2.2 Both:
  - 2.2.1 Child was born in the last 24 months; and
  - 2.2.2 Any of the following:
    - 2.2.2.1 Child has severe lung, airway, neurological or neuromuscular disease that requires ongoing ventilatory/respiratory support (see Note A) in the community; or
    - 2.2.2.2 Both:
      - 2.2.2.2.1 Child has haemodynamically significant heart disease; and
      - 2.2.2.2.2 Any of the following:
        - 2.2.2.2.2.1 Child has unoperated simple congenital heart disease with significant left to right shunt (see Note B); or
        - 2.2.2.2.2.2 Child has unoperated or surgically palliated complex congenital heart disease; or
        - 2.2.2.2.2.3 Child has severe pulmonary hypertension (see Note C); or
        - 2.2.2.2.2.4 Child has moderate or severe left ventricular (LV) failure (see Note D); or
      - 2.2.2.2.3 Child has severe combined immune deficiency, confirmed by an immunologist, but has not received a stem cell transplant; or
      - 2.2.2.2.4 Child has inborn errors of immunity (see Note E) that increase susceptibility to life-threatening viral respiratory infections, confirmed by an immunologist.

**Renewal** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Palivizumab to be administered during the annual RSV season; and
- 2 Child was born in the last 24 months; and
- 3 Any of the following:
  - 3.1 Child has severe lung, airway, neurological or neuromuscular disease that requires ongoing ventilatory/respiratory support (see Note A) in the community; or
  - 3.2 Both:
    - 3.2.1 Child has haemodynamically significant heart disease; and
    - 3.2.2 Any of the following:
      - 3.2.2.1 Child has unoperated simple congenital heart disease with significant left to right shunt (see Note B); or
      - 3.2.2.2 Child has unoperated or surgically palliated complex congenital heart disease; or
      - 3.2.2.3 Child has severe pulmonary hypertension (see Note C); or
      - 3.2.2.4 Child has moderate or severe left ventricular (LV) failure (see Note D); or
  - 3.3 Child has severe combined immune deficiency, confirmed by an immunologist, but has not received a stem cell transplant; or
  - 3.4 Child has inborn errors of immunity (see Note E) that increase susceptibility to life-threatening viral respiratory infections, confirmed by an immunologist.

Notes:

- a) Ventilatory/respiratory support includes those on home oxygen, CPAP/VPAP and those with tracheostomies in situ managed at home
- b) Child requires/will require heart failure medication, and/or child has significant pulmonary hypertension, and/or infant will require surgical palliation/definitive repair within the next 3 months
- c) Mean pulmonary artery pressure more than 25 mmHg
- d) LV Ejection Fraction less than 40%
- e) Inborn errors of immunity include, but are not limited to, IFNAR deficiencies

PERTUZUMAB – PCT only – Specialist – Special Authority see [SA2276 on the next page](#)

Inj 30 mg per ml, 14 ml vial.....	3,927.00	1	✓ Perjeta
Inj 420 mg for ECP .....	3,927.00	420 mg OP	✓ Baxter

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

## ►SA2276 Special Authority for Subsidy

**Initial application — (metastatic breast cancer)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology); and
- 2 Either:
  - 2.1 Patient is chemotherapy treatment naïve; or
  - 2.2 Patient has not received prior treatment for their metastatic disease and has had a treatment free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer; and
- 3 The patient has good performance status (ECOG grade 0-1); and
- 4 Pertuzumab to be administered in combination with trastuzumab; and
- 5 Pertuzumab maximum first dose of 840 mg, followed by maximum of 420 mg every 3 weeks; and
- 6 Pertuzumab to be discontinued at disease progression.

**Renewal — (metastatic breast cancer)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology); and
  - 1.2 The cancer has not progressed at any time point during the previous 12 months whilst on pertuzumab and trastuzumab; or
- 2 All of the following:
  - 2.1 Patient has previously discontinued treatment with pertuzumab and trastuzumab for reasons other than severe toxicity or disease progression; and
  - 2.2 Patient has signs of disease progression; and
  - 2.3 Disease has not progressed during previous treatment with pertuzumab and trastuzumab.

PERTUZUMAB WITH TRASTUZUMAB – PCT only – Special Authority see SA2534 below

Inj 600 mg with trastuzumab 600 mg, 10 ml vial .....	7,707.00	1	✓ Phesgo
Inj 1,200 mg with trastuzumab 600 mg, 15 ml vial .....	12,894.00	1	✓ Phesgo

## ►SA2534 Special Authority for Subsidy

**Initial application — (metastatic breast cancer)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 The individual has received an initial Special Authority approval for intravenous pertuzumab and trastuzumab for metastatic breast cancer; and
  - 1.2 Pertuzumab with trastuzumab to be administered subcutaneously at a maximum dose of 600 mg pertuzumab with 600 mg trastuzumab every three weeks (or equivalent); or
- 2 All of the following:
  - 2.1 The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology); and
  - 2.2 Either:
    - 2.2.1 Patient is chemotherapy treatment naïve; or
    - 2.2.2 Patient has not received prior treatment for their metastatic disease and has had a treatment free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer; and

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- 2.3 The patient has good performance status (ECOG grade 0-1); and
- 2.4 Loading dose of pertuzumab with trastuzumab to be administered subcutaneously at a maximum dose of 1200 mg pertuzumab with 600 mg trastuzumab, respectively; and
- 2.5 Maintenance doses of pertuzumab with trastuzumab to be administered subcutaneously at a maximum dose of 600 mg pertuzumab with 600 mg trastuzumab every three weeks (or equivalent); and
- 2.6 Pertuzumab with trastuzumab to be discontinued at disease progression.

**Renewal — (metastatic breast cancer)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 The individual has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology); and
  - 1.2 The cancer has not progressed at any time point during the previous 12 months whilst on pertuzumab and trastuzumab; or
- 2 All of the following:
  - 2.1 Individual has previously discontinued treatment with pertuzumab with trastuzumab for reasons other than severe toxicity or disease progression; and
  - 2.2 Individual has signs of disease progression; and
  - 2.3 Disease has not progressed during previous treatment with pertuzumab with trastuzumab.

RITUXIMAB (MABTHERA) – PCT only – Specialist – Special Authority see [SA2622 below](#)

Inj 100 mg per 10 ml vial .....	1,075.50	2	✓ Mabthera
Inj 500 mg per 50 ml vial .....	2,688.30	1	✓ Mabthera
Inj 1 mg for ECP .....	5.64	1 mg	✓ Baxter (Mabthera)

**▶SA2622 Special Authority for Subsidy**

**Initial application — (arthritis - rheumatoid - TNF inhibitors contraindicated)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Treatment with a Tumour Necrosis Factor alpha inhibitor is contraindicated; and
- 2 Patient has had rheumatoid arthritis (either confirmed by radiologic imaging, or the patient is CCP antibody positive); and
- 3 Disease has not responded to at least 3 months of methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose, unless contraindicated; and
- 4 Disease has not responded to at least 3 months of methotrexate in combination with sulfasalazine and hydroxychloroquine sulphate (at maximum tolerated doses), unless contraindicated; and
- 5 Either:
  - 5.1 Disease has not responded to at least 3 months of methotrexate in combination with the maximum tolerated dose of ciclosporin, unless contraindicated; or
  - 5.2 Disease has not responded to at least 3 months of therapy at the maximum tolerated dose of leflunomide alone or in combination with methotrexate, unless contraindicated; and
- 6 Either:
  - 6.1 Patient has persistent symptoms of poorly controlled and active disease in at least 20 joints; or
  - 6.2 Patient has persistent symptoms of poorly controlled and active disease in at least 4 joints from the following: wrist, elbow, knee, ankle, shoulder, or hip; and
- 7 Either:
  - 7.1 Patient has CRP greater than 15 mg/L measured within one month before the application; or
  - 7.2 CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day received for more than 3 months; and

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

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8 Maximum of two 1000 mg infusions given two weeks apart.

**Initial application — (arthritis - rheumatoid - prior TNF inhibitor use)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Patient has had a Special Authority approval for etanercept or adalimumab for rheumatoid arthritis; and
- 2 Either:
  - 2.1 Patient has experienced intolerable side effects; or
  - 2.2 Following at least a 4 month trial of adalimumab or etanercept, the renewal criteria for rheumatoid arthritis were not met; and
- 3 Maximum of two 1000 mg infusions given two weeks apart.

**Renewal — (arthritis - rheumatoid - re-treatment for people who have experienced a partial response to rituximab)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Any of the following:
  - 1.1 Following the initial course of rituximab the patient experienced between a 30% and 50% decrease in active joint count from baseline; or
  - 1.2 Following the second course of rituximab the patient experienced at least a 50% decrease in active joint count from baseline; or
  - 1.3 Following the third and subsequent courses of rituximab, the patient experienced at least a continuing 30% improvement in active joint count from baseline; and
- 2 Rituximab re-treatment not to be given within 6 months of the previous course of treatment; and
- 3 Maximum of two 1000 mg infusions given two weeks apart.

**Renewal — (arthritis - rheumatoid - re-treatment for people who experience a response to rituximab)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Either:
  - 1.1 Following the initial course of rituximab infusions the patient experienced at least a 50% decrease in active joint count from baseline; or
  - 1.2 Following the second and subsequent courses of rituximab, the patient experienced at least a continuing 30% improvement in active joint count from baseline; and
- 2 Rituximab re-treatment not to be given within 6 months of the previous course of treatment; and
- 3 Maximum of two 1000 mg infusions per course given two weeks apart.

RITUXIMAB (RIXIMYO) – PCT only – Specialist – Special Authority see [SA2641](#) below

Inj 100 mg per 10 ml vial .....	275.33	2	✓ Riximyo
Inj 500 mg per 50 ml vial .....	688.20	1	✓ Riximyo
Inj 1 mg for ECP .....	1.38	1 mg	✓ Baxter (Riximyo)

➔ **SA2641** | Special Authority for Subsidy

**Initial application — (ABO-incompatible organ transplant)** from any relevant practitioner. Approvals valid without further renewal unless notified where patient is to undergo an ABO-incompatible solid organ transplant\*.

Note: Indications marked with \* are unapproved indications.

**Initial application — (ANCA associated vasculitis)** from any relevant practitioner. Approvals valid for 8 weeks for applications meeting the following criteria:

All of the following:

- 1 Patient has been diagnosed with ANCA associated vasculitis\*; and
- 2 The total rituximab dose would not exceed the equivalent of 375 mg/m<sup>2</sup> of body-surface area per week for a total of 4 weeks; and

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3 Any of the following:

- 3.1 Induction therapy with daily oral or pulse intravenous cyclophosphamide has failed to achieve significant improvement of disease after at least 3 months; or
- 3.2 Patient has previously had a cumulative dose of cyclophosphamide > 15 g or a further repeat 3 month induction course of cyclophosphamide would result in a cumulative dose > 15 g; or
- 3.3 Cyclophosphamide and methotrexate are contraindicated; or
- 3.4 Patient is a female of child-bearing potential; or
- 3.5 Patient has a previous history of haemorrhagic cystitis, urological malignancy or haematological malignancy.

Note: Indications marked with \* are unapproved indications.

**Renewal — (ANCA associated vasculitis)** from any relevant practitioner. Approvals valid for 8 weeks for applications meeting the following criteria:

All of the following:

- 1 Patient has been diagnosed with ANCA associated vasculitis\*; and
- 2 Patient has previously responded to treatment with rituximab but is now experiencing an acute flare of vasculitis; and
- 3 The total rituximab dose would not exceed the equivalent of 375 mg/m<sup>2</sup> of body-surface area per week for a total of 4 weeks.

Note: Indications marked with \* are unapproved indications.

**Initial application — (Antibody-mediated organ transplant rejection)** from any relevant practitioner. Approvals valid without further renewal unless notified where patient has been diagnosed with antibody-mediated organ transplant rejection\*.

Note: Indications marked with \* are unapproved indications.

**Initial application — (Chronic lymphocytic leukaemia)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has progressive Binet stage A, B or C chronic lymphocytic leukaemia (CLL) requiring treatment; and
- 2 Any of the following:
  - 2.1 The patient is rituximab treatment naive; or
  - 2.2 Either:
    - 2.2.1 The patient is chemotherapy treatment naive; or
    - 2.2.2 Both:
      - 2.2.2.1 The patient's disease has relapsed following no more than three prior lines of chemotherapy treatment; and
      - 2.2.2.2 The patient has had a treatment-free interval of 12 months or more if previously treated with fludarabine and cyclophosphamide chemotherapy; or
  - 2.3 The patient's disease has relapsed and rituximab treatment is to be used in combination with funded venetoclax; and
- 3 The patient has good performance status; and
- 4 Rituximab to be administered in combination with fludarabine and cyclophosphamide, bendamustine or venetoclax for a maximum of 6 treatment cycles; and
- 5 It is planned that the patient receives full dose fludarabine and cyclophosphamide (orally or dose equivalent intravenous administration), bendamustine or venetoclax.

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma. A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL disease symptoms a higher ECOG (2 or 3) is acceptable where treatment with rituximab is expected to improve symptoms and improve ECOG score to < 2.

**Renewal — (Chronic lymphocytic leukaemia)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Both:

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

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1 Either:

- 1.1 The patient's disease has relapsed and rituximab treatment is to be used in combination with funded venetoclax; or
- 1.2 All of the following:
  - 1.2.1 The patient's disease has relapsed following no more than one prior line of treatment with rituximab for CLL; and
  - 1.2.2 The patient has had an interval of 36 months or more since commencement of initial rituximab treatment; and
  - 1.2.3 It is planned that the patient receives full dose fludarabine and cyclophosphamide (orally or dose equivalent intravenous administration) or bendamustine; and

2 Rituximab to be administered in combination with fludarabine and cyclophosphamide, bendamustine or venetoclax for a maximum of 6 treatment cycles.

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma. A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments.

**Initial application — (neuromyelitis optica spectrum disorder (NMOSD)\*)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Cumulative dose up to 1,500 mg/m<sup>2</sup> body surface area up to 2,000 mg total per cycle; and

2 Either:

- 2.1 Patient has experienced a severe episode or attack of NMOSD (rapidly progressing symptoms with supporting clinical investigations); or
- 2.2 All of the following:
  - 2.2.1 Patient has experienced a breakthrough attack of NMOSD; and
  - 2.2.2 Patient is receiving treatment with mycophenolate unless contraindicated or not tolerated; and
  - 2.2.3 Patient is receiving treatment with corticosteroids unless contraindicated or not tolerated; and

3 Each treatment cycle at least 6 months apart.

Note: Indications marked with \* are unapproved indications.

**Initial application — (Post-transplant)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 The patient has B-cell post-transplant lymphoproliferative disorder\*; and
- 2 To be used for a maximum of 8 treatment cycles.

Note: Indications marked with \* are unapproved indications.

**Renewal — (Post-transplant)** from any relevant practitioner. Approvals valid for 9 months for applications meeting the following criteria:

All of the following:

- 1 The patient has had a rituximab treatment-free interval of 12 months or more; and
- 2 The patient has B-cell post-transplant lymphoproliferative disorder\*; and
- 3 To be used for no more than 6 treatment cycles.

Note: Indications marked with \* are unapproved indications.

**Initial application — (refractory myasthenia gravis\*)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 Cumulative dose up to 1,500 mg/m<sup>2</sup> body surface area up to 2,000 mg total per cycle; and

2 Either:

- 2.1 Treatment with corticosteroids and at least one other immunosuppressant for a minimum period of 12 months has been ineffective; or
- 2.2 Both:

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- 2.2.1 Treatment with at least one other immunosuppressant for a period of at least 12 months; and
- 2.2.2 Corticosteroids have been trialed for at least 12 months and have been discontinued due to unacceptable side effects.

Note: Indications marked with \* are unapproved indications.

**Renewal — (refractory myasthenia gravis\*)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

All of the following:

- 1 Cumulative dose up to 1,500 mg/m<sup>2</sup> body surface area up to 2,000 mg total per cycle; and
- 2 An initial response lasting at least 12 months was demonstrated; and
- 3 Either:
  - 3.1 Patient has relapsed despite treatment with corticosteroids and at least one other immunosuppressant for a period of at least 12 months; or
  - 3.2 Both:
    - 3.2.1 Patient's myasthenia gravis has relapsed despite treatment with at least one immunosuppressant for a period of at least 12 months; and
    - 3.2.2 Corticosteroids have been trialed for at least 12 months and have been discontinued due to unacceptable side effects.

Note: Indications marked with \* are unapproved indications.

**Initial application — (Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRNS))** from any relevant practitioner. Approvals valid for 8 weeks for applications meeting the following criteria:

All of the following:

- 1 Patient is a child with SDNS\* or FRNS\*; and
- 2 Treatment with corticosteroids, ciclosporin, and mycophenolate for at least 3 months for each agent has been ineffective, not tolerated, or is contraindicated; and
- 3 The total rituximab dose used would not exceed the equivalent of 375 mg/m<sup>2</sup> of body surface area per week for a total of 4 weeks.

Note: Indications marked with \* are unapproved indications.

**Renewal — (Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRNS))** from any relevant practitioner. Approvals valid for 8 weeks for applications meeting the following criteria:

All of the following:

- 1 Patient who was previously treated with rituximab for nephrotic syndrome\*; and
- 2 Treatment with rituximab was previously successful and has demonstrated sustained response for greater than 6 months, but the condition has relapsed and the patient now requires repeat treatment; and
- 3 The total rituximab dose used would not exceed the equivalent of 375 mg/m<sup>2</sup> of body surface area per week for a total of 4 weeks.

Note: Indications marked with \* are unapproved indications.

**Initial application — (Steroid resistant nephrotic syndrome (SRNS))** from any relevant practitioner. Approvals valid for 8 weeks for applications meeting the following criteria:

All of the following:

- 1 Patient is a child with SRNS\* and treatment with corticosteroids, ciclosporin and tacrolimus for at least 3 months for each agent has been ineffective, not tolerated, or is contraindicated; and
- 2 Genetic causes of nephrotic syndrome have been excluded; and
- 3 The total rituximab dose per cycle would not exceed the equivalent of 375 mg/m<sup>2</sup> of body surface area per week for a total of 4 weeks.

Note: Indications marked with \* are unapproved indications.

**Renewal — (Steroid resistant nephrotic syndrome (SRNS))** only from a nephrologist or Practitioner on the recommendation of a nephrologist. Approvals valid for 8 weeks for applications meeting the following criteria:

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

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All of the following:

- 1 Patient who was previously treated with rituximab for nephrotic syndrome\*; and
- 2 Treatment with rituximab was previously successful and has demonstrated sustained response for greater than 6 months, but the condition has relapsed and the patient now requires repeat treatment; and
- 3 The total rituximab dose used would not exceed the equivalent of 375 mg/m<sup>2</sup> of body surface area per week for a total of 4 weeks.

Note: Indications marked with \* are unapproved indications.

**Initial application — (aggressive CD20 positive NHL)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Either:

- 1 All of the following:
  - 1.1 The patient has treatment naive aggressive CD20 positive NHL; and
  - 1.2 To be used with a multi-agent chemotherapy regimen given with curative intent; and
  - 1.3 To be used for a maximum of 8 treatment cycles; or
- 2 Both:
  - 2.1 The patient has aggressive CD20 positive NHL with relapsed disease following prior chemotherapy; and
  - 2.2 To be used for a maximum of 6 treatment cycles.

Note: 'Aggressive CD20 positive NHL' includes large B-cell lymphoma and Burkitt's lymphoma/leukaemia

**Renewal — (aggressive CD20 positive NHL)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has had a rituximab treatment-free interval of 12 months or more; and
- 2 The patient has relapsed refractory/aggressive CD20 positive NHL; and
- 3 To be used with a multi-agent chemotherapy regimen given with curative intent; and
- 4 To be used for a maximum of 4 treatment cycles.

Note: 'Aggressive CD20 positive NHL' includes large B-cell lymphoma and Burkitt's lymphoma/leukaemia

**Initial application — (haemophilia with inhibitors)** only from a haematologist or Practitioner on the recommendation of a haematologist. Approvals valid for 4 months for applications meeting the following criteria:

Any of the following:

- 1 Patient has mild congenital haemophilia complicated by inhibitors; or
- 2 Patient has severe congenital haemophilia complicated by inhibitors and has failed immune tolerance therapy; or
- 3 Patient has acquired haemophilia.

**Renewal — (haemophilia with inhibitors)** only from a haematologist or Practitioner on the recommendation of a haematologist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Patient was previously treated with rituximab for haemophilia with inhibitors; and
- 2 An initial response lasting at least 12 months was demonstrated; and
- 3 Patient now requires repeat treatment.

**Initial application — (immune thrombocytopenic purpura (ITP))** only from a haematologist or Practitioner on the recommendation of a haematologist. Approvals valid for 8 weeks for applications meeting the following criteria:

All of the following:

- 1 Either:
  - 1.1 Patient has immune thrombocytopenic purpura\* with a platelet count of less than or equal to 20,000 platelets per microlitre; or
  - 1.2 Patient has immune thrombocytopenic purpura\* with a platelet count of 20,000 to 30,000 platelets per microlitre and significant mucocutaneous bleeding; and
- 2 Any of the following:

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- 2.1 Treatment with steroids and splenectomy have been ineffective; or
  - 2.2 Treatment with steroids has been ineffective and splenectomy is an absolute contraindication; or
  - 2.3 Other treatments including steroids have been ineffective and patient is being prepared for elective surgery (e.g. splenectomy); and
- 3 The total rituximab dose used would not exceed the equivalent of 375 mg/m<sup>2</sup> of body surface area per week for a total of 4 weeks.

Note: Indications marked with \* are unapproved indications.

**Renewal — (immune thrombocytopenic purpura (ITP))** only from a haematologist or Practitioner on the recommendation of a haematologist. Approvals valid for 8 weeks for applications meeting the following criteria:

Either:

- 1 Previous treatment with lower doses of rituximab (100 mg weekly for 4 weeks) have proven ineffective and treatment with higher doses (375 mg/m<sup>2</sup> weekly for 4 weeks) is now planned; or
- 2 All of the following:
  - 2.1 Patient was previously treated with rituximab for immune thrombocytopenic purpura\*; and
  - 2.2 An initial response lasting at least 12 months was demonstrated; and
  - 2.3 Patient now requires repeat treatment.

Note: Indications marked with \* are unapproved indications.

**Initial application — (indolent, low-grade lymphomas or hairy cell leukaemia\*)** from any relevant practitioner. Approvals valid for 9 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 The patient has indolent low grade NHL or hairy cell leukaemia\* with relapsed disease following prior chemotherapy; and
  - 1.2 To be used for a maximum of 6 treatment cycles; or
- 2 Both:
  - 2.1 The patient has indolent, low grade lymphoma or hairy cell leukaemia\* requiring first-line systemic chemotherapy; and
  - 2.2 To be used for a maximum of 6 treatment cycles.

Note: 'Indolent, low-grade lymphomas' includes follicular, mantle, marginal zone and lymphoplasmacytic/Waldenström macroglobulinaemia. \*Unapproved indication. 'Hairy cell leukaemia' also includes hairy cell leukaemia variant.

**Renewal — (indolent, low-grade lymphomas or hairy cell leukaemia\*)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has had a rituximab treatment-free interval of 12 months or more; and
- 2 The patient has indolent, low-grade NHL or hairy cell leukaemia\* with relapsed disease following prior chemotherapy; and
- 3 To be used for no more than 6 treatment cycles.

Note: 'Indolent, low-grade lymphomas' includes follicular, mantle, marginal zone and lymphoplasmacytic/Waldenström macroglobulinaemia. \*Unapproved indication. 'Hairy cell leukaemia' also includes hairy cell leukaemia variant.

**Initial application — (pure red cell aplasia (PRCA))** only from a haematologist or Practitioner on the recommendation of a haematologist. Approvals valid for 6 weeks where patient has autoimmune pure red cell aplasia\* associated with a demonstrable B-cell lymphoproliferative disorder.

Note: Indications marked with \* are unapproved indications.

**Renewal — (pure red cell aplasia (PRCA))** only from a haematologist or Practitioner on the recommendation of a haematologist. Approvals valid for 6 weeks where patient was previously treated with rituximab for pure red cell aplasia\* associated with a demonstrable B-cell lymphoproliferative disorder and demonstrated an initial response lasting at least 12 months.

Note: Indications marked with \* are unapproved indications.

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

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**Initial application — (severe cold haemagglutinin disease (CHAD))** only from a haematologist or Practitioner on the recommendation of a haematologist. Approvals valid for 8 weeks for applications meeting the following criteria:

All of the following:

- 1 Patient has cold haemagglutinin disease\*; and
- 2 Patient has severe disease which is characterized by symptomatic anaemia, transfusion dependence or disabling circulatory symptoms; and
- 3 The total rituximab dose used would not exceed the equivalent of 375 mg/m<sup>2</sup> of body surface area per week for a total of 4 weeks.

Note: Indications marked with \* are unapproved indications.

**Renewal — (severe cold haemagglutinin disease (CHAD))** only from a haematologist or Practitioner on the recommendation of a haematologist. Approvals valid for 8 weeks for applications meeting the following criteria:

Either:

- 1 Previous treatment with lower doses of rituximab (100 mg weekly for 4 weeks) have proven ineffective and treatment with higher doses (375 mg/m<sup>2</sup> weekly for 4 weeks) is now planned; or
- 2 All of the following:
  - 2.1 Patient was previously treated with rituximab for severe cold haemagglutinin disease\*; and
  - 2.2 An initial response lasting at least 12 months was demonstrated; and
  - 2.3 Patient now requires repeat treatment.

Note: Indications marked with \* are unapproved indications.

**Initial application — (thrombotic thrombocytopenic purpura (TTP\*))** only from a haematologist or any relevant practitioner on the recommendation of a haematologist. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 The total rituximab dose per cycle would not exceed the equivalent of 375 mg/m<sup>2</sup> of body surface area per week for a total of 4 weeks; and
- 2 Each treatment cycle at least 6 months apart; and
- 3 Either:
  - 3.1 Patient has experienced progression of clinical symptoms or persistent thrombocytopenia despite plasma exchange; or
  - 3.2 Patient has acute idiopathic TTP\* with neurological or cardiovascular pathology.

Note: Indications marked with \* are unapproved indications.

**Initial application — (treatment refractory systemic lupus erythematosus (SLE\*))** only from a rheumatologist, nephrologist or any relevant practitioner on the recommendation of a rheumatologist or nephrologist. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Patient has severe, immediately life- or organ-threatening SLE\*; and
- 2 The condition has been refractory to treatment with corticosteroids at a dose of at least 1 mg/kg unless contraindicated; and
- 3 The condition has relapsed following prior treatment for at least 6 months with maximal tolerated doses of azathioprine, mycophenolate mofetil and high dose cyclophosphamide, or cyclophosphamide is contraindicated; and
- 4 Initial treatment maximum of four 1000 mg infusions; and
- 5 Treatment for relapse following initial partial response to rituximab up to a maximum of two 1000 mg infusions every 6 months.

Note: Indications marked with \* are unapproved indications.

**Initial application — (warm autoimmune haemolytic anaemia (warm AIHA))** only from a haematologist or Practitioner on the recommendation of a haematologist. Approvals valid for 8 weeks for applications meeting the following criteria:

All of the following:

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- 1 Patient has warm autoimmune haemolytic anaemia\*; and
- 2 One of the following treatments has been ineffective: steroids (including if patient requires ongoing steroids at doses equivalent to > 5 mg prednisone daily), cytotoxic agents (e.g. cyclophosphamide monotherapy or in combination), intravenous immunoglobulin; and
- 3 The total rituximab dose used would not exceed the equivalent of 375 mg/m<sup>2</sup> of body surface area per week for a total of 4 weeks.

Note: Indications marked with \* are unapproved indications.

**Renewal — (warm autoimmune haemolytic anaemia (warm AIHA))** only from a haematologist or Practitioner on the recommendation of a haematologist. Approvals valid for 8 weeks for applications meeting the following criteria:

Either:

- 1 Previous treatment with lower doses of rituximab (100 mg weekly for 4 weeks) have proven ineffective and treatment with higher doses (375 mg/m<sup>2</sup> weekly for 4 weeks) is now planned; or
- 2 All of the following:
  - 2.1 Patient was previously treated with rituximab for warm autoimmune haemolytic anaemia\*; and
  - 2.2 An initial response lasting at least 12 months was demonstrated; and
  - 2.3 Patient now requires repeat treatment.

Note: Indications marked with \* are unapproved indications.

**Initial application — (antisyndetase syndrome)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Patient has severe, immediately life- or organ-threatening disease, including interstitial lung disease; and
- 2 Either:
  - 2.1 Treatment with at least 3 immunosuppressants (oral corticosteroids, cyclophosphamide, methotrexate, mycophenolate, ciclosporin, azathioprine) has been ineffective controlling active disease; or
  - 2.2 Rapid treatment is required for life threatening complications; and
- 3 Maximum of two 1000mg infusions every 6 months.

**Initial application — (graft versus host disease)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Patient has refractory graft versus host disease following transplant; and
- 2 Treatment with at least 3 immunosuppressants (oral steroids, ciclosporin, tacrolimus, mycophenolate, sirolimus) has not be effective at controlling active disease; and
- 3 The total rituximab dose used would not exceed the equivalent of 375 mg/m<sup>2</sup> of body surface area per week for a total of 4 weeks.

**Initial application — (chronic inflammatory demyelinating polyneuropathy (CIPD\*))** only from a neurologist or any relevant practitioner on the recommendation of a neurologist. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Either:
  - 1.1 Both:
    - 1.1.1 Treatment with corticosteroids and intravenous immunoglobulin and/or plasma exchange has been ineffective controlling active disease, is not tolerated, or is contraindicated; and
    - 1.1.2 At least one other immunosuppressant (cyclophosphamide, ciclosporin, tacrolimus, mycophenolate) is not tolerated or has been ineffective controlling active disease. If an immunosuppressant is contraindicated, a trial has occurred of one of those which is not contraindicated (unless all are contraindicated); or
  - 1.2 Rapid treatment is required for life threatening complications; and
- 2 Cumulative dose up to 1500 mg/m<sup>2</sup> body surface area up to 2000 mg total per cycle; and

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

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- 3 Each treatment cycle at least 6 months apart.

Note: Indications marked with \* are unapproved indications.

**Initial application — (anti-NMDA receptor autoimmune encephalitis\*)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Either:
  - 1.1 Both:
    - 1.1.1 Treatment with corticosteroids and intravenous immunoglobulin and/or plasma exchange has been ineffective controlling active disease, is not tolerated or is contraindicated; and
    - 1.1.2 At least one other immunosuppressant (cyclophosphamide, ciclosporin, tacrolimus, mycophenolate) has been ineffective controlling active disease, is not tolerated or is contraindicated; or
  - 1.2 Rapid treatment is required for life threatening complications; and
- 2 Cumulative dose up to 1500 mg/m<sup>2</sup> body surface area up to 2000 mg total per cycle; and
- 3 Each treatment cycle at least 6 months apart.

Note: Indications marked with \* are unapproved indications.

**Initial application — (CD20+ low grade or follicular B-cell NHL)** from any relevant practitioner. Approvals valid for 9 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 The patient has CD20+ low grade or follicular B-cell NHL with relapsed disease following prior chemotherapy; and
  - 1.2 To be used for a maximum of 6 treatment cycles; or
- 2 Both:
  - 2.1 The patient has CD20+ low grade or follicular B-cell NHL requiring first-line systemic chemotherapy; and
  - 2.2 To be used for a maximum of 6 treatment cycles.

**Renewal — (CD20+ low grade or follicular B-cell NHL)** from any relevant practitioner. Approvals valid for 24 months for applications meeting the following criteria:

Both:

- 1 Rituximab is to be used for maintenance in CD20+ low grade or follicular B-cell NHL following induction with first-line systemic chemotherapy; and
- 2 Patient is intended to receive rituximab maintenance therapy for 2 years at a dose of 375 mg/m<sup>2</sup> every 8 weeks (maximum of 12 cycles).

**Initial application — (Membranous nephropathy)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Either:
  - 1.1 Patient has biopsy-proven primary/idiopathic membranous nephropathy\*; or
  - 1.2 Patient has PLA2 antibodies with no evidence of secondary cause, and an eGFR of > 60ml/min/1.73m<sup>2</sup>; and
- 2 Patient remains at high risk of progression to end-stage kidney disease despite more than 3 months of treatment with conservative measures that include (unless contraindicated or the patient has experienced intolerable side effects) renin-angiotensin system blockade, blood-pressure management, dietary sodium and protein restriction, treatment of dyslipidaemia, and anticoagulation agents; and
- 3 The total rituximab dose per cycle would not exceed the equivalent of 375 mg/m<sup>2</sup> of body surface area per week for a total of 4 weeks; and
- 4 Subsequent retreatment only for disease relapse or after partial response.

Note: Indications marked with \* are unapproved indications.

**Initial application — (B-cell acute lymphoblastic leukaemia/lymphoma\*)** only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 2 years for applications meeting the following

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criteria:

All of the following:

- 1 Patient has newly diagnosed B-cell acute lymphoblastic leukaemia/lymphoma\*; and
- 2 Treatment must be in combination with an intensive chemotherapy protocol with curative intent; and
- 3 The total rituximab dose would not exceed the equivalent of 375 mg/m<sup>2</sup> per dose for a maximum of 18 doses.

Note: Indications marked with \* are unapproved indications.

**Initial application — (desensitisation prior to transplant)** from any relevant practitioner. Approvals valid for 6 weeks for applications meeting the following criteria:

Both:

- 1 Patient requires desensitisation prior to mismatched allogenic stem cell transplant\*; and
- 2 Patient would receive no more than two doses at 375 mg/m<sup>2</sup> of body-surface area.

Note: Indications marked with \* are unapproved indications.

**Initial application — (pemphigus\*)** only from a dermatologist or relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:

Either:

1 All of the following:

- 1.1 Patient has severe rapidly progressive pemphigus; and
- 1.2 Is used in combination with systemic corticosteroids (20 mg/day); and
- 1.3 Any of the following:
  - 1.3.1 Skin involvement is at least 5% body surface area; or
  - 1.3.2 Significant mucosal involvement (10 or more mucosal erosions) or diffuse gingivitis or confluent large erosions; or
  - 1.3.3 Involvement of two or more mucosal sites; or

2 Both:

- 2.1 Patient has pemphigus; and
- 2.2 Patient has not experienced adequate clinical benefit from systemic corticosteroids (20 mg/day) in combination with a steroid sparing agent, unless contraindicated.

Note: Indications marked with \* are unapproved indications.

**Renewal — (pemphigus\*)** only from a dermatologist or relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Patient has experienced adequate clinical benefit from rituximab treatment, with improvement in symptoms and healing of skin ulceration and reduction in corticosteroid requirement; and
- 2 Patient has not received rituximab in the previous 6 months.

Note: Indications marked with \* are unapproved indications.

**Initial application — (immunoglobulin G4-related disease (IgG4-RD\*))** from any relevant practitioner. Approvals valid for 6 weeks for applications meeting the following criteria:

All of the following:

- 1 Patient has confirmed diagnosis of IgG4-RD\*; and
- 2 Either:
  - 2.1 Treatment with corticosteroids and/or disease modifying anti-rheumatic drugs for at least 3 months has been ineffective in lowering corticosteroid dose below 5 mg per day (prednisone equivalent) without relapse; or
  - 2.2 Treatment with corticosteroids and/or disease modifying anti-rheumatic drugs is contraindicated or associated with evidence of toxicity or intolerance; and
- 3 Total rituximab dose used should not exceed a maximum of two 1000 mg infusions of rituximab given two weeks apart.

Note: Indications marked with \* are unapproved indications.

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

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**Renewal — (immunoglobulin G4-related disease (IgG4-RD\*))** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Either:
  - 1.1 Treatment with rituximab for IgG4-RD\* was previously successful and patient's disease has demonstrated sustained response, but the condition has relapsed; or
  - 1.2 Patient is receiving maintenance treatment for IgG4-RD\*; and
- 2 Rituximab re-treatment not to be given within 6 months of previous course of treatment; and
- 3 Maximum of two 1000 mg infusions of rituximab given two weeks apart.

Note: Indications marked with \* are unapproved indications.

SECUKINUMAB – Special Authority see [SA2624 below](#) – Retail pharmacy

Inj 150 mg per ml, 1 ml prefilled syringe.....	799.50	1	✓ Cosentyx
	1,599.00	2	✓ Cosentyx

## ►SA2624 Special Authority for Subsidy

**Initial application — (plaque psoriasis)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 All of the following:
  - 1.1 Any of the following:
    - 1.1.1 Patient has "whole body" plaque psoriasis with a PASI score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis; or
    - 1.1.2 Patient has plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis; or
    - 1.1.3 Patient has localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and with a DLQI score greater than 10; and
  - 1.2 Patient has received insufficient benefit (see Note) or has experienced intolerable side effects from at least 3 of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin; and
  - 1.3 A PASI assessment or DLQI assessment has been completed for the most recent prior treatment course, within 1 month of stopping that treatment; and
  - 1.4 The most recent PASI or DQLI assessment is within 1 month before the application; or
- 2 All of the following:
  - 2.1 Patient has had a Special Authority approval for adalimumab, etanercept, or infliximab, for plaque psoriasis; and
  - 2.2 Either:
    - 2.2.1 Patient has experienced intolerable side effects; or
    - 2.2.2 Patient has received insufficient benefit to meet the renewal criteria for plaque psoriasis; and
  - 2.3 A PASI assessment or DLQI assessment has been completed for the most recent prior treatment within 1 month of stopping that treatment; and
  - 2.4 The most recent PASI or DQLI assessment is within 1 month before the application.

Note: A treatment course is defined as a minimum of 12 weeks of treatment. "Insufficient benefit" is defined as: for whole body plaque psoriasis, a PASI score of greater than 10; for plaque psoriasis of the face, hand, foot, genital or flexural areas, at least 2 of the 3 PASI symptom sub scores for erythema, thickness and scaling are rated as severe or very severe, and for the face, palm of a hand or sole of a foot the skin area affected is 30% or more of the face, palm of a hand or sole of a foot. As assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment

**Renewal — (plaque psoriasis)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

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1 Any of the following:

- 1.1 Patient's PASI score has reduced by 75% or more compared to pre-secukinumab baseline; or
- 1.2 Patient has a DLQI improvement of 5 or more, compared to pre-secukinumab baseline; or
- 1.3 Both:
  - 1.3.1 Patient had localised genital or flexural plaque psoriasis at the start of treatment; and
  - 1.3.2 Either:
    - 1.3.2.1 Patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, compared to the pre-secukinumab baseline; or
    - 1.3.2.2 Patient has a DLQI improvement of 5 or more, compared to pre-secukinumab baseline; and

2 Maximum dose 300 mg monthly.

**Initial application — (ankylosing spondylitis – second-line biologic)** from any relevant practitioner. Approvals valid for 3 months for applications meeting the following criteria:

Both:

- 1 Patient has had a Special Authority approval for adalimumab or etanercept for ankylosing spondylitis; and
- 2 Either:
  - 2.1 Patient has experienced intolerable side effects; or
  - 2.2 Patient has received insufficient benefit to meet the renewal criteria for ankylosing spondylitis.

**Renewal — (ankylosing spondylitis – second-line biologic)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 BASDAI has improved from the pre-secukinumab baseline either by at least 4 points on a 10-point scale, or by at least 50%, whichever is less; and
- 2 Maximum dose 300 mg monthly.

**Initial application — (arthritis - psoriatic)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 Patient has had a Special Authority approval for adalimumab, etanercept or infliximab for psoriatic arthritis; and
  - 1.2 Either:
    - 1.2.1 Patient has experienced intolerable side effects; or
    - 1.2.2 Patient has received insufficient benefit to meet the renewal criteria for psoriatic arthritis; or
- 2 All of the following:
  - 2.1 Patient has received insufficient benefit from at least 3 months of methotrexate at a maximum tolerated dose unless contraindicated; and
  - 2.2 Patient has received insufficient benefit from at least 3 months of sulfasalazine or leflunomide at maximum tolerated doses unless contraindicated; and
  - 2.3 Either:
    - 2.3.1 Patient has persistent symptoms of poorly controlled and active disease in at least 15 joints; or
    - 2.3.2 Patient has persistent symptoms of poorly controlled and active disease in at least 4 joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip; and
  - 2.4 Any of the following:
    - 2.4.1 CRP greater than 15 mg/L measured within one month before the application; or
    - 2.4.2 ESR greater than 25 mm per hour measured within one month before the application; or
    - 2.4.3 ESR and CRP not measured as patient is receiving prednisone therapy greater than 5 mg per day received for more than 3 months.

**Renewal — (arthritis - psoriatic)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

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Both:

- 1 Either:
  - 1.1 Following initial treatment, at least a 50% decrease in active joint count from baseline; or
  - 1.2 At least a continuing 30% improvement in active joint count from baseline; and
- 2 Maximum dose 300 mg monthly.

SILTUXIMAB – Special Authority see [SA1596 below](#) – Retail pharmacy

Note: Siltuximab is to be administered at doses no greater than 11 mg/kg every 3 weeks.

Inj 100 mg vial .....	770.57	1	✓ Sylvant
Inj 400 mg vial .....	3,082.33	1	✓ Sylvant

## ►SA1596 Special Authority for Subsidy

**Initial application** only from a haematologist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has severe HHV-8 negative idiopathic multicentric Castleman's Disease; and
- 2 Treatment with an adequate trial of corticosteroids has proven ineffective; and
- 3 Siltuximab is to be administered at doses no greater than 11 mg/kg every 3 weeks.

**Renewal** only from a haematologist or rheumatologist. Approvals valid for 12 months where the treatment remains appropriate and the patient has sustained improvement in inflammatory markers and functional status.

TOCILIZUMAB – PCT only – Special Authority see [SA2489 below](#)

Inj 20 mg per ml, 4 ml vial.....	220.00	1	✓ Actemra
Inj 20 mg per ml, 10 ml vial.....	550.00	1	✓ Actemra
Inj 20 mg per ml, 20 ml vial.....	1,100.00	1	✓ Actemra
Inj 1 mg for ECP .....	2.85	1 mg	✓ Baxter

## ►SA2489 Special Authority for Subsidy

**Initial application** — (cytokine release syndrome) from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 The patient has developed grade 3 or 4 cytokine release syndrome associated with the administration of blinatumomab for the treatment of acute lymphoblastic leukaemia; and
  - 1.2 Tocilizumab is to be administered at doses no greater than 8 mg/kg IV for a maximum of 3 doses (if less than 30kg, maximum of 12 mg/kg); or
- 2 All of the following:
  - 2.1 The patient is enrolled in the Malaghan Institute of Medical Research ENABLE trial programme; and
  - 2.2 The patient has developed CRS or Immune Effector Cell-Associated Neurotoxicity Syndrome (ICANS) following CAR T-cell therapy for the treatment of relapsed or refractory B-cell non-Hodgkin lymphoma; and
  - 2.3 Tocilizumab is to be administered according to the consensus guidelines for CRS or ICANS for CAR T-cell therapy at doses no greater than 8 mg/kg IV for a maximum of 3 doses.

**Initial application** — (previous use) from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Patient was being treated with tocilizumab prior to 1 February 2019; and
- 2 Any of the following:
  - 2.1 rheumatoid arthritis; or
  - 2.2 systemic juvenile idiopathic arthritis; or
  - 2.3 adult-onset Still's disease; or

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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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- 2.4 polyarticular juvenile idiopathic arthritis; or
- 2.5 idiopathic multicentric Castleman's disease.

**Initial application — (Rheumatoid Arthritis (patients previously treated with adalimumab or etanercept))** only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 The patient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis; and
- 2 Either:
  - 2.1 The patient has experienced intolerable side effects from adalimumab and/or etanercept; or
  - 2.2 The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or etanercept such that they do not meet the renewal criteria for rheumatoid arthritis; and
- 3 Either:
  - 3.1 The patient is seronegative for both anti-cyclic citrullinated peptide (CCP) antibodies and rheumatoid factor; or
  - 3.2 Both:
    - 3.2.1 The patient has been started on rituximab for rheumatoid arthritis in a Health NZ Hospital; and
    - 3.2.2 Either:
      - 3.2.2.1 The patient has experienced intolerable side effects from rituximab; or
      - 3.2.2.2 At four months following the initial course of rituximab the patient has received insufficient benefit such that they do not meet the renewal criteria for rheumatoid arthritis.

**Initial application — (Rheumatoid Arthritis)** only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has had severe and active erosive rheumatoid arthritis (either confirmed by radiology imaging, or the patient is cyclic citrullinated peptide (CCP) antibody positive) for six months duration or longer; and
- 2 Tocilizumab is to be used as monotherapy; and
- 3 Either:
  - 3.1 Treatment with methotrexate is contraindicated; or
  - 3.2 Patient has tried and did not tolerate oral and/or parenteral methotrexate; and
- 4 Either:
  - 4.1 Patient has tried and not responded to at least three months therapy at the maximum tolerated dose of ciclosporin alone or in combination with another agent; or
  - 4.2 Patient has tried and not responded to at least three months therapy at the maximum tolerated dose of leflunomide alone or in combination with another agent; and
- 5 Either:
  - 5.1 Patient has persistent symptoms of poorly controlled and active disease in at least 20 active, swollen, tender joints; or
  - 5.2 Patient has persistent symptoms of poorly controlled and active disease in at least four active joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip; and
- 6 Either:
  - 6.1 Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application; or
  - 6.2 C-reactive protein levels not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months.

**Initial application — (systemic juvenile idiopathic arthritis)** only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Patient diagnosed with systemic juvenile idiopathic arthritis; and

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

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- 2 Patient has tried and not responded to a reasonable trial of all of the following, either alone or in combination: oral or parenteral methotrexate; non-steroidal anti-inflammatory drugs (NSAIDs); and systemic corticosteroids.

**Initial application — (adult-onset Still's disease)** only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 Either:
    - 1.1.1 The patient has had an initial Special Authority approval for adalimumab and/or etanercept for adult-onset Still's disease (AOSD); or
    - 1.1.2 The patient has been started on tocilizumab for AOSD in a Health NZ Hospital; and
  - 1.2 Either:
    - 1.2.1 The patient has experienced intolerable side effects from adalimumab and/or etanercept; or
    - 1.2.2 The patient has received insufficient benefit from at least a three-month trial of adalimumab and/or etanercept such that they do not meet the renewal criteria for AOSD; or
- 2 All of the following:
  - 2.1 Patient diagnosed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430); and
  - 2.2 Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-steroidal antiinflammatory drugs (NSAIDs) and methotrexate; and
  - 2.3 Patient has persistent symptoms of disabling poorly controlled and active disease.

**Initial application — (polyarticular juvenile idiopathic arthritis)** only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 The patient has had an initial Special Authority approval for both etanercept and adalimumab for polyarticular course juvenile idiopathic arthritis (JIA); and
  - 1.2 The patient has experienced intolerable side effects, or has received insufficient benefit from, both etanercept and adalimumab; or
- 2 All of the following:
  - 2.1 Treatment with a tumour necrosis factor alpha inhibitor is contraindicated; and
  - 2.2 Patient has had polyarticular course JIA for 6 months duration or longer; and
  - 2.3 To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance; and
  - 2.4 Any of the following:
    - 2.4.1 At least 5 active joints and at least 3 joints with limited range of motion, pain or tenderness after a 3-month trial of methotrexate (at the maximum tolerated dose); or
    - 2.4.2 Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial of methotrexate (at the maximum tolerated dose); or
    - 2.4.3 Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of methotrexate.

**Initial application — (idiopathic multicentric Castleman's disease)** only from a haematologist, rheumatologist or Practitioner on the recommendation of a haematologist or rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has severe HHV-8 negative idiopathic multicentric Castleman's disease; and
- 2 Treatment with an adequate trial of corticosteroids has proven ineffective; and
- 3 Tocilizumab to be administered at doses no greater than 8 mg/kg IV every 3-4 weeks.

**Initial application — (moderate to severe COVID-19)** from any relevant practitioner. Approvals valid for 4 weeks for applications meeting the following criteria:

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All of the following:

- 1 Patient has confirmed (or probable) COVID-19; and
- 2 Oxygen saturation of < 92% on room air, or requiring supplemental oxygen; and
- 3 Patient is receiving adjunct systemic corticosteroids, or systemic corticosteroids are contraindicated; and
- 4 Tocilizumab is to be administered at doses no greater than 8mg/kg IV for a maximum of one dose; and
- 5 Tocilizumab is not to be administered in combination with baricitinib.

**Renewal — (Rheumatoid Arthritis)** only from a rheumatologist or Practitioner on the recommendation of a rheumatologist.

Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Following 6 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician; or
- 2 On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician.

**Renewal — (systemic juvenile idiopathic arthritis)** only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Following up to 6 months' initial treatment, the patient has achieved at least an American College of Rheumatology paediatric 30% improvement criteria (ACR Pedi 30) response from baseline; or
- 2 On subsequent reapplications, the patient demonstrates at least a continuing ACR Pedi 30 response from baseline.

**Renewal — (adult-onset Still's disease)** only from a rheumatologist or Practitioner on the recommendation of a rheumatologist.

Approvals valid for 6 months where the patient has a sustained improvement in inflammatory markers and functional status.

**Renewal — (polyarticular juvenile idiopathic arthritis)** only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance; and
- 2 Either:
  - 2.1 Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline; or
  - 2.2 On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline.

**Renewal — (idiopathic multicentric Castleman's disease)** only from a haematologist, rheumatologist or Practitioner on the recommendation of a haematologist or rheumatologist. Approvals valid for 12 months where the treatment remains appropriate and the patient has a sustained improvement in inflammatory markers and functional status.

**Initial application — (immune checkpoint inhibitor toxicity in malignancy\*)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 The individual requires treatment for moderate to severe autoimmune toxicity following immune checkpoint inhibitor treatment for malignancy; and
- 2 The individual has received insufficient benefit from use of corticosteroids; and
- 3 Tocilizumab is to be administered at a maximum dose of 8 mg/kg fortnightly.

**Renewal — (immune checkpoint inhibitor toxicity in malignancy\*)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

Both:

- 1 The individual has shown clinical improvement and ongoing treatment is required; and
- 2 Tocilizumab is to be administered at a maximum dose of 8 mg/kg fortnightly.

Note: Indications marked with \* are unapproved indications.

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
TRASTUZUMAB (HERZUMA) – PCT only – Special Authority see <a href="#">SA2293</a> below				
Inj 150 mg vial .....	100.00	1	✓	<b>Herzuma</b>
Inj 440 mg vial .....	293.35	1	✓	<b>Herzuma</b>
Inj 1 mg for ECP .....	0.70	1 mg	✓	<b>Baxter</b>

## ► [SA2293](#) Special Authority for Subsidy

**Initial application — (early breast cancer)** from any relevant practitioner. Approvals valid for 15 months for applications meeting the following criteria:

Both:

- 1 The patient has early breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology); and
- 2 Maximum cumulative dose of 106 mg/kg (12 months' treatment).

**Renewal — (early breast cancer\*)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Either:

- 1 All of the following:
  - 1.1 The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology); and
  - 1.2 The patient received prior adjuvant trastuzumab treatment for early breast cancer; and
  - 1.3 Any of the following:
    - 1.3.1 The patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer; or
    - 1.3.2 The patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst on lapatinib; or
    - 1.3.3 The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab; and
  - 1.4 Either:
    - 1.4.1 Trastuzumab will not be given in combination with pertuzumab; or
    - 1.4.2 All of the following:
      - 1.4.2.1 Trastuzumab to be administered in combination with pertuzumab; and
      - 1.4.2.2 Patient has not received prior treatment for their metastatic disease and has had a treatment-free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer; and
      - 1.4.2.3 The patient has good performance status (ECOG grade 0-1); and
    - 1.5 Trastuzumab to be discontinued at disease progression; or
- 2 All of the following:
  - 2.1 Patient has previously discontinued treatment with trastuzumab in the metastatic setting for reasons other than severe toxicity or disease progression; and
  - 2.2 Patient has signs of disease progression; and
  - 2.3 Disease has not progressed during previous treatment with trastuzumab.

Note: \* For patients with relapsed HER-2 positive disease who have previously received adjuvant trastuzumab for early breast cancer

**Initial application — (metastatic breast cancer)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology); and
- 2 Either:
  - 2.1 The patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer; or
  - 2.2 The patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst on lapatinib; and
- 3 Either:

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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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continued...

- 3.1 Trastuzumab will not be given in combination with pertuzumab; or
- 3.2 All of the following:
  - 3.2.1 Trastuzumab to be administered in combination with pertuzumab; and
  - 3.2.2 Patient has not received prior treatment for their metastatic disease and has had a treatment-free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer; and
  - 3.2.3 The patient has good performance status (ECOG grade 0-1); and
- 4 Trastuzumab to be discontinued at disease progression.

**Renewal — (metastatic breast cancer)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Either:

- 1 All of the following:
  - 1.1 The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology); and
  - 1.2 The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab; and
  - 1.3 Trastuzumab to be discontinued at disease progression; or
- 2 All of the following:
  - 2.1 Patient has previously discontinued treatment with trastuzumab for reasons other than severe toxicity or disease progression; and
  - 2.2 Patient has signs of disease progression; and
  - 2.3 Disease has not progressed during previous treatment with trastuzumab.

**Initial application — (gastric, gastro-oesophageal junction and oesophageal cancer)** from any relevant practitioner.

Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 The patient has locally advanced or metastatic gastric, gastro-oesophageal junction or oesophageal cancer expressing HER-2 IHC 2+ FISH+ or IHC3+ (or other current technology); and
- 2 Patient has an ECOG score of 0-2.

**Renewal — (gastric, gastro-oesophageal junction and oesophageal cancer)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- 1 The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab; and
- 2 Trastuzumab to be discontinued at disease progression.

TRASTUZUMAB DERUXTECAN – PCT only – Special Authority see [SA2420 below](#)

Inj 100 mg per ml, 1 ml vial.....	2,550.00	1	✓	Enherthu
Inj 1 mg for ECP .....	27.05	1 mg	✓	Baxter

► **SA2420** **Special Authority for Subsidy**

**Initial application** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist.

Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Patient is currently on treatment with trastuzumab deruxtecan and met all remaining criteria prior to commencing treatment; or
- 2 All of the following:
  - 2.1 Patient has metastatic breast cancer expressing HER-2 IHC3+ or ISH+ (including FISH or other current technology); and
  - 2.2 Patient has previously received trastuzumab and chemotherapy, separately or in combination; and
  - 2.3 Either:

continued...

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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- 2.3.1 The patient has received prior therapy for metastatic disease; or
- 2.3.2 The patient developed disease recurrence during, or within six months of completing adjuvant therapy; and
- 2.4 Patient has a good performance status (ECOG 0-1); and
- 2.5 Patient has not received prior funded trastuzumab deruxtecan treatment; and
- 2.6 Treatment to be discontinued at disease progression.

**Renewal** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab deruxtecan; and
- 2 Treatment to be discontinued at disease progression.

Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy, biological drugs, or endocrine therapy.

TRASTUZUMAB EMTANSINE – PCT only – Specialist – Special Authority see [SA2424](#) below

Inj 100 mg vial .....	2,320.00	1	✓ Kadcyła
Inj 160 mg vial .....	3,712.00	1	✓ Kadcyła
Inj 1 mg for ECP .....	24.52	1 mg	✓ Baxter

► [SA2424](#) **Special Authority for Subsidy**

**Initial application — (early breast cancer)** only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient has early breast cancer expressing HER2 IHC3+ or ISH+; and
- 2 Documentation of pathological invasive residual disease in the breast and/or axillary lymph nodes following completion of surgery; and
- 3 Patient has completed systemic neoadjuvant therapy with trastuzumab and chemotherapy prior to surgery; and
- 4 Disease has not progressed during neoadjuvant therapy; and
- 5 Patient has left ventricular ejection fraction of 45% or greater; and
- 6 Adjuvant treatment with trastuzumab emtansine to be commenced within 12 weeks of surgery; and
- 7 Trastuzumab emtansine to be discontinued at disease progression; and
- 8 Total adjuvant treatment duration must not exceed 42 weeks (14 cycles).

**Initial application — (metastatic breast cancer)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology); and
- 2 Patient has previously received trastuzumab and chemotherapy, separately or in combination; and
- 3 Either:
  - 3.1 The patient has received prior therapy for metastatic disease\*; or
  - 3.2 The patient developed disease recurrence during, or within six months of completing adjuvant therapy\*; and
- 4 Patient has a good performance status (ECOG 0-1); and
- 5 Either:
  - 5.1 Patient does not have symptomatic brain metastases; or
  - 5.2 Patient has brain metastases and has received prior local CNS therapy; and
- 6 Either:
  - 6.1 Patient has not received prior funded trastuzumab emtansine or trastuzumab deruxtecan treatment; or
  - 6.2 Both:
    - 6.2.1 Patient has discontinued trastuzumab deruxtecan due to intolerance; and
    - 6.2.2 The cancer did not progress while on trastuzumab deruxtecan; and

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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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7 Treatment to be discontinued at disease progression.

**Renewal — (metastatic breast cancer)** only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:

- Both:
- 1 The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab emtansine; and
  - 2 Treatment to be discontinued at disease progression.

Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy, biological drugs, or endocrine therapy.

USTEKINUMAB – Special Authority see SA2182 below – Retail pharmacy

Inj 90 mg per ml, 1 ml pre-filled syringe..... 4,162.00      1      ✓ **Stelara**

►SA2182 Special Authority for Subsidy

**Initial application — (Crohn's disease - adults)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

- Either:
- 1 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
  - 2 Both:
    - 2.1 Patient has active Crohn's disease; and
    - 2.2 Either:
      - 2.2.1 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
      - 2.2.2 Both:
        - 2.2.2.1 Patient meets the initiation criteria for prior biologic therapies for Crohn's disease; and
        - 2.2.2.2 Other biologics for Crohn's disease are contraindicated.

**Renewal — (Crohn's disease - adults)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

- Both:
- 1 Any of the following:
    - 1.1 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
    - 1.2 CDAI score is 150 or less, or HBI is 4 or less; or
    - 1.3 The patient has experienced an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed; and
  - 2 Ustekinumab to be administered at a dose no greater than 90 mg every 8 weeks.

**Initial application — (Crohn's disease - children\*)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

- Either:
- 1 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
  - 2 Both:
    - 2.1 Patient has active Crohn's disease; and
    - 2.2 Either:
      - 2.2.1 Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria; or
      - 2.2.2 Both:
        - 2.2.2.1 Patient meets the initiation criteria for prior biologic therapies for Crohn's disease; and

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time



Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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- 2.5 Patient has an ileostomy or colostomy, and has intestinal inflammation; and
- 3 Any of the following:
  - 3.1 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
  - 3.2 Patient has experienced intolerable side effects from immunomodulators and corticosteroids; or
  - 3.3 Immunomodulators and corticosteroids are contraindicated.

**Renewal — (Crohn's disease - adults)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

- Both:
- 1 Any of the following:
    - 1.1 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
    - 1.2 CDAI score is 150 or less, or HBI is 4 or less; or
    - 1.3 The patient has experienced an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed; and
  - 2 Vedolizumab to administered at a dose no greater than 300 mg every 8 weeks.

**Initial application — (Crohn's disease - children\*)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

- All of the following:
- 1 Paediatric patient has active Crohn's disease; and
  - 2 Any of the following:
    - 2.1 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
    - 2.2 Patient has a Paediatric Crohn's Disease Activity Index (PCDAI) score of greater than or equal to 30; or
    - 2.3 Patient has extensive small intestine disease; and
  - 3 Any of the following:
    - 3.1 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
    - 3.2 Patient has experienced intolerable side effects from immunomodulators and corticosteroids; or
    - 3.3 Immunomodulators and corticosteroids are contraindicated.

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

**Renewal — (Crohn's disease - children\*)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

- Both:
- 1 Any of the following:
    - 1.1 PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy; or
    - 1.2 PCDAI score is 15 or less; or
    - 1.3 The patient has experienced an adequate response to treatment, but CDAI score cannot be assessed; and
  - 2 Vedolizumab to administered at a dose no greater than 300mg every 8 weeks.

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

**Initial application — (ulcerative colitis)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

- All of the following:
- 1 Patient has active ulcerative colitis; and
  - 2 Any of the following:
    - 2.1 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

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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- 2.2 Patient has a SCCAI score is greater than or equal to 4; or
- 2.3 Patient's PUCAI score is greater than or equal to 20\*; and
- 3 Any of the following:
  - 3.1 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
  - 3.2 Patient has experienced intolerable side effects from immunomodulators and corticosteroids; or
  - 3.3 Immunomodulators and corticosteroids are contraindicated.

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

**Renewal — (ulcerative colitis)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- 1 Either:
  - 1.1 The SCCAI score has reduced by 2 points or more from the SCCAI score since initiation on biologic therapy; or
  - 1.2 The PUCAI score has reduced by 10 points or more from the PUCAI score since initiation on biologic therapy \*; and
- 2 Vedolizumab will be used at a dose no greater than 300 mg intravenously every 8 weeks.

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

## Programmed Cell Death-1 (PD-1) Inhibitors

ATEZOLIZUMAB – PCT only – Specialist – Special Authority see SA2630 below

Inj 60 mg per ml, 20 ml vial.....	9,503.00	1	✓ Tecentriq
Inj 1 mg for ECP .....	8.08	1 mg	✓ Baxter

►SA2630 Special Authority for Subsidy

**Initial application — (non-small cell lung cancer second line monotherapy)** only from a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Patient has locally advanced or metastatic non-small cell lung cancer; and
- 2 Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC; and
- 3 For patients with non-squamous histology there is documentation confirming that the disease does not express activating mutations of EGFR, ROS-1 or ALK tyrosine kinase unless not possible to ascertain; and
- 4 Patient has an ECOG 0-2; and
- 5 Patient has documented disease progression following treatment with at least two cycles of platinum-based chemotherapy; and
- 6 Atezolizumab is to be used as monotherapy at a dose of 1200 mg every three weeks (or equivalent) for a maximum of 16 weeks; and
- 7 Baseline measurement of overall tumour burden is documented clinically and radiologically.

**Renewal — (non-small cell lung cancer second line monotherapy)** only from a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Any of the following:
  - 1.1 Patient's disease has had a complete response to treatment; or
  - 1.2 Patient's disease has had a partial response to treatment; or
  - 1.3 Patient has stable disease; and
- 2 Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period; and
- 3 No evidence of disease progression; and

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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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- 4 The treatment remains clinically appropriate and patient is benefitting from treatment; and
- 5 Atezolizumab to be used at a maximum dose of 1200 mg every three weeks (or equivalent); and
- 6 Treatment with atezolizumab to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks).

**Initial application — (unresectable hepatocellular carcinoma)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Patient is currently on treatment with atezolizumab and met all remaining criteria prior to commencing treatment; or
- 2 All of the following:
  - 2.1 Patient has locally advanced or metastatic, unresectable hepatocellular carcinoma; and
  - 2.2 Patient has preserved liver function (Child-Pugh A); and
  - 2.3 Transarterial chemoembolisation (TACE) is unsuitable; and
  - 2.4 Any of the following:
    - 2.4.1 Patient has not received prior systemic therapy for the treatment of hepatocellular carcinoma; or
    - 2.4.2 Patient received funded lenvatinib before 1 March 2025; or
    - 2.4.3 Both:
      - 2.4.3.1 Patient has experienced treatment-limiting toxicity from treatment with lenvatinib; and
      - 2.4.3.2 No disease progression since initiation of lenvatinib; and
  - 2.5 Patient has an ECOG performance status of 0-2; and
  - 2.6 To be given in combination with bevacizumab.

**Renewal — (unresectable hepatocellular carcinoma)** from any relevant practitioner. Approvals valid for 6 months where there is no evidence of disease progression.

**DURVALUMAB – PCT only – Specialist – Special Authority see SA2425 below**

Inj 50 mg per ml, 10 ml vial.....	4,700.00	1	✓ Imfinzi
Inj 50 mg per ml, 2.4 ml vial.....	1,128.00	1	✓ Imfinzi
Inj 1 mg for ECP .....	9.59	1 mg	✓ Baxter

►SA2425 Special Authority for Subsidy

**Initial application — (Non-small cell lung cancer)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Either:
  - 1.1 Patient has histologically or cytologically documented stage III, locally advanced, unresectable non-small cell lung cancer (NSCLC); or
  - 1.2 Patient has histologically or cytologically documented stage IIb (T1N2a only), locally advanced, unresectable non-small cell lung cancer (NSCLC); and
- 2 Patient has received two or more cycles of platinum-based chemotherapy concurrently with definitive radiation therapy; and
- 3 Patient has no disease progression following the second or subsequent cycle of platinum-based chemotherapy with definitive radiation therapy treatment; and
- 4 Patient has a ECOG performance status of 0 or 1; and
- 5 Patient has completed last radiation dose within 8 weeks of starting treatment with durvalumab; and
- 6 Patient must not have received prior PD-1 or PD-L1 inhibitor therapy for this condition; and
- 7 Either:
  - 7.1 Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks; or
  - 7.2 Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks; and
- 8 Treatment with durvalumab to cease upon signs of disease progression.

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▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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**Renewal — (Non-small cell lung cancer)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 The treatment remains clinically appropriate and the patient is benefitting from treatment; and
- 2 Either:
  - 2.1 Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks; or
  - 2.2 Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks; and
- 3 Treatment with durvalumab to cease upon signs of disease progression; and
- 4 Total continuous treatment duration must not exceed 12 months.

**IPILIMUMAB – PCT only – Specialist – Special Authority see SA2642 below**

Inj 5 mg per ml, 10 ml vial.....	5,000.00	1	✓ Yervoy
Inj 5 mg per ml, 40 ml vial.....	20,000.00	1	✓ Yervoy
Inj 1 mg for ECP .....	106.00	1 mg	✓ Baxter

► **SA2642 Special Authority for Subsidy**

**Initial application — (stage III or IV resectable melanoma)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 The individual is currently on treatment with ipilimumab for neoadjuvant treatment of resectable stage IIIB, IIIC, IIID or IVD melanoma and met all remaining criteria prior to commencing treatment; or
- 2 All of the following:
  - 2.1 The individual has resectable stage IIIB, IIIC, IIID or IVD melanoma (excluding uveal) (see note); and
  - 2.2 The individual has not received prior funded systemic treatment in the perioperative setting for their stage IIIB, IIIC, IIID or IVD melanoma; and
  - 2.3 The individual has ECOG performance score 0-2; and
  - 2.4 Treatment must be prior to complete surgical resection; and
  - 2.5 Neoadjuvant ipilimumab must be administered in combination with nivolumab; and
  - 2.6 Ipilimumab to be administered for maximum of two cycles prior to surgical resection.

Notes:

- a) Stage IIIB, IIIC, IIID or IVD melanoma defined as per American Joint Committee on Cancer (AJCC) 8th Edition.
- b) Disease must be completely resectable and amenable to curative intent surgery, including stage IVD disease.

**Initial application — (renal cell carcinoma)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 The patient is currently on treatment with ipilimumab and met all remaining criteria prior to commencing treatment; or
- 2 All of the following:
  - 2.1 The patient has metastatic renal cell carcinoma; and
  - 2.2 The patient is treatment naive; and
  - 2.3 The patient has ECOG performance status 0-2; and
  - 2.4 The disease is predominantly of clear cell histology; and
  - 2.5 Any of the following:
    - 2.5.1 The patient has sarcomatoid histology; or
    - 2.5.2 Haemoglobin levels less than the lower limit of normal; or
    - 2.5.3 Corrected serum calcium level greater than 10 mg/dL (2.5 mmol/L); or
    - 2.5.4 Neutrophils greater than the upper limit of normal; or
    - 2.5.5 Platelets greater than the upper limit of normal; or
    - 2.5.6 Interval of less than 1 year from original diagnosis to the start of systemic therapy; or
    - 2.5.7 Karnofsky performance score of less than or equal to 70; and
  - 2.6 Ipilimumab is to be used at a maximum dose of 1 mg/kg for up to four cycles in combination with nivolumab..

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>NIVOLUMAB – PCT only – Specialist – Special Authority see SA2643 below</b>				
Inj 10 mg per ml, 4 ml vial.....	1,051.98	1	✓	<b>Opdivo</b>
Inj 10 mg per ml, 10 ml vial.....	2,629.96	1	✓	<b>Opdivo</b>
Inj 1 mg for ECP .....	27.22	1 mg	✓	<b>Baxter</b>

► **SA2643 Special Authority for Subsidy**

**Initial application — (stage III or IV resectable melanoma)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:  
Either:

- 1 The individual is currently on treatment with nivolumab for neoadjuvant treatment of resectable stage IIIB, IIIC, IIID or IV melanoma and met all remaining criteria prior to commencing treatment; or
- 2 All of the following:
  - 2.1 The individual has resectable stage IIIB, IIIC, IIID or IV melanoma (excluding uveal) (see note); and
  - 2.2 The individual has not received prior funded systemic treatment in the perioperative setting for their stage IIIB, IIIC, IIID or IV melanoma; and
  - 2.3 The individual has ECOG performance score 0-2; and
  - 2.4 Treatment must be initiated prior to complete surgical resection; and
  - 2.5 Neoadjuvant nivolumab must be administered in combination with ipilimumab; and
  - 2.6 Nivolumab to be administered for maximum of two cycles prior to surgical resection.

**Renewal — (stage III or IV resectable melanoma)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:  
Any of the following:

- 1 All of the following:
  - 1.1 The individual has received funded neoadjuvant treatment with nivolumab in combination with ipilimumab; and
  - 1.2 Adjuvant treatment with nivolumab is required; and
  - 1.3 Treatment must be initiated within 13 weeks of complete surgical resection, unless delay is necessary due to post-surgery recovery; and
  - 1.4 Nivolumab must be administered as monotherapy; and
  - 1.5 Nivolumab to be discontinued at signs of disease recurrence or at completion of 12 months total treatment duration including any systemic neoadjuvant treatment (equivalent to 11 adjuvant cycles at 480 mg every 4 weeks plus initial 2 neoadjuvant treatment cycles); or
- 2 All of the following:
  - 2.1 The individual has received neoadjuvant treatment with nivolumab and ipilimumab; and
  - 2.2 The individual has unresectable or metastatic melanoma (excluding uveal) stage III or IV; and
  - 2.3 The individual meets initial application criteria for nivolumab for unresectable or metastatic melanoma; or
- 3 All of the following:
  - 3.1 The individual has received neoadjuvant treatment with nivolumab and ipilimumab; and
  - 3.2 The individual has received treatment with nivolumab for unresectable or metastatic melanoma; and
  - 3.3 The individual meets the renewal criteria for nivolumab for unresectable or metastatic melanoma.

Notes:

- a) Stage IIIB, IIIC, IIID or IV melanoma defined as per American Joint Committee on Cancer (AJCC) 8th Edition.
- b) Disease must be completely resectable and amenable to curative intent surgery, including stage IV disease.

**Initial application — (unresectable or metastatic melanoma)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:  
All of the following:

- 1 The individual has metastatic or unresectable melanoma (excluding uveal) stage III or IV; and
- 2 Baseline measurement of overall tumour burden is documented clinically and radiologically; and
- 3 The individual has ECOG performance 0-2; and
- 4 Either:

continued...

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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- 4.1 The individual has not received funded pembrolizumab; or
- 4.2 Both:
  - 4.2.1 The individual has received an initial Special Authority approval for pembrolizumab and has discontinued pembrolizumab within 12 weeks of starting treatment due to intolerance; and
  - 4.2.2 The cancer did not progress while the individual was on pembrolizumab; and
- 5 Any of the following:
  - 5.1 The individual has been diagnosed in the metastatic or unresectable stage III or IV setting; or
  - 5.2 The individual did not receive treatment in the perioperative setting with a PD-1/PD-L1 inhibitor; or
  - 5.3 All of the following:
    - 5.3.1 The individual received treatment in the perioperative setting with a PD-1/PD-L1 inhibitor; and
    - 5.3.2 The individual did not experience disease recurrence while on treatment with that PD-1/PD-L1 inhibitor; and
    - 5.3.3 The individual did not experience disease recurrence within six months of completing perioperative treatment with a PD-1/PD-L1 inhibitor.

**Renewal — (unresectable or metastatic melanoma, less than 24 months on treatment)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 Both:
  - 1.1 Any of the following:
    - 1.1.1 The individual's disease has had a complete response to treatment; or
    - 1.1.2 The individual's disease has had a partial response to treatment; or
    - 1.1.3 The individual has stable disease; and
  - 1.2 Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period; or
- 2 All of the following:
  - 2.1 The individual has previously discontinued treatment with nivolumab for reasons other than severe toxicity or disease progression; and
  - 2.2 The individual has signs of disease progression; and
  - 2.3 Disease has not progressed during previous treatment with nivolumab.

**Renewal — (unresectable or metastatic melanoma, more than 24 months on treatment)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:

Both:

- 1 The individual has been on treatment for more than 24 months; and
- 2 Either:
  - 2.1 Both:
    - 2.1.1 Any of the following:
      - 2.1.1.1 The individual's disease has had a complete response to treatment; or
      - 2.1.1.2 The individual's disease has had a partial response to treatment; or
      - 2.1.1.3 The individual has stable disease; and
    - 2.1.2 Response to treatment in target lesions has been determined by comparable radiologic or clinical assessment following the most recent treatment period; or
  - 2.2 All of the following:
    - 2.2.1 The individual has previously discontinued treatment with nivolumab for reasons other than severe toxicity or disease progression; and
    - 2.2.2 The individual has signs of disease progression; and
    - 2.2.3 Disease has not progressed during previous treatment with nivolumab.

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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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**Initial application — (renal cell carcinoma, first line)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 Patient is currently on treatment with nivolumab and met all remaining criteria prior to commencing treatment; or
- 2 All of the following:
  - 2.1 The patient has metastatic renal cell carcinoma; and
  - 2.2 The patient is treatment naïve; and
  - 2.3 The patient has ECOG performance status 0-2; and
  - 2.4 The disease is predominantly of clear cell histology; and
  - 2.5 Any of the following:
    - 2.5.1 The patient has sarcomatoid histology; or
    - 2.5.2 Haemoglobin levels less than the lower limit of normal; or
    - 2.5.3 Corrected serum calcium level greater than 10 mg/dL (2.5 mmol/L); or
    - 2.5.4 Neutrophils greater than the upper limit of normal; or
    - 2.5.5 Platelets greater than the upper limit of normal; or
    - 2.5.6 Interval of less than 1 year from original diagnosis to the start of systemic therapy; or
    - 2.5.7 Karnofsky performance score of less than or equal to 70; and
- 2.6 Nivolumab is to be used in combination with ipilimumab for the first four treatment cycles at a maximum dose of 3 mg/kg; and
- 2.7 Nivolumab is to be used as monotherapy at a maximum maintenance dose of 240 mg every 2 weeks (or equivalent).

**Initial application — (Renal cell carcinoma, second line)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Patient has metastatic renal-cell carcinoma; and
- 2 The disease is of predominant clear-cell histology; and
- 3 Patient has ECOG performance status 0-2; and
- 4 Patient has documented disease progression following one or two previous regimens of antiangiogenic therapy; and
- 5 Patient has not previously received a funded immune checkpoint inhibitor; and
- 6 Nivolumab is to be used as monotherapy at a maximum dose of 240 mg every 2 weeks (or equivalent) and discontinued at disease progression.

**Renewal — (Renal cell carcinoma)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Any of the following:
  - 1.1 Patient's disease has had a complete response to treatment; or
  - 1.2 Patient's disease has had a partial response to treatment; or
  - 1.3 Patient has stable disease; and
- 2 No evidence of disease progression; and
- 3 Nivolumab is to be used as monotherapy at a maximum dose of 240 mg every 2 weeks (or equivalent) and discontinued at disease progression.

PEMBROLIZUMAB – PCT only – Specialist – Special Authority see [SA2631](#) below

Inj 25 mg per ml, 4 ml vial.....	4,680.00	1	✓ <b>Keytruda</b>
Inj 1 mg for ECP .....	47.74	1 mg	✓ <b>Baxter</b>

➔ **SA2631** Special Authority for Subsidy

**Initial application — (stage III or IV resectable melanoma - neoadjuvant)** only from a relevant specialist or any relevant

continued...

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

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practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 The individual has resectable stage IIIB, IIIC, IIID or IV melanoma (excluding uveal) (see note); and
- 2 The individual has not received prior funded systemic treatment in the perioperative setting for their stage IIIB, IIIC, IIID or IV melanoma; and
- 3 Treatment must be prior to complete surgical resection; and
- 4 Pembrolizumab must be administered as monotherapy; and
- 5 The individual has ECOG performance score 0-2; and
- 6 Pembrolizumab to be administered at a fixed dose of 200 mg every 3 weeks (or equivalent).

**Renewal — (stage III or IV resectable melanoma - neoadjuvant)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:

Any of the following:

- 1 Both:
  - 1.1 The individual has received neoadjuvant treatment with an immune checkpoint inhibitor; and
  - 1.2 The individual meets initial application criteria for pembrolizumab for stage III or IV resected melanoma – adjuvant; or
- 2 Both:
  - 2.1 The individual has received neoadjuvant and adjuvant treatment with an immune checkpoint inhibitor; and
  - 2.2 The individual meets renewal criteria for pembrolizumab for stage III or IV resected melanoma – adjuvant; or
- 3 All of the following:
  - 3.1 The individual has received neoadjuvant and adjuvant treatment with an immune checkpoint inhibitor; and
  - 3.2 The individual has metastatic or unresectable melanoma (excluding uveal) stage III or IV; and
  - 3.3 The individual meets initial application criteria for pembrolizumab for unresectable or metastatic melanoma; or
- 4 All of the following:
  - 4.1 The individual has received neoadjuvant and adjuvant treatment with an immune checkpoint inhibitor; and
  - 4.2 The individual has received treatment with an immune checkpoint inhibitor for unresectable or metastatic melanoma; and
  - 4.3 The individual meets renewal criteria for pembrolizumab for unresectable or metastatic melanoma.

Notes:

- a) Stage IIIB, IIIC, IIID or IV melanoma defined as per American Joint Committee on Cancer (AJCC) 8th Edition
- b) Initiating treatment within 13 weeks of complete surgical resection means either 13 weeks after resection (primary or lymphadenectomy) or 13 weeks prior to the scheduled date of the resection (primary or lymphadenectomy)

**Initial application — (stage III or IV resected melanoma - adjuvant)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 The individual has resected stage IIIB, IIIC, IIID or IV melanoma (excluding uveal) (see note a); and
- 2 Adjuvant treatment with pembrolizumab is required; and
- 3 The individual has not received prior funded systemic treatment in the adjuvant setting for stage IIIB, IIIC, IIID or IV melanoma; and
- 4 Treatment must be in addition to complete surgical resection; and
- 5 Treatment must be initiated within 13 weeks of complete surgical resection, unless delay is necessary due to post-surgery recovery (see note b); and
- 6 Pembrolizumab must be administered as monotherapy; and
- 7 The individual has ECOG performance score 0-2; and
- 8 Pembrolizumab to be administered at a fixed dose of 200 mg every 3 weeks (or equivalent).

Notes:

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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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- a) Stage IIIB, IIIC, IIID or IV melanoma defined as per American Joint Committee on Cancer (AJCC) 8th Edition
- b) Initiating treatment within 13 weeks of complete surgical resection means 13 weeks after resection (primary or lymphadenectomy)

**Renewal — (stage III or IV resected melanoma - adjuvant)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:

Any of the following:

- 1 All of the following:
  - 1.1 No evidence of disease recurrence; and
  - 1.2 Pembrolizumab must be administered as monotherapy; and
  - 1.3 Pembrolizumab to be administered at a fixed dose of 200 mg every three weeks (or equivalent) for a maximum of 12 months total treatment course, including any systemic neoadjuvant treatment; and
  - 1.4 Treatment to be discontinued at signs of disease recurrence or at completion of 12 months total treatment course (equivalent to 18 cycles at a dose of 200 mg every 3 weeks), including any systemic neoadjuvant treatment; or
- 2 All of the following:
  - 2.1 The individual has received adjuvant treatment with an immune checkpoint inhibitor; and
  - 2.2 The individual has metastatic or unresectable melanoma (excluding uveal) stage III or IV; and
  - 2.3 The individual meets initial application criteria for pembrolizumab for unresectable or metastatic melanoma; or
- 3 All of the following:
  - 3.1 The individual has received adjuvant treatment with an immune checkpoint inhibitor; and
  - 3.2 The individual has received treatment with an immune checkpoint inhibitor for unresectable or metastatic melanoma; and
  - 3.3 The individual meets renewal criteria for pembrolizumab for unresectable or metastatic melanoma.

**Initial application — (unresectable or metastatic melanoma)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 The individual has metastatic or unresectable melanoma (excluding uveal) stage III or IV; and
- 2 Baseline measurement of overall tumour burden is documented clinically and radiologically; and
- 3 The individual has ECOG performance score of 0-2; and
- 4 Either:
  - 4.1 The individual has not received funded nivolumab; or
  - 4.2 Both:
    - 4.2.1 The individual has received an initial Special Authority approval for nivolumab and has discontinued nivolumab within 12 weeks of starting treatment due to intolerance; and
    - 4.2.2 The cancer did not progress while the individual was on nivolumab; and
- 5 Any of the following:
  - 5.1 The individual has been diagnosed in the metastatic or unresectable stage III or IV setting; or
  - 5.2 The individual did not receive treatment in the perioperative setting with a PD-1/PD-L1 inhibitor; or
  - 5.3 All of the following:
    - 5.3.1 The individual received treatment in the perioperative setting with a PD-1/PD-L1 inhibitor; and
    - 5.3.2 The individual did not experience disease recurrence while on treatment with that PD-1/PD-L1 inhibitor; and
    - 5.3.3 The individual did not experience disease recurrence within six months of completing perioperative treatment with a PD-1/PD-L1 inhibitor.

**Renewal — (unresectable or metastatic melanoma, less than 24 months on treatment)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 Both:

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- 1.1 Any of the following:
  - 1.1.1 The individual's disease has had a complete response to treatment; or
  - 1.1.2 The individual's disease has had a partial response to treatment; or
  - 1.1.3 The individual has stable disease; and
- 1.2 Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period; or
- 2 All of the following:
  - 2.1 The individual has previously discontinued treatment with pembrolizumab for reasons other than severe toxicity or disease progression; and
  - 2.2 The individual has signs of disease progression; and
  - 2.3 Disease has not progressed during previous treatment with pembrolizumab.

**Renewal — (unresectable or metastatic melanoma, more than 24 months on treatment)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:

Both:

- 1 The individual has been on treatment for more than 24 months; and
- 2 Either:
  - 2.1 Both:
    - 2.1.1 Any of the following:
      - 2.1.1.1 The individual's disease has had a complete response to treatment; or
      - 2.1.1.2 The individual's disease has had a partial response to treatment; or
      - 2.1.1.3 The individual has stable disease; and
    - 2.1.2 Response to treatment in target lesions has been determined by comparable radiologic or clinical assessment following the most recent treatment period; or
  - 2.2 All of the following:
    - 2.2.1 The individual has previously discontinued treatment with pembrolizumab for reasons other than severe toxicity or disease progression; and
    - 2.2.2 The individual has signs of disease progression; and
    - 2.2.3 Disease has not progressed during previous treatment with pembrolizumab.

**Initial application — (non-small cell lung cancer first-line monotherapy)** only from a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Patient has locally advanced or metastatic, unresectable, non-small cell lung cancer; and
- 2 Patient has not had chemotherapy for their disease in the palliative setting; and
- 3 Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC; and
- 4 For patients with non-squamous histology there is documentation confirming that the disease does not express activating mutations of EGFR, ROS-1 or ALK tyrosine kinase unless not possible to ascertain; and
- 5 Pembrolizumab to be used as monotherapy; and
- 6 Either:
  - 6.1 There is documentation confirming the disease expresses PD-L1 at a level greater than or equal to 50% as determined by a validated test unless not possible to ascertain; or
  - 6.2 Both:
    - 6.2.1 There is documentation confirming the disease expresses PD-L1 at a level greater than or equal to 1% as determined by a validated test unless not possible to ascertain; and
    - 6.2.2 Chemotherapy is determined to be not in the best interest of the patient based on clinician assessment; and
- 7 Patient has an ECOG 0-2; and

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- 8 Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent) for a maximum of 16 weeks; and
- 9 Baseline measurement of overall tumour burden is documented clinically and radiologically.

**Renewal — (non-small cell lung cancer first line monotherapy)** only from a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Any of the following:
  - 1.1 Patient's disease has had a complete response to treatment; or
  - 1.2 Patient's disease has had a partial response to treatment; or
  - 1.3 Patient has stable disease; and
- 2 Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period; and
- 3 No evidence of disease progression; and
- 4 The treatment remains clinically appropriate and patient is benefitting from treatment; and
- 5 Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent); and
- 6 Treatment with pembrolizumab to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks).

**Initial application — (non-small cell lung cancer first-line combination therapy)** only from a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Patient has locally advanced or metastatic, unresectable, non-small cell lung cancer; and
- 2 The patient has not had chemotherapy for their disease in the palliative setting; and
- 3 Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC; and
- 4 For patients with non-squamous histology there is documentation confirming that the disease does not express activating mutations of EGFR, ROS-1 or ALK tyrosine kinase unless not possible to ascertain; and
- 5 Pembrolizumab to be used in combination with platinum-based chemotherapy; and
- 6 Patient has an ECOG 0-2; and
- 7 Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent) for a maximum of 16 weeks; and
- 8 Baseline measurement of overall tumour burden is documented clinically and radiologically.

**Renewal — (non-small cell lung cancer first line combination therapy)** only from a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Any of the following:
  - 1.1 Patient's disease has had a complete response to treatment; or
  - 1.2 Patient's disease has had a partial response to treatment; or
  - 1.3 Patient has stable disease; and
- 2 Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period; and
- 3 No evidence of disease progression; and
- 4 The treatment remains clinically appropriate and patient is benefitting from treatment; and
- 5 Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent); and
- 6 Treatment with pembrolizumab to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks).

**Initial application — (breast cancer, advanced)** only from a relevant specialist or any relevant practitioner on the

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

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recommendation of a relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Patient is currently on treatment with pembrolizumab and met all remaining criteria prior to commencing treatment; or
- 2 All of the following:
  - 2.1 Either:
    - 2.1.1 Patient has recurrent or de novo unresectable, inoperable locally advanced triple-negative breast cancer (that does not express ER, PR or HER2 IHC3+ or ISH+ [including FISH or other technology]); or
    - 2.1.2 Patient has recurrent or de novo metastatic triple-negative breast cancer (that does not express ER, PR or HER2 IHC3+ or ISH+ [including FISH or other technology]); and
  - 2.2 Patient is treated with palliative intent; and
  - 2.3 Patient's cancer has confirmed PD-L1 Combined Positive Score (CPS) is greater than or equal to 10; and
  - 2.4 Patient has received no prior systemic therapy in the palliative setting; and
  - 2.5 Patient has an ECOG score of 0–2; and
  - 2.6 Pembrolizumab is to be used in combination with chemotherapy; and
  - 2.7 Baseline measurement of overall tumour burden is documented clinically and radiologically; and
  - 2.8 Pembrolizumab is to be used at a maximum dose of 200 mg every three weeks (or equivalent) for a maximum of 16 weeks.

**Renewal — (breast cancer, advanced)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Any of the following:
  - 1.1 Patient's disease has had a complete response to treatment; or
  - 1.2 Patient's disease has had a partial response to treatment; or
  - 1.3 Patient has stable disease; and
- 2 No evidence of disease progression; and
- 3 Response to treatment in target lesions has been determined by a comparable radiologic assessment following the most recent treatment period; and
- 4 Pembrolizumab is to be used at a maximum dose of 200 mg every three weeks (or equivalent); and
- 5 Treatment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks).

**Initial application — (head and neck squamous cell carcinoma)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 Patient is currently on treatment with pembrolizumab and met all remaining criteria prior to commencing treatment; or
- 2 All of the following:
  - 2.1 Patient has recurrent or metastatic head and neck squamous cell carcinoma of mucosal origin (excluding nasopharyngeal carcinoma) that is incurable by local therapies; and
  - 2.2 Patient has not received prior systemic therapy in the recurrent or metastatic setting; and
  - 2.3 Patient has a positive PD-L1 combined positive score (CPS) of greater than or equal to 1; and
  - 2.4 Patient has an ECOG performance score of 0-2; and
  - 2.5 Either:
    - 2.5.1 Pembrolizumab to be used in combination with platinum-based chemotherapy; or
    - 2.5.2 Pembrolizumab to be used as monotherapy; and
  - 2.6 Pembrolizumab is to be used at a maximum dose of 200 mg every three weeks (or equivalent) for a maximum of 16 weeks.

**Renewal — (head and neck squamous cell carcinoma)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

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All of the following:

- 1 Any of the following:
  - 1.1 Patient's disease has had a complete response to treatment; or
  - 1.2 Patient's disease has had a partial response to treatment; or
  - 1.3 Patient has stable disease; and
- 2 No evidence of disease progression; and
- 3 Pembrolizumab is to be used at a maximum dose of 200 mg every three weeks (or equivalent); and
- 4 Treatment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks).

**Initial application — (MSI-H/dMMR advanced colorectal cancer)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 Individual is currently on treatment with pembrolizumab and met all remaining criteria prior to commencing treatment; or
- 2 All of the following:
  - 2.1 Either:
    - 2.1.1 Individual has deficient mismatch repair (dMMR) or microsatellite instability-high (MSI-H) metastatic colorectal cancer; or
    - 2.1.2 Individual has deficient mismatch repair (dMMR) or microsatellite instability-high (MSI-H) unresectable colorectal cancer; and
  - 2.2 Individual is treated with palliative intent; and
  - 2.3 Individual has not previously received funded treatment with pembrolizumab for MSI-H/dMMR advanced colorectal cancer; and
  - 2.4 Individual has an ECOG performance score of 0-2; and
  - 2.5 Baseline measurement of overall tumour burden is documented clinically and radiologically; and
  - 2.6 Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent) for a maximum of 16 weeks.

**Renewal — (MSI-H/dMMR advanced colorectal cancer)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 No evidence of disease progression; and
- 2 Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent); and
- 3 Treatment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks).

**Initial application — (Urothelial carcinoma)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 Patient is currently on treatment with pembrolizumab and met all remaining criteria prior to commencing treatment; or
- 2 All of the following:
  - 2.1 Patient has inoperable locally advanced (T4) or metastatic urothelial carcinoma; and
  - 2.2 Patient has an ECOG performance score of 0-2; and
  - 2.3 Patient has documented disease progression following treatment with chemotherapy; and
  - 2.4 Pembrolizumab to be used as monotherapy at a maximum dose of 200 mg every three weeks (or equivalent) for a maximum of 16 weeks.

**Renewal — (Urothelial carcinoma)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:

All of the following:

- 1 Any of the following:

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# ONCOLOGY AGENTS AND IMMUNOSUPPRESSANTS

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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- 1.1 Patient's disease has had a complete response to treatment; or
- 1.2 Patient's disease has had a partial response to treatment; or
- 1.3 Patient has stable disease; and
- 2 No evidence of disease progression; and
- 3 Pembrolizumab to be used at a maximum dose of 200 mg every three weeks (or equivalent); and
- 4 Treatment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks).

**Initial application — (relapsed/refractory Hodgkin lymphoma)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 Individual is currently on treatment with pembrolizumab and met all remaining criteria prior to commencing treatment; or
- 2 All of the following:
  - 2.1 Either:
    - 2.1.1 Both:
      - 2.1.1.1 Individual has relapsed/refractory Hodgkin lymphoma after two or more lines of chemotherapy; and
      - 2.1.1.2 Individual is ineligible for autologous stem cell transplant; or
    - 2.1.2 Individual has relapsed/refractory Hodgkin lymphoma and has previously undergone an autologous stem cell transplant; and
  - 2.2 Individual has not previously received funded pembrolizumab for relapsed/refractory Hodgkin lymphoma; and
  - 2.3 Pembrolizumab to be administered at doses no greater than 200 mg once every 3 weeks.

**Renewal — (relapsed/refractory Hodgkin lymphoma)** only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Patient has received a partial or complete response to pembrolizumab; and
- 2 Treatment with pembrolizumab is to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks).

## Other Immunosuppressants

### CYCLOSPORIN

Cap 25 mg .....	44.63	50	✓ Neoral
Cap 50 mg .....	88.91	50	✓ Neoral
Cap 100 mg .....	177.81	50	✓ Neoral
Oral liq 100 mg per ml .....	198.13	50 ml OP	✓ Neoral

### EVEROLIMUS – Special Authority see SA2598 below – Retail pharmacy

Wastage claimable			
Tab 10 mg .....	6,512.29	30	✓ Afinitor
Tab 5 mg .....	4,555.76	30	✓ Afinitor

### ► SA2598 Special Authority for Subsidy

**Initial application** only from a neurologist or oncologist. Approvals valid for 4 months for applications meeting the following criteria:

Both:

- 1 Patient has tuberous sclerosis; and
- 2 Patient has progressively enlarging sub-ependymal giant cell astrocytomas (SEGAs) that require treatment.

**Renewal** only from a neurologist or oncologist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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- 1 Documented evidence of SEGA reduction or stabilisation by MRI within the last 3 months; and
- 2 The treatment remains appropriate and the patient is benefiting from treatment; and
- 3 Everolimus to be discontinued at progression of SEGAs.

**Initial application — (renal cell carcinoma)** from any relevant practitioner. Approvals valid for 4 months for applications meeting the following criteria:

Either:

- 1 All of the following:
  - 1.1 The patient has metastatic renal cell carcinoma; and
  - 1.2 The disease is of predominant clear-cell histology; and
  - 1.3 The patient has documented disease progression following one previous line of treatment; and
  - 1.4 The patient has an ECOG performance status of 0-2; and
  - 1.5 Everolimus is to be used in combination with lenvatinib; or
- 2 All of the following:
  - 2.1 Patient has received funded treatment with nivolumab for the second line treatment of metastatic renal cell carcinoma; and
  - 2.2 Patient has experienced treatment limiting toxicity from treatment with nivolumab; and
  - 2.3 Everolimus is to be used in combination with lenvatinib; and
  - 2.4 There is no evidence of disease progression.

**Renewal — (renal cell carcinoma)** from any relevant practitioner. Approvals valid for 4 months where there is no evidence of disease progression.

SIROLIMUS – Special Authority see SA2270 below – Retail pharmacy

Tab 1 mg .....	749.99	100	✓ Rapamune
Tab 2 mg .....	1,499.99	100	✓ Rapamune
Oral liq 1 mg per ml .....	449.99	60 ml OP	✓ Rapamune

►SA2270 Special Authority for Subsidy

**Initial application** from any medical practitioner. Approvals valid without further renewal unless notified where the drug is to be used for rescue therapy for an organ transplant recipient.

Notes: Rescue therapy defined as unresponsive to calcineurin inhibitor treatment as defined by refractory rejection; or intolerant to calcineurin inhibitor treatment due to any of the following:

- GFR< 30 ml/min; or
- Rapidly progressive transplant vasculopathy; or
- Rapidly progressive obstructive bronchiolitis; or
- HUS or TTP; or
- Leukoencephalopathy; or
- Significant malignant disease

**Initial application — (severe non-malignant lymphovascular malformations\*)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has severe non-malignant lymphovascular malformation\*; and
- 2 Any of the following:
  - 2.1 Malformations are not adequately controlled by sclerotherapy and surgery; or
  - 2.2 Malformations are widespread/extensive and sclerotherapy and surgery are not considered clinically appropriate; or
  - 2.3 Sirolimus is to be used to reduce malformation prior to consideration of surgery; and
- 3 Patient is being treated by a specialist lymphovascular malformation multi-disciplinary team; and
- 4 Patient has measurable disease as defined by RECIST version 1.1 (see Note).

**Renewal — (severe non-malignant lymphovascular malformations\*)** from any relevant practitioner. Approvals valid for 12

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

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continued...

months for applications meeting the following criteria:

All of the following:

1 Either:

- 1.1 Patient's disease has had either a complete response or a partial response to treatment, or patient has stable disease according to RECIST version 1.1 (see Note); or
- 1.2 Patient's disease has stabilised or responded clinically and disease response to treatment has been clearly documented in patient notes; and

2 No evidence of progressive disease; and

3 The treatment remains clinically appropriate and the patient is benefitting from the treatment.

Notes: Baseline assessment and disease responses to be assessed according to the Response Evaluation Criteria in Solid Tumours (RECIST) version 1.1 (Eisenhauer et al. Eur J Cancer 2009;45:228-47)

Indications marked with \* are unapproved indications

**Initial application — (renal angiomyolipoma(s) associated with tuberous sclerosis complex\*)** only from a nephrologist or urologist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Patient has tuberous sclerosis complex\*; and
- 2 Evidence of renal angiomyolipoma(s) measuring 3 cm or greater and that have shown interval growth.

**Renewal — (renal angiomyolipoma(s) associated with tuberous sclerosis complex\*)** from any relevant practitioner.

Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Documented evidence of renal angiomyolipoma reduction or stability by magnetic resonance imaging (MRI) or ultrasound; and
- 2 Demonstrated stabilisation or improvement in renal function; and
- 3 The patient has not experienced angiomyolipoma haemorrhage or significant adverse effects to sirolimus treatment; and
- 4 The treatment remains appropriate and the patient is benefitting from treatment.

Note: Indications marked with \* are unapproved indications

**Initial application — (refractory seizures associated with tuberous sclerosis complex\*)** only from a neurologist. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

1 Patient has epilepsy with a background of documented tuberous sclerosis complex; and

2 Either:

2.1 Both:

- 2.1.1 Vigabatrin has been trialled and has not adequately controlled seizures; and
- 2.1.2 Seizures are not adequately controlled by, or the patient has experienced unacceptable side effects from, optimal treatment with at least two of the following: sodium valproate, topiramate, levetiracetam, carbamazepine, lamotrigine, phenytoin sodium, and lacosamide (see Note); or

2.2 Both:

- 2.2.1 Vigabatrin is contraindicated; and
- 2.2.2 Seizures are not adequately controlled by, or the patient has experienced unacceptable side effects from, optimal treatment with at least three of the following: sodium valproate, topiramate, levetiracetam, carbamazepine, lamotrigine, phenytoin sodium, and lacosamide (see Note); and

3 Seizures have a significant impact on quality of life; and

4 Patient has been assessed and surgery is considered inappropriate for this patient, or the patient has been assessed and would benefit from mTOR inhibitor treatment prior to surgery.

Note: Those of childbearing age potential are not required to trial phenytoin sodium, sodium valproate, or topiramate. Those who can father children are not required to trial sodium valproate.

**Renewal — (refractory seizures associated with tuberous sclerosis complex\*)** only from a neurologist. Approvals valid for

continued...

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continued...

12 months where demonstrated significant and sustained improvement in seizure rate (e.g. 50% reduction in seizure frequency) or severity and/or patient quality of life compared with baseline prior to starting sirolimus treatment.

Note: Indications marked with \* are unapproved indications

TACROLIMUS – Special Authority see SA2455 below – Retail pharmacy

Cap 0.5 mg.....	49.60	100	✓ Tacrolimus Sandoz
Cap 0.75 mg.....	99.30	100	✓ Tacrolimus Sandoz
Cap 1 mg.....	84.30	100	✓ Tacrolimus Sandoz
Cap 5 mg.....	248.20	50	✓ Tacrolimus Sandoz

►SA2455 Special Authority for Subsidy

**Initial application — (organ transplant)** only from a relevant specialist. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 The individual is an organ transplant recipient; or
- 2 The individual is receiving induction therapy for an organ transplant.

Note: Subsidy applies for either primary or rescue therapy.

**Initial application — (non-transplant indications\*)** only from a relevant specialist. Approvals valid without further renewal unless sufficient for applications meeting the following criteria:

Both:

- 1 Patient requires long-term systemic immunosuppression; and
- 2 Either:
  - 2.1 Ciclosporin has been trialled and discontinued treatment because of unacceptable side effects or inadequate clinical response; or
  - 2.2 Patient is a child with nephrotic syndrome\*.

Note: Indications marked with \* are unapproved indications

**JAK inhibitors**

UPADACITINIB – Special Authority see SA2599 below – Retail pharmacy

Tab modified-release 15 mg.....	1,271.00	28	✓ Rinvoq
Tab modified-release 30 mg.....	2,033.00	28	✓ Rinvoq
Tab modified-release 45 mg.....	3,049.00	28	✓ Rinvoq

►SA2599 Special Authority for Subsidy

**Initial application — (Rheumatoid Arthritis (previously treated with adalimumab or etanercept))** from any relevant practitioner. Approvals valid for 7 months for applications meeting the following criteria:

All of the following:

- 1 The individual has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis; and
- 2 Either:
  - 2.1 The individual has experienced intolerable side effects with adalimumab and/or etanercept; or
  - 2.2 The individual has received insufficient benefit from at least a three-month trial of adalimumab and/or etanercept such that they do not meet the renewal criteria for rheumatoid arthritis; and
- 3 Any of the following:
  - 3.1 Rituximab is not clinically appropriate; or
  - 3.2 The individual is seronegative for both anti-cyclic citrullinated peptide (CCP) antibodies and rheumatoid factor; or
  - 3.3 Both:
    - 3.3.1 The individual has been started on rituximab for rheumatoid arthritis in a Health NZ Hospital; and
    - 3.3.2 Either:

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

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continued...

3.3.2.1 The individual has experienced intolerable side effects with rituximab; or

3.3.2.2 At four months following the initial course of rituximab the individual has received insufficient benefit such that they do not meet the renewal criteria for rheumatoid arthritis.

**Renewal — (Rheumatoid Arthritis)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Following 6 months' initial treatment, the individual has experienced at least a 50% decrease in active joint count from baseline; or
- 2 On subsequent reapplications, the individual has experienced at least a continuing 30% improvement in active joint count from baseline.

**Initial application — (atopic dermatitis)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Individual is currently on treatment with upadacitinib for atopic dermatitis and met all remaining criteria prior to commencing treatment; or
- 2 All of the following:
  - 2.1 Individual has moderate to severe atopic dermatitis, severity as defined by an Eczema Area and Severity Index (EASI) score of greater than or equal to 16 or a Dermatology Life Quality Index (DLQI) score of greater than or equal to 10; and
  - 2.2 Individual has received insufficient benefit from topical therapy (including topical corticosteroids or topical calcineurin inhibitors) for a 28-day trial within the last 6 months, unless contraindicated to all; and
  - 2.3 Individual has trialed and received insufficient benefit from at least one systemic therapy for a minimum of three months (eg ciclosporin, azathioprine, methotrexate or mycophenolate mofetil), unless contraindicated to all; and
  - 2.4 An EASI assessment or DLQI assessment has been completed for at least the most recent prior treatment course, preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course; and
  - 2.5 The most recent EASI or DQLI assessment is no more than 1 month old at the time of application.

**Renewal — (atopic dermatitis)** from any relevant practitioner. Approvals valid for 12 months for applications meeting the following criteria:

Either:

- 1 Individual has received a 75% or greater reduction in EASI score (EASI 75) as compared to baseline EASI prior to commencing upadacitinib; or
- 2 Individual has received a DLQI improvement of 4 or more as compared to baseline DLQI prior to commencing upadacitinib.

**Initial application — (Crohn's disease - adult)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Individual is currently on treatment with upadacitinib for Crohn's disease and met all remaining criteria prior to commencing treatment; or
- 2 Both:
  - 2.1 Individual has active Crohn's disease; and
  - 2.2 Either:
    - 2.2.1 Individual has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria; or
    - 2.2.2 Both:
      - 2.2.2.1 Individual meets the initiation criteria for prior biologic therapies for Crohn's disease; and
      - 2.2.2.2 Other biologic therapies for Crohn's disease are contraindicated.

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Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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continued...

**Renewal — (Crohn's disease - adult)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Any of the following:

- 1 CDAI score has reduced by 100 points from the CDAI score when the individual was initiated on biologic therapy; or
- 2 HBI score has reduced by 3 points from when individual was initiated on biologic therapy; or
- 3 CDAI score is 150 or less; or
- 4 HBI score is 4 or less; or
- 5 The individual has experienced an adequate response to treatment, but CDAI score cannot be assessed.

**Initial application — (Crohn's disease - children\*)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Individual is currently on treatment with upadacitinib for Crohn's disease and met all remaining criteria prior to commencing treatment; or
- 2 Both:
  - 2.1 Child has active Crohn's disease; and
  - 2.2 Either:
    - 2.2.1 Child 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
    - 2.2.2 Both:
      - 2.2.2.1 Child meets the initiation criteria for prior biologic therapies for Crohn's disease; and
      - 2.2.2.2 Other biologic therapies for Crohn's disease are contraindicated.

**Renewal — (Crohn's disease - children\*)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Any of the following:

- 1 PCDAI score has reduced by 10 points from the child was initiated on treatment; or
- 2 PCDAI score is 15 or less; or
- 3 The child has experienced an adequate response to treatment, but PCDAI score cannot be assessed.

Note: Indications marked with \* are unapproved indications.

**Initial application — (ulcerative colitis)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Either:

- 1 Individual is currently on treatment with upadacitinib for ulcerative colitis and met all remaining criteria prior to commencing treatment; or
- 2 Both:
  - 2.1 Individual has active ulcerative colitis; and
  - 2.2 Either:
    - 2.2.1 Individual 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
    - 2.2.2 Both:
      - 2.2.2.1 Individual meets the initiation criteria for prior biologic therapies for ulcerative colitis; and
      - 2.2.2.2 Other biologic therapies for ulcerative colitis are contraindicated.

**Renewal — (ulcerative colitis)** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:

Either:

- 1 The SCCAI score has reduced by 2 points or more from the SCCAI score when the individual was initiated on treatment; or
- 2 PUCAI score has reduced by 10 points or more from the PUCAI score when the individual was initiated on treatment.

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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## Antiallergy Preparations

### Allergic Emergencies

ADRENALINE – Special Authority see [SA2185 below](#) – Retail pharmacy

- Maximum of 2 inj per prescription
- Additional prescriptions limited to replacement of up to two devices prior to expiry, or replacement of used device for treatment of anaphylaxis.

Inj 0.15 mg per 0.3 ml auto-injector.....	85.50	1 OP	✓ <b>Epipen Jr</b>
Inj 0.3 mg per 0.3 ml auto-injector.....	85.50	1 OP	✓ <b>Epipen</b>

#### ► [SA2185](#) Special Authority for Subsidy

**Initial application** — (anaphylaxis) from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- Either:
  - Patient has experienced an anaphylactic reaction which has resulted in presentation to a hospital or emergency department; or
  - Patient has been assessed to be at significant risk of anaphylaxis by a relevant practitioner; and
- Patient is not to be prescribed more than two devices in initial prescription.

ICATIBANT – Special Authority see [SA1558 below](#) – Retail pharmacy

Inj 10 mg per ml, 3 ml prefilled syringe.....	479.00	1	✓ <b>Icatibant Lupin</b>
	2,668.00		✓ <b>Firazyr</b>

*(Firazyr Inj 10 mg per ml, 3 ml prefilled syringe to be delisted 1 October 2026)*

#### ► [SA1558](#) Special Authority for Subsidy

**Initial application** only from a clinical immunologist or relevant specialist. Approvals valid for 12 months for applications meeting the following criteria:

Both:

- Supply for anticipated emergency treatment of laryngeal/oro-pharyngeal or severe abdominal attacks of acute hereditary angioedema (HAE) for patients with confirmed diagnosis of C1-esterase inhibitor deficiency; and
- The patient has undergone product training and has agreed upon an action plan for self-administration.

**Renewal** from any relevant practitioner. Approvals valid for 12 months where the treatment remains appropriate and the patient is benefiting from treatment.

### Allergy Desensitisation

#### ► [SA1367](#) Special Authority for Subsidy

**Initial application** only from a relevant specialist. Approvals valid for 2 years for applications meeting the following criteria:

Both:

- RAST or skin test positive; and
- Patient has had severe generalised reaction to the sensitising agent.

**Renewal** only from a relevant specialist. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefiting from treatment.

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>BEE VENOM ALLERGY TREATMENT – Special Authority see SA1367 on the previous page – Retail pharmacy</b>				
Initiation kit - 1 vial freeze dried venom with diluent .....	305.00	1 OP	✓	<b>VENOX</b> <sup>S29</sup>
Maintenance kit - 1 vial freeze dried venom with diluent .....	305.00	1 OP	✓	<b>VENOX</b> <sup>S29</sup>
Maintenance kit - 6 vials 120 mcg freeze dried venom, with diluent .....	285.00	1 OP	✓	<b>Venomil</b> <sup>S29</sup>
Treatment kit - 1 vial 550 mcg freeze dried venom, 1 diluent 9 ml, 3 diluent 1.8 ml .....	334.39	1 OP	✓	<b>Albey</b>
Treatment kit - 1 vial 550 mcg freeze dried venom, with diluent .....	305.00	1 OP	✓	<b>Hymenoptera</b> <sup>S29</sup>
<b>WASP VENOM ALLERGY TREATMENT – Special Authority see SA1367 on the previous page – Retail pharmacy</b>				
Treatment kit (Paper wasp venom) - 1 vial 550 mcg freeze dried polistes venom, 1 diluent 9 ml, 3 diluent 1.8 ml .....	382.23	1 OP	✓	<b>Albey</b>
Treatment kit (Paper wasp venom) - 1 vial 550 mcg freeze dried venom, with diluent .....	305.00	1 OP	✓	<b>Hymenoptera</b> <sup>S29</sup>
Treatment kit (Paper wasp venom) - 6 vials 120 mcg freeze dried venom, with diluent .....	305.00	1 OP	✓	<b>Venomil</b> <sup>S29</sup>
Treatment kit (Yellow Jacket venom) - 1 vial 550 mcg freeze dried venom, with diluent .....	305.00	1 OP	✓	<b>Hymenoptera</b> <sup>S29</sup>
Treatment kit (Yellow jacket venom) - 1 vial 550 mcg freeze dried vespula venom, 1 diluent 9 ml, 3 diluent 1.8 ml .....	431.24	1 OP	✓	<b>Albey</b>
Treatment kit (Yellow jacket venom) - 6 vials 120 mcg freeze dried venom, with diluent .....	305.00	1 OP	✓	<b>Venomil</b> <sup>S29</sup>

## Antihistamines

<b>CETIRIZINE HYDROCHLORIDE</b>				
* Tab 10 mg .....	1.71	100	✓	<b>Zista</b>
* Oral liq 1 mg per ml .....	3.99	200 ml	✓	<b>Histaclear</b>
<b>DEXTROCHLORPHENIRAMINE MALEATE</b>				
* Tab 2 mg .....	2.02 (8.40)	40		Polaramine
	1.01 (5.99)	20		Polaramine
* Oral liq 2 mg per 5 ml .....	1.77 (10.29)	100 ml		Polaramine
<b>FEXOFENADINE HYDROCHLORIDE</b>				
* Tab 60 mg .....	4.34 (8.23)	20		Telfast
* Tab 120 mg .....	3.49	30	✓	<b>Fexaclear</b>
* Tab 180 mg .....	4.10	30	✓	<b>Fexaclear</b>
<b>LORATADINE</b>				
* Tab 10 mg .....	1.59	100	✓	<b>Loratadine Noumed</b>
* Oral liq 1 mg per ml .....	1.43	100 ml	✓	<b>Haylor syrup</b>
<b>PROMETHAZINE HYDROCHLORIDE</b>				
* Tab 10 mg .....	2.19	100	✓	<b>Allersoothe</b>
* Tab 25 mg .....	2.69	100	✓	<b>Allersoothe</b>
* Oral liq 1 mg per 1 ml .....	3.39	100 ml	✓	<b>Allersoothe</b>
* Inj 25 mg per ml, 2 ml ampoule – Up to 5 inj available on a PSO .....	21.09	5	✓	<b>Hospira</b>

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# RESPIRATORY SYSTEM AND ALLERGIES

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
<b>Inhaled Corticosteroids</b>			
<b>BECLOMETHASONE DIPROPIONATE</b>			
Aerosol inhaler, 50 mcg per dose.....	14.01	200 dose OP	✓ <b>Qvar</b>
Aerosol inhaler, 50 mcg per dose CFC-free.....	8.54	200 dose OP	✓ <b>Beclazone 50</b>
Aerosol inhaler, 100 mcg per dose.....	17.52	200 dose OP	✓ <b>Qvar</b>
Aerosol inhaler, 100 mcg per dose CFC-free.....	12.50	200 dose OP	✓ <b>Beclazone 100</b>
Aerosol inhaler, 250 mcg per dose CFC-free.....	22.67	200 dose OP	✓ <b>Beclazone 250</b>
<b>BUDESONIDE</b>			
Powder for inhalation, 100 mcg per dose.....	17.00	200 dose OP	✓ <b>Pulmicort Turbuhaler</b>
Powder for inhalation, 200 mcg per dose.....	19.00	200 dose OP	✓ <b>Pulmicort Turbuhaler</b>
Powder for inhalation, 400 mcg per dose.....	32.00	200 dose OP	✓ <b>Pulmicort Turbuhaler</b>
<b>FLUTICASONE</b>			
Aerosol inhaler, 50 mcg per dose.....	7.19	120 dose OP	✓ <b>Flixotide</b>
Powder for inhalation, 50 mcg per dose.....	8.61	60 dose OP	✓ <b>Flixotide Accuhaler</b>
Powder for inhalation, 100 mcg per dose.....	7.81	60 dose OP	✓ <b>Flixotide Accuhaler</b>
Aerosol inhaler, 125 mcg per dose.....	13.60	120 dose OP	✓ <b>Flixotide</b>
Aerosol inhaler, 250 mcg per dose.....	24.62	120 dose OP	✓ <b>Flixotide</b>
Powder for inhalation, 250 mcg per dose.....	11.93	60 dose OP	✓ <b>Flixotide Accuhaler</b>

## Inhaled Long-acting Beta-adrenoceptor Agonists

<b>EFORMOTEROL FUMARATE DIHYDRATE</b>			
Powder for inhalation 4.5 mcg per dose, breath activated (equivalent to eformoterol fumarate 6 mcg metered dose).....	10.32 (16.90)	60 dose OP	Oxis Turbuhaler
<b>INDACATEROL</b>			
Powder for inhalation 150 mcg.....	61.00	30 dose OP	✓ <b>Onbrez Breezhaler</b>
Powder for inhalation 300 mcg.....	61.00	30 dose OP	✓ <b>Onbrez Breezhaler</b>
<b>SALMETEROL</b>			
Aerosol inhaler CFC-free, 25 mcg per dose.....	26.25	120 dose OP	✓ <b>Serevent</b>
Powder for inhalation, 50 mcg per dose, breath activated.....	26.25	60 dose OP	✓ <b>Serevent Accuhaler</b>

Subsidy (Manufacturer's Price) \$ Fully Subsidised Per ✓ Brand or Generic Manufacturer

**Inhaled Corticosteroids with Long-Acting Beta-Adrenoceptor Agonists**

**BUDESONIDE WITH EFOMTEROL**

* Powder for inhalation 160 mcg with 4.5 mcg eformoterol fumarate per dose (equivalent to 200 mcg budesonide with 6 mcg eformoterol fumarate metered dose) – Up to 120 dose available on a PSO .....	41.50	120 dose OP	✓ DuoResp Spiromax
Powder for inhalation 320 mcg with 9 mcg eformoterol fumarate per dose (equivalent to 400 mcg budesonide with 12 mcg eformoterol fumarate metered dose) – No more than 2 dose per day .....	82.50	120 dose OP	✓ DuoResp Spiromax
* Aerosol inhaler 100 mcg with eformoterol fumarate 6 mcg – Up to 120 dose available on a PSO .....	18.23	120 dose OP	✓ Vannair
* Powder for inhalation 100 mcg with eformoterol fumarate 6 mcg – Up to 120 dose available on a PSO .....	33.74	120 dose OP	✓ Symbicort Turbuhaler 100/6
* Aerosol inhaler 200 mcg with eformoterol fumarate 6 mcg – Up to 120 dose available on a PSO .....	21.40	120 dose OP	✓ Vannair
* Powder for inhalation 200 mcg with eformoterol fumarate 6 mcg – Up to 120 dose available on a PSO .....	33.74	120 dose OP	✓ Symbicort Turbuhaler 200/6
Powder for inhalation 400 mcg with eformoterol fumarate 12 mcg – No more than 2 dose per day .....	33.74	60 dose OP	✓ Symbicort Turbuhaler 400/12

**FLUTICASONE FUROATE WITH VILANTEROL**

Powder for inhalation 100 mcg with vilanterol 25 mcg ..... 44.08 30 dose OP ✓ Breo Ellipta

**FLUTICASONE WITH SALMETEROL**

Aerosol inhaler 50 mcg with salmeterol 25 mcg ..... 25.79 120 dose OP ✓ Seretide  
 Aerosol inhaler 125 mcg with salmeterol 25 mcg ..... 32.60 120 dose OP ✓ Seretide  
 Powder for inhalation 100 mcg with salmeterol 50 mcg – No more than 2 dose per day..... 33.74 60 dose OP ✓ Seretide Accuhaler  
 Powder for inhalation 250 mcg with salmeterol 50 mcg – No more than 2 dose per day..... 44.08 60 dose OP ✓ Seretide Accuhaler

**Beta-Adrenoceptor Agonists**

**SALBUTAMOL**

Oral liq 400 mcg per ml ..... 50.00 150 ml ✓ Ventolin  
 Infusion 1 mg per ml, 5 ml ..... 130.00 10 ✓ Ventolin  
 Inj 500 mcg per ml, 1 ml – Up to 5 inj available on a PSO ..... 130.00 5 ✓ Ventolin

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# RESPIRATORY SYSTEM AND ALLERGIES

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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## Inhaled Beta-Adrenoceptor Agonists

### SALBUTAMOL

Aerosol inhaler, 100 mcg per dose CFC free – Up to 1000 dose available on a PSO .....	4.18 (7.45)	200 dose OP	✓ <b>SalAir</b> Ventolin
Nebuliser soln, 1 mg per ml, 2.5 ml ampoule – Up to 30 neb available on a PSO .....	8.96	20	✓ <b>Asthalin</b> ✓ <b>UK Cipla</b> <sup>\$29</sup>
Nebuliser soln, 2 mg per ml, 2.5 ml ampoule – Up to 30 neb available on a PSO .....	9.43	20	✓ <b>Asthalin</b> ✓ <b>UK Cipla</b> <sup>\$29</sup>

### TERBUTALINE SULPHATE

Powder for inhalation, 200 mcg per dose (equivalent to 250 mcg metered dose), breath activated .....	22.20	120 dose OP	✓ <b>Bricanyl Turbuhaler</b>
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## Anticholinergic Agents

### IPRATROPIUM BROMIDE

Aerosol inhaler, 20 mcg per dose CFC-free – Up to 400 dose available on a PSO .....	16.20	200 dose OP	✓ <b>Atrovent</b>
Nebuliser soln, 250 mcg per ml, 2 ml ampoule – Up to 40 neb available on a PSO .....	8.11	10	✓ <b>Ipratropium</b> <b>Viatris</b> <sup>\$29</sup>
	11.73	20	✓ <b>Accord</b> <sup>\$29</sup> ✓ <b>Univent</b>

## Inhaled Beta-Adrenoceptor Agonists with Anticholinergic Agents

### SALBUTAMOL WITH IPRATROPIUM BROMIDE

Aerosol inhaler, 100 mcg with ipratropium bromide, 20 mcg per dose CFC-free .....	12.19	200 dose OP	✓ <b>Duolin HFA</b>
Nebuliser soln, 2.5 mg with ipratropium bromide 0.5 mg per vial, 3 ml vial .....	16.56	30	✓ <b>Cipla</b> <sup>\$29</sup>
Nebuliser soln, 2.5 mg with ipratropium bromide 0.5 mg per vial, 2.5 ml ampoule – Up to 20 neb available on a PSO .....	11.04 96.50	20 60	✓ <b>Duolin</b> ✓ <b>Combiprasal</b> <sup>\$29</sup>

## Long-Acting Muscarinic Antagonists

### GLYCOPYRRONIUM – Subsidy by endorsement

- Inhaled glycopyrronium treatment will not be subsidised if patient is also receiving treatment with subsidised tiotropium or umeclidinium.
  - Glycopyrronium powder for inhalation 50 mcg per dose is subsidised only for patients who have been diagnosed as having COPD using spirometry if spirometry is possible, and the prescription is endorsed accordingly.
- |   |       |            |                            |
|---|-------|------------|----------------------------|
| Powder for inhalation 50 mcg per dose ..... | 61.00 | 30 dose OP | ✓ <b>Seebri Breezhaler</b> |
|---|-------|------------|----------------------------|

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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**TIOTROPIUM BROMIDE – Subsidy by endorsement**

- a) Tiotropium treatment will not be subsidised if patient is also receiving treatment with subsidised inhaled glycopyrronium or umeclidinium.
  - b) Tiotropium bromide is subsidised only for patients who have been diagnosed as having COPD using spirometry if spirometry is possible, and the prescription is endorsed accordingly. Patients who had tiotropium dispensed before 1 October 2018 with a valid Special Authority are deemed endorsed.
- |  |       |            |                    |
|--|-------|------------|--------------------|
| Powder for inhalation, 18 mcg per dose ..... | 50.37 | 30 dose    | ✓ Spiriva          |
| Soln for inhalation 2.5 mcg per dose .....   | 50.37 | 60 dose OP | ✓ Spiriva Respimat |

**UMECLIDINIUM – Subsidy by endorsement**

- a) Umeclidinium will not be subsidised if patient is also receiving treatment with subsidised inhaled glycopyrronium or tiotropium bromide.
  - b) Umeclidinium powder for inhalation 62.5 mcg per dose is subsidised only for patients who have been diagnosed as having COPD using spirometry if spirometry is possible, and the prescription is endorsed accordingly.
- |   |       |            |                   |
|---|-------|------------|-------------------|
| Powder for inhalation 62.5 mcg per dose ..... | 61.50 | 30 dose OP | ✓ Incruse Ellipta |
|---|-------|------------|-------------------|

**Long-Acting Muscarinic Antagonists with Long-Acting Beta-Adrenoceptor Agonists**

Combination long acting muscarinic antagonist and long acting beta-2 agonist will not be subsidised if patient is also receiving treatment with a combination inhaled corticosteroid and long acting beta-2 agonist.

►SA2554 **Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

- Both:
- 1 Patient has been stabilised on a long acting muscarinic antagonist; and
  - 2 The prescriber considers that the patient would receive additional benefit from switching to a combination product.

<b>GLYCOPYRRONIUM WITH INDACATEROL – Special Authority see SA2554 above – Retail pharmacy</b>			
Powder for Inhalation 50 mcg with indacaterol 110 mcg .....	81.00	30 dose OP	✓ Ultibro Breezhaler
<b>TIOTROPIUM BROMIDE WITH OLODATEROL – Special Authority see SA2554 above – Retail pharmacy</b>			
Soln for inhalation 2.5 mcg with olodaterol 2.5 mcg .....	81.00	60 dose OP	✓ Spiolto Respimat
<b>UMECLIDINIUM WITH VILANTEROL – Special Authority see SA2554 above – Retail pharmacy</b>			
Powder for inhalation 62.5 mcg with vilanterol 25 mcg .....	77.00	30 dose OP	✓ Anoro Ellipta

**Inhaled Corticosteroid with Long-Acting Muscarinic Antagonist and Beta Agonist**

<b>BUDESONIDE WITH GLYCOPYRRONIUM AND EFORMOTEROL – Special Authority see SA2421 below – Retail pharmacy</b>			
Aerosol inhaler budesonide 160 mcg with glycopyrronium			
7.2 mcg and formoterol 5 mcg per dose .....	79.15	120 dose OP	✓ Breztri Aerosphere

►SA2421 **Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

- Both:
- 1 Patient has a diagnosis of COPD confirmed by spirometry or spirometry has been attempted and technically acceptable results are not possible; and
  - 2 Either:
    - 2.1 Both:
      - 2.1.1 Patient is currently receiving an inhaled corticosteroid with long acting beta-2 agonist (ICS/LABA) or a long

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# RESPIRATORY SYSTEM AND ALLERGIES

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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continued...

acting muscarinic antagonist with long acting beta-2 agonist (LAMA/LABA); and

2.1.2 Any of the following:

Clinical criteria:

- 2.1.2.1 Patient has a COPD Assessment Test (CAT) score greater than 10; or
- 2.1.2.2 Patient has had 2 or more exacerbations in the previous 12 months; or
- 2.1.2.3 Patient has had one exacerbation requiring hospitalisation in the previous 12 months; or
- 2.1.2.4 Patient has had an eosinophil count greater than or equal to  $0.3 \times 10^9$  cells/L in the previous 12 months; or

2.2 Patient is currently receiving multiple inhaler triple therapy (inhaled corticosteroid with long-acting muscarinic antagonist and long-acting beta-2 agonist – ICS/LAMA/LABA) and met at least one of the clinical criteria above prior to commencing multiple inhaler therapy.

FLUTICASONE FUROATE WITH UMECLIDINIUM AND VILANTEROL – Special Authority see [SA2326 below](#) – Retail pharmacy

Powder for inhalation fluticasone furoate 100 mcg with umeclidinium 62.5 mcg and vilanterol 25 mcg.....	104.24	30 dose OP	✓ <b>Trelegy Ellipta</b>
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➔[SA2326](#) **Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

1 Patient has a diagnosis of COPD confirmed by spirometry or spirometry has been attempted and technically acceptable results are not possible; and

2 Either:

2.1 Both:

2.1.1 Patient is currently receiving an inhaled corticosteroid with long acting beta-2 agonist (ICS/LABA) or a long acting muscarinic antagonist with long acting beta-2 agonist (LAMA/LABA); and

2.1.2 Any of the following:

Clinical criteria:

- 2.1.2.1 Patient has a COPD Assessment Test (CAT) score greater than 10; or
- 2.1.2.2 Patient has had 2 or more exacerbations in the previous 12 months; or
- 2.1.2.3 Patient has had one exacerbation requiring hospitalisation in the previous 12 months; or
- 2.1.2.4 Patient has had an eosinophil count greater than or equal to  $0.3 \times 10^9$  cells/L in the previous 12 months; or

2.2 Patient is currently receiving multiple inhaler triple therapy (inhaled corticosteroid with long acting muscarinic antagonist and long acting beta-2 agonist – ICS/LAMA/LABA) and met at least one of the clinical criteria above prior to commencing multiple inhaler triple therapy.

## Antifibrotics

NINTEDANIB – Special Authority see [SA2012 below](#) – Retail pharmacy

Note: Nintedanib not subsidised in combination with subsidised pirfenidone.

Cap 100 mg.....	2,554.00	60 OP	✓ <b>Ofev</b>
Cap 150 mg.....	3,870.00	60 OP	✓ <b>Ofev</b>

➔[SA2012](#) **Special Authority for Subsidy**

**Initial application — (idiopathic pulmonary fibrosis)** only from a respiratory specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

1 Patient has been diagnosed with idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist; and

continued...

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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continued...

- 2 Forced vital capacity is between 50% and 90% predicted; and
- 3 Nintedanib is to be discontinued at disease progression (See Note); and
- 4 Nintedanib is not to be used in combination with subsidised pirfenidone; and
- 5 Any of the following:
  - 5.1 The patient has not previously received treatment with pirfenidone; or
  - 5.2 Patient has previously received pirfenidone, but discontinued pirfenidone within 12 weeks due to intolerance; or
  - 5.3 Patient has previously received pirfenidone, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with pirfenidone).

**Renewal — (idiopathic pulmonary fibrosis)** only from a respiratory specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment; and
- 2 Nintedanib is not to be used in combination with subsidised pirfenidone; and
- 3 Nintedanib is to be discontinued at disease progression (See Note).

Note: disease progression is defined as a decline in percent predicted FVC of 10% or more within any 12 month period.

PIRFENIDONE – Retail pharmacy-Specialist – Special Authority see SA2013 below

Note: Pirfenidone is not subsidised in combination with subsidised nintedanib.

Tab 801 mg .....	437.40	90	✓ Pirfenidone Sandoz
	3,645.00	90 OP	✓ Esbriet
Tab 267 mg .....	145.80	90	✓ Pirfenidone Sandoz
	1,215.00		✓ Esbriet

*(Esbriet Tab 801 mg to be delisted 1 October 2026)*

*(Esbriet Tab 267 mg to be delisted 1 October 2026)*

►SA2013 **Special Authority for Subsidy**

**Initial application — (idiopathic pulmonary fibrosis)** only from a respiratory specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient has been diagnosed with idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist; and
- 2 Forced vital capacity is between 50% and 90% predicted; and
- 3 Pirfenidone is to be discontinued at disease progression (See Note); and
- 4 Pirfenidone is not to be used in combination with subsidised nintedanib; and
- 5 Any of the following:
  - 5.1 The patient has not previously received treatment with nintedanib; or
  - 5.2 Patient has previously received nintedanib, but discontinued nintedanib within 12 weeks due to intolerance; or
  - 5.3 Patient has previously received nintedanib, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with nintedanib).

**Renewal — (idiopathic pulmonary fibrosis)** only from a respiratory specialist. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Treatment remains clinically appropriate and patient is benefitting from and tolerating treatment; and
- 2 Pirfenidone is not to be used in combination with subsidised nintedanib; and
- 3 Pirfenidone is to be discontinued at disease progression (See Note).

Note: disease progression is defined as a decline in percent predicted FVC of 10% or more within any 12 month period.

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# RESPIRATORY SYSTEM AND ALLERGIES

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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## Leukotriene Receptor Antagonists

### MONTELUKAST

* Tab 4 mg .....	3.10	28	✓	<b>Montelukast Viatris</b>
* Tab 5 mg .....	3.10	28	✓	<b>Montelukast Paediatric (Relonchem) <sup>S29</sup></b>
* Tab 10 mg .....	2.45	28	✓	<b>Montelukast Viatris</b>
			✓	<b>Montelukast Viatris</b>

## Methylxanthines

### AMINOPHYLLINE

* Inj 25 mg per ml, 10 ml ampoule – Up to 5 inj available on a PSO .....	180.00	5	✓	<b>DBL Aminophylline</b>
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### THEOPHYLLINE

* Tab long-acting 250 mg .....	25.65	100	✓	<b>Nuelin-SR</b>
* Oral liq 80 mg per 15 ml .....	18.49	500 ml	✓	<b>Nuelin</b>

## Mucolytics

DORNASE ALFA – Special Authority see <a href="#">SA1978 below</a> – Retail pharmacy Nebuliser soln, 2.5 mg per 2.5 ml ampoule .....	250.00	6	✓	<b>Pulmozyme</b>
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### ►SA1978 Special Authority for Subsidy

**Initial application — (cystic fibrosis)** only from a respiratory physician or paediatrician. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient has a confirmed diagnosis of cystic fibrosis; and
- 2 Patient has previously undergone a trial with, or is currently being treated with, hypertonic saline; and
- 3 Any of the following:
  - 3.1 Patient has required one or more hospital inpatient respiratory admissions in the previous 12 month period; or
  - 3.2 Patient has had 3 exacerbations due to CF, requiring oral or intravenous (IV) antibiotics in the previous 12 month period; or
  - 3.3 Patient has had 1 exacerbation due to CF, requiring oral or IV antibiotics in the previous 12 month period and a Brasfield score of < 22/25; or
  - 3.4 Patient has a diagnosis of allergic bronchopulmonary aspergillosis (ABPA).

**Renewal — (cystic fibrosis)** only from a respiratory physician or paediatrician. Approvals valid without further renewal unless notified where the treatment remains appropriate and the patient continues to benefit from treatment.

ELEXACAFTOR WITH TEZACAFTOR, IVACAFTOR AND IVACAFTOR – PCT only – Special Authority see [SA2652 on the next page](#)

Tab elexacaftor 50 mg with tezacaftor 25 mg, ivacaftor 37.5 mg (56) and ivacaftor 75 mg (28) .....	27,647.39	84 OP	✓	<b>Trikafta</b>
Tab elexacaftor 100 mg with tezacaftor 50 mg, ivacaftor 75 mg (56) and ivacaftor 150 mg (28) .....	27,647.39	84 OP	✓	<b>Trikafta</b>
Oral granules elexacaftor 80 mg with tezacaftor 40 mg, ivacaftor 60 mg (28) and ivacaftor 59.5mg (28), sachets .....	27,647.39	56 OP	✓	<b>Trikafta</b>
Oral granules elexacaftor 100 mg with tezacaftor 50 mg, ivacaftor 75 mg (28) and ivacaftor 75 mg (28), sachets .....	27,647.39	56 OP	✓	<b>Trikafta</b>

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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►SA2652 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Patient has been diagnosed with cystic fibrosis; and
- 2 Either:
  - 2.1 Patient has two cystic fibrosis-causing mutations in the cystic fibrosis transmembrane regulator (CFTR) gene (one from each parental allele); or
  - 2.2 Patient has a sweat chloride value of at least 60 mmol/L; and
- 3 Either:
  - 3.1 Patient has a heterozygous or homozygous F508del mutation; or
  - 3.2 Patient has a mutation responsive to elexacaftor/tezacaftor/ivacaftor (see note); and
- 4 The treatment must be the sole funded CFTR modulator therapy for this condition; and
- 5 Treatment with elexacaftor/tezacaftor/ivacaftor must be given concomitantly with standard therapy for this condition.

Note: Eligible mutations are listed in the Food and Drug Administration (FDA) Trikafta prescribing information

[https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2026/212273s014lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2026/212273s014lbl.pdf)

IVACAFTOR – PCT only – Specialist – Special Authority see SA2650 below

Tab 150 mg .....	29,386.00	56	✓ Kalydeco
Oral granules 13.4 mg, sachet .....	29,386.00	56	✓ Kalydeco
Oral granules 25 mg, sachet .....	29,386.00	56	✓ Kalydeco
Oral granules 50 mg, sachet .....	29,386.00	56	✓ Kalydeco
Oral granules 75 mg, sachet .....	29,386.00	56	✓ Kalydeco

►SA2650 Special Authority for Subsidy

Initial application from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Patient has been diagnosed with cystic fibrosis; and
- 2 Either:
  - 2.1 Patient has two cystic fibrosis-causing mutations in the cystic fibrosis transmembrane regulator (CFTR) gene (one from each parental allele); or
  - 2.2 Patients must have a sweat chloride value of at least 60 mmol/L; and
- 3 Patient has a mutation responsive to ivacaftor (see note); and
- 4 Treatment with ivacaftor must be given concomitantly with standard therapy for this condition; and
- 5 The dose of ivacaftor will not exceed one tablet or one sachet twice daily.

Note: Mutations listed in Table 3 of the Food and Drug Administration (FDA) Ivacaftor prescribing information

[https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2023/203188s038lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/203188s038lbl.pdf)

SODIUM CHLORIDE

Not funded for use as a nasal drop.

Soln 7% .....	25.73	90 ml OP	✓ Biomed
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VANZACFTOR WITH TEZACFTOR AND DEUTIVACFTOR – PCT only – Special Authority see SA2648 on the next page

Tab vanzacaftor 4 mg with tezacaftor 20 mg and deutivacaftor 50 mg.....	29,029.76	84 OP	✓ Alyftrek
Tab vanzacaftor 10 mg with tezacaftor 50 mg and deutivacaftor 125 mg.....	29,029.76	56 OP	✓ Alyftrek

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

# RESPIRATORY SYSTEM AND ALLERGIES

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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## ►SA2648 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

All of the following:

- 1 Patient has been diagnosed with cystic fibrosis; and
- 2 Either:
  - 2.1 Patient has two cystic fibrosis-causing mutations in the cystic fibrosis transmembrane regulator (CFTR) gene (one from each parental allele); or
  - 2.2 Patient has a sweat chloride value of at least 60 mmol/L; and
- 3 Either:
  - 3.1 Patient has a heterozygous or homozygous F508del mutation; or
  - 3.2 Patient has a mutation responsive to vanzacaftor/tezacaftor/deutivacaftor (see note); and
- 4 The treatment must be the sole funded CFTR modulator therapy for this condition; and
- 5 Treatment with vanzacaftor/tezacaftor/deutivacaftor must be given concomitantly with standard therapy for this condition.

Note: Eligible mutations are listed in the in the Food and Drug Administration (FDA) Alyftrek prescribing information

[https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2026/218730s0011bl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2026/218730s0011bl.pdf)

## Nasal Preparations

### Allergy Prophylactics

#### BUDESONIDE

Metered aqueous nasal spray, 50 mcg per dose .....	2.59	200 dose OP	✓ <b>SteroClear</b>
Metered aqueous nasal spray, 100 mcg per dose .....	2.89	200 dose OP	✓ <b>SteroClear</b>

#### FLUTICASONE PROPIONATE

Metered aqueous nasal spray, 50 mcg per dose .....	2.57	120 dose OP	✓ <b>Flixonase Hayfever &amp; Allergy</b>
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Flixonase Hayfever & Allergy to be Principal Supply on 1 August 2026

#### IPRATROPIUM BROMIDE

Aqueous nasal spray, 0.03% .....	5.23	15 ml OP	✓ <b>Univent</b>
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## Respiratory Devices

#### MASK FOR SPACER DEVICE

a) Up to 50 dev available on a PSO			
b) Only on a PSO			
c) Only for children aged six years and under			
Small .....	2.70	1	✓ <b>e-chamber Mask</b>

#### PEAK FLOW METER

a) Up to 25 dev available on a PSO			
b) Only on a PSO			
Low range .....	9.54	1	✓ <b>Mini-Wright AFS Low Range</b>
Normal range .....	9.54	1	✓ <b>Mini-Wright Standard</b>

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>SPACER DEVICE</b>				
a) Up to 50 dev available on a PSO				
b) Only on a PSO				
220 ml (single patient) .....	3.65	1	✓	e-chamber Turbo
510 ml (single patient) .....	5.95	1	✓	e-chamber La Grande
800 ml.....	6.50	1	✓	Volumatic

**Respiratory Stimulants**

<b>CAFFEINE CITRATE</b>				
Oral liq 20 mg per ml (10 mg base per ml) .....	16.91	25 ml OP	✓	Biomed

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

## SENSORY ORGANS

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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### Ear Preparations

#### FLUMETASONE PIVALATE

Ear drops 0.02% with clioquinol 1% .....	4.46	7.5 ml OP	✓ <b>Locacorten-Viaform ED's</b> ✓ <b>Locorten-Vioform</b>
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#### TRIAMCINOLONE ACETONIDE WITH GRAMICIDIN, NEOMYCIN AND NYSTATIN

Ear drops 1 mg with nystatin 100,000 u, neomycin sulphate 2.5 mg and gramicidin 250 mcg per g .....	5.16	7.5 ml OP	✓ <b>Kenacomb</b>
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### Ear/Eye Preparations

#### DEXAMETHASONE WITH FRAMYCETIN AND GRAMICIDIN

Ear/Eye drops 500 mcg with framycetin sulphate 5 mg and gramicidin 50 mcg per ml .....	4.50 (9.27)	8 ml OP	Sofradex
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#### FRAMYCETIN SULPHATE

Ear/Eye drops 0.5% .....	4.13 (8.65)	8 ml OP	Soframycin
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### Eye Preparations

Eye preparations are only funded for use in the eye, unless explicitly stated otherwise.

### Anti-Infective Preparations

#### ACICLOVIR

* Eye oint 3% .....	15.89	4.5 g OP	✓ <b>ViruPOS</b>
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#### CHLORAMPHENICOL

Note: Direct Provision by a pharmacist permitted under the provisions in Part I of Section A in accordance with the Integrated Community Pharmaceuticals Agreement (ICPSA) – Extended Pharmacy Services.

Eye oint 1% .....	1.55	5 g OP	✓ <b>Devatis</b>
Eye drops 0.5% .....	1.84	10 ml OP	✓ <b>Chlorafast</b>

Funded for use in the ear\*. Indications marked with \* are unapproved indications.

#### CIPROFLOXACIN

Eye drops 0.3% – Subsidy by endorsement .....	10.85	5 ml OP	✓ <b>Ciprofloxacin Teva</b>
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When prescribed for the treatment of bacterial keratitis or severe bacterial conjunctivitis resistant to chloramphenicol; or for the second line treatment of chronic suppurative otitis media (CSOM)\*; and the prescription is endorsed accordingly.

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

#### SODIUM FUSIDATE [FUSIDIC ACID]

Eye drops 1% .....	5.29	5 g OP	✓ <b>Fucithalmic</b> ✓ <b>Fucithalmic Canada</b> (ON) <sup>S29</sup> ✓ <b>Fucithalmic</b> Spain <sup>S29</sup>
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#### TOBRAMYCIN

Eye oint 0.3% .....	10.45	3.5 g OP	✓ <b>Tobrex</b>
Eye drops 0.3% .....	11.48	5 ml OP	✓ <b>Tobrex</b>

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
<b>Corticosteroids and Other Anti-Inflammatory Preparations</b>			
<b>DEXAMETHASONE</b>			
* Eye oint 0.1% .....	5.86	3.5 g OP	✓ <b>Maxidex</b>
* Eye drops 0.1% .....	4.50	5 ml OP	✓ <b>Maxidex</b>
Ocular implant 700 mcg – Special Authority see <a href="#">SA1680 below</a>			
– Retail pharmacy.....	1,444.50	1	✓ <b>Ozurdex</b>
<b>►SA1680 Special Authority for Subsidy</b>			
<b>Initial application — (Diabetic macular oedema)</b> only from an ophthalmologist. Approvals valid for 12 months for applications meeting the following criteria:			
All of the following:			
1 Patient has diabetic macular oedema with pseudophakic lens; and			
2 Patient has reduced visual acuity of between 6/9 - 6/48 with functional awareness of reduction in vision; and			
3 Either:			
3.1 Patient's disease has progressed despite 3 injections with bevacizumab; or			
3.2 Patient is unsuitable or contraindicated to treatment with anti-VEGF agents; and			
4 Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year.			
<b>Renewal — (Diabetic macular oedema)</b> only from an ophthalmologist. Approvals valid for 12 months for applications meeting the following criteria:			
Both:			
1 Patient's vision is stable or has improved (prescriber determined); and			
2 Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year.			
<b>Initial application — (Women of child bearing age with diabetic macular oedema)</b> only from an ophthalmologist. Approvals valid for 12 months for applications meeting the following criteria:			
All of the following:			
1 Patient has diabetic macular oedema; and			
2 Patient has reduced visual acuity of between 6/9 - 6/48 with functional awareness of reduction in vision; and			
3 Patient is of child bearing potential and has not yet completed a family; and			
4 Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year.			
<b>Renewal — (Women of child bearing age with diabetic macular oedema)</b> only from an ophthalmologist. Approvals valid for 12 months for applications meeting the following criteria:			
All of the following:			
1 Patient's vision is stable or has improved (prescriber determined); and			
2 Patient is of child bearing potential and has not yet completed a family; and			
3 Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year.			
<b>DEXAMETHASONE WITH NEOMYCIN SULPHATE AND POLYMYXIN B SULPHATE</b>			
* Eye oint 0.1% with neomycin sulphate 0.35% and polymyxin b sulphate 6,000 u per g.....	5.39	3.5 g OP	✓ <b>Maxitrol</b>
* Eye drops 0.1% with neomycin sulphate 0.35% and polymyxin b sulphate 6,000 u per ml.....	4.50	5 ml OP	✓ <b>Maxitrol</b>
<b>DICLOFENAC SODIUM</b>			
Eye drops 0.1%, single dose.....	1.85	10 dose	✓ <b>Diclofenac Devatis</b>
	5.54	30 dose	✓ <b>Diclofenac Devatis</b>
<b>FLUOROMETHOLONE</b>			
* Eye drops 0.1%.....	3.09	5 ml OP	✓ <b>FML</b>
	5.20		✓ <b>Flucon</b>

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

## SENSORY ORGANS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
LEVOCABASTINE				
Eye drops 0.5 mg per ml .....	8.71 (10.34)	4 ml OP		Livostin
LODOXAMIDE				
Eye drops 0.1% .....	8.71	10 ml OP	✓	Lomide
PREDNISOLONE ACETATE				
Eye drops 1% .....	6.92 7.00	10 ml OP 5 ml OP	✓	Prednisolone-AFT Pred Forte
PREDNISOLONE SODIUM PHOSPHATE – Special Authority see <a href="#">SA1715 below</a> – Retail pharmacy				
Eye drops 0.5%, single dose (preservative free).....	43.26	20 dose	✓	Minims Prednisolone

### ►SA1715 Special Authority for Subsidy

**Initial application** only from an ophthalmologist or optometrist. Approvals valid for 6 months for applications meeting the following criteria:

Both:

- 1 Patient has severe inflammation; and
- 2 Patient has a confirmed allergic reaction to preservative in eye drops.

**Renewal** from any relevant practitioner. Approvals valid for 6 months where the treatment remains appropriate and the patient is benefiting from treatment.

### SODIUM CROMOGLICATE

Eye drops 2% .....2.91 10 ml OP ✓ **Allerfix**

### Glaucoma Preparations - Beta Blockers

#### TIMOLOL

\* Eye drops 0.25% .....2.42 5 ml OP ✓ **Arrow-Timolol**  
\* Eye drops 0.5% .....2.50 5 ml OP ✓ **Arrow-Timolol**

### Glaucoma Preparations - Carbonic Anhydrase Inhibitors

#### ACETAZOLAMIDE

\* Tab 250 mg .....13.96 100 ✓ **Medsurge**

#### BRINZOLAMIDE

\* Eye drops 1% .....5.11 5 ml OP ✓ **Azopt**

#### DORZOLAMIDE WITH TIMOLOL

\* Eye drops 2% with timolol 0.5% .....3.58 5 ml OP ✓ **Dortimopt**

### Glaucoma Preparations - Prostaglandin Analogues

#### BIMATOPROST

\* Eye drops 0.03% .....5.15 3 ml OP ✓ **Lumigan**

#### LATANOPROST

\* Eye drops 0.005% .....2.08 2.5 ml OP ✓ **Teva**

#### TRAVOPROST

\* Eye drops 0.004% .....6.80 2.5 ml OP ✓ **Travatan**

### Glaucoma Preparations - Other

#### BRIMONIDINE TARTRATE

\* Eye drops 0.2% .....5.16 5 ml OP ✓ **Arrow-Brimonidine**

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>BRIMONIDINE TARTRATE WITH TIMOLOL MALEATE</b>				
* Eye drops 0.2% with timolol maleate 0.5% .....	7.13	5 ml OP	✓	<b>Combigan</b>
<b>LATANOPROST WITH TIMOLOL</b>				
* Eye drops 0.005% with timolol 0.5% .....	4.95	2.5 ml OP	✓	<b>Arrow - Lattim</b>
<b>PILOCARPINE HYDROCHLORIDE</b>				
* Eye drops 1% .....	4.26	15 ml OP	✓	<b>Isopto Carpine</b>
* Eye drops 2% .....	5.35	15 ml OP	✓	<b>Isopto Carpine</b>
* Eye drops 4% .....	7.99	15 ml OP	✓	<b>Isopto Carpine</b>
Subsidised for oral use pursuant to the Standard Formulae.				
<b>PILOCARPINE NITRATE</b>				
* Eye drops 2% single dose – Special Authority see <a href="#">SA2644</a> below – Retail pharmacy .....	35.90	20 dose	✓	<b>Minims Pilocarpine</b>

**▶SA2644 Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid for 2 years for applications meeting the following criteria:  
Either:

- 1 Patient has to use an unpreserved solution due to an allergy to the preservative; or
- 2 Patient wears soft contact lenses.

**Renewal** from any relevant practitioner. Approvals valid for 2 years where the treatment remains appropriate and the patient is benefiting from treatment.

**Mydriatics and Cycloplegics**

<b>ATROPINE SULPHATE</b>				
* Eye drops 1% .....	18.27	15 ml OP	✓	<b>Atropt</b>
<b>CYCLOPENTOLATE HYDROCHLORIDE</b>				
* Eye drops 1% .....	25.16	15 ml OP	✓	<b>Cyclogyl</b>
<b>TROPICAMIDE</b>				
* Eye drops 0.5% .....	20.52	15 ml OP	✓	<b>Mydriacyl</b>
* Eye drops 1% .....	24.82	15 ml OP	✓	<b>Mydriacyl</b>

**Preparations for Tear Deficiency**

For acetylcysteine eye drops refer Standard Formulae, [page 285](#)

<b>HYPROMELLOSE</b>				
* Eye drops 0.5% .....	19.50	15 ml OP	✓	<b>Methopt</b>
<b>HYPROMELLOSE WITH DEXTRAN</b>				
* Eye drops 0.3% with dextran 0.1%.....	2.30	15 ml OP	✓	<b>Poly-Tears</b>

**Preservative Free Ocular Lubricants**

**▶SA2431 Special Authority for Subsidy**

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Both:

- 1 Confirmed diagnosis by slit lamp or Schirmer test of severe secretory dry eye; and
- 2 Either:
  - 2.1 Patient is using eye drops more than four times daily on a regular basis; or
  - 2.2 Patient has had a confirmed allergic reaction to preservative in eye drop.

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

## SENSORY ORGANS

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
POLYETHYLENE GLYCOL 400 AND PROPYLENE GLYCOL – Special Authority see <a href="#">SA2431 on the previous page</a> – Retail pharmacy			
Eye drops 0.4% and propylene glycol 0.3%, 0.8 ml .....	10.06	28	✓ <b>Systane Unit Dose</b>
SODIUM HYALURONATE [HYALURONIC ACID] – Special Authority see <a href="#">SA2431 on the previous page</a> – Retail pharmacy			
Eye drops 1 mg per ml .....	13.58	10 ml OP	✓ <b>Hilo-Fresh</b>
Hilo-Fresh has a 6 month expiry after opening. The Pharmacy Procedures Manual restriction allowing one bottle per month is not relevant and therefore only the prescribed dosage to the nearest OP may be claimed.			

### Other Eye Preparations

NAPHAZOLINE HYDROCHLORIDE			
* Eye drops 0.1% .....	5.65	15 ml OP	✓ <b>Albalon</b>
OLOPATADINE			
Eye drops 0.1% .....	3.39	5 ml OP	✓ <b>Olopatadine Teva</b>
PARAFFIN LIQUID WITH WOOL FAT			
* Eye oint 3% with wool fat 3% .....	3.63	3.5 g OP	✓ <b>Poly-Visc</b>
RETINOL PALMITATE			
Eye oint 138 mcg per g .....	3.80	5 g OP	✓ <b>VitA-POS</b>

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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## Various

### PHARMACY SERVICES

* Brand switch fee.....	4.50	1 fee	✓	BSF Lyrica
a) May only be claimed once per patient.				
b) The Pharmacode for BSF Lyrica is 2723727 - see also <a href="#">page 134</a>				
<i>(BSF Lyrica Brand switch fee to be delisted 1 July 2026)</i>				

## Agents Used in the Treatment of Poisonings

### Antidotes

#### ACETYL CYSTEINE

Inj 200 mg per ml, 10 ml ampoule .....	42.99	10	✓	DBL Acetylcysteine
Inj 200 mg per ml, 10 ml vial.....	42.99	10	✓	Hikma Acetylcysteine <sup>S29</sup>

#### NALOXONE HYDROCHLORIDE

a) Up to 10 inj available on a PSO				
b) Only on a PSO				
* Inj 400 mcg per ml, 1 ml ampoule .....	13.29	5	✓	DBL Naloxone Hydrochloride

### Removal and Elimination

#### CHARCOAL

* Oral liq 50 g per 250 ml .....	59.85	250 ml OP	✓	Carbosorb-X
a) Up to 250 ml available on a PSO				
b) Only on a PSO				

#### DEFERASIROX – Special Authority see [SA1492 below](#) – Retail pharmacy

Wastage claimable

Tab 125 mg dispersible .....	276.00	28	✓	Exjade
Tab 250 mg dispersible .....	552.00	28	✓	Exjade
Tab 500 mg dispersible .....	1,105.00	28	✓	Exjade

#### ►SA1492 Special Authority for Subsidy

**Initial application** only from a haematologist. Approvals valid for 2 years for applications meeting the following criteria:

All of the following:

- 1 The patient has been diagnosed with chronic iron overload due to congenital inherited anaemia; and
- 2 Deferasirox is to be given at a daily dose not exceeding 40 mg/kg/day; and
- 3 Any of the following:
  - 3.1 Treatment with maximum tolerated doses of deferiprone monotherapy or deferiprone and desferrioxamine combination therapy have proven ineffective as measured by serum ferritin levels, liver or cardiac MRI T2\*; or
  - 3.2 Treatment with deferiprone has resulted in severe persistent vomiting or diarrhoea; or
  - 3.3 Treatment with deferiprone has resulted in arthritis; or
  - 3.4 Treatment with deferiprone is contraindicated due to a history of agranulocytosis (defined as an absolute neutrophil count (ANC) of < 0.5 cells per µL) or recurrent episodes (greater than 2 episodes) of moderate neutropenia (ANC 0.5 - 1.0 cells per µL).

**Renewal** only from a haematologist. Approvals valid for 2 years for applications meeting the following criteria:

continued...

▲Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\*Three months or six months, as applicable, dispensed at one time

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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continued...

Either:

- 1 For the first renewal following 2 years of therapy, the treatment has been tolerated and has resulted in clinical improvement in all three parameters namely serum ferritin, cardiac MRI T2\* and liver MRI T2\* levels; or
- 2 For subsequent renewals, the treatment has been tolerated and has resulted in clinical stability or continued improvement in all three parameters namely serum ferritin, cardiac MRI T2\* and liver MRI T2\* levels.

DEFERIPRONE – Special Authority see [SA1480 below](#) – Retail pharmacy

Tab 500 mg .....	533.17	100	✓	<b>Ferriprox</b>
Oral liq 100 mg per 1 ml .....	266.59	250 ml OP	✓	<b>Ferriprox</b>

➔ **SA1480 Special Authority for Subsidy**

**Initial application** only from a haematologist. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 The patient has been diagnosed with chronic iron overload due to congenital inherited anaemia; or
- 2 The patient has been diagnosed with chronic iron overload due to acquired red cell aplasia.

DEFERRIOXAMINE MESILATE

* Inj 500 mg vial .....	332.88	10	✓	<b>DBL</b> <b>Desferrioxamine</b> <b>Mesylate for Inj</b> <b>BP</b>
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SODIUM CALCIUM EDETATE

* Inj 200 mg per ml, 5 ml .....	53.31 (156.71)	6		Calcium Disodium Versenate
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**Standard Formulae**

<b>ACETYLCYSTEINE EYE DROPS</b>			<b>PHENOBARBITONE SODIUM PAEDIATRIC ORAL LIQUID (10 mg per ml)</b>
Acetylcysteine inj 200 mg per ml, 10 ml	qs		Phenobarbitone Sodium 400 mg
Suitable eye drop base	qs		Glycerol BP 4 ml
			Water to 40 ml
<b>CODEINE LINCTUS (3 mg per 5 ml)</b>			<b>PILOCARPINE ORAL LIQUID</b>
Codeine phosphate	60 mg		Pilocarpine 4% eye drops qs
Glycerol	40 ml		Preservative qs
Preservative	qs		Water to 500 ml
Water	to 100 ml		(Preservative should be used if quantity supplied is for more than 5 days.)
<b>CODEINE LINCTUS (15 mg per 5 ml)</b>			<b>SALIVA SUBSTITUTE FORMULA</b>
Codeine phosphate	300 mg		Methylcellulose 5 g
Glycerol	40 ml		Preservative qs
Preservative	qs		Water to 500 ml
Water	to 100 ml		(Preservative should be used if quantity supplied is for more than 5 days. Maximum 500 ml per prescription.)
<b>FOLINIC MOUTHWASH</b>			<b>SODIUM CHLORIDE ORAL LIQUID</b>
Calcium folinate 15 mg tab	1 tab		Sodium chloride inj 23.4%, 20 ml qs
Preservative	qs		Water qs
Water	to 500 ml		(Only funded if prescribed for treatment of hyponatraemia)
(Preservative should be used if quantity supplied is for more than 5 days. Maximum 500 ml per prescription.)			<b>VANCOMYCIN ORAL SOLUTION (25 mg per ml)</b>
<b>METHYL HYDROXYBENZOATE 10% SOLUTION</b>			Vancomycin 500 mg injection 5 vials
Methyl hydroxybenzoate	10 g		Glycerin with sucrose suspension 37.5 ml
Propylene glycol	to 100 ml		Water to 100 ml
(Use 1 ml of the 10% solution per 100 ml of oral liquid mixture)			(Only funded if prescribed for treatment of Clostridium difficile following metronidazole failure)
<b>OMEPRAZOLE SUSPENSION</b>			
Omeprazole capsules or powder	qs		
Sodium bicarbonate powder BP	8.4 g		
Water	to 100 ml		
<b>PHENOBARBITONE ORAL LIQUID</b>			
Phenobarbitone Sodium	1 g		
Glycerol BP	70 ml		
Water	to 100 ml		

# EXTEMPORANEOUSLY COMPOUNDED PREPARATIONS AND GALENICALS

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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## Extemporaneously Compounded Preparations and Galenicals

### COLLODION FLEXIBLE

Note: This product is no longer being manufactured by the supplier and will be delisted from the Schedule at a date to be determined.

Collodion flexible ..... 19.30      100 ml      ✓ PSM

### COMPOUND HYDROXYBENZOATE – Only in combination

Only in extemporaneously compounded oral mixtures.

Soln ..... 36.00      100 ml      ✓ Midwest

### GLYCERIN WITH SODIUM SACCHARIN – Only in combination

Suspension ..... 38.00      473 ml      ✓ Ora-Sweet SF

### GLYCERIN WITH SUCROSE – Only in combination

Suspension ..... 38.00      473 ml      ✓ Ora-Sweet

### GLYCEROL

\* Liquid – Only in combination ..... 3.23      500 ml      ✓ healthE Glycerol BP  
Only in extemporaneously compounded oral liquid preparations.

### METHYL HYDROXYBENZOATE

Powder ..... 11.00      25 g      ✓ Midwest

### METHYLCELLULOSE

Powder ..... 44.00      100 g      ✓ MidWest

Suspension – Only in combination ..... 38.00      473 ml      ✓ Ora-Plus

*(MidWest Powder to be delisted 1 February 2028)*

### METHYLCELLULOSE WITH GLYCERIN AND SODIUM SACCHARIN – Only in combination

Suspension ..... 38.00      473 ml      ✓ Ora-Blend SF

### METHYLCELLULOSE WITH GLYCERIN AND SUCROSE – Only in combination

Suspension ..... 38.00      473 ml      ✓ Ora-Blend

### PHENOBARBITONE SODIUM

Powder – Only in combination ..... 125.00      10 g      ✓ MidWest

Only in children up to 12 years

### PROPYLENE GLYCOL

Only in extemporaneously compounded methyl hydroxybenzoate 10% solution.

Liq ..... 16.00      500 ml      ✓ Midwest

### SODIUM BICARBONATE

Powder BP – Only in combination ..... 13.50      500 g      ✓ Midwest

Only in extemporaneously compounded omeprazole and lansoprazole suspension.

### SYRUP (PHARMACEUTICAL GRADE) – Only in combination

Only in extemporaneously compounded oral liquid preparations.

Liq ..... 25.00      500 ml      ✓ Midwest

### WATER

Tap – Only in combination ..... 0.00      1 ml      ✓ Tap water

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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## Nutrient Modules

### Carbohydrate

#### ►SA1930 Special Authority for Subsidy

**Initial application — (Cystic fibrosis or kidney disease)** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years for applications meeting the following criteria:

Either:

- 1 cystic fibrosis; or
- 2 chronic kidney disease.

**Initial application — (Indications other than cystic fibrosis or renal failure)** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Any of the following:

- 1 cancer in children; or
- 2 cancers affecting alimentary tract where there are malabsorption problems in patients over the age of 20 years; or
- 3 faltering growth in an infant/child; or
- 4 bronchopulmonary dysplasia; or
- 5 premature and post premature infant; or
- 6 for use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk.

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

**Initial application — (Inborn errors of metabolism)** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid without further renewal unless notified where the patient has inborn errors of metabolism.

**Renewal — (Cystic fibrosis or renal failure)** only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

**Renewal — (Indications other than cystic fibrosis or renal failure)** only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

CARBOHYDRATE SUPPLEMENT – Special Authority see SA1930 above – Hospital pharmacy [HP3]

Powder ..... 6.72 400 g OP ✓ Polycal

### Carbohydrate And Fat

#### ►SA1376 Special Authority for Subsidy

**Initial application — (Cystic fibrosis)** only from a dietitian, relevant specialist or vocationally registered general practitioner.

Approvals valid for 3 years for applications meeting the following criteria:

Both:

continued...

# SPECIAL FOODS

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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continued...

- 1 Infant or child aged four years or under; and
- 2 cystic fibrosis.

**Initial application — (Indications other than cystic fibrosis)** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

- 1 infant or child aged four years or under; and
- 2 Any of the following:
  - 2.1 cancer in children; or
  - 2.2 faltering growth; or
  - 2.3 bronchopulmonary dysplasia; or
  - 2.4 premature and post premature infants.

**Renewal — (Cystic fibrosis)** only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

**Renewal — (Indications other than cystic fibrosis)** only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

CARBOHYDRATE AND FAT SUPPLEMENT – Special Authority see [SA1376 on the previous page](#) – Hospital pharmacy [HP3]

Powder (neutral) ..... 71.77      400 g OP      ✓ **Duocal Super Soluble Powder**

## Fat

» **SA2204** Special Authority for Subsidy

**Initial application — (Inborn errors of metabolism)** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid without further renewal unless notified where the patient has an inborn error of metabolism.

**Initial application — (Indications other than inborn errors of metabolism)** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Any of the following:

- 1 faltering growth in an infant/child; or
- 2 bronchopulmonary dysplasia; or
- 3 fat malabsorption; or
- 4 lymphangiectasia; or
- 5 short bowel syndrome; or
- 6 infants with necrotising enterocolitis; or
- 7 biliary atresia; or
- 8 for use in a ketogenic diet; or
- 9 chyle leak; or

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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continued...

10 ascites; or

11 for use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk.

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

**Renewal — (Indications other than inborn errors of metabolism)** only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

FAT SUPPLEMENT – Special Authority see [SA2204 on the previous page](#) – Hospital pharmacy [HP3]

Emulsion (neutral) .....	15.38	200 ml OP	✓ Calogen
Emulsion (strawberry).....	15.38	200 ml OP	✓ Calogen
Oil .....	37.50	500 ml OP	✓ MCT oil (Nutricia)
MCT Emulsion, 250 ml .....	143.65	4 OP	✓ Liquigen

## Protein

### ▶SA1524 Special Authority for Subsidy

**Initial application** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Any of the following:

- 1 protein losing enteropathy; or
- 2 high protein needs; or
- 3 for use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk.

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

**Renewal** only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

PROTEIN SUPPLEMENT – Special Authority see [SA1524 above](#) – Hospital pharmacy [HP3]

Powder .....	8.95	227 g OP	✓ Resource Beneprotein
	13.82	225 g OP	✓ Protifar

Subsidy (Manufacturer's Price)	Fully Subsidised	Brand or Generic Manufacturer
\$	Per	✓

## Oral and Enteral Feeds

### Diabetic Products

► **SA1095** Special Authority for Subsidy

**Initial application** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year where the patient is a type I or and II diabetic who is suffering weight loss and malnutrition that requires nutritional support.

**Renewal** only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

- Both:
- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
  - 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

DIABETIC ENTERAL FEED 1KCAL/ML – Special Authority see <a href="#">SA1095 above</a> – Hospital pharmacy [HP3]			
Liquid, 500 ml bottle .....	4.65	1 OP	✓ <b>Glucerna Select</b>
DIABETIC ORAL FEED 1KCAL/ML – Special Authority see <a href="#">SA1095 above</a> – Hospital pharmacy [HP3]			
Liquid (strawberry), 200 ml bottle .....	2.25	1 OP	✓ <b>Diasip</b>
Liquid (vanilla), 200 ml bottle.....	2.25	1 OP	✓ <b>Diasip</b>
	8.40	4	✓ <b>Nutren Diabetes</b>

### Fat Modified Products

► **SA2205** Special Authority for Subsidy

**Initial application — (Inborn errors of metabolism)** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid without further renewal unless notified where the patient has an inborn error of metabolism.

**Initial application — (Indications other than errors of inborn metabolism)** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

- Either:
- 1 Patient has a chyle leak; or
  - 2 Modified as a modular feed, made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule, for adults.

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

**Renewal** only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

- Both:
- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
  - 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

FAT MODIFIED FEED – Special Authority see <a href="#">SA2205 above</a> – Hospital pharmacy [HP3]			
Powder .....	62.90	400 g OP	✓ <b>Monogen</b>

Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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**Paediatric Products For Children Awaiting Liver Transplant**

►SA1098 **Special Authority for Subsidy**

**Initial application** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years where the patient is a child (up to 18 years) who requires a liver transplant.

**Renewal** only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

ENTERAL/ORAL FEED 1KCAL/ML – Special Authority see SA1098 above – Hospital pharmacy [HP3]

Powder (unflavoured) .....93.97      400 g OP      ✓ **Heparon Junior**

**Paediatric Products For Children With Chronic Renal Failure**

►SA1099 **Special Authority for Subsidy**

**Initial application** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years where the patient is a child (up to 18 years) with acute or chronic kidney disease.

**Renewal** only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

ENTERAL/ORAL FEED 1KCAL/ML – Special Authority see SA1099 above – Hospital pharmacy [HP3]

Powder .....64.26      400 g OP      ✓ **Kindergen**

**Paediatric Products**

►SA1379 **Special Authority for Subsidy**

**Initial application** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

- 1 Child is aged one to ten years; and
- 2 Any of the following:
  - 2.1 the child is being fed via a tube or a tube is to be inserted for the purposes of feeding; or
  - 2.2 any condition causing malabsorption; or
  - 2.3 faltering growth in an infant/child; or
  - 2.4 increased nutritional requirements; or
  - 2.5 the child is being transitioned from TPN or tube feeding to oral feeding.

**Renewal** only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for

continued...

## SPECIAL FOODS

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
continued...			
applications meeting the following criteria:			
Both:			
1 The treatment remains appropriate and the patient is benefiting from treatment; and			
2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.			
PAEDIATRIC ENTERAL FEED 1.5KCAL/ML – Special Authority see <a href="#">SA1379 on the previous page</a> – Hospital pharmacy [HP3]			
Liquid, 500 ml bottle .....	7.46	1 OP	✓ <b>Nutrini Energy RTH</b>
PAEDIATRIC ENTERAL FEED 1KCAL/ML – Special Authority see <a href="#">SA1379 on the previous page</a> – Hospital pharmacy [HP3]			
Liquid, 500 ml bottle .....	3.32	1 OP	✓ <b>Pediasure RTH</b>
	4.69		✓ <b>Nutrini RTH</b>
PAEDIATRIC ENTERAL FEED WITH FIBRE 1.5KCAL/ML – Special Authority see <a href="#">SA1379 on the previous page</a> – Hospital pharmacy [HP3]			
Liquid, 500 ml bottle .....	7.14	1 OP	✓ <b>Nutrini Energy Multi Fibre</b>
PAEDIATRIC ORAL FEED 1.5KCAL/ML – Special Authority see <a href="#">SA1379 on the previous page</a> – Hospital pharmacy [HP3]			
Liquid (strawberry), 200 ml bottle .....	1.90	1 OP	✓ <b>Fortini</b>
Liquid (vanilla), 200 ml bottle .....	1.90	1 OP	✓ <b>Fortini</b>
Liquid (vanilla), 500 ml bottle .....	8.67	1 OP	✓ <b>Pediasure Plus</b>
PAEDIATRIC ORAL FEED 1KCAL/ML – Special Authority see <a href="#">SA1379 on the previous page</a> – Hospital pharmacy [HP3]			
Liquid (chocolate), 200 ml bottle .....	1.33	1 OP	✓ <b>Pediasure</b>
Liquid (strawberry), 200 ml bottle .....	1.33	1 OP	✓ <b>Pediasure</b>
Liquid (vanilla), 200 ml bottle .....	1.33	1 OP	✓ <b>Pediasure</b>
PAEDIATRIC ORAL FEED WITH FIBRE 1.5KCAL/ML – Special Authority see <a href="#">SA1379 on the previous page</a> – Hospital pharmacy [HP3]			
Liquid (chocolate), 200 ml bottle .....	1.90	1 OP	✓ <b>Fortini Multi Fibre</b>
Liquid (strawberry), 200 ml bottle .....	1.90	1 OP	✓ <b>Fortini Multi Fibre</b>
Liquid (unflavoured), 200 ml bottle .....	1.90	1 OP	✓ <b>Fortini Multi Fibre</b>
Liquid (vanilla), 200 ml bottle .....	1.90	1 OP	✓ <b>Fortini Multi Fibre</b>
PEPTIDE-BASED ORAL FEED – Special Authority see <a href="#">SA1379 on the previous page</a> – Hospital pharmacy [HP3]			
Powder .....	43.60	400 g OP	✓ <b>Peptamen Junior</b>

## Renal Products

### ►SA1101 Special Authority for Subsidy

**Initial application** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years where the patient has acute or chronic kidney disease.

**Renewal** only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years for applications meeting the following criteria:

- Both:
- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
  - 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

RENAL ORAL FEED 1.8 KCAL/ML – Special Authority see [SA1101 above](#) – Hospital pharmacy [HP3]

Liquid, 220 ml bottle .....	3.31	1 OP	✓ <b>Nepro HP (strawberry)</b>
			✓ <b>Nepro HP (vanilla)</b>

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
RENAL ORAL FEED 2 KCAL/ML – Special Authority see <a href="#">SA1101 on the previous page</a> – Hospital pharmacy [HP3]				
Liquid, 200 ml bottle .....	13.24	4 OP	✓	<b>NovaSource Renal</b>
Liquid (apricot) 125 ml.....	13.72	4 OP	✓	<b>Renilon 7.5</b>
Liquid (caramel) 125 ml .....	13.72	4 OP	✓	<b>Renilon 7.5</b>

**Specialised And Elemental Products**

►**SA1377** **Special Authority for Subsidy**

**Initial application** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Any of the following:

- 1 malabsorption; or
- 2 short bowel syndrome; or
- 3 enterocutaneous fistulas; or
- 4 eosinophilic oesophagitis; or
- 5 inflammatory bowel disease; or
- 6 patients with multiple food allergies requiring enteral feeding.

Notes: Each of these products is highly specialised and would be prescribed only by an expert for a specific disorder. The alternative is hospitalisation.

Elemental 028 Extra is more expensive than other products listed in this section and should only be used where the alternatives have been tried first and/or are unsuitable.

**Renewal** only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

ENTERAL/ORAL SEMI-ELEMENTAL FEED 1.5KCAL/ML – Special Authority see [SA1377 above](#) – Hospital pharmacy [HP3]

Liquid, 1,000 ml bottle .....22.39 1 OP ✓ **Vital**

ORAL ELEMENTAL FEED 0.8KCAL/ML – Special Authority see [SA1377 above](#) – Hospital pharmacy [HP3]

Liquid (grapefruit), 250 ml carton..... 179.46 18 OP ✓ **Elemental 028 Extra**

Liquid (pineapple & orange), 250 ml carton..... 179.46 18 OP ✓ **Elemental 028 Extra**

Liquid (summer fruits), 250 ml carton..... 179.46 18 OP ✓ **Elemental 028 Extra**

ORAL ELEMENTAL FEED 1KCAL/ML – Special Authority see [SA1377 above](#) – Hospital pharmacy [HP3]

Powder (unflavoured), 80 g sachet.....45.00 10 ✓ **Vivonex TEN**

SEMI-ELEMENTAL ENTERAL FEED 1KCAL/ML – Special Authority see [SA1377 above](#) – Hospital pharmacy [HP3]

Liquid, 500 ml bottle .....7.47 1 OP ✓ **Nutrison Advanced Peptisorb**

**Paediatric Products For Children With Low Energy Requirements**

►**SA1196** **Special Authority for Subsidy**

**Initial application** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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continued...

- 1 Child aged one to eight years; and
- 2 The child has a low energy requirement but normal protein and micronutrient requirements.

**Renewal** only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

- Both:
- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
  - 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

PAEDIATRIC ENTERAL FEED WITH FIBRE 0.76 KCAL/ML – Special Authority see [SA1196 on the previous page](#) – Hospital pharmacy [HP3]

Liquid, 500 ml bottle .....	6.27	1 OP	✓ <b>Nutri Low Energy Multi Fibre</b>
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## Standard Supplements

### ►SA1859 Special Authority for Subsidy

**Initial application — (Children - indications other than exclusive enteral nutrition for Crohn's disease)** from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

All of the following:

- 1 The patient is under 18 years of age; and
- 2 Any of the following:
  - 2.1 The patient has a condition causing malabsorption; or
  - 2.2 The patient has failure to thrive; or
  - 2.3 The patient has increased nutritional requirements; and
- 3 Nutrition goal has been set (eg reach a specific weight or BMI).

**Renewal — (Children - indications other than exclusive enteral nutrition for Crohn's disease)** from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

All of the following:

- 1 The patient is under 18 years of age; and
- 2 The treatment remains appropriate and the patient is benefiting from treatment; and
- 3 A nutrition goal has been set (eg reach a specific weight or BMI).

**Initial application — (Children - exclusive enteral nutrition for Crohn's disease)** only from a gastroenterologist or dietitian on the recommendation of a gastroenterologist. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 The patient is under 18 years of age; and
- 2 It is to be used as exclusive enteral nutrition for the treatment of Crohn's disease; and
- 3 Dietitians must include the name of the gastroenterologist recommending treatment and the date the gastroenterologist was contacted.

**Renewal — (Children - exclusive enteral nutrition for Crohn's disease)** from any relevant practitioner on the recommendation of a gastroenterologist. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 The patient is under 18 years of age; and
- 2 It is to be used as exclusive enteral nutrition for the treatment of Crohn's disease; and
- 3 General Practitioners and dietitians must include the name of the gastroenterologist recommending treatment and the date the gastroenterologist was contacted.

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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continued...

**Initial application — (Adults)** from any relevant practitioner. Approvals valid for 3 months for applications meeting the following criteria:

All of the following:

- 1 Any of the following:
  - Patient is Malnourished
  - 1.1 Patient has a body mass index (BMI) of less than 18.5 kg/m<sup>2</sup>; or
  - 1.2 Patient has unintentional weight loss greater than 10% within the last 3-6 months; or
  - 1.3 Patient has a BMI of less than 20 kg/m<sup>2</sup> and unintentional weight loss greater than 5% within the last 3-6 months; and
- 2 Any of the following:
  - Patient has not responded to first-line dietary measures over a 4 week period by:
    - 2.1 Increasing their food intake frequency (eg snacks between meals); or
    - 2.2 Using high-energy foods (e.g. milkshakes, full fat milk, butter, cream, cheese, sugar etc); or
    - 2.3 Using over the counter supplements (e.g. Complian); and
- 3 A nutrition goal has been set (e.g. to reach a specific weight or BMI).

**Renewal — (Adults)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria: Both:

- 1 A nutrition goal has been set (eg reach a specific weight or BMI); and
- 2 Any of the following:
  - Patient is Malnourished
  - 2.1 Patient has a body mass index (BMI) of less than 18.5 kg/m<sup>2</sup>; or
  - 2.2 Patient has unintentional weight loss greater than 10% within the last 3-6 months; or
  - 2.3 Patient has a BMI of less than 20 kg/m<sup>2</sup> and unintentional weight loss greater than 5% within the last 3-6 months.

**Initial application — (Short-term medical condition)** from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Any of the following:

- 1 Is being fed via a nasogastric tube or a nasogastric tube is to be inserted for feeding; or
- 2 Malignancy and is considered likely to develop malnutrition as a result; or
- 3 Is undergoing a bone marrow transplant; or
- 4 Tempomandibular surgery or glossectomy; or
- 5 Both:
  - 5.1 Pregnant; and
  - 5.2 Any of the following:
    - 5.2.1 Patient is in early pregnancy (< 13 weeks) and has severe clinical hyperemesis gravidarum requiring admission to hospital and is unlikely to meet her nutritional requirements due to continuing hyperemesis gravidarum; or
    - 5.2.2 Patient has clinical hyperemesis gravidarum continuing past 13 weeks and either there is concern that the patient is unlikely to meet the Institute of Medicine's (1990) recommended weight gain guidelines for pregnancy or the patient's weight has not increased past her booking/pre-pregnancy weight; or
    - 5.2.3 Patient is having multiple births and is under the care of an obstetric team who consider the nutritional needs of the patient are not being met.

**Renewal — (Short-term medical condition)** from any relevant practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Any of the following:

- 1 Is being fed via a nasogastric tube; or
- 2 Malignancy and is considered likely to develop malnutrition as a result; or
- 3 Has undergone a bone marrow transplant; or

continued...

## SPECIAL FOODS

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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continued...

4 Tempomandibular surgery or glossectomy; or

5 Both:

5.1 Pregnant; and

5.2 Any of the following:

5.2.1 Patient is in early pregnancy (< 13 weeks) and has severe clinical hyperemesis gravidarum requiring admission to hospital and is unlikely to meet her nutritional requirements due to continuing hyperemesis gravidarum; or

5.2.2 Patient has clinical hyperemesis gravidarum continuing past 13 weeks and either there is concern that the patient is unlikely to meet the Institute of Medicine's (1990) recommended weight gain guidelines for pregnancy or the patient's weight has not increased past her booking/pre-pregnancy weight; or

5.2.3 Patient is having multiple births and is under the care of an obstetric team who consider the nutritional needs of the patient are not being met.

**Initial application — (Long-term medical condition)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Any of the following:

1 Is being fed via a tube or a tube is to be inserted for the purpose of feeding (not nasogastric tube - refer to specific medical condition criteria); or

2 Cystic Fibrosis; or

3 Liver disease; or

4 Chronic Renal failure; or

5 Inflammatory bowel disease; or

6 Chronic obstructive pulmonary disease with hypercapnia; or

7 Short bowel syndrome; or

8 Bowel fistula; or

9 Severe chronic neurological conditions; or

10 Epidermolysis bullosa; or

11 AIDS (CD4 count < 200 cells/mm<sup>3</sup>); or

12 Chronic pancreatitis.

**Renewal — (Chronic disease OR tube feeding for patients who have previously been funded under Special Authority forms SA0702 or SA0583)** from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Any of the following:

1 Is being fed via a tube or a tube is to be inserted for the purpose of feeding (not nasogastric tube - refer to specific medical condition criteria); or

2 Cystic Fibrosis; or

3 Liver disease; or

4 Chronic Renal failure; or

5 Inflammatory bowel disease; or

6 Chronic obstructive pulmonary disease with hypercapnia; or

7 Short bowel syndrome; or

8 Bowel fistula; or

9 Severe chronic neurological conditions.

ENTERAL FEED 1.5KCAL/ML – Special Authority see [SA1859 on page 294](#) – Hospital pharmacy [HP3]

Liquid, 1,000 ml bottle .....	8.68	1 OP	✓ Ensure Plus HN RTH
	9.00		✓ Nutrison Energy

ENTERAL FEED 1KCAL/ML – Special Authority see [SA1859 on page 294](#) – Hospital pharmacy [HP3]

Liquid, 1,000 ml bottle .....	6.56	1 OP	✓ Osmolite RTH
	6.90		✓ Nutrison RTH

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
ENTERAL FEED WITH FIBRE 0.83 KCAL/ML – Special Authority see <a href="#">SA1859 on page 294</a> – Hospital pharmacy [HP3]				
Liquid, 1,000 ml bottle .....	9.05	1 OP	✓	<b>Nutrison 800 Complete Multi Fibre</b>
ENTERAL FEED WITH FIBRE 1 KCAL/ML – Special Authority see <a href="#">SA1859 on page 294</a> – Hospital pharmacy [HP3]				
Liquid, 1,000 ml bottle .....	6.56	1 OP	✓	<b>Jevity RTH</b>
	7.21		✓	<b>Nutrison Multi Fibre</b>
ENTERAL FEED WITH FIBRE 1.5KCAL/ML – Special Authority see <a href="#">SA1859 on page 294</a> – Hospital pharmacy [HP3]				
Liquid, 1,000 ml bottle .....	8.68	1 OP	✓	<b>Jevity HiCal RTH</b>
			✓	<b>Nutrison Energy Multi Fibre</b>
ORAL FEED (POWDER) – Special Authority see <a href="#">SA1859 on page 294</a> – Hospital pharmacy [HP3]				
Powder (chocolate).....	15.90	840 g OP	✓	<b>Sustagen Hospital Formula</b>
	40.00	800 g OP	✓	<b>Ensure</b>
		850 g OP	✓	<b>Ensure</b>
Powder (vanilla).....	15.90	840 g OP	✓	<b>Sustagen Hospital Formula</b>
	40.00	800 g OP	✓	<b>Ensure</b>
		850 g OP	✓	<b>Ensure</b>
ORAL FEED 1.5KCAL/ML – Special Authority see <a href="#">SA1859 on page 294</a> – Hospital pharmacy [HP3]				
Additional subsidy by endorsement is available for patients being bolus fed through a feeding tube, who have severe epidermolysis bullosa, or as exclusive enteral nutrition for the treatment of Crohn's disease, or for patients with COPD and hypercapnia, defined as CO <sub>2</sub> value exceeding 55mmHg. The prescription must be endorsed accordingly.				
Liquid (banana), 200 ml bottle – Higher subsidy of up to \$1.76				
per 1 btl with Endorsement.....	0.72	1 OP		
	(1.56)			Ensure Plus
	(1.76)			Fortisip
Liquid (chocolate), 200 ml bottle – Higher subsidy of up to \$1.76 per 1 btl with Endorsement.....				
	0.72	1 OP		
	(1.56)			Ensure Plus
	(1.76)			Fortisip
Liquid (fruit of the forest), 200 ml bottle – Higher subsidy of \$1.56 per 1 btl with Endorsement.....				
	0.72	1 OP		
	(1.56)			Ensure Plus
Liquid (strawberry), 200 ml bottle – Higher subsidy of \$1.76 per 1 btl with Endorsement.....				
	0.72	1 OP		
	(1.76)			Fortisip
Liquid (vanilla), 200 ml bottle – Higher subsidy of up to \$1.76 per 1 btl with Endorsement.....				
	0.72	1 OP		
	(1.56)			Ensure Plus
	(1.76)			Fortisip
Liquid (vanilla), 237 ml can – Higher subsidy of \$1.65 per 1 can with Endorsement.....				
	0.85	1 OP		
	(1.65)			Ensure Plus

(Ensure Plus Liquid (vanilla), 237 ml can to be delisted 1 July 2026)

## SPECIAL FOODS

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
<b>ORAL FEED WITH FIBRE 1.5 KCAL/ML – Special Authority see SA1859 on page 294 – Hospital pharmacy [HP3]</b>			
Additional subsidy by endorsement is available for patients being bolus fed through a feeding tube, or who have severe epidermolysis bullosa. The prescription must be endorsed accordingly.			
Liquid (chocolate), 200 ml bottle – Higher subsidy of \$1.76 per 1 btl with Endorsement.....	0.72 (1.76)	1 OP	Fortisip Multi Fibre
Liquid (strawberry), 200 ml bottle – Higher subsidy of \$1.76 per 1 btl with Endorsement.....	0.72 (1.76)	1 OP	Fortisip Multi Fibre
Liquid (vanilla), 200 ml bottle – Higher subsidy of \$1.76 per 1 btl with Endorsement.....	0.72 (1.76)	1 OP	Fortisip Multi Fibre

### High Calorie Products

#### ►SA1195 Special Authority for Subsidy

**Initial application — (Cystic fibrosis)** only from a dietitian, relevant specialist or vocationally registered general practitioner.

Approvals valid for 3 years for applications meeting the following criteria:

All of the following:

- 1 Cystic fibrosis; and
- 2 other lower calorie products have been tried; and
- 3 patient has substantially increased metabolic requirements.

**Initial application — (Indications other than cystic fibrosis)** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

All of the following:

- 1 Any of the following:
  - 1.1 any condition causing malabsorption; or
  - 1.2 faltering growth in an infant/child; or
  - 1.3 increased nutritional requirements; or
  - 1.4 fluid restricted; and
- 2 other lower calorie products have been tried; and
- 3 patient has substantially increased metabolic requirements or is fluid restricted.

**Renewal — (Cystic fibrosis)** only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

**Renewal — (Indications other than cystic fibrosis)** only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>ENTERAL FEED 2 KCAL/ML – Special Authority see SA1195 on the previous page – Hospital pharmacy [HP3]</b>				
Liquid, 1,000 ml bottle .....	13.64	1 OP	✓	<b>Ensure Two Cal HN RTH</b>
Liquid, 500 ml bottle .....	6.82	1 OP	✓	<b>Nutrison Concentrated</b>
<b>ORAL FEED 2 KCAL/ML – Special Authority see SA1195 on the previous page – Hospital pharmacy [HP3]</b>				
Additional subsidy by endorsement is available for patients being bolus fed through a feeding tube, or who have severe epidermolysis bullosa. The prescription must be endorsed accordingly.				
Liquid (vanilla), 200 ml bottle – Higher subsidy of \$2.34 per 1 btl with Endorsement .....	0.96 (2.34)	1 OP		Two Cal HN

**Food Thickeners**

► **SA1106** Special Authority for Subsidy

**Initial application** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year where the patient has motor neurone disease with swallowing disorder.

**Renewal** only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

Both:

- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
- 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

**FOOD THICKENER – Special Authority see SA1106 above – Hospital pharmacy [HP3]**

Powder .....	8.29	300 g OP	✓	<b>Nutillis</b>
	24.00	380 g OP	✓	<b>Aptamil Feed Thickener</b>

**Gluten Free Foods**

The funding of gluten free foods is no longer being actively managed by Pharmac from 1 April 2011. This means that we are no longer considering the listing of new products, or making subsidy, or other changes to the existing listings. As a result we anticipate that the range of funded items will reduce over time. Management of Coeliac disease with a gluten free diet is necessary for good outcomes. A range of gluten free options are available through retail outlets.

► **SA1729** Special Authority for Subsidy

**Initial application — (all patients)** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:

Either:

- 1 Gluten enteropathy has been diagnosed by biopsy; or
- 2 Patient suffers from dermatitis herpetiformis.

**Initial application — (paediatric patients diagnosed by ESPGHAN criteria)** only from a paediatric gastroenterologist. Approvals valid without further renewal unless notified where the paediatric patient fulfils ESPGHAN criteria for biopsy free diagnosis of coeliac disease.

**GLUTEN FREE BAKING MIX – Special Authority see SA1729 above – Hospital pharmacy [HP3]**

Powder .....	2.81 (5.15)	1,000 g OP		Healthieries Simple Baking Mix
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## SPECIAL FOODS

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
GLUTEN FREE BREAD MIX – Special Authority see <a href="#">SA1729 on the previous page</a> – Hospital pharmacy [HP3]			
Powder .....	3.93 (7.32)	1,000 g OP	NZB Low Gluten Bread Mix
	3.51 (10.87)		Horleys Bread Mix
GLUTEN FREE FLOUR – Special Authority see <a href="#">SA1729 on the previous page</a> – Hospital pharmacy [HP3]			
Powder .....	5.62 (18.10)	2,000 g OP	Horleys Flour

## Foods And Supplements For Inherited Metabolic Disease

### ►SA2357 Special Authority for Subsidy

**Initial application** from any relevant practitioner. Approvals valid without further renewal unless notified where patient requires dietary management of inherited metabolic disorders.

### Supplements For Homocystinuria

AMINOACID FORMULA WITHOUT METHIONINE – Special Authority see <a href="#">SA2357 above</a> – Hospital pharmacy [HP3]			
Powder (neutral), 36 g sachets.....	750.30	30	✓ HCU Anamix Junior
Powder, 12.5 g sachets .....	349.65	30	✓ HCU Explore 5
Powder, 25 g sachets .....	1,048.95	30	✓ HCU Express 15
Powder (neutral), can .....	480.42	500 g OP	✓ XMET Maxamum
Powder (unflavoured), can .....	260.00	400 g OP	✓ HCU Anamix Infant
Liquid (juicy berries), 125 ml bottle.....	1,684.80	30	✓ HCU Lophlex LQ
Liquid (orange), 125 ml bottle.....	941.40	36	✓ HCU Anamix Junior LQ

### Supplements For MSUD and short chain enoyl coA hydratase deficiency

AMINOACID FORMULA WITHOUT VALINE, LEUCINE AND ISOLEUCINE – Special Authority see <a href="#">SA2357 above</a> – Hospital pharmacy [HP3]			
Powder (neutral) 36 g sachets.....	750.00	30	✓ MSUD Anamix Junior
Powder, 12.5 g sachets .....	349.65	30	✓ MSUD Explore 5
Powder, 25 g sachets .....	1,048.95	30	✓ MSUD Express 15
Powder (neutral), can .....	454.71	500 g OP	✓ MSUD Maxamum
Powder (orange), can .....	454.71	500 g OP	✓ MSUD Maxamum
Powder (unflavoured), can .....	260.00	400 g OP	✓ MSUD Anamix Infant
Liquid (orange) 125 ml bottles.....	941.40	36	✓ MSUD Anamix Junior LQ
Liquid (juicy berries) 125 ml pouches .....	1,684.80	30	✓ MSUD Lophlex LQ 20

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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**Supplements For PKU**

AMINOACID FORMULA WITHOUT PHENYLALANINE – Special Authority see [SA2357 on the previous page](#) – Hospital pharmacy [HP3]

Tabs.....	99.00	75 OP	✓ Phlexy 10
Powder (Lemon), 34 g sachets.....	883.50	30	✓ PKU Express 20
Powder (Neutral), 12.5 g sachets.....	220.88	30	✓ PKU Explore 5
Powder (Neutral), 34 g sachets.....	883.50	30	✓ PKU Express 20
Powder (Orange), 25 g sachets.....	441.75	30	✓ PKU Explore 10
Powder (Orange), 34 g sachets.....	883.50	30	✓ PKU Express 20
Powder (Raspberry), 25 g sachets.....	441.75	30	✓ PKU Explore 10
Powder (Tropical), 34 g sachets.....	883.50	30	✓ PKU Express 20
Powder (berry) 28 g sachets .....	936.00	30	✓ PKU Lophlex Powder
Powder (chocolate) 36 g sachet .....	393.00	30	✓ PKU Anamix Junior Chocolate
Powder (neutral) 28 g sachets.....	936.00	30	✓ PKU Lophlex Powder
Powder (neutral) 36 g sachets.....	393.00	30	✓ PKU Anamix Junior
Powder (orange) 28 g sachets .....	936.00	30	✓ PKU Lophlex Powder
Powder (orange) 36 g sachet .....	393.00	30	✓ PKU Anamix Junior Orange
Powder (unflavoured) 12.5 g sachets.....	234.00	30	✓ PKU First Spoon
Powder (vanilla) 36 g sachet .....	393.00	30	✓ PKU Anamix Junior Vanilla
Infant formula.....	174.72	400 g OP	✓ PKU Anamix Infant
Powder (neutral), 4 x 400 g can .....	715.16	1,600 g OP	✓ Pku Start
Powder (orange).....	320.00	500 g OP	✓ XP Maxamum
Powder (unflavoured) .....	320.00	500 g OP	✓ XP Maxamum
Liquid (berry), 125 ml bottle.....	13.10	1 OP	✓ PKU Anamix Junior LQ
Liquid (orange), 125 ml bottle.....	13.10	1 OP	✓ PKU Anamix Junior LQ
Liquid (forest berries), 250 ml carton.....	540.00	18 OP	✓ Easiphen Liquid
Liquid (juicy tropical) 125 ml.....	936.00	30 OP	✓ PKU Lophlex LQ 20
Oral semi-solid (berries) 109 g .....	1,123.20	36 OP	✓ PKU Lophlex Sensation 20
Liquid (juicy berries) 62.5 ml.....	939.00	60 OP	✓ PKU Lophlex LQ 10
Liquid (juicy berries) 125 ml.....	936.00	30 OP	✓ PKU Lophlex LQ 20
Liquid (juicy orange) 125 ml .....	936.00	30 OP	✓ PKU Lophlex LQ 20

## SPECIAL FOODS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
GLYCOMACROPEPTIDE AND AMINO ACID CONTAINS SOME PHENYLALANINE – Special Authority see <a href="#">SA2357 on page 300</a> – Hospital pharmacy [HP3]				
Powder (Banana) 35 g sachets .....	930.00	30	✓	PKU sphere20 Banana
Powder (Berry), 20 g sachets .....	449.28	60	✓	PKU Restore Powder
Powder (Chocolate) 32 g sachets .....	898.56	30	✓	PKU Build 20 Chocolate
Powder (Chocolate) 35 g sachets .....	930.00	30	✓	PKU sphere20 Chocolate
Powder (Lemon) 35 g sachets .....	930.00	30	✓	PKU sphere20 Lemon
Powder (Lemonade) 33.4 g sachets .....	936.00	30	✓	PKU GMP Ultra Lemonade
Powder (Neutral), 15 g sachets .....	449.28	30	✓	PKU Build 10
Powder (Orange), 20 g sachets .....	449.28	60	✓	PKU Restore Powder
Powder (Raspberry Lemonade) 31 g sachets .....	898.56	30	✓	PKU Build 20 Raspberry Lemonade
Powder (Smooth) 31 g sachets .....	898.56	30	✓	PKU Build 20 Smooth
Powder (Vanilla) 33 g sachets .....	898.56	30	✓	PKU Build 20 Vanilla
Powder (neutral), 40 g sachets .....	673.92	30	✓	Glytactin Bettermilk
Powder (unflavoured) 12.5 g sachets .....	468.00	30	✓	PKU GMP Mix-In
Powder (vanilla) 33.4 g sachets .....	936.00	30	✓	PKU GMP Ultra Vanilla
Powder (Red Berry) 35 g sachets .....	930.00	30	✓	PKU sphere20 Red Berry
Powder (Vanilla) 35 g sachets .....	930.00	30	✓	PKU sphere20 Vanilla
Liquid (neutral), 250 ml carton .....	280.80	18	✓	PKU GMP LQ
Liquid (original), 250 ml carton .....	684.45	30 OP	✓	PKU Glytactin RTD 15
Liquid (Coffee Mocha), 250 ml carton .....	684.45	30 OP	✓	PKU Glytactin RTD 15 Lite
Liquid (chocolate), 250 ml carton .....	684.45	30 OP	✓	PKU Glytactin RTD 15
Liquid (vanilla), 250 ml carton .....	684.45	30 OP	✓	PKU Glytactin RTD 15 Lite

## Foods

LOW PROTEIN BAKING MIX – Special Authority see <a href="#">SA2357 on page 300</a> – Hospital pharmacy [HP3]				
Powder .....	8.55	500 g OP	✓	Loprofin Mix

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
<b>LOW PROTEIN PASTA – Special Authority see <a href="#">SA2357 on page 300</a> – Hospital pharmacy [HP3]</b>			
Animal shapes .....	12.39	500 g OP	✓ <b>Loprofin</b>
Lasagne .....	6.19	250 g OP	✓ <b>Loprofin</b>
Low protein rice pasta .....	12.39	500 g OP	✓ <b>Loprofin</b>
Macaroni .....	6.19	250 g OP	✓ <b>Loprofin</b>
Penne .....	12.39	500 g OP	✓ <b>Loprofin</b>
Spaghetti .....	12.39	500 g OP	✓ <b>Loprofin</b>
Spirals .....	12.39	500 g OP	✓ <b>Loprofin</b>

**Supplements for Tyrosinaemia**

**AMINOACID FORMULA WITHOUT PHENYLALANINE AND TYROSINE – Special Authority see [SA2357 on page 300](#) – Hospital pharmacy [HP3]**

Powder (Neutral), 12.5 g sachets .....	349.65	30	✓ <b>TYR Explore 5</b>
Powder (neutral) 36 g sachets .....	471.00	30	✓ <b>TYR Anamix Junior</b>
Powder, can .....	260.00	400 g OP	✓ <b>TYR Anamix Infant</b>
Liquid (juicy berries) 125 ml pouches .....	1,684.80	30	✓ <b>TYR Lophlex LQ 20</b>
Liquid (orange) 125 ml bottle .....	941.40	36	✓ <b>TYR Anamix Junior LQ</b>

**GLYCOMACROPEPTIDE AND AMINO ACID CONTAINS SOME TYROSINE AND PHENYLALANINE – Special Authority see [SA2357 on page 300](#) – Hospital pharmacy [HP3]**

Powder (Red Berry), 35 g sachets .....	1,398.60	30	✓ <b>TYR Sphere 20</b>
Powder (Vanilla), 35 g sachets .....	1,398.60	30	✓ <b>TYR Sphere 20</b>

**Supplements for Organic Acidaemias**

**AMINOACID FORMULA WITHOUT ISOLEUCINE, METHIONINE, THREONINE AND VALINE – Special Authority see [SA2357 on page 300](#) – Hospital pharmacy [HP3]**

Powder, can .....	260.00	400 g OP	✓ <b>MMA/PA Anamix Infant</b>
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**AMINOACID FORMULA WITHOUT METHIONINE, THREONINE AND VALINE – Special Authority see [SA2357 on page 300](#) – Hospital pharmacy [HP3]**

Powder (neutral), 18 g sachets .....	750.30	30	✓ <b>MMA/PA Anamix Junior</b>
Powder, 12.5 g sachets .....	349.65	30	✓ <b>MMA/PA Explore 5</b>
Powder, 25 g sachets .....	1,048.95	30	✓ <b>MMA/PA Express 15</b>

**Supplements for Glutaric Aciduria type 1**

**AMINOACID FORMULA WITHOUT LYSINE – Special Authority see [SA2357 on page 300](#) – Hospital pharmacy [HP3]**

Powder (neutral), 18 g sachets .....	750.30	30	✓ <b>GA1 Anamix Junior</b>
Powder, 12.5 g sachets .....	349.65	30	✓ <b>GA Explore 5</b>
Powder, can .....	260.00	400 g OP	✓ <b>GA1 Anamix Infant</b>

**Supplements for Glycogen Storage Disease**

**HIGH AMYLOPECTIN CORN-STARCH – Special Authority see [SA2357 on page 300](#) – Hospital pharmacy [HP3]**

Powder, 60 g sachets .....	241.62	30	✓ <b>Glycosade</b>
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**Single dose amino acids**

**ARGININE – Special Authority see [SA2357 on page 300](#) – Hospital pharmacy [HP3]**

Powder, 4 g sachets .....	211.45	30	✓ <b>Arginine2000</b>
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## SPECIAL FOODS

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>CITRULLINE</b> – Special Authority see <a href="#">SA2357 on page 300</a> – Hospital pharmacy [HP3]				
Powder, 4 g sachets.....	211.45	30	✓	<b>Citrulline1000</b>
<b>ISOLEUCINE</b> – Special Authority see <a href="#">SA2357 on page 300</a> – Hospital pharmacy [HP3]				
Powder, 4 g sachets.....	141.05	30	✓	<b>Isoleucine50</b>
<b>LEUCINE</b> – Special Authority see <a href="#">SA2357 on page 300</a> – Hospital pharmacy [HP3]				
Powder, 4 g sachets.....	141.05	30	✓	<b>Leucine100</b>
<b>PHENYLALANINE</b> – Special Authority see <a href="#">SA2357 on page 300</a> – Hospital pharmacy [HP3]				
Powder, 4 g sachets.....	141.05	30	✓	<b>Phenylalanine50</b>
<b>TYROSINE</b> – Special Authority see <a href="#">SA2357 on page 300</a> – Hospital pharmacy [HP3]				
Powder, 4 g sachets.....	211.45	30	✓	<b>Tyrosine1000</b>
<b>VALINE</b> – Special Authority see <a href="#">SA2357 on page 300</a> – Hospital pharmacy [HP3]				
Powder, 4 g sachets.....	141.05	30	✓	<b>Valine50</b>

### Other Fat Modified Products

<b>ELEMENTAL FEED WITH HIGH MEDIUM CHAIN TRIGLYCERIDES</b> – Special Authority see <a href="#">SA2357 on page 300</a> – Hospital pharmacy [HP3]				
Powder (neutral), 100 g sachets.....	47.01	10	✓	<b>Emsogen</b>

### Carbohydrate and Fat with added vitamins and minerals

<b>PROTEIN FREE SUPPLEMENT CONTAINING CARBOHYDRATE, FAT WITH ADDED VITAMINS AND MINERALS</b> – Special Authority see <a href="#">SA2357 on page 300</a> – Hospital pharmacy [HP3]				
Powder (neutral), can.....	49.29	400 g OP	✓	<b>Energivit</b>

### Essential Amino Acids

<b>ESSENTIAL AMINOACID FORMULA</b> – Special Authority see <a href="#">SA2357 on page 300</a> – Hospital pharmacy [HP3]				
Powder (neutral), can.....	313.73	200 g OP	✓	<b>Essential Amino Acid Mix</b>

### Infant Formulae

#### For Williams Syndrome

##### ►[SA1110](#) Special Authority for Subsidy

**Initial application** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year where the patient is an infant suffering from Williams Syndrome and associated hypercalcaemia.

**Renewal** only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year for applications meeting the following criteria:

- Both:
- 1 The treatment remains appropriate and the patient is benefiting from treatment; and
  - 2 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.

<b>LOW CALCIUM INFANT FORMULA</b> – Special Authority see <a href="#">SA1110 above</a> – Hospital pharmacy [HP3]				
Powder.....	46.18	400 g OP	✓	<b>Locasol</b>

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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### Gastrointestinal and Other Malabsorptive Problems

AMINO ACID FORMULA – Special Authority see <a href="#">SA2092 below</a> – Hospital pharmacy [HP3]		
Powder .....	43.60	400 g OP
		✓ <b>Alfamino</b>
		✓ <b>Alfamino Junior</b>
Powder (unflavoured) .....	55.61	400 g OP
		✓ <b>Neocate Gold</b>
		✓ <b>Neocate Junior</b>
		Unflavoured
	65.72	✓ <b>Neocate SYNEO</b>
		✓ <b>Elecare</b>
		✓ <b>Elecare LCP</b>
Powder (vanilla).....	55.61	400 g OP
		✓ <b>Neocate Junior</b>
		Vanilla
	65.72	✓ <b>Elecare</b>

► **SA2092** Special Authority for Subsidy

**Initial application — (Infants under 12 months of age)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Any of the following:

- 1 History of anaphylaxis to cow's milk protein formula or dairy products; or
- 2 Eosinophilic oesophagitis; or
- 3 Ultra-short gut; or
- 4 Severe Immune deficiency; or
- 5 Extensively hydrolysed formula has been trialled in an inpatient setting and is clinically inappropriate; or
- 6 Both:
  - 6.1 Extensively hydrolysed formula has been reasonably trialled for 2-4 weeks and is inappropriate due to documented severe intolerance or allergy or malabsorption; and
  - 6.2 Either:
    - 6.2.1 The patient has a valid Special Authority approval for extensively hydrolysed formula: approval number; or
    - 6.2.2 Patient has IgE mediated allergy.

**Initial application — (Children 12 months of age and over)** only from a paediatrician, paediatric gastroenterologist, paediatric immunologist or dietitian on the recommendation of a paediatrician, paediatric gastroenterologist or paediatric immunologist.

Approvals valid for 6 months for applications meeting the following criteria:

- Both:
- 1 Either:
    - 1.1 Applicant is a paediatrician, paediatric gastroenterologist or paediatric immunologist; or
    - 1.2 Applicant is a dietitian and confirms that a paediatrician, paediatric gastroenterologist or paediatric immunologist has been consulted within the last 12 months and has recommended treatment for the patient; and
  - 2 Any of the following:
    - 2.1 History of anaphylaxis to cow's milk protein formula or dairy products; or
    - 2.2 Eosinophilic oesophagitis; or
    - 2.3 Ultra-short gut; or
    - 2.4 Severe Immune deficiency; or
    - 2.5 Extensively hydrolysed formula has been trialled in an inpatient setting and is clinically inappropriate; or
    - 2.6 Both:
      - 2.6.1 Extensively hydrolysed formula has been reasonably trialled for 2-4 weeks and is inappropriate due to documented severe intolerance or allergy or malabsorption; and
      - 2.6.2 Either:
        - 2.6.2.1 The patient has a valid Special Authority approval for extensively hydrolysed formula: approval

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

continued...

number; or

2.6.2.2 Patient has IgE mediated allergy.

**Renewal — (Infants up to 12 months of age)** from any relevant practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Either:

1 Both:

1.1 Patient has IgE mediated allergy; and

1.2 All of the following:

1.2.1 Patient remains allergic to cow's milk; and

1.2.2 An assessment as to whether the infant can be transitioned to a cow's milk protein, soy or extensively hydrolysed infant formula has been undertaken; and

1.2.3 The outcome of the assessment is that the infant continues to require an amino acid infant formula; and

1.2.4 Amino acid formula is required for a nutritional deficit; and

1.2.5 It has been more than three months from the previous approval; or

2 Both:

2.1 Patient has non IgE mediated severe gastrointestinal intolerance (including eosinophilic oesophagitis, ultra-short gut and severe immune deficiency); and

2.2 All of the following:

2.2.1 An assessment as to whether the infant can be transitioned to a cow's milk protein, soy, or extensively hydrolysed infant formula has been undertaken; and

2.2.2 The outcome of the assessment is that the infant continues to require an amino acid infant formula; and

2.2.3 Amino acid formula is required for a nutritional deficit; and

2.2.4 It has been more than three months from the previous approval.

**Renewal — (Children 12 months of age and over)** only from a paediatrician, paediatric gastroenterologist, paediatric immunologist or dietitian on the recommendation of a paediatrician, paediatric gastroenterologist or paediatric immunologist.

Approvals valid for 6 months for applications meeting the following criteria:

Both:

1 Either:

1.1 Applicant is a paediatrician, paediatric gastroenterologist or paediatric immunologist; or

1.2 Applicant is a dietitian and confirms that a paediatrician, paediatric gastroenterologist or paediatric immunologist has been consulted within the last 12 months and has recommended treatment for the patient; and

2 Any of the following:

2.1 History of anaphylaxis to cow's milk protein formula or dairy products; or

2.2 Eosinophilic oesophagitis; or

2.3 Ultra-short gut; or

2.4 Severe Immune deficiency; or

2.5 Extensively hydrolysed formula has been trialled in an inpatient setting and is clinically inappropriate; or

2.6 Both:

2.6.1 Extensively hydrolysed formula has been reasonably trialled for 2-4 weeks and is inappropriate due to documented severe intolerance or allergy or malabsorption; and

2.6.2 Either:

2.6.2.1 The patient has a valid Special Authority approval for extensively hydrolysed formula: approval number; or

2.6.2.2 Patient has IgE mediated allergy.

**Initial application — (for patients who have a current funding under Special Authority form SA1557)** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 months for applications meeting the following criteria:

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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continued...

All of the following:

- 1 Patient has a valid Special Authority approval for extensively hydrolysed formula (SA1557); and
- 2 Extensively hydrolysed formula (Aptamil Gold+ Pepti Junior, AllerPro SYNEO 1 and 2) is unable to be supplied at this time; and
- 3 The approval only applies to funded dispensings of Neocate Gold and Neocate Syneo.

Note: This criteria is short term funding to cover an out-of-stock situation on some extensively hydrolysed formula powder funded under Special Authority form SA1557. There is no renewal criteria under this restriction.

ENTERAL LIQUID PEPTIDE FORMULA – Special Authority see [SA1953 below](#) – Hospital pharmacy [HP3]

Liquid 1 kcal/ml, 500 ml bottle .....	12.44	1 OP	✓ Nutrini Peptisorb
Liquid 1.5 kcal/ml, 500 ml bottle .....	18.66	1 OP	✓ Nutrini Peptisorb Energy

**▶SA1953 Special Authority for Subsidy**

**Initial application** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient has impaired gastrointestinal function and either cannot tolerate polymeric feeds, or polymeric feeds are unsuitable; and
- 2 Any of the following:
  - 2.1 Severe malabsorption; or
  - 2.2 Short bowel syndrome; or
  - 2.3 Intractable diarrhoea; or
  - 2.4 Biliary atresia; or
  - 2.5 Cholestatic liver diseases causing malabsorption; or
  - 2.6 Cystic fibrosis; or
  - 2.7 Proven fat malabsorption; or
  - 2.8 Severe intestinal motility disorders causing significant malabsorption; or
  - 2.9 Intestinal failure; or
  - 2.10 Both:
    - 2.10.1 The patient is currently receiving funded amino acid formula; and
    - 2.10.2 The patient is to be trialled on, or transitioned to, an enteral liquid peptide formula; and
- 3 Either:
  - 3.1 A semi-elemental or partially hydrolysed powdered feed has been reasonably trialled and considered unsuitable; or
  - 3.2 For step down from intravenous nutrition.

Note: A reasonable trial is defined as a 2-4 week trial.

**Renewal** only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 An assessment as to whether the patient can be transitioned to a cows milk protein or soy infant formula or extensively hydrolysed formula has been undertaken; and
- 2 The outcome of the assessment is that the patient continues to require an enteral liquid peptide formula; and
- 3 General practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and the date contacted.

EXTENSIVELY HYDROLYSED FORMULA – Special Authority see [SA1557 on the next page](#) – Hospital pharmacy [HP3]

Powder .....	18.10	450 g OP	✓ Pepti-Junior
	36.20	900 g OP	✓ Allerpro Syneo 1
			✓ Allerpro Syneo 2

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
	✓	

► **SA1557** **Special Authority for Subsidy**

**Initial application** only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months for applications meeting the following criteria:

Any of the following:

- 1 Both:
  - 1.1 Cows milk formula is inappropriate due to severe intolerance or allergy to its protein content; and
  - 1.2 Either:
    - 1.2.1 Soy milk formula has been reasonably trialled without resolution of symptoms; or
    - 1.2.2 Soy milk formula is considered clinically inappropriate or contraindicated; or
- 2 Severe malabsorption; or
- 3 Short bowel syndrome; or
- 4 Intractable diarrhoea; or
- 5 Biliary atresia; or
- 6 Cholestatic liver diseases causing malabsorption; or
- 7 Cystic fibrosis; or
- 8 Proven fat malabsorption; or
- 9 Severe intestinal motility disorders causing significant malabsorption; or
- 10 Intestinal failure; or
- 11 All of the following:
  - 11.1 For step down from Amino Acid Formula; and
  - 11.2 The infant is currently receiving funded amino acid formula; and
  - 11.3 The infant is to be trialled on, or transitioned to, an extensively hydrolysed formula; and
  - 11.4 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and the date contacted.

Note: A reasonable trial is defined as a 2-4 week trial, or signs of an immediate IgE mediated allergic reaction.

**Renewal** only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 An assessment as to whether the infant can be transitioned to a cows milk protein or soy infant formula has been undertaken; and
- 2 The outcome of the assessment is that the infant continues to require an extensively hydrolysed infant formula; and
- 3 General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and the date contacted.

**Fluid Restricted**

PAEDIATRIC ORAL/ENTERAL FEED 1 KCAL/ML – Special Authority see [SA1698](#) below – Hospital pharmacy [HP3]  
 Liquid, 125 ml bottle .....2.80      1 OP      ✓ **Infatrini**

► **SA1698** **Special Authority for Subsidy**

**Initial application** only from a paediatrician, dietitian or general practitioner on the recommendation of a paediatrician or dietitian. Approvals valid for 12 months for applications meeting the following criteria:

All of the following:

- 1 Patient is fluid restricted or volume intolerant and has been diagnosed with faltering growth; and
- 2 Patient is under the care of a paediatrician or dietitian who has recommended treatment with a high energy infant formula; and
- 3 Patient is under 18 months of age or weighs less than 8 kg.

continued...

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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continued...

Note: 'Volume intolerant' patients are those who are unable to tolerate an adequate volume of infant formula to achieve expected growth rate. These patients should have first trialed appropriate clinical alternative treatments, such as concentrating, fortifying and adjusting the frequency of feeding.

**Renewal** only from a paediatrician, dietitian or general practitioner on the recommendation of a paediatrician or dietitian.

Approvals valid for 6 months for applications meeting the following criteria:

All of the following:

- 1 Patient continues to be fluid restricted or volume intolerant and has faltering growth; and
- 2 Patient is under the care of a hospital paediatrician or dietitian who has recommended treatment with a high energy infant formula; and
- 3 Patient is under 18 months of age or weighs less than 8 kg.

Note: 'Volume intolerant' patients are those who are unable to tolerate an adequate volume of infant formula to achieve expected growth rate. These patients should have first trialed appropriate clinical alternative treatments, such as concentrating, fortifying and adjusting the frequency of feeding.

## Ketogenic Diet

### ►SA1197 Special Authority for Subsidy

**Initial application** only from a metabolic physician or paediatric neurologist. Approvals valid for 3 months where the patient has intractable epilepsy, pyruvate dehydrogenase deficiency or glucose transported type-1 deficiency and other conditions requiring a ketogenic diet.

**Renewal** only from a metabolic physician or paediatric neurologist. Approvals valid for 2 years where the patient is on a ketogenic diet and the patient is benefiting from the diet.

HIGH FAT LOW CARBOHYDRATE FORMULA – Special Authority see [SA1197 above](#) – Hospital pharmacy [HP3]

Powder (unflavoured) .....	36.92	300 g OP	✓ KetoCal 4:1
			✓ KetoCal 3:1
Powder (vanilla).....	36.92	300 g OP	✓ KetoCal 4:1

## SECTION I: NATIONAL IMMUNISATION SCHEDULE

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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### Vaccinations

#### BACILLUS CALMETTE-GUERIN VACCINE – [Xpharm]

For infants at increased risk of tuberculosis. Increased risk is defined as:

- 1) living in a house or family with a person with current or past history of TB; or
- 2) having one or more household members or carers who within the last 5 years lived in a country with a rate of TB > or equal to 40 per 100,000 for 6 months or longer; or
- 3) during their first 5 years will be living 3 months or longer in a country with a rate of TB > or equal to 40 per 100,000

Note a list of countries with high rates of TB are available at [www.health.govt.nz/tuberculosis](http://www.health.govt.nz/tuberculosis) (search for downloads) or [www.bcgatlas.org/index.php](http://www.bcgatlas.org/index.php).

Inj Mycobacterium bovis BCG (Bacillus Calmette-Guerin),

Danish strain 1331, live attenuated, vial with diluent.....0.00 10 ✓ **BCG Vaccine AJV**

#### COVID-19 VACCINE – [Xpharm]

Inj 3 mcg SARS-CoV-2 spike protein (mRNA) LP.8.1 per 0.3 ml,

0.48 ml multi-dose vial; infant vaccine, yellow cap.....0.00 10 ✓ **Comirnaty (LP.8.1)**

Any of the following:

- 1) Up to three doses for previously unvaccinated children aged 6 months - 4 years at high risk of severe illness or highly immunocompromised; or
- 2) One additional dose with the most current variant-matched vaccine every 6 months for highly immunocompromised children aged 6 months to 4 years; or
- 3) One additional dose with the most current variant-matched vaccine every 12 months for children aged 6 months to 4 years old at high risk of severe illness.

Inj 10 mcg SARS-CoV-2 spike protein (mRNA) LP.8.1 per

0.3 ml, 0.48 ml single-dose vial; paediatric vaccine, light blue cap.....0.00 10 ✓ **Comirnaty (LP.8.1)**

Any of the following:

- 1) One dose for previously unvaccinated children aged 5–11 years old; or
- 2) Up to three doses for immunocompromised children aged 5-11 years old; or
- 3) One additional dose with the most current variant-matched vaccine every 6 months for highly immunocompromised children aged 5 to 11 years; or
- 4) One additional dose with the most current variant-matched vaccine up to every 12 months for children aged 5 to 11 years old at high risk of severe illness.

Inj 30 mcg SARS-CoV-2 spike protein (mRNA) LP.8.1 per

0.3 ml, pre-filled syringe; adult dose.....0.00 10 ✓ **Comirnaty (LP.8.1)**

Any of the following:

- 1) One dose for previously unvaccinated people aged 12-15 years and over 30 years old; or
- 2) Two doses for previously unvaccinated people aged 16-29 years old; or
- 3) Up to three doses for previously unvaccinated immunocompromised people from 12 years old; or
- 4) Up to four doses for people at risk of severe illness aged from 12-29 years; or
- 5) One additional dose with the most current variant-matched vaccine every 6 months, any of the following criteria:
  - i) Previously vaccinated people aged 30 years and over; or
  - ii) Previously vaccinated immunocompromised people from 12 years; or
  - iii) Previously vaccinated people at high-risk from 12 years.

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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## DIPHTHERIA, TETANUS AND PERTUSSIS VACCINE

- a) Only on a prescription
- b) No patient co-payment payable
- c)
  - A) Funded for any of the following criteria:
    - 1) A single dose for pregnant women in the second or third trimester of each pregnancy; or
    - 2) A single dose for parents or primary caregivers of infants admitted to a Neonatal Intensive Care Unit or Specialist Care Baby Unit for more than 3 days, who had not been exposed to maternal vaccination at least 14 days prior to birth; or
    - 3) A course of up to four doses is funded for children from age 7 up to the age of 18 years inclusive to complete full primary immunisation; or
    - 4) An additional four doses (as appropriate) are funded for (re-)immunisation for patients post haematopoietic stem cell transplantation or chemotherapy; pre or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens; or
    - 5) A single dose for vaccination of patients aged from 65 years old; or
    - 6) A single dose for vaccination of patients aged from 45 years old who have not had 4 previous tetanus doses; or
    - 7) For vaccination of previously unimmunised or partially immunised patients; or
    - 8) For revaccination following immunosuppression; or
    - 9) For boosting of patients with tetanus-prone wounds.

Notes: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.

- B) Contractors will be entitled to claim payment from the Funder for the supply of diphtheria, tetanus and pertussis vaccine to patients eligible under the above criteria pursuant to their contract with Health New Zealand (Health NZ) for subsidised immunisation, and they may only do so in respect of the diphtheria, tetanus and pertussis vaccine listed in the Pharmaceutical Schedule.
- C) Contractors may only claim for patient populations within the criteria that are covered by their contract, which may be a sub-set of the population described in paragraphs 1 – 9 above.

Inj 2 IU diphtheria toxoid with 20 IU tetanus toxoid, 8 mcg pertussis toxoid, 8 mcg pertussis filamentous haemagglutinin and 2.5 mcg pertactin in 0.5 ml prefilled syringe.....	0.00	10	✓ <b>Boostrix</b>
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▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# NATIONAL IMMUNISATION SCHEDULE

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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## DIPHTHERIA, TETANUS, PERTUSSIS AND POLIO VACCINE

- a) Only on a prescription
- b) No patient co-payment payable
- c)
  - A) Funded for any of the following:
    - 1) A single dose for children up to the age of 7 who have completed primary immunisation; or
    - 2) A course of four vaccines is funded for catch up programmes for children (to the age of 10 years) to complete full primary immunisation; or
    - 3) An additional four doses (as appropriate) are funded for (re-)immunisation for people post HSCT, or chemotherapy; pre- or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens; or
    - 4) Five doses will be funded for children requiring solid organ transplantation.
  - B) Contractors will be entitled to claim payment from the Funder for the supply of Diphtheria, tetanus, pertussis and polio vaccine to people eligible under the above criteria pursuant to their contract with Health New Zealand (Health NZ) for subsidised immunisation, and they may only do so in respect of the Diphtheria, tetanus, pertussis and polio vaccine listed in the Pharmaceutical Schedule.
  - C) Contractors may only claim for populations within the criteria that are covered by their contract, which may be a sub-set of the population described in paragraph A above.

Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.

Inj 30 IU diphtheria toxoid with 40 IU tetanus toxoid, 25 mcg pertussis toxoid, 25 mcg pertussis filamentous haemagglutinin, 8 mcg pertactin and 80 D-antigen units poliomyelitis virus in 0.5ml syringe .....	0.00	10	✓ <b>Infanrix IPV</b>
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## DIPHTHERIA, TETANUS, PERTUSSIS, POLIO, HEPATITIS B AND HAEMOPHILUS INFLUENZAE TYPE B VACCINE

- a) Only on a prescription
- b) No patient co-payment payable
- c)
  - A) Funded for children meeting any of the following criteria
    - 1) Up to four doses for children under the age of 10 years for primary immunisation; or
    - 2) An additional four doses (as appropriate) for (re-)immunisation of children under the age of 18 years post haematopoietic stem cell transplantation; or
    - 3) An additional four doses (as appropriate) for (re-)immunisation of children under the age of 10 years who are post chemotherapy; pre or post splenectomy; undergoing renal dialysis and other severely immunosuppressive regimens; or
    - 4) Up to five doses for children under the age of 10 years receiving solid organ transplantation.
  - B) Contractors will be entitled to claim payment from the Funder for the supply of Diphtheria, tetanus, pertussis, polio, hepatitis B and haemophilus influenzae type b vaccine to people eligible under the above criteria pursuant to their contract with Health New Zealand (Health NZ) for subsidised immunisation, and they may only do so in respect of the Diphtheria, tetanus, pertussis, polio, hepatitis B and haemophilus influenzae type b vaccine listed in the Pharmaceutical Schedule.
  - C) Contractors may only claim for populations within the criteria that are covered by their contract, which may be a sub-set of the population described in paragraph A above.

Note: A course of up-to four vaccines is funded for catch up programmes for children (up to and under the age of 10 years) to complete full primary immunisation. Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

Inj 30IU diphtheria with 40IU tetanus and 25mcg pertussis toxoids, 25mcg pertussis filamentous haemagglutinin, 8mcg pertactin, 80D-AgU polio virus, 10mcg hepatitis B antigen, 10mcg H. influenzae type b with tetanus toxoid 20-40mcg in 0.5ml syringe .....	0.00	10	✓ <b>Infanrix-hexa</b>
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	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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## HAEMOPHILUS INFLUENZAE TYPE B VACCINE

- a) Only on a prescription
- b) No patient co-payment payable
- c)
  - A) One dose for people meeting any of the following:
    - 1) For primary vaccination in children; or
    - 2) An additional dose (as appropriate) is funded for (re-)immunisation for people post haematopoietic stem cell transplantation, or chemotherapy; functional asplenic; pre or post splenectomy; pre- or post solid organ transplant, pre or post cochlear implants, renal dialysis and other severely immunosuppressive regimens; or
    - 3) For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician.
  - B) Contractors will be entitled to claim payment from the Funder for the supply of Haemophilus influenzae type b vaccine to people eligible under the above criteria pursuant to their contract with Health New Zealand (Health NZ) for subsidised immunisation, and they may only do so in respect of the Haemophilus influenzae type b vaccine listed in the Pharmaceutical Schedule.
  - C) Contractors may only claim for populations within the criteria that are covered by their contract, which may be a sub-set of the population described in paragraph A above.

Inj 10 mcg vial with diluent syringe.....	0.00	1	✓ <b>Act-HIB</b>
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## HEPATITIS A VACCINE – [Xpharm]

Funded for patients meeting any of the following criteria:

- 1) Two vaccinations for use in transplant patients; or
- 2) Two vaccinations for use in children with chronic liver disease; or
- 3) One dose of vaccine for close contacts of known hepatitis A cases.

Inj 1440 ELISA units in 1 ml syringe.....	0.00	1	✓ <b>Havrix 1440</b>
Inj 720 ELISA units in 0.5 ml syringe.....	0.00	1	✓ <b>Havrix Junior</b>

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# NATIONAL IMMUNISATION SCHEDULE

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>HEPATITIS B RECOMBINANT VACCINE – [Xpharm]</b>				
Inj 10 mcg per 0.5 ml prefilled syringe.....	0.00	1	✓	<b><u>Engerix-B</u></b>
Funded for patients meeting any of the following criteria:				
1) for household or sexual contacts of known acute hepatitis B patients or hepatitis B carriers; or				
2) for children born to mothers who are hepatitis B surface antigen (HBsAg) positive; or				
3) for children up to and under the age of 18 years inclusive who are considered not to have achieved a positive serology and require additional vaccination or require a primary course of vaccination; or				
4) for HIV positive patients; or				
5) for hepatitis C positive patients; or				
6) for patients following non-consensual sexual intercourse; or				
7) for patients prior to planned immunosuppression for greater than 28 days; or				
8) for patients following immunosuppression; or				
9) for solid organ transplant patients; or				
10) for post-haematopoietic stem cell transplant (HSCT) patients; or				
11) following needle stick injury.				
Inj 20 mcg per 1 ml prefilled syringe.....	0.00	1	✓	<b><u>Engerix-B</u></b>
Funded for patients meeting any of the following criteria:				
1) for household or sexual contacts of known acute hepatitis B patients or hepatitis B carriers; or				
2) for children born to mothers who are hepatitis B surface antigen (HBsAg) positive; or				
3) for children up to and under the age of 18 years inclusive who are considered not to have achieved a positive serology and require additional vaccination or require a primary course of vaccination; or				
4) for HIV positive patients; or				
5) for hepatitis C positive patients; or				
6) for patients following non-consensual sexual intercourse; or				
7) for patients prior to planned immunosuppression for greater than 28 days; or				
8) for patients following immunosuppression; or				
9) for solid organ transplant patients; or				
10) for post-haematopoietic stem cell transplant (HSCT) patients; or				
11) following needle stick injury; or				
12) for chronic kidney disease (CKD) stage 4 or 5 patients; or				
13) for liver or kidney transplant patients.				

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
<b>HUMAN PAPILLOMAVIRUS (6, 11, 16, 18, 31, 33, 45, 52 AND 58) VACCINE [HPV]</b>			
<ul style="list-style-type: none"> <li>a) Maximum of 1 inj per prescription</li> <li>b) Only on a prescription</li> <li>c) No patient co-payment payable</li> <li>d)               <ul style="list-style-type: none"> <li>a) A) Any of the following:                   <ul style="list-style-type: none"> <li>1) Maximum of two doses for children aged 14 years and under; or</li> <li>2) Maximum of three doses for people meeting any of the following criteria:                       <ul style="list-style-type: none"> <li>1) People aged 15 to 26 years inclusive; or</li> <li>2) Either:                           <ul style="list-style-type: none"> <li>People aged 9 to 26 years inclusive who have                               <ul style="list-style-type: none"> <li>1) Confirmed HIV infection; or</li> <li>2) Received a transplant (including stem cell); or</li> </ul> </li> <li>3) Maximum of four doses for people aged 9 to 26 years inclusive post chemotherapy</li> </ul> </li> </ul> </li> </ul> </li> <li>B) Contractors will be entitled to claim payment from the Funder for the supply of Human papillomavirus vaccine to people eligible under the above criteria pursuant to their contract with Health New Zealand (Health NZ) for subsidised immunisation, and they may only do so in respect of the Human papillomavirus vaccine listed in the Pharmaceutical Schedule.</li> <li>C) Contractors may only claim for populations within the criteria that are covered by their contract, which may be a sub-set of the population described in paragraphs A above.</li> </ul> </li> </ul>			
Inj 270 mcg in 0.5 ml syringe.....	0.00	10	✓ <b>Gardasil 9</b>

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# NATIONAL IMMUNISATION SCHEDULE

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
INFLUENZA VACCINE				
Inj 60 mcg in 0.5 ml syringe (quadrivalent vaccine).....	120.00	10	✓	<b>Influvac Tetra (2026 formulation)</b>

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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- a) Maximum of 1 inj per prescription
- b) Only on a prescription
- c) No patient co-payment payable
- d)

## A) INFLUENZA VACCINE

is available each year for patients who meet the following criteria, as set by Pharmac:

- a) all people 65 years of age and over; or
  - b) people under 65 years of age who:
    - i) have any of the following cardiovascular diseases:
      - a) ischaemic heart disease, or
      - b) congestive heart failure, or
      - c) rheumatic heart disease, or
      - d) congenital heart disease, or
      - e) cerebo-vascular disease; or
    - ii) have either of the following chronic respiratory diseases:
      - a) asthma, if on a regular preventative therapy, or
      - b) other chronic respiratory disease with impaired lung function; or
    - iii) have diabetes; or
    - iv) have chronic renal disease; or
    - v) have any cancer, excluding basal and squamous skin cancers if not invasive; or
    - vi) have any of the following other conditions:
      - a) autoimmune disease, or
      - b) immune suppression or immune deficiency, or
      - c) HIV, or
      - d) transplant recipients, or
      - e) neuromuscular and CNS diseases/disorders, or
      - f) haemoglobinopathies, or
      - g) are children on long term aspirin, or
      - h) have a cochlear implant, or
      - i) errors of metabolism at risk of major metabolic decompensation, or
      - j) pre and post splenectomy, or
      - k) Down syndrome, or
    - vii) are pregnant; or
  - c) children 4 years of age and under who have been hospitalised for respiratory illness or have a history of significant respiratory illness; or
  - d) people under 65 years of age who:
    - i) have any of the following serious mental health conditions:
      - a) schizophrenia, or
      - b) major depressive disorder, or
      - c) bipolar disorder, or
      - d) schizoaffective disorder, or
    - ii) are currently accessing secondary or tertiary mental health and addiction services; or
- Unless meeting the criteria set out above, the following conditions are excluded from funding:
- a) asthma not requiring regular preventative therapy,
  - b) hypertension and/or dyslipidaemia without evidence of end-organ disease.
- B) Contractors will be entitled to claim payment for the supply of influenza vaccine to patients eligible under the above criteria pursuant to their contract with Health NZ for subsidised immunisation, and they may only do so in respect of the influenza vaccine listed in the Pharmaceutical Schedule.
  - C) Contractors may only claim for patient populations within the criteria that are covered by their contract, which may be a sub-set of the population described in paragraph A above.

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

# NATIONAL IMMUNISATION SCHEDULE

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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## MEASLES, MUMPS AND RUBELLA VACCINE

- a) Only on a prescription
- b) No patient co-payment payable
- c)

### A) Measles, mumps and rubella vaccine

A maximum of two doses for any patient meeting the following criteria:

- 1) For primary vaccination in children; or
- 2) For revaccination following immunosuppression; or
- 3) For any individual susceptible to measles, mumps or rubella; or
- 4) A maximum of three doses for children who have had their first dose prior to 12 months.

Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes. Although a price is listed for the vaccine, doctors can still order measles mumps and rubella vaccine free of charge, as with other Schedule vaccines.

- B) Contractors will be entitled to claim payment for the supply of measles, mumps and rubella vaccine to patients eligible under the above criteria pursuant to their contract with Health NZ for subsidised immunisation, and they may only do so in respect of the measles, mumps and rubella vaccine listed in the Pharmaceutical Schedule.
- C) Contractors can only claim for patient populations within the criteria that are covered by their contract, which may be a sub-set of the population described in paragraph A above.

Inj, measles virus 1,000 CCID50, mumps virus 5,012 CCID50,  
 Rubella virus 1,000 CCID50; prefilled syringe/ampoule of  
 diluent 0.5 ml ..... 0.00

10

✓ Priorix

	Subsidy (Manufacturer's Price) \$	Per	Fully Subsidised ✓	Brand or Generic Manufacturer
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## MENINGOCOCCAL (GROUPS A, C, Y AND W-135) CONJUGATE VACCINE

Inj 10 mcg of each meningococcal polysaccharide conjugated to a total of approximately 55 mcg of tetanus toxoid carrier per 0.5 ml vial ..... 0.00      1      ✓ **MenQuadfi**

- a) Only on a prescription
- b) No patient co-payment payable
- c)
  - A) Any of the following:
    - 1) Up to three doses and a booster every five years for patients pre- and post splenectomy and for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited), or pre or post solid organ transplant; or
    - 2) One dose for close contacts of meningococcal cases of any group; or
    - 3) One dose for person who has previously had meningococcal disease of any group; or
    - 4) A maximum of two doses for bone marrow transplant patients; or
    - 5) A maximum of two doses for person pre- and post-immunosuppression\*; or
  - B) Both:
    - 1) Person is aged between 13 and 25 years, inclusive; and
    - 2) Either:
      - 1) One dose for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons; or
      - 2) One dose for individuals who turn 13 years of age while living in boarding school hostels.
  - C) Contractors will be entitled to claim payment from the Funder for the supply of Meningococcal A, C, Y and W-135 vaccine to patients eligible under the above criteria pursuant to their contract with Health New Zealand (Health NZ) for subsidised immunisation, and they may only do so in respect of the Meningococcal A, C, Y and W-135 vaccine listed in the Pharmaceutical Schedule.
  - D) Contractors may only claim for patient populations within the criteria that are covered by their contract, which may be a sub-set of the population described in paragraphs A-B above.

Note: children under seven years of age require two doses 8 weeks apart, a booster dose three years after the primary series and then five yearly.

\*Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than 28 days.

Inj 5 mcg of each meningococcal polysaccharide conjugated to a total of approximately 44 mcg of tetanus toxoid carrier per 0.5 ml vial – [Xpharm]..... 0.00      1      ✓ **Nimenrix**

- A) Both:
  - 1) The child is under 12 months of age; and
  - 2) Any of the following:
    - 1) A maximum of three doses (dependant on age at first dose) for patients pre- and post- splenectomy and for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited), or pre- or post- solid organ transplant; or
    - 2) A maximum of three doses (dependant on age at first dose) for close contacts of meningococcal cases of any group; or
    - 3) A maximum of three doses (dependant on age at first dose) for child who has previously had meningococcal disease of any group; or
    - 4) A maximum of three doses (dependant on age at first dose) for bone marrow transplant patients; or
    - 5) A maximum of three doses (dependant on age at first dose) for child pre- and post-immunosuppression\*.

Note: infants from 6 weeks to less than 6 months of age require a 2+1 schedule, infants from 6 months to less than 12 months of age require a 1+1 schedule. Refer to the Immunisation Handbook for recommended booster schedules with meningococcal ACWY vaccine.

\*Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than 28 days.

# NATIONAL IMMUNISATION SCHEDULE

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>MENINGOCOCCAL B MULTICOMPONENT VACCINE</b>				
a) Only on a prescription				
b) No patient co-payment payable				
c) Any of the following:				
A) A primary course of up to three doses for children up to the age of 59 months inclusive; or				
B) Both:				
1) Person is 5 years of age or over; and				
2) Any of the following:				
i) up to two doses and a booster every five years for patients pre- and post-splenectomy; or				
ii) up to two doses and a booster every five years for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited); or				
iii) up to two doses and a booster every five years pre- or post-solid organ transplant; or				
iv) up to two doses for close contacts of meningococcal cases of any group; or				
v) up to two doses for person who has previously had meningococcal disease of any group; or				
vi) up to two doses for bone marrow transplant patients; or				
vii) up to two doses for person pre- and post-immunosuppression*; or				
C) Both:				
1) Person is aged between 13 and 25 years (inclusive); and				
2) Either:				
i) Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences or prison; or				
ii) Two doses for individuals who turn 13 years of age while living in boarding school hostels.				
D) Contractors will be entitled to claim payment from the Funder for the supply of Meningococcal B multicomponent vaccine to patients eligible under the above criteria pursuant to their contract with Health New Zealand (Health NZ) for subsidised immunisation, and they may only do so in respect of the Meningococcal B multicomponent vaccine listed in the Pharmaceutical Schedule.				
E) Contractors may only claim for patient populations within the criteria that are covered by their contract, which may be a sub-set of the population described in paragraphs A-C above.				
*Immunosuppression due to corticosteroid or other immunosuppressive therapy must be for a period of greater than 28 days.				
Inj 175 mcg per 0.5 ml prefilled syringe.....	0.00	1	✓	<b>Bexsero</b>
		10	✓	<b>Bexsero</b>

Subsidy (Manufacturer's Price) \$	Fully Subsidised Per ✓	Brand or Generic Manufacturer
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## PNEUMOCOCCAL (PCV13) CONJUGATE VACCINE

- a) Only on a prescription
- b) No patient co-payment payable
- c)
  - A) Any of the following:
    - 1) A course of three doses for previously unvaccinated children up to the age of 59 months inclusive; or
    - 2) Two doses are funded for high risk individuals (over the age of 12 months and under 18 years) who have previously received two doses of the primary course of PCV10; or
    - 3) Up to an additional four doses (as appropriate) are funded for the (re)immunisation of high risk children aged under 5 years with any of the following:
      - a) on immunosuppressive therapy or radiation therapy, vaccinate when there is expected to be a sufficient immune response; or
      - b) primary immune deficiencies; or
      - c) HIV infection; or
      - d) renal failure, or nephrotic syndrome; or
      - e) who are immune-suppressed following organ transplantation (including haematopoietic stem cell transplant); or
      - f) cochlear implants or intracranial shunts; or
      - g) cerebrospinal fluid leaks; or
      - h) receiving corticosteroid therapy for more than two weeks, and who are on an equivalent daily dosage of prednisone of 2 mg/kg per day or greater, or children who weigh more than 10 kg on a total daily dosage of 20 mg or greater; or
      - i) chronic pulmonary disease (including asthma treated with high-dose corticosteroid therapy); or
      - j) pre term infants, born before 28 weeks gestation; or
      - k) cardiac disease, with cyanosis or failure; or
      - l) diabetes; or
      - m) Down syndrome; or
      - n) who are pre- or post-splenectomy, or with functional asplenia; or
    - 4) Up to an additional four doses (as appropriate) are funded for the (re-)immunisation of individuals 5 years and over with HIV, pre or post haematopoietic stem cell transplantation, or chemotherapy; pre- or post splenectomy; functional asplenia, pre- or post- solid organ transplant, renal dialysis, complement deficiency (acquired or inherited), cochlear implants, intracranial shunts, cerebrospinal fluid leaks or primary immunodeficiency; or
    - 5) For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician.
  - B) Contractors will be entitled to claim payment from the Funder for the supply of Pneumococcal (PCV13) conjugate vaccine to people eligible under the above criteria pursuant to their contract with Health New Zealand (Health NZ) for subsidised immunisation, and they may only do so in respect of the Pneumococcal (PCV13) conjugate vaccine listed in the Pharmaceutical Schedule.
  - C) Contractors may only claim for populations within the criteria that are covered by their contract, which may be a sub-set of the population described in paragraph A above.

Note: please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes

Inj 30.8 mcg of pneumococcal polysaccharide serotypes 1, 3, 4,

5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F and 23F in 0.5ml

syringe .....	0.00	10		✓ <b>Prevenar 13</b>
		1		✓ <b>Prevenar 13</b>

# NATIONAL IMMUNISATION SCHEDULE

	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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## PNEUMOCOCCAL (PPV23) POLYSACCHARIDE VACCINE – [Xpharm]

Any of the following:

- 1) Up to three doses (as appropriate) for patients with HIV, for patients post haematopoietic stem cell transplant, or chemotherapy; pre- or post-splenectomy or with functional asplenia, pre- or post-solid organ transplant, renal dialysis, complement deficiency (acquired or inherited), cochlear implants, or primary immunodeficiency; or
- 2) All of the following:
  - a) Patient is a child under 18 years for (re-)immunisation; and
  - b) Treatment is for a maximum of two doses; and
  - c) Any of the following:
    - i) on immunosuppressive therapy or radiation therapy, vaccinate when there is expected to be a sufficient immune response; or
    - ii) with primary immune deficiencies; or
    - iii) with HIV infection; or
    - iv) with renal failure, or nephrotic syndrome; or
    - v) who are immune-suppressed following organ transplantation (including haematopoietic stem cell transplant); or
    - vi) with cochlear implants or intracranial shunts; or
    - vii) with cerebrospinal fluid leaks; or
    - viii) receiving corticosteroid therapy for more than two weeks, and who are on an equivalent daily dosage of prednisone of 2 mg/kg per day or greater, or children who weigh more than 10 kg on a total daily dosage of 20 mg or greater; or
    - ix) with chronic pulmonary disease (including asthma treated with high-dose corticosteroid therapy); or
    - x) pre term infants, born before 28 weeks gestation; or
    - xi) with cardiac disease, with cyanosis or failure; or
    - xii) with diabetes; or
    - xiii) with Down syndrome; or
    - xiv) who are pre- or post-splenectomy, or with functional asplenia; or
- 3) For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician

Inj 575 mcg in 0.5 ml prefilled syringe (25 mcg of each 23 pneumococcal serotype) .....	0.00	1	✓ <b>Pneumovax 23</b>
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## POLIOMYELITIS VACCINE – [Xpharm]

Up to three doses for patients meeting either of the following:

- 1) For partially vaccinated or previously unvaccinated individuals; or
- 2) For revaccination following immunosuppression.

Note: Please refer to the Immunisation Handbook for appropriate schedule for catch-up programmes.

Inj 80D antigen units in 0.5 ml syringe.....	0.00	1	✓ <b>IPOL</b>
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Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Brand or Generic Manufacturer
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## ROTAVIRUS ORAL VACCINE

- a) Only on a prescription
- b) No patient co-payment payable
- c)
  - A) Maximum of two doses for people meeting the following:
    - 1) first dose to be administered in infants aged under 14 weeks of age; and
    - 2) no vaccination being administered to children aged 24 weeks or over.
  - B) Contractors will be entitled to claim payment from the Funder for the supply of Rotavirus oral vaccine to people eligible under the above criteria pursuant to their contract with Health New Zealand (Health NZ) for subsidised immunisation, and they may only do so in respect of the Rotavirus oral vaccine listed in the Pharmaceutical Schedule.
  - C) Contractors may only claim for populations within the criteria that are covered by their contract, which may be a sub-set of the population described in paragraph A above.

Oral susp live attenuated human rotavirus 1,000,000 CCID50 per dose, squeezable tube (PVC free) ..... 0.00	10	✓ <b>Rotarix</b>
Oral susp live attenuated human rotavirus 1,000,000 CCID50 per dose, prefilled oral applicator..... 0.00	10	✓ <b>Rotarix</b>

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time



	Subsidy (Manufacturer's Price) \$	Fully Subsidised Per	Fully Subsidised ✓	Brand or Generic Manufacturer
<b>VARICELLA ZOSTER VACCINE [SHINGLES VACCINE]</b>				
<ul style="list-style-type: none"> <li>a) Only on a prescription</li> <li>b) No patient co-payment payable</li> <li>c)               <ul style="list-style-type: none"> <li>A) Funded for patients meeting the following criteria:                   <ul style="list-style-type: none"> <li>1) Either:                       <ul style="list-style-type: none"> <li>1) Two doses for all people aged 65 years, or</li> <li>2) Two doses for people 18 years of age or older with any of the following:                           <ul style="list-style-type: none"> <li>a) pre- and post-haematopoietic stem cell transplant or cellular therapy; or</li> <li>b) pre- or post-solid organ transplant; or</li> <li>c) haematological malignancies; or</li> <li>d) people living with poorly controlled HIV infection; or</li> <li>e) planned or receiving disease modifying anti-rheumatic drugs (DMARDs – targeted synthetic, biologic, or conventional synthetic) for polymyalgia rheumatica, systemic lupus erythematosus or rheumatoid arthritis; or</li> <li>f) end stage kidney disease (CKD 4 or 5); or</li> <li>g) primary immunodeficiency</li> </ul> </li> </ul> </li> <li>B) Contractors will be entitled to claim payment from the Funder for the supply of Varicella zoster vaccine (Shingles vaccine) to patients eligible under the above criteria pursuant to their contract with Health New Zealand (Health NZ) for subsidised immunisation, and they may only do so in respect of the Varicella zoster vaccine [Shingles vaccine] listed in the Pharmaceutical Schedule.</li> <li>C) Contractors may only claim for patient populations within the criteria that are covered by their contract, which may be a sub-set of the population described in paragraph A above.</li> </ul> </li> </ul> </li> </ul>				
Inj 50 mcg per 0.5 ml vial plus vial.....	0.00	1	✓	Shingrix
		10	✓	Shingrix

## Diagnostic Agents

<b>TUBERCULIN PPD [MANTOUX] TEST – [Xpharm]</b>				
Inj 5 TU per 0.1 ml, 1 ml vial.....	0.00	1	✓	Tubersol

▲ Three months supply may be dispensed at one time if endorsed "certified exemption" by the prescriber or pharmacist.

\* Three months or six months, as applicable, dispensed at one time

<b>- Symbols -</b>		
3TC.....	115	Albendazole.....95
<b>- A -</b>		
A-Scabies.....	75	Albey.....267
Abacavir sulphate.....	114	Albustix.....84
Abacavir sulphate with lamivudine.....	114	Alchemy Oxalipatin.....158
Abacavir/Lamivudine Viatrix.....	114	Alchemy Oxybutynin.....83
Abilify Maintena.....	140	Aldara.....78
Abiraterone acetate.....	181	Aldurazyme.....28
Acarbose.....	12	Alecensa.....169
Accarb.....	12	Alectinib.....169
Acetazolamide.....	280	Alendronate sodium.....120
Acetec.....	47	Alendronate sodium with colecalfiferol.....
Acetic acid with hydroxyquinoline and ricinoleic acid.....	82	120
Acetylcysteine.....	283	Alfacalcidol.....33
Aci-Jel.....	82	Alfamino.....305
Aciclovir.....		Alfamino Junior.....305
Infection.....	108	Alginate acid.....6
Sensory.....	278	Alglucosidase alfa.....26
Acidex.....	6	Alkeran.....158
Acipimox.....	55	Allegron.....131
Acitretin.....	75	Allerfix.....280
Act-HIB.....	313	Allergoval.....8
Actemra.....	238	Allerpro Syneo 1.....307
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Actrapid.....	11	Allersoothe.....267
Actrapid Penfill.....	11	Allmercap.....160
Acupan.....	127	Allopurinol.....122
Adalimumab (Amgevita).....	190	Almarytm.....50
Adalimumab (Humira - Alternative brand).....	198	Alpha-Adrenoceptor Blockers.....47
Adapalene.....	69	Alpha-Keri Lotion.....74
Adcetris.....	208	Alphamox 125.....98
ADR Cartridge 1.8.....	22	Alphamox 250.....98
Adrenaline.....		Alprolix.....38
Cardiovascular.....	57	Alu-Tab.....6
Respiratory.....	266	Aluminium hydroxide.....6
Adriamycin.....	161	Alyftrek.....275
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Adynovate.....	40	Ambrisentan Viatrix.....58
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Aflibercept.....	205	Amiloride hydrochloride.....53
AFT-Pyrazinamide.....	107	Amiloride hydrochloride with furosemide.....
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Agents for Parkinsonism and Related Disorders.....	124	Amiloride hydrochloride with hydrochlorothiazide.....
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		Amisulpride.....137
		Amitriptyline.....131
		Amiodipine.....52
		Amorolfine.....70
		Amoxicillin.....98
		Amoxicillin with clavulanic acid.....98
		Amoxiclav Devatis Forte.....98
		Amoxycillin Sandoz.....98
		Amphotericin B.....32
		Amsacrine.....160
		AmsaLyo.....160
		Amsidine.....160
		Amzoate.....30
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		Anagrelide hydrochloride.....160
		Analgics.....126
		Anastrozole.....184
		Anatrole.....184
		Anoro Ellipta.....271
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		Antacids and Antiflatulents.....6
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		Antiacne Preparations.....69
		Antiallergy Preparations.....266
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		Antandrogen Oral Contraceptives.....
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		Antiarrhythmics.....49
		Antibacterials.....95
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		Antidiarrhoeals.....6
		Antiepilepsy Drugs.....132
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		Antifibrotics.....272
		Antifungals.....102
		Antifungals Topical.....70
		Antihistamines.....267
		Antihypotensives.....50
		Antimalarials.....105
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		Antispasmodics and Other Agents Altering Gut Motility.....
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		Antivirals.....108
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		Anzatax.....165
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APO-Atomoxetine .....	147	ATGAM.....	189	Benzylpenicillin sodium [Penicillin	
Apo-Azithromycin .....	96	Ativan.....	142	G].....	98
APO-Candesartan HCTZ		Atnahs Olsalazine.....	8	Besponsa.....	218
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APO-Candesartan HCTZ		Atorvastatin.....	55	Beta Ointment.....	72
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APO-Olanzapine.....	139	Cardiovascular.....	49	Beta-Adrenoceptor Agonists.....	269
Apo-Temozolomide .....	166	Sensory.....	281	Beta-Adrenoceptor Blockers.....	50
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Arginine2000 .....	303	Axitinib .....	170	Betamethasone dipropionate with	
Aripiprazole.....	138, 140	Azacitidine .....	158	calcipotriol.....	76
Aripiprazole Sandoz .....	138	Azacitidine Dr Reddy's .....	158	Betamethasone sodium phosphate	
Aristocort .....	72	Azamun .....	184	with betamethasone acetate.....	86
Arrotex-Prazosin S29 .....	47	Azathioprine.....	184	Betamethasone valerate.....	72, 77
Arrow - Clopid.....	41	Azilect .....	124	Betamethasone valerate with sodium	
Arrow - Lattim .....	281	Azithromycin .....	96	fusidate [fusidic acid].....	73
Arrow-Amitriptyline .....	131	Azopt .....	280	Betnovate .....	72
Arrow-Bendrofluazide .....	54			Bevacizumab .....	206
Arrow-Brimonidine.....	280	- B -		Bexsero .....	320
Arrow-Diazepam.....	142	B-D Micro-Fine.....	17	Bezafibrate .....	55
Arrow-Doxorubicin .....	161	B-D Ultra Fine.....	17	Bezalip.....	55
Arrow-Fluoxetine .....	132	B-D Ultra Fine II.....	17	Bezalip Retard .....	55
Arrow-Losartan &		Bacillus Calmette-Guerin (BCG)		Bicalutamide .....	182
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Arrow-Norfloxacin.....	118	Bacillus Calmette-Guerin		BiCNU.....	157
Arrow-Ornidazole.....	106	vaccine .....	310	Bile and Liver Therapy.....	10
Arrow-Quinapril 10.....	48	Baclufen.....	123	Bimatoprost .....	280
Arrow-Quinapril 20.....	48	Bactroban .....	70	Binarex .....	182
Arrow-Quinapril 5.....	48	Balance.....	29	Binocrit .....	37
Arrow-Roxithromycin .....	97	Barrier Creams and Emollients.....	73	Biocon.....	51
Arrow-Timolol .....	280	Bayshore .....	105	Biodone .....	129
Arrow-Topiramate.....	135	BCG Vaccine AJV .....	310	Biodone Extra Forte.....	129
Arrow-Tramadol.....	131	Beclazone 100.....	268	Biodone Forte .....	129
Arsenic trioxide .....	161	Beclazone 250.....	268	Bisacodyl .....	26
Asacol.....	7	Beclazone 50.....	268	Bisacodyl Viatris .....	26
Asacol S29 .....	7	Beclomethasone dipropionate .....	268	Bisacodyl-AFT .....	26
Ascend-Cefuroxime .....	96	Bedaquiline .....	106	Bisoprolol fumarate.....	50
Ascorbic acid .....	33	Bee venom allergy treatment.....	267	BK Lotion.....	74
Aspen Adrenaline .....	57	Bendamustine hydrochloride.....	156	Bleomycin sulphate .....	161
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Atazanavir Viatris.....	115	Benzathine benzylpenicillin .....	98	strip.....	16
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Atenolol AFT.....	50	Benzbromarone .....	122	impaired).....	16
		Benzetacil .....	98		

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Boostrix .....	311	Candesartan cilexetil with hydrochlorothiazide .....	48	Cetuximab .....	209
Bortezomib .....	161	Candesartan Viatris .....	48	Champix .....	155
Bortezomib Eugia .....	161	Candesartan Viatris Sante.....	48	Charcoal .....	283
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Brentuximab Vedotin .....	208	Capecitabine Viatris.....	159	Chlorafast .....	278
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Brimonidine tartrate .....	280	Carafate .....	10	Chlortalidone [Chlorthalidone] .....	54
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Budesonide with eformoterol.....	269	Cardizem CD.....	52	Cinaclet Devatis.....	85
Budesonide with glycopyrronium and eformoterol .....	271	CareSens Dual.....	15	Cipla .....	270
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Buprenorphine Naloxone BNM.....	153	CareSens N POP .....	16	Infection .....	100
Buprenorphine with naloxone.....	153	CareSens N Premier .....	16	Sensory .....	278
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Burinex .....	53	Carmustine .....	157	Cisplatin Accord.....	157
Buspiron hydrochloride.....	142	Carvedilol .....	51	Cisplatin Ebewe.....	157
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		Cefaclor monohydrate .....	95	Cladribine .....	159
		Cefalexin.....	95	Clarithromycin .....	
		Cefalexin Lupin.....	95	Alimentary .....	9
		Cefalexin Sandoz .....	95	Infection .....	97
		Cefazolin .....	95	Clexane .....	43
		Cefazolin-AFT.....	95	Clexane Forte .....	43
		Ceftriaxone .....	96	Clindamycin .....	100
		Ceftriaxone-AFT .....	96	Clinicians .....	27, 33
		Cefuroxime axetil.....	96	Clinicians Renal Vit.....	33
		Celapram .....	132	Clobazam .....	133
		Celebrex .....	120	Clobetasol propionate.....	72, 77
		Celecoxib .....	120	Clobetasone butyrate .....	72
		Celecoxib Pfizer.....	120	Clofazimine .....	106
		Celestone Chronodose.....	86	Clomazol .....	
		Cellcept.....	184	Dermatological .....	71
		Celostea .....	120	Genito-Urinary .....	82
		Centrally-Acting Agents .....	53	Clomifene citrate.....	94
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		Cerazette .....	81	Clonazepam .....	133, 142
		Cerubidine .....	161	Clonidine .....	53
		Cetirizine hydrochloride.....	267	Clonidine hydrochloride .....	53
		Cetomacrogol .....	73	Clonidine Teva.....	53
		Cetomacrogol with glycerol .....	73	Clopidogrel .....	41
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Musculoskeletal	Doxycycline	99	Empagliflozin	14
Sensory	DP Lotion	74	Empagliflozin with metformin hydrochloride	14
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Diffiam	DP-Captopril	47	Emtricitabine	114
Diflucan	Dr Reddy's Omeprazole	10	Emtricitabine with tenofovir disoproxil	111
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Digoxin	Droperidol	137	Emulsifying ointment	73
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Dilantin	Drugs Affecting Bone Metabolism	120	Enbrel	185
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Dimethicone	Duolin	270	Enhertu	243
Dimethyl fumarate	Duolin HFA	270	Enlifax XR	132
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Diprosone	e-chamber La Grande	277	Ensure Plus	297
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Domperidone	Elaprase	28	Epilim S/F Liquid	134
Domperidone Viatrix	Elecare	305	Epilim Syrup	134
Donepezil hydrochloride	Elecare LCP	305	Epipen	266
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Dorzolamide with timolol	Elemental O28 Extra	293	Epirubicin hydrochloride	162
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