SA Health

Streamline Non Formulary Request: Ticagrelor 90mg Tablet

Ticagrelor 90mg tablet is available on request, by Neurointerventionalist and/or Stroke Neurologist, for:

- ☐ Intracranial or extracranial (carotid/vertebral) angioplasty AND/OR stenting in the setting of acute ischaemic stroke, where bleeding risk is deemed sufficiently low and thrombosis risk deemed high
- ☐ Dual antiplatelet cover (with aspirin) in clopidogrel resistant patients undergoing elective endovascular treatment with stenting of cerebral aneurysm and intracranial or extracranial (carotid or vertebral) stenotic lesions

The following information is required to be provided by the prescriber prior to (or in the hyperacute setting at the time of) dispensing.

Patient details:

Name:		
UR #:	Date of birth:	Gender:
Patient location (site/hospital):		

Prescriber eligibility for Ticagrelor 90mg tablets:

☐ Neurointerventionalist:
AND / OR
☐ Stroke Neurologist:

Patient eligibility for Ticagrelor 90mg tablets:

1. ☐ Acute ischaemic stroke
   AND
2. ☐ Intracranial or extracranial (carotid/vertebral) angioplasty AND/OR stenting
   AND
3. ☐ Dual antiplatelet cover (with aspirin)
   AND
4. ☐ Bleeding risk is deemed sufficiently low and thrombosis risk is deemed high
   AND
5. ☐ Written informed patient consent obtained (where practicable) for the off-label use of this medication

OR

1. ☐ Elective endovascular treatment
   AND
2. ☐ Stenting of cerebral aneurysm and intracranial or extracranial (carotid or vertebral) stenotic lesions
   AND
3. ☐ Dual antiplatelet cover (with aspirin)
   AND
4. ☐ Clopidogrel resistance as determined clinically (including a best possible medication history) and supported by other tools: _____

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AND 5. ☐ Written informed patient consent obtained for the off-label use of this medication
Duration of treatment for a maximum of: ☐ 3 months for intracranial stents for aneurysms or stenosis, extracranial stents and intracranial angioplasty Start date: _____ **OR** ☐ 6 months for intracranial stents for distal/smaller vessel aneurysms or stenosis, Start date: _____ **OR** ☐ 12 months for intracranial drug eluting stents Start date: _____

Prescriber details:

I certify that the above information is correct Date: Prescriber Name: Position:	
Clinical unit, hospital:	
Telephone No:	Pager No:

PHARMACY USE INFORMATION

Entered in iPharmacy	Yes ☐ No ☐	Signature:
Entered in database	Yes ☐ No ☐	Date:

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