Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.

				, 0,				
PRESCRIBER							PATIENT:	
Name:							Name:	
Ward	:						NHI:	
Deferasirox								
INIT	IATIO	Preso	(tick I cribec ital.	patient has been of erasirox is to be given the following treatment with a distribution of the following treatment with	ded by a haematological diagnosed with chronic ven at a daily dose not be assumed to the control of the control	ic iron overload du it exceeding 40 mg uses of deferiprone by serum ferritin le ed in severe persis ed in arthritis	the with a protocol or guideline that has been endorsed by the Health NZ e to congenital inherited anaemia l/kg/day monotherapy or deferiprone and desferrioxamine combination therapy vels, liver or cardiac MRI T2* stent vomiting or diarrhoea istory of agranulocytosis (defined as an absolute neutrophil count ter than 2 episodes) of moderate neutropenia (ANC 0.5 - 1.0 cells per	
Re-a	equis	smen sites	t required tribed ital. For the para	the first renewal fo meters namely se subsequent renew	ded by a haematologion	rapy, the treatmen IRI T2* and liver M s been tolerated ar	nd has resulted in clinical stability or continued improvement in all three	