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

PRESCRIBER

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Dexrazoxane

INITIATION

Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a medical oncologist, paediatric oncologist, haematologist or paediatric haematologist, or in accordance with a protocol or guideline that has been endorsed by the Te Whatu Ora Hospital.

and

- ○ Patient is to receive treatment with high dose anthracycline given with curative intent

and

- ○ Based on current treatment plan, patient's cumulative lifetime dose of anthracycline will exceed 250mg/m2 doxorubicin equivalent or greater

and

- ○ Dexrazoxane to be administered only whilst on anthracycline treatment

and

- ○ Treatment to be used as a cardioprotectant for a child or young adult

or

- ○ Treatment to be used as a cardioprotectant for secondary malignancy

I confirm that the above details are correct:

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