## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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	PATIENT:
Name:	Name:
Ward:	NHI:
Ibrutinib	
INITIATION – chronic lymphocytic leukaemia (CLL)	

and (	С	Patient has chronic lymphocytic leukaemia (CLL) requiring therapy
and (	С	Patient has not previously received funded ibrutinib
and (	С	Ibrutinib is to be used as monotherapy
		O There is documentation confirming that patient has 17p deletion or TP53 mutation
		O Patient has experienced intolerable side effects with venetoclax monotherapy
	or	O Patient has received at least one prior immunochemotherapy for CLL
		Patient's CLL has relapsed within 36 months of previous treatment
		and O Patient has experienced intolerable side effects with venetoclax in combination with rituximab regimen
	or	O Patient's CLL is refractory to or has relapsed within 36 months of a venetoclax regimen
assessi	ment	N – chronic lymphocytic leukaemia (CLL) required after 12 months tick boxes where appropriate)

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) and B-cell prolymphocytic leukaemia (B-PLL)\*. Indications marked with \* are Unapproved indications.

O The treatment remains appropriate and the patient is benefitting from treatment

I confirm that the above details are correct:

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