# 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**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

## Brentuximab

**INITIATION – relapsed/refractory Hodgkin lymphoma**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ Patient has relapsed/refractory CD30-positive Hodgkin lymphoma after two or more lines of chemotherapy
- **and**
- ○ Patient is ineligible for autologous stem cell transplant

**or**

- ○ Patient has relapsed/refractory CD30-positive Hodgkin lymphoma
- **and**
- ○ Patient has previously undergone autologous stem cell transplant

**and**
○ Patient has not previously received funded brentuximab vedotin
**and**
○ Response to brentuximab vedotin treatment is to be reviewed after a maximum of 6 treatment cycles
**and**
○ Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks

**CONTINUATION – relapsed/refractory Hodgkin lymphoma**
Re-assessment required after 9 months
**Prerequisites** (tick boxes where appropriate)

○ Patient has achieved a partial or complete response to brentuximab vedotin after 6 treatment cycles
**and**
○ Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated
**and**
○ Patient is to receive a maximum of 16 total cycles of brentuximab vedotin treatment

**INITIATION – anaplastic large cell lymphoma**
Re-assessment required after 9 months
**Prerequisites** (tick boxes where appropriate)

○ Patient has relapsed/refractory CD30-positive systemic anaplastic large cell lymphoma
**and**
○ Patient has an ECOG performance status of 0-1
**and**
○ Patient has not previously received brentuximab vedotin
**and**
○ Response to brentuximab vedotin treatment is to be reviewed after a maximum of 6 treatment cycles
**and**
○ Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks



I confirm that the above details are correct:

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

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: .....

## Brentuximab *- continued*

**CONTINUATION – anaplastic large cell lymphoma**
Re-assessment required after 9 months
**Prerequisites** (tick boxes where appropriate)

- ❍ Patient has achieved a partial or complete response to brentuximab vedotin after 6 treatment cycles

**and**

- ❍ Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated

**and**

- ❍ Patient is to receive a maximum of 16 total cycles of brentuximab vedotin treatment



I confirm that the above details are correct:

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