

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: .....

**Thalidomide**

**INITIATION**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- ☐ The patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment
- or
- ☐ The patient has erythema nodosum leprosum

**CONTINUATION**

**Prerequisites** (tick box where appropriate)

- ☐ Patient has obtained a response from treatment during the initial approval period

Note: Prescription must be written by a registered prescriber in the thalidomide risk management programme operated by the supplier  
Maximum dose of 400 mg daily as monotherapy or in a combination therapy regimen

I confirm that the above details are correct:

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