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: .....

Inotuzumab ozogamicin

INITIATION
Re-assessment required after 4 months
Prerequisites (tick boxes where appropriate)

- ○ Patient has relapsed or refractory CD22-positive B-cell acute lymphoblastic leukaemia/lymphoma, including minimal residual disease

and

- ○ Patient has ECOG performance status of 0-2

and

- ○ Patient has Philadelphia chromosome positive B-Cell ALL

  and

  ○ Patient has previously received a tyrosine kinase inhibitor

  or

- ○ Patient has received one prior line of treatment involving intensive chemotherapy

and

- ○ Treatment is to be administered for a maximum of 3 cycles

CONTINUATION
Re-assessment required after 4 months
Prerequisites (tick boxes where appropriate)

- ○ Patient is not proceeding to a stem cell transplant

and

- ○ Patient has experienced complete disease response

  or

  ○ Patient has experienced complete remission with incomplete haematological recovery

and

- ○ Treatment with inotuzumab ozogamicin is to cease after a total duration of 6 cycles

I confirm that the above details are correct:

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