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: .....

Bortezomib

INITIATION – plasma cell dyscrasia

Prerequisites (tick box where appropriate)

- ○ The patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment

INITIATION – Waldenström Macroglobulinaemia

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

- ○ The patient has Waldenström Macroglobulinaemia/Lymphoplasmacytic Lymphoma requiring treatment

and

- ○ The patient has not received prior bortezomib treatment

CONTINUATION – Waldenström Macroglobulinaemia

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

- ○ Patient has no evidence of clinical disease progression during bortezomib use

I confirm that the above details are correct:

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