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: .....

Ibrutinib

INITIATION – previously untreated chronic lymphocytic leukaemia in combination with venetoclax

Prerequisites (tick boxes where appropriate)

- ○ Individual is currently on treatment with ibrutinib and/or venetoclax and met all of the following criteria prior to commencing treatment

or

- ○ Individual has previously untreated CLL

and

- ○ Ibrutinib is to be administered at a maximum dose of 420 mg daily for 3 (28 day) cycles as monotherapy, followed by a maximum of 12 (28 day) cycles in combination with venetoclax

INITIATION – chronic lymphocytic leukaemia (CLL)

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

- ○ Individual has chronic lymphocytic leukaemia (CLL) requiring therapy

and

- ○ Ibrutinib is to be used as monotherapy

and

- ○ Individual has experienced intolerable side effects, or their disease has relapsed or is refractory following at least one prior line of therapy

and

- ○ Individual has not received ibrutinib monotherapy previously

CONTINUATION – chronic lymphocytic leukaemia (CLL)

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

- ○ No evidence of clinical disease progression

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

I confirm that the above details are correct:

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