

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: .....

**Temozolomide**

**INITIATION – gliomas**

Re-assessment required after 12 months

**Prerequisites** (tick box where appropriate)

- Patient has a glioma

**CONTINUATION – gliomas**

Re-assessment required after 12 months

**Prerequisites** (tick box where appropriate)

- Treatment remains appropriate and patient is benefitting from treatment

**INITIATION – Neuroendocrine tumours**

Re-assessment required after 9 months

**Prerequisites** (tick boxes where appropriate)

- Patient has been diagnosed with metastatic or unresectable well-differentiated neuroendocrine tumour  
**and**  
 Temozolomide is to be given in combination with capecitabine  
**and**  
 Temozolomide is to be used in 28 day treatment cycles for a maximum of 5 days treatment per cycle at a maximum dose of 200 mg/m<sup>2</sup> per day  
**and**  
 Temozolomide to be discontinued at disease progression

**CONTINUATION – Neuroendocrine tumours**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- No evidence of disease progression  
**and**  
 The treatment remains appropriate and the patient is benefitting from treatment

**INITIATION – ewing's sarcoma**

Re-assessment required after 9 months

**Prerequisites** (tick box where appropriate)

- Patient has relapse or refractory Ewing's sarcoma

**CONTINUATION – ewing's sarcoma**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- No evidence of disease progression  
**and**  
 The treatment remains appropriate and the patient is benefitting from treatment

**INITIATION – Neuroblastoma**

Re-assessment required after 12 months

**Prerequisites** (tick box where appropriate)

- Patient has neuroblastoma

I confirm that the above details are correct:

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

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**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

**Temozolomide** - *continued*

**CONTINUATION – Neuroblastoma**

Re-assessment required after 12 months

**Prerequisites** (tick box where appropriate)

Patient has no evidence of disease progression

HOSPITAL

I confirm that the above details are correct:

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