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	PATIENT:
Name:	Name:
Ward:	NHI:
Thalidomide	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
O The patient has multiple myeloma or O or O O The patient has systemic AL amyloidosis* or O The patient has erythema nodosum leprosum	
CONTINUATION Prerequisites (tick box where appropriate)	

O 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 Indication marked with * is an unapproved indication