Form RS1695
July 2024

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: ....

Dexrazoxane

INITIATION

Prerequisites (tick boxes where appropriate)

- ❍ Prescribed by, or recommended by a medical oncologist, paediatric oncologist, haematologist or paediatric haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ❍ Patient is to receive treatment with high dose anthracycline given with curative intent

  and
- ❍ Based on current treatment plan, patient's cumulative lifetime dose of anthracycline will exceed 250mg/m2 doxorubicin equivalent or greater

  and
- ❍ Dexrazoxane to be administered only whilst on anthracycline treatment

  and
  - ❍ Treatment to be used as a cardioprotectant for a child or young adult

    or
  - ❍ Treatment to be used as a cardioprotectant for secondary malignancy

I confirm that the above details are correct:

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

HOSPITAL