## 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:			
Bortezomib						
INITIATION – multiple myeloma/amyloidosis Prerequisites (tick boxes where appropriate)						
		O The patient has symptomatic multiple myeloma				
	or	O The patient has symptomatic systemic AL amyloidosis				

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Signed.	Date:	
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