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: .....

Azacitidine

INITIATION
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

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

and

- ○ The patient has International Prognostic Scoring System (IPSS) intermediate-2 or high risk myelodysplastic syndrome

or

- ○ The patient has chronic myelomonocytic leukaemia (10%-29% marrow blasts without myeloproliferative disorder)

or

- ○ The patient has acute myeloid leukaemia with 20-30% blasts and multi-lineage dysplasia, according to World Health Organisation Classification (WHO)

and

- ○ The patient has performance status (WHO/ECOG) grade 0-2

and

- ○ The patient has an estimated life expectancy of at least 3 months

CONTINUATION
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ○ No evidence of disease progression

and

- ○ The treatment remains appropriate and patient is benefitting from treatment

HOSPITAL

I confirm that the above details are correct:

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