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:
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	nent
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/m² per day and	
CONTINUATION – Neuroendocrine tumours Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O 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) O Patient has relapse or refractory Ewing's sarcoma	
CONTINUATION – ewing's sarcoma Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O No evidence of disease progression and The treatment remains appropriate and the patient is benefitting	ng from treatment
Note: Indication marked with a * is an unapproved indication. Temozolomic relapsed high grade glioma.	de is not funded for the treatment of

I confirm that the above details are correct:	
Signed:	Date: