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## **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:
Pomalidomide	
INITIATION – Relapsed/refractory plasma cell dyscrasia   Re-assessment required after 6 months   Prerequisites (tick boxes where appropriate)	

Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

Patient has relapsed or refractory plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment

Patient has not received prior funded pomalidomide

## CONTINUATION - Relapsed/refractory plasma cell dyscrasia

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

Patient has no evidence of disease progression

I confirm that the above details are correct: