## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

January 2025

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:	
Dasatinib		
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Or Prescribed by, or recommended by a haematologist or any relevant with a protocol or guideline that has been endorsed by the Health Name	practitioner on the recommendation of a haematologist, or in accordance Z Hospital.	
O The patient has a diagnosis of chronic myeloid leukaemia (CM or O The patient has a diagnosis of Philadelphia chromosome-posi or		
The patient has a diagnosis of CML in chronic phase and  Patient has documented treatment failure* with im or Patient has experienced treatment-limiting toxicity or Patient has high-risk chronic-phase CML defined by the patient has a diagnosis of CML in chronic phase	with imatinib precluding further treatment with imatinib	
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  Or Prescribed by, or recommended by a haematologist or any relevant practitioner on the recommendation of a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  Or Lack of treatment failure while on dasatinib*		
O Dasatinib treatment remains appropriate and the patient is ber  Note: *treatment failure for CML as defined by Leukaemia Net Guidelines.	nefiting from treatment	

I confirm that the above details are correct:

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