# 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**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

## Plerixafor

**INITIATION – Autologous stem cell transplant**
Re-assessment required after 3 days
**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**

- ○ Patient is to undergo stem cell transplantation

**and**

- ○ Patient has not had a previous unsuccessful mobilisation attempt with plerixafor

**and**

- ○ Patient is undergoing G-CSF mobilisation

  **and**

  - ○ Has a suboptimal peripheral blood CD34 count of less than or equal to $10 \times 10^6$/L on day 5 after 4 days of G-CSF treatment

  **or**

  - ○ Efforts to collect > $1 \times 10^6$ CD34 cells/kg have failed after one apheresis procedure

**or**

- ○ Patient is undergoing chemotherapy and G-CSF mobilisation

  **and**

  - ○ Has rising white blood cell counts of > $5 \times 10^9$/L

    **and**

    ○ Has a suboptimal peripheral blood CD34 count of less than or equal to $10 \times 10^6$/L

  **or**

  - ○ Efforts to collect > $1 \times 10^6$ CD34 cells/kg have failed after one apheresis procedure

  **or**

  - ○ The peripheral blood CD34 cell counts are decreasing before the target has been received

**or**

- ○ A previous mobilisation attempt with G-CSF or G-CSF plus chemotherapy has failed



I confirm that the above details are correct:

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