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.

PATIENT:
Name:
NHI:
diatric oncologist, haematologist or paediatric haematologist, or in accordance with NZ Hospital. ine given with curative intent etime dose of anthracycline will exceed 250mg/m2 doxorubicin equivalent or cline treatment child or young adult
i .

C:	D-1	
Signed.	Date:	
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