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:	
Gemtuzuma	b ozogamicin		
INITIATION Prerequisites	(tick boxes where appropriate)		
and	Patient has not received prior chemotherapy for this condition		
and	Patient has de novo CD33-positive acute myeloid leukaemia		
and	Patient does not have acute promyelocytic leukaemia		
and	O Gemtuzumab ozogamicin will be used in combination with standard anthracycline and cytarabine (AraC)		
and	Patient is being treated with curative intent		
and	Patient's disease risk has been assessed by cytogenetic testing	ng to be good or intermediate	
	Patient must be considered eligible for standard intensive rem cytarabine (AraC)	ission induction chemotherapy with standard anthracycline and	
and	Gemtuzumab ozogamicin to be funded for one course only (or separate doses)	ne dose at 3 mg per m² body surface area or up to 2 vials of 5 mg as	

Note: Acute myeloid leukaemia excludes acute promyelocytic leukaemia and acute myeloid leukaemia that is secondary to another haematological disorder (eg myelodysplasia or myeloproliferative disorder).

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