# 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: .....

## Ibrutinib

**INITIATION – chronic lymphocytic leukaemia (CLL)**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ❍ Patient has chronic lymphocytic leukaemia (CLL) requiring therapy

**and**

- ❍ Patient has not previously received funded ibrutinib

**and**

- ❍ Ibrutinib is to be used as monotherapy

**and**

- ❍ There is documentation confirming that patient has 17p deletion or TP53 mutation

  **and**

  ❍ Patient has experienced intolerable side effects with venetoclax monotherapy

**or**

- ❍ Patient has received at least one prior immunochemotherapy for CLL

  **and**

  ❍ Patient's CLL has relapsed within 36 months of previous treatment

  **and**

  ❍ Patient has experienced intolerable side effects with venetoclax in combination with rituximab regimen

**or**

- ❍ Patient's CLL is refractory to or has relapsed within 36 months of a venetoclax regimen

**CONTINUATION – chronic lymphocytic leukaemia (CLL)**
Re-assessment required after 12 months
**Prerequisites** (tick boxes where appropriate)

- ❍ No evidence of clinical disease progression

**and**

- ❍ The treatment remains appropriate and the patient is benefitting from treatment

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) and B-cell prolymphocytic leukaemia (B-PLL)*. Indications marked with * are Unapproved indications.



I confirm that the above details are correct:

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