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:	
Nilotinib		
Hospital. Patient has a diagnosis of chronic myeloid leukaemia (CML) ir and Patient has documented CML treatment failure* with a tyor		
O Subsidised for use as monotherapy only Note: *treatment failure as defined by Leukaemia Net Guidelines.		
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	ce with a protocol or guideline that has been endorsed by the Health NZ	
Lack of treatment failure while on nilotinib as defined by Leuka and Nilotinib treatment remains appropriate and the patient is beneated. Maximum nilotinib dose of 800 mg/day and Subsidised for use as monotherapy only		

I confirm that the above details are correct:

Cianad.	Data.	
Signeg	 Date	