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:
Midostaurin			
	ATION equisites	O Patient has a diagnosis of acute myeloid leukaemia	
	and and	Condition must be FMS tyrosine kinase 3 (FLT3) mutation positive Patient must not have received a prior line of intensive chemotherapy for acute myeloid leukaemia Patient is to receive standard intensive chemotherapy in combination with midostaurin only	
	and	Midostaurin to be funded for a maximum of 4 cycles	