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:
Dasatinib	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a haematologist or any relevant with a protocol or guideline that has been endorsed by the Health Na	practitioner on the recommendation of a haematologist, or in accordance Z Hospital.
The patient has a diagnosis of chronic myeloid leukaemia (CM or O The patient has a diagnosis of Philadelphia chromosome-posi or O The patient has a diagnosis of Philadelphia chromosome-posi	
The patient has a diagnosis of CML in chronic phase and Patient has documented treatment failure* with im or Patient has experienced treatment-limiting toxicity or Patient has high-risk chronic-phase CML defined in the patient has a diagnosis of CML in chronic phase	with imatinib precluding further treatment with imatinib
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a haematologist or any relevant practitioner on the recommendation of a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. Lack of treatment failure while on dasatinib* and Dasatinib treatment remains appropriate and the patient is benefiting from treatment	
Note: *treatment failure for CML as defined by Leukaemia Net Guidelines.	

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