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: .....

## Gemtuzumab ozogamicin

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

- ○ 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**

- ○ 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 to be good or intermediate

**and**

- ○ Patient must be considered eligible for standard intensive remission induction chemotherapy with standard anthracycline and cytarabine (AraC)

**and**

- ○ Gemtuzumab ozogamicin to be funded for one course only (one dose at 3 mg per $m^2$ body surface area or up to 2 vials of 5 mg as separate doses)

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: .....