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.

PRESCRIB	ER	PATIENT:
Name:		Name:
Ward:		NHI:
Ibrutinib		
INITIATION Re-assess Prerequisi and and and	O Patient's CLL is refractory to or has relapsed within	ent has 17p deletion or TP53 mutation ects with venetoclax monotherapy unochemotherapy for CLL s of previous treatment ects with venetoclax in combination with rituximab regimen
Re-assessi	ATION – chronic lymphocytic leukaemia (CLL) ment required after 12 months ites (tick boxes where appropriate) No evidence of clinical disease progression	
	The treatment remains appropriate and the patient is be	nefitting from treatment
	ronic lymphocytic leukaemia (CLL)' includes small lymphocytic a (B-PLL)*. Indications marked with * are Unapproved indicat	

I confirm that the above details are correct:

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Oigilica.	 Duic.	