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 | |
| INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) | |
| Prescribed by, or recommended by a haematologist, or in accordan Hospital. | ce with a protocol or guideline that has been endorsed by the Health NZ |
| Patient has a diagnosis of chronic myeloid leukaemia (CML) i | n blast crisis, high risk chronic phase, or in chronic phase |
| O Patient has documented CML treatment failure* with a top or _ | tyrosine kinase inhibitor (TKI) |
| O Patient has experienced treatment limiting toxicity with | a tyrosine kinase inhibitor (TKI) precluding further treatment |
| and Maximum nilotinib dose of 800 mg/day and | |
| 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) | |
| Prescribed by, or recommended by a haematologist, or in accordan Hospital. | ce with a protocol or guideline that has been endorsed by the Health NZ |
| C Lack of treatment failure while on nilotinib as defined by Leuk and _ | aemia Net Guidelines |
| O Nilotinib treatment remains appropriate and the patient is ben | efiting from treatment |
| O Maximum nilotinib dose of 800 mg/day | |
| O Subsidised for use as monotherapy only | |
| | |

I confirm that the above details are correct:

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