HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

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: .....

Pomalidomide

INITIATION – Relapsed/refractory plasma cell dyscrasia
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

- ❍ Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ❍ Patient has relapsed or refractory plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment

and

- ❍ Patient has not received prior funded pomalidomide

CONTINUATION – Relapsed/refractory plasma cell dyscrasia
Re-assessment required after 12 months
Prerequisites (tick box where appropriate)

- ❍ Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ❍ Patient has no evidence of disease progression

I confirm that the above details are correct:

Signed: ..... Date: .....