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: .....

Thalidomide

INITIATION
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ○ The patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment

or

- ○ The patient has erythema nodosum leprosum

CONTINUATION
Prerequisites (tick box where appropriate)

- ○ Patient has obtained a response from treatment during the initial approval period

Note: Prescription must be written by a registered prescriber in the thalidomide risk management programme operated by the supplier
Maximum dose of 400 mg daily as monotherapy or in a combination therapy regimen

I confirm that the above details are correct:

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