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: .....

Dasatinib

INITIATION
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

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

and

- ○ The patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis or accelerated phase

or

- ○ The patient has a diagnosis of Philadelphia chromosome-positive acute lymphoid leukaemia (Ph+ ALL)

or

- ○ The patient has a diagnosis of CML in chronic phase

and

- ○ Patient has documented treatment failure* with imatinib

or

- ○ Patient has experienced treatment-limiting toxicity with imatinib precluding further treatment with imatinib

or

- ○ Patient has high-risk chronic-phase CML defined by the Sokal or EURO scoring system

CONTINUATION
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

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

and

- ○ Lack of treatment failure while on dasatinib*

and

- ○ Dasatinib treatment remains appropriate and the patient is benefiting from treatment

Note: *treatment failure for CML as defined by Leukaemia Net Guidelines.

I confirm that the above details are correct:

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