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: .....

Brentuximab

INITIATION – relapsed/refractory Hodgkin lymphoma
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

- ○ Patient has relapsed/refractory CD30-positive Hodgkin lymphoma after two or more lines of chemotherapy
- **and**
- ○ Patient is ineligible for autologous stem cell transplant

or

- ○ Patient has relapsed/refractory CD30-positive Hodgkin lymphoma
- **and**
- ○ Patient has previously undergone autologous stem cell transplant

and
○ Patient has not previously received funded brentuximab vedotin
and
○ Response to brentuximab vedotin treatment is to be reviewed after a maximum of 6 treatment cycles
and
○ Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks

CONTINUATION – relapsed/refractory Hodgkin lymphoma
Re-assessment required after 9 months
Prerequisites (tick boxes where appropriate)

○ Patient has achieved a partial or complete response to brentuximab vedotin after 6 treatment cycles
and
○ Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated
and
○ Patient is to receive a maximum of 16 total cycles of brentuximab vedotin treatment

INITIATION – anaplastic large cell lymphoma
Re-assessment required after 9 months
Prerequisites (tick boxes where appropriate)

○ Patient has relapsed/refractory CD30-positive systemic anaplastic large cell lymphoma
and
○ Patient has an ECOG performance status of 0-1
and
○ Patient has not previously received brentuximab vedotin
and
○ Response to brentuximab vedotin treatment is to be reviewed after a maximum of 6 treatment cycles
and
○ Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks

I confirm that the above details are correct:

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

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: .....

Brentuximab *- continued*

CONTINUATION – anaplastic large cell lymphoma
Re-assessment required after 9 months
Prerequisites (tick boxes where appropriate)

- ❍ Patient has achieved a partial or complete response to brentuximab vedotin after 6 treatment cycles

and

- ❍ Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated

and

- ❍ Patient is to receive a maximum of 16 total cycles of brentuximab vedotin treatment

I confirm that the above details are correct:

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