

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:

Midostaurin

INITIATION

Prerequisites (tick boxes where appropriate)

- ☐ Patient has a diagnosis of acute myeloid leukaemia
and
☐ Condition must be FMS tyrosine kinase 3 (FLT3) mutation positive
and
☐ Patient must not have received a prior line of intensive chemotherapy for acute myeloid leukaemia
and
☐ Patient is to receive standard intensive chemotherapy in combination with midostaurin only
and
☐ Midostaurin to be funded for a maximum of 4 cycles

I confirm that the above details are correct:

Signed: Date: