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: .....

Plerixafor

INITIATION – Autologous stem cell transplant
Re-assessment required after 3 days
Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ○ Patient is to undergo stem cell transplantation

and

- ○ Patient has not had a previous unsuccessful mobilisation attempt with plerixafor

and

- ○ Patient is undergoing G-CSF mobilisation

  and

  - ○ Has a suboptimal peripheral blood CD34 count of less than or equal to 10×10^6/L on day 5 after 4 days of G-CSF treatment

  or

  - ○ Efforts to collect > 1×10^6 CD34 cells/kg have failed after one apheresis procedure

or

- ○ Patient is undergoing chemotherapy and G-CSF mobilisation

  and

  - ○ Has rising white blood cell counts of > 5×10^9/L

    and

    ○ Has a suboptimal peripheral blood CD34 count of less than or equal to 10×10^6/L

  or

  - ○ Efforts to collect > 1×10^6 CD34 cells/kg have failed after one apheresis procedure

  or

  - ○ The peripheral blood CD34 cell counts are decreasing before the target has been received

or

- ○ A previous mobilisation attempt with G-CSF or G-CSF plus chemotherapy has failed

I confirm that the above details are correct:

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