

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:

Temozolomide**INITIATION – gliomas**

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

- ☐ Patient has a glioma

CONTINUATION – gliomas

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

- ☐ Treatment remains appropriate and patient is benefitting from treatment

INITIATION – Neuroendocrine tumours

Re-assessment required after 9 months

Prerequisites (tick boxes where appropriate)

- ☐ Patient has been diagnosed with metastatic or unresectable well-differentiated neuroendocrine tumour*
- and
- ☐ Temozolomide is to be given in combination with capecitabine
- and
- ☐ Temozolomide is to be used in 28 day treatment cycles for a maximum of 5 days treatment per cycle at a maximum dose of 200 mg/m² per day
- and
- ☐ Temozolomide to be discontinued at disease progression

CONTINUATION – Neuroendocrine tumours

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

- ☐ No evidence of disease progression
- and
- ☐ The treatment remains appropriate and the patient is benefitting from treatment

INITIATION – ewing's sarcoma

Re-assessment required after 9 months

Prerequisites (tick box where appropriate)

- ☐ Patient has relapse or refractory Ewing's sarcoma

CONTINUATION – ewing's sarcoma

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

- ☐ No evidence of disease progression
- and
- ☐ The treatment remains appropriate and the patient is benefitting from treatment

Note: Indication marked with a * is an unapproved indication. Temozolomide is not funded for the treatment of relapsed high grade glioma.

I confirm that the above details are correct:

Signed: Date: