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: .....

Ipilimumab

INITIATION – renal cell carcinoma
Re-assessment required after 4 months
Prerequisites (tick boxes where appropriate)

- ○ The patient is currently on treatment with ipilimumab and met all remaining criteria prior to commencing treatment

or

- ○ The patient has metastatic renal cell carcinoma

and

- ○ The patient is treatment naive

and

- ○ The patient has ECOG performance status 0-2

and

- ○ The disease is predominantly of clear cell histology

and

- ○ The patient has sarcomatoid histology

or

- ○ Haemoglobin levels less than the lower limit of normal

or

- ○ Corrected serum calcium level greater than 10 mg/dL (2.5 mmol/L)

or

- ○ Neutrophils greater than the upper limit of normal

or

- ○ Platelets greater than the upper limit of normal

or

- ○ Interval of less than 1 year from original diagnosis to the start of systemic therapy

or

- ○ Karnofsky performance score of less than or equal to 70

and

- ○ Ipilimumab is to be used at a maximum dose of 1 mg/kg for up to four cycles in combination with nivolumab

I confirm that the above details are correct:

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