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: .....

Azacitidine

INITIATION
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ○ The individual has intermediate or high risk MDS based on an internationally recognised scoring system

or

- ○ The individual has chronic myelomonocytic leukaemia (based on an intermediate or high risk score from an internationally recognised scoring system or 10%-29% marrow blasts without myeloproliferative disorder)

or

- ○ The individual has acute myeloid leukaemia according to World Health Organisation (WHO) Classification

and

- ○ The individual has an estimated life expectancy of at least 3 months

CONTINUATION
Re-assessment required after 12 months
Prerequisites (tick box where appropriate)

- ○ No evidence of disease progression

I confirm that the above details are correct:

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