## 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.

PRES	SCRIB	ER			PATIENT:
Name	e:				Name:
Ward	:				NHI:
Ibrut	tinib				
Re-a	ssess	ment	required a	phocytic leukaemia (CLL) fter 6 months where appropriate)	
	(	therapy			
	and ( and	C	Individual h	nas not previously received funded ibrutinib	
	and	C	Ibrutinib is	to be used as monotherapy	
		or	and	There is documentation confirming that the individ	dual has 17p deletion or TP53 mutation
			O Individual has experienced intolerable side effe		s with venetoclax monotherapy
			and and	Individual has received at least one prior immuno Individual's CLL has relapsed	
		or	O Indiv	idual's CLL is refractory to or has relapsed followin	g a venetoclax regimen
Re-a	equisi	ment ites (	required a tick box wh	c lymphocytic leukaemia (CLL) fter 12 months aere appropriate) linical disease progression	
				c leukaemia (CLL)' includes small lymphocytic lymp cations marked with * are Unapproved indications.	homa (SLL) and B-cell prolymphocytic

I confirm that the above details are correct:		
Signed:	Date:	