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: .....

Aminolevulinic acid hydrochloride

INITIATION – high grade malignant glioma

Prerequisites (tick boxes where appropriate)

- ○ Patient has newly diagnosed, untreated, glioblastoma multiforme

and

- ○ Treatment to be used as adjuvant to fluorescence-guided resection

and

- ○ Patient's tumour is amenable to complete resection

I confirm that the above details are correct:

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