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: .....

Ruxolitinib

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

- ○ Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ○ The patient has primary myelofibrosis or post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis

and

- ○ A classification of risk of intermediate-2 or high-risk myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS

or

- ○ A classification of risk of intermediate-1 myelofibrosis according to either the International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or the Age-Adjusted DIPSS

and

- ○ Patient has severe disease-related symptoms that are resistant, refractory or intolerant to available therapy

and

- ○ A maximum dose of 20 mg twice daily is to be given

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

- ○ The treatment remains appropriate and the patient is benefiting from treatment

and

- ○ A maximum dose of 20 mg twice daily is to be given

I confirm that the above details are correct:

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