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: .....

Pegaspargase

INITIATION – Newly diagnosed ALL
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ○ The patient has newly diagnosed acute lymphoblastic leukaemia

and

- ○ Pegaspargase to be used with a contemporary intensive multi-agent chemotherapy treatment protocol

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

- ○ The patient has relapsed acute lymphoblastic leukaemia

and

- ○ Pegaspargase to be used with a contemporary intensive multi-agent chemotherapy treatment protocol

INITIATION – Lymphoma
Re-assessment required after 12 months
Prerequisites (tick box where appropriate)

- ○ Patient has lymphoma requiring L-asparaginase containing protocol (e.g. SMILE)

I confirm that the above details are correct:

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