

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: .....

**Midostaurin**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

- ☐ Patient has a diagnosis of acute myeloid leukaemia
- and
- ☐ Condition must be FMS tyrosine kinase 3 (FLT3) mutation positive
- and
- ☐ Patient must not have received a prior line of intensive chemotherapy for acute myeloid leukaemia
- and
- ☐ Patient is to receive standard intensive chemotherapy in combination with midostaurin only
- and
- ☐ Midostaurin to be funded for a maximum of 4 cycles

I confirm that the above details are correct:

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