HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

August 2025

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.

Schedule. For community funding, see the Special Authority Criteria.	
PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Lenalidomide	
INITIATION – Plasma cell dyscrasia Prerequisites (tick boxes where appropriate)	
O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	
Patient has plasma cell dyscrasia, not including Waldenström and Patient is not refractory to prior lenalidomide use	macroglobulinaemia, requiring treatment
Patient is not retractory to prior lenandomide use	
INITIATION – Myelodysplastic syndrome Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) Or Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.	
Patient has low or intermediate-1 risk myelodysplastic syndror a deletion 5q cytogenetic abnormality and Patient has transfusion-dependent anaemia	me (based on IPSS or an IPSS-R score of less than 3.5) associated with
CONTINUATION – Myelodysplastic syndrome Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	ccordance with a protocol or guideline that has been endorsed by the Health
Patient has not needed a transfusion in the last 4 months	
O No evidence of disease progression	

I confirm that the above details are correct:

Signed: Date: