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		PATIENT:
Name:		Name:
Ward:		NHI:
Ibrutinib		
INITIATION – chronic lyn Re-assessment required a Prerequisites (tick boxes Individual and Individual brutinib is and or or or or or	where appropriate) has chronic lymphocytic leukaemia (CLL) requiring has not previously received funded ibrutinib to be used as monotherapy There is documentation confirming that the individual has experienced intolerable side effects Individual has received at least one prior immunod Individual's CLL has relapsed	dual has 17p deletion or TP53 mutation s with venetoclax monotherapy chemotherapy for CLL s with venetoclax in combination with rituximab regimen
Re-assessment required a Prerequisites (tick box wh		
	tic leukaemia (CLL)' includes small lymphocytic lympl cations marked with * are Unapproved indications.	homa (SLL) and B-cell prolymphocytic

I confirm that the above details are correct:	
Signed:	Date: