

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: .....

**Venetoclax**

**INITIATION – relapsed/refractory chronic lymphocytic leukaemia**

Re-assessment required after 7 months

**Prerequisites** (tick boxes where appropriate)

- ☐ Individual has chronic lymphocytic leukaemia requiring treatment  
**and**  
☐ Individual has received at least one prior therapy for chronic lymphocytic leukaemia  
**and**  
☐ Individual has not previously received funded venetoclax  
**and**  
☐ The individual's disease has relapsed  
**and**  
☐ Venetoclax to be used in combination with six 28-day cycles of rituximab commencing after the 5-week dose titration schedule with venetoclax  
**and**  
☐ Individual has an ECOG performance status of 0-2

**CONTINUATION – relapsed/refractory chronic lymphocytic leukaemia**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- ☐ Treatment remains clinically appropriate and the individual is benefitting from and tolerating treatment  
**and**  
☐ Venetoclax is to be discontinued after a maximum of 24 months of treatment following the titration schedule unless earlier discontinuation is required due to disease progression or unacceptable toxicity

**INITIATION – previously untreated chronic lymphocytic leukaemia with 17p deletion or TP53 mutation\***

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- ☐ Individual has previously untreated chronic lymphocytic leukaemia  
**and**  
☐ There is documentation confirming that the individual has 17p deletion by FISH testing or TP53 mutation by sequencing  
**and**  
☐ Individual has an ECOG performance status of 0-2

**CONTINUATION – previously untreated chronic lymphocytic leukaemia with 17p deletion or TP53 mutation\***

Re-assessment required after 6 months

**Prerequisites** (tick box where appropriate)

- ☐ No evidence of disease progression

Note: 'Chronic lymphocytic leukaemia (CLL)\*' includes small lymphocytic lymphoma (SLL)\* and B-cell prolymphocytic leukaemia (B-PLL)\*. Indications marked with \* are unapproved indications

I confirm that the above details are correct:

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

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**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

**Venetoclax** - *continued*

**INITIATION – previously untreated acute myeloid leukaemia**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- ☐ The individual is currently on treatment with venetoclax and met all remaining special authority criteria prior to commencing treatment
- or
- ☐ Individual has previously untreated acute myeloid leukaemia (see note a), according to World Health Organization (WHO) Classification
- and
- ☐ Venetoclax not to be used in combination with standard intensive remission induction chemotherapy
- and
- ☐ Venetoclax to be used in combination with azacitidine or low dose cytarabine

**CONTINUATION – previously untreated acute myeloid leukaemia**

Re-assessment required after 6 months

**Prerequisites** (tick box where appropriate)

- ☐ No evidence of disease progression

Note:

a) 'Acute myeloid leukaemia' includes myeloid sarcoma\*

b) Indications marked with \* are Unapproved indications

I confirm that the above details are correct:

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