

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:

Deferasirox**INITIATION**

Re-assessment required after 2 years

Prerequisites (tick boxes where appropriate)

- ☐ Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ☐ The patient has been diagnosed with chronic iron overload due to congenital inherited anaemia

and

- ☐ Deferasirox is to be given at a daily dose not exceeding 40 mg/kg/day

and

- ☐ Treatment with maximum tolerated doses of deferiprone monotherapy or deferiprone and desferrioxamine combination therapy have proven ineffective as measured by serum ferritin levels, liver or cardiac MRI T2*
- or
- ☐ Treatment with deferiprone has resulted in severe persistent vomiting or diarrhoea
- or
- ☐ Treatment with deferiprone has resulted in arthritis
- or
- ☐ Treatment with deferiprone is contraindicated due to a history of agranulocytosis (defined as an absolute neutrophil count (ANC) of < 0.5 cells per μ L) or recurrent episodes (greater than 2 episodes) of moderate neutropenia (ANC 0.5 - 1.0 cells per μ L)

CONTINUATION

Re-assessment required after 2 years

Prerequisites (tick boxes where appropriate)

- ☐ Prescribed by, or recommended by a haematologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ☐ For the first renewal following 2 years of therapy, the treatment has been tolerated and has resulted in clinical improvement in all three parameters namely serum ferritin, cardiac MRI T2* and liver MRI T2* levels

or

- ☐ For subsequent renewals, the treatment has been tolerated and has resulted in clinical stability or continued improvement in all three parameters namely serum ferritin, cardiac MRI T2* and liver MRI T2* levels.

I confirm that the above details are correct:

Signed: Date: