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: ....

Temozolomide

INITIATION – gliomas
Re-assessment required after 12 months
Prerequisites (tick box where appropriate)

◯ Patient has a glioma

CONTINUATION – gliomas
Re-assessment required after 12 months
Prerequisites (tick box where appropriate)

◯ Treatment remains appropriate and patient is benefitting from treatment

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INITIATION – Neuroendocrine tumours
Re-assessment required after 9 months
Prerequisites (tick boxes where appropriate)

◯ Patient has been diagnosed with metastatic or unresectable well-differentiated neuroendocrine tumour*
and
◯ Temozolomide is to be given in combination with capecitabine
and
◯ Temozolomide is to be used in 28 day treatment cycles for a maximum of 5 days treatment per cycle at a maximum dose of 200 mg/m^2 per day
and
◯ Temozolomide to be discontinued at disease progression

CONTINUATION – Neuroendocrine tumours
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

◯ No evidence of disease progression
and
◯ The treatment remains appropriate and the patient is benefitting from treatment

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INITIATION – ewing's sarcoma
Re-assessment required after 9 months
Prerequisites (tick box where appropriate)

◯ Patient has relapse or refractory Ewing's sarcoma

CONTINUATION – ewing's sarcoma
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

◯ No evidence of disease progression
and
◯ The treatment remains appropriate and the patient is benefitting from treatment

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Note: Indication marked with a * is an unapproved indication. Temozolomide is not funded for the treatment of relapsed high grade glioma.

I confirm that the above details are correct:

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