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.

PRES	SCRIBER	PATIENT:			
Name	Σ	Name:			
Ward		NHI:			
Pom	alidomide				
1	ATION – Relapsed/refractory plasma cell dyscrasia ssessment required after 6 months				
Prerequisites (tick boxes where appropriate)					
and	O Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by NZ Hospital.				
	Patient has relapsed or refractory plasma cell dyscrasia, not in and Patient has not received prior funded pomalidomide	cluding Waldenström macroglobulinaemia, requiring treatment			
	T attent has not received prior funded pornaidonnide				
CONTINUATION – Relapsed/refractory plasma cell dyscrasia Re-assessment required after 12 months					
Prer	equisites (tick box where appropriate)				
ond (Prescribed by, or recommended by any relevant practitioner, or in ac NZ Hospital.	cordance with a protocol or guideline that has been endorsed by the Health			
and (Patient has no evidence of disease progression				

I confirm that the above details are correct:

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