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: |
| Azacitidine | |
| INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) | |
| The individual has intermediate or high risk MDS based The individual has chronic myelomonocytic leukaemia (by recognised scoring system or 10%-29% marrow blasts where the individual has acute myeloid leukaemia according to and The individual has an estimated life expectancy of at least 3 methods. | passed on an intermediate or high risk score from an internationally without myeloproliferative disorder) De World Health Organisation (WHO) Classification |
| CONTINUATION Re-assessment required after 12 months Prerequisites (tick box where appropriate) O No evidence of disease progression | |

Signed: Date: