

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:

Dexrazoxane

INITIATION

Prerequisites (tick boxes where appropriate)

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

and

- ☐ Patient is to receive treatment with high dose anthracycline given with curative intent

and

- ☐ Based on current treatment plan, patient's cumulative lifetime dose of anthracycline will exceed 250mg/m² doxorubicin equivalent or greater

and

- ☐ Dexrazoxane to be administered only whilst on anthracycline treatment

and

- ☐ Treatment to be used as a cardioprotectant for a child or young adult
or
☐ Treatment to be used as a cardioprotectant for secondary malignancy

I confirm that the above details are correct:

Signed: Date: