

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: ..... Name: .....

Ward: ..... 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/m<sup>2</sup> 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: .....