

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: .....

**Gemtuzumab ozogamicin**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

- ☐ Patient has not received prior chemotherapy for this condition  
**and**  
☐ Patient has de novo CD33-positive acute myeloid leukaemia  
**and**  
☐ Patient does not have acute promyelocytic leukaemia  
**and**  
☐ Gemtuzumab ozogamicin will be used in combination with standard anthracycline and cytarabine (AraC)  
**and**  
☐ Patient is being treated with curative intent  
**and**  
☐ Patient's disease risk has been assessed by cytogenetic testing to be good or intermediate  
**and**  
☐ Patient must be considered eligible for standard intensive remission induction chemotherapy with standard anthracycline and cytarabine (AraC)  
**and**  
☐ Gemtuzumab ozogamicin to be funded for one course only (one dose at 3 mg per m<sup>2</sup> body surface area or up to 2 vials of 5 mg as separate doses)

Note: Acute myeloid leukaemia excludes acute promyelocytic leukaemia and acute myeloid leukaemia that is secondary to another haematological disorder (eg myelodysplasia or myeloproliferative disorder).

I confirm that the above details are correct:

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