

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:

Pomalidomide

INITIATION – Relapsed/refractory plasma cell dyscrasia

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

- ☐ Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ☐ Patient has relapsed or refractory plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment
- ☐ Patient has not received prior funded pomalidomide

CONTINUATION – Relapsed/refractory plasma cell dyscrasia

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

- ☐ Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ☐ Patient has no evidence of disease progression

I confirm that the above details are correct:

Signed: Date: