

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: NHI:

Azacitidine

INITIATION

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

or The individual has intermediate or high risk MDS based on an internationally recognised scoring system

or The individual has chronic myelomonocytic leukaemia (based on an intermediate or high risk score from an internationally recognised scoring system or 10%-29% marrow blasts without myeloproliferative disorder)

and The individual has acute myeloid leukaemia according to World Health Organisation (WHO) Classification

The individual has an estimated life expectancy of at least 3 months

CONTINUATION

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

No evidence of disease progression

I confirm that the above details are correct:

Signed: Date: