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: .....

Ibrutinib

INITIATION – chronic lymphocytic leukaemia (CLL)
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

- ○ Individual has chronic lymphocytic leukaemia (CLL) requiring therapy

and

- ○ Individual has not previously received funded ibrutinib

and

- ○ Ibrutinib is to be used as monotherapy

and

- ○ There is documentation confirming that the individual has 17p deletion or TP53 mutation

  and

  ○ Individual has experienced intolerable side effects with venetoclax monotherapy

or

- ○ Individual has received at least one prior immunochemotherapy for CLL

  and

  ○ Individual's CLL has relapsed

  and

  ○ Individual has experienced intolerable side effects with venetoclax in combination with rituximab regimen

or

- ○ Individual's CLL is refractory to or has relapsed following a venetoclax regimen

CONTINUATION – chronic lymphocytic leukaemia (CLL)
Re-assessment required after 12 months
Prerequisites (tick box where appropriate)

- ○ No evidence of clinical disease progression

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) and B-cell prolymphocytic leukaemia (B-PLL)*. Indications marked with * are Unapproved indications.

I confirm that the above details are correct:

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