

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:

Aminolevulinic acid hydrochloride

INITIATION – high grade malignant glioma

Prerequisites (tick boxes where appropriate)

- ☐ Patient has newly diagnosed, untreated, glioblastoma multiforme
and
☐ Treatment to be used as adjuvant to fluorescence-guided resection
and
☐ Patient's tumour is amenable to complete resection

I confirm that the above details are correct:

Signed: Date: