

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: .....

**Nilotinib**

**INITIATION**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

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

and

- Patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis, high risk chronic phase, or in chronic phase

and

- Patient has documented CML treatment failure\* with a tyrosine kinase inhibitor (TKI)  
or  
 Patient has experienced treatment limiting toxicity with a tyrosine kinase inhibitor (TKI) precluding further treatment

and

- Maximum nilotinib dose of 800 mg/day

and

- Subsidised for use as monotherapy only

Note: \*treatment failure as defined by Leukaemia Net Guidelines.

**CONTINUATION**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

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

and

- Lack of treatment failure while on nilotinib as defined by Leukaemia Net Guidelines

and

- Nilotinib treatment remains appropriate and the patient is benefiting from treatment

and

- Maximum nilotinib dose of 800 mg/day

and

- Subsidised for use as monotherapy only

I confirm that the above details are correct:

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