HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

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: .....

Midostaurin

INITIATION

Prerequisites (tick boxes where appropriate)

- ○ Patient has a diagnosis of acute myeloid leukaemia

and

- ○ Condition must be FMS tyrosine kinase 3 (FLT3) mutation positive

and

- ○ Patient must not have received a prior line of intensive chemotherapy for acute myeloid leukaemia

and

- ○ Patient is to receive standard intensive chemotherapy in combination with midostaurin only

and

- ○ Midostaurin to be funded for a maximum of 4 cycles

I confirm that the above details are correct:

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