

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**

**PATIENT:**

Name: .....

Name: .....

Ward: .....

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: .....