

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: .....

**Gemtuzumab ozogamicin**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

- Patient has not received prior chemotherapy for this condition
- and  Patient has de novo CD33-positive acute myeloid leukaemia
- and  Patient does not have acute promyelocytic leukaemia
- and  Gemtuzumab ozogamicin will be used in combination with standard anthracycline and cytarabine (AraC)
- and  Patient is being treated with curative intent
- and  Patient's disease risk has been assessed by cytogenetic testing to be good or intermediate
- and  Patient must be considered eligible for standard intensive remission induction chemotherapy with standard anthracycline and cytarabine (AraC)
- and  Gemtuzumab ozogamicin to be funded for one course only (one dose at 3 mg per m<sup>2</sup> body surface area or up to 2 vials of 5 mg as separate doses)

Note: Acute myeloid leukaemia excludes acute promyelocytic leukaemia and acute myeloid leukaemia that is secondary to another haematological disorder (eg myelodysplasia or myeloproliferative disorder).

I confirm that the above details are correct:

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