

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: .....

**Pomalidomide**

**INITIATION – Relapsed/refractory plasma cell dyscrasia**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

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

and

- Patient has relapsed or refractory plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment
- and
- Patient has not received prior funded pomalidomide

**CONTINUATION – Relapsed/refractory plasma cell dyscrasia**

Re-assessment required after 12 months

**Prerequisites** (tick box where appropriate)

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

and

- Patient has no evidence of disease progression

I confirm that the above details are correct:

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