

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:

Azacitidine

INITIATION

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

- The individual has intermediate or high risk MDS based on an internationally recognised scoring system
- or
- The individual has chronic myelomonocytic leukaemia (based on an intermediate or high risk score from an internationally recognised scoring system or 10%-29% marrow blasts without myeloproliferative disorder)
- or
- The individual has acute myeloid leukaemia according to World Health Organisation (WHO) Classification

and

- The individual has an estimated life expectancy of at least 3 months

CONTINUATION

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

- No evidence of disease progression

I confirm that the above details are correct:

Signed: Date: