

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: .....

Ward: ..... NHI: .....

**Plerixafor**

**INITIATION – Stem cell transplant**

Re-assessment required after 3 days

**Prerequisites** (tick boxes where appropriate)

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

and

Patient is to undergo stem cell transplantation

or

Patient is a donor for stem cell transplantation

and

Patient has not had more than one previous unsuccessful mobilisation attempt with plerixafor

and

Patient is undergoing G-CSF mobilisation

and

Has a suboptimal peripheral blood CD34 count of less than or equal to  $20 \times 10^6/L$  on day 5 after 4 days of G-CSF treatment

or

Efforts to collect  $> 1 \times 10^6$  CD34 cells/kg have failed after one apheresis procedure

or

Patient is undergoing chemotherapy and G-CSF mobilisation

and

Has rising white blood cell counts of  $> 2 \times 10^9/L$

and

Has a suboptimal peripheral blood CD34 count of less than or equal to  $20 \times 10^6/L$

or

Efforts to collect  $> 1 \times 10^6$  CD34 cells/kg have failed after one apheresis procedure

or

The peripheral blood CD34 cell counts are decreasing before the target has been received

or

A previous mobilisation attempt with G-CSF or G-CSF plus chemotherapy has failed

I confirm that the above details are correct:

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