

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: .....

**Nilotinib**

**INITIATION**

Re-assessment required after 6 months

**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 has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis, high risk chronic phase, or in chronic phase

and

Patient has documented CML treatment failure\* with a tyrosine kinase inhibitor (TKI)

or

Patient has experienced treatment limiting toxicity with a tyrosine kinase inhibitor (TKI) precluding further treatment

and

Maximum nilotinib dose of 800 mg/day

and

Subsidised for use as monotherapy only

Note: \*treatment failure as defined by Leukaemia Net Guidelines.

**CONTINUATION**

Re-assessment required after 6 months

**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

Lack of treatment failure while on nilotinib as defined by Leukaemia Net Guidelines

and

Nilotinib treatment remains appropriate and the patient is benefiting from treatment

and

Maximum nilotinib dose of 800 mg/day

and

Subsidised for use as monotherapy only

I confirm that the above details are correct:

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