

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: .....

**Inotuzumab ozogamicin**

**INITIATION**

Re-assessment required after 4 months

**Prerequisites** (tick boxes where appropriate)

- Patient has relapsed or refractory CD22-positive B-cell acute lymphoblastic leukaemia/lymphoma, including minimal residual disease
- and  Patient has ECOG performance status of 0-2
- and
  - Patient has Philadelphia chromosome positive B-Cell ALL
  - and  Patient has previously received a tyrosine kinase inhibitor
- or  Patient has received one prior line of treatment involving intensive chemotherapy
- and  Treatment is to be administered for a maximum of 3 cycles

**CONTINUATION**

Re-assessment required after 4 months

**Prerequisites** (tick boxes where appropriate)

- Patient is not proceeding to a stem cell transplant
- and
  - Patient has experienced complete disease response
  - or  Patient has experienced complete remission with incomplete haematological recovery
- and  Treatment with inotuzumab ozogamicin is to cease after a total duration of 6 cycles

I confirm that the above details are correct:

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