

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: .....

**Bortezomib**

**INITIATION – plasma cell dyscrasia**

Prerequisites (tick box where appropriate)

- The patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment

**INITIATION – Waldenström Macroglobulinaemia**

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

- The patient has Waldenström Macroglobulinaemia/Lymphoplasmacytic Lymphoma requiring treatment  
**and**  
 The patient has not received prior bortezomib treatment

**CONTINUATION – Waldenström Macroglobulinaemia**

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

- Patient has no evidence of clinical disease progression during bortezomib use

I confirm that the above details are correct:

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