

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: .....

**Ibrutinib**

**INITIATION – previously untreated chronic lymphocytic leukaemia in combination with venetoclax**

**Prerequisites** (tick boxes where appropriate)

- Individual is currently on treatment with ibrutinib and/or venetoclax and met all of the following criteria prior to commencing treatment
- or
- Individual has previously untreated CLL
- and
- Ibrutinib is to be administered at a maximum dose of 420 mg daily for 3 (28 day) cycles as monotherapy, followed by a maximum of 12 (28 day) cycles in combination with venetoclax

**INITIATION – chronic lymphocytic leukaemia (CLL)**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- Individual has chronic lymphocytic leukaemia (CLL) requiring therapy
- and
- Ibrutinib is to be used as monotherapy
- and
- Individual has experienced intolerable side effects, or their disease has relapsed or is refractory following at least one prior line of therapy
- and
- Individual has not received ibrutinib monotherapy previously

**CONTINUATION – chronic lymphocytic leukaemia (CLL)**

Re-assessment required after 12 months

**Prerequisites** (tick box where appropriate)

- No evidence of clinical disease progression

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) and B-cell prolymphocytic leukaemia (B-PLL)\*. Indications marked with \* are Unapproved indications.

I confirm that the above details are correct:

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