HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

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: .....

Temozolomide

INITIATION – gliomas
Re-assessment required after 12 months
Prerequisites (tick box where appropriate)

- ○ Patient has a glioma

CONTINUATION – gliomas
Re-assessment required after 12 months
Prerequisites (tick box where appropriate)

- ○ Treatment remains appropriate and patient is benefitting from treatment

INITIATION – Neuroendocrine tumours
Re-assessment required after 9 months
Prerequisites (tick boxes where appropriate)

- ○ Patient has been diagnosed with metastatic or unresectable well-differentiated neuroendocrine tumour

and

- ○ Temozolomide is to be given in combination with capecitabine

and

- ○ Temozolomide is to be used in 28 day treatment cycles for a maximum of 5 days treatment per cycle at a maximum dose of 200 mg/m^2 per day

and

- ○ Temozolomide to be discontinued at disease progression

CONTINUATION – Neuroendocrine tumours
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

- ○ No evidence of disease progression

and

- ○ The treatment remains appropriate and the patient is benefitting from treatment

INITIATION – ewing's sarcoma
Re-assessment required after 9 months
Prerequisites (tick box where appropriate)

- ○ Patient has relapse or refractory Ewing's sarcoma

CONTINUATION – ewing's sarcoma
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

- ○ No evidence of disease progression

and

- ○ The treatment remains appropriate and the patient is benefitting from treatment

INITIATION – Neuroblastoma
Re-assessment required after 12 months
Prerequisites (tick box where appropriate)

- ○ Patient has neuroblastoma

I confirm that the above details are correct:

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

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PRESCRIBER

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Temozolomide *- continued*

CONTINUATION – Neuroblastoma
Re-assessment required after 12 months
Prerequisites (tick box where appropriate)

- ○ Patient has no evidence of disease progression

I confirm that the above details are correct:

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