

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: