

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:

Pegaspargase

INITIATION – Newly diagnosed ALL

Re-assessment required after 15 months

Prerequisites (tick boxes where appropriate)

- ☐ The patient has newly diagnosed acute lymphoblastic leukaemia
and
☐ Pegaspargase to be used with a contemporary intensive multi-agent chemotherapy treatment protocol

INITIATION – Relapsed ALL

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

- ☐ The patient has relapsed acute lymphoblastic leukaemia
and
☐ Pegaspargase to be used with a contemporary intensive multi-agent chemotherapy treatment protocol

INITIATION – Lymphoma

Re-assessment required after 12 months

Prerequisites (tick box where appropriate)

- ☐ Patient has lymphoma requiring L-asparaginase containing protocol (e.g. SMILE)

I confirm that the above details are correct:

Signed: Date: