

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/m² 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: