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: .....

Alectinib

INITIATION
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

- ○ Patient has locally advanced, or metastatic, unresectable, non-small cell lung cancer

and

- ○ There is documentation confirming that the patient has an ALK tyrosine kinase gene rearrangement using an appropriate ALK test

and

- ○ Patient has an ECOG performance score of 0-2

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

- ○ No evidence of progressive disease according to RECIST criteria

and

- ○ The patient is benefitting from and tolerating treatment

I confirm that the above details are correct:

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