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: .....

Gefitinib

INITIATION
Re-assessment required after 4 months
Prerequisites (tick boxes where appropriate)

- ○ Patient has locally advanced, or metastatic, unresectable, non-squamous Non Small Cell Lung Cancer (NSCLC)

and

- ○ Patient is treatment naive

or

- ○ The patient has discontinued erlotinib due to intolerance

and

- ○ The cancer did not progress whilst on erlotinib

and

- ○ There is documentation confirming that disease expresses activating mutations of EGFR tyrosine kinase

and

- ○ Gefitinib is to be given for a maximum of 3 months

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

- ○ Radiological assessment (preferably including CT scan) indicates NSCLC has not progressed

and

- ○ Gefitinib is to be given for a maximum of 3 months

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

- ○ The patient is clinically benefiting from treatment and continued treatment remains appropriate

and

- ○ Gefitinib to be discontinued at progression

and

- ○ The regular renewal requirements cannot be met due to COVID-19 constraints on the health sector

I confirm that the above details are correct:

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