

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: .....

**Cetuximab**

**INITIATION – head and neck cancer, locally advanced**

Prerequisites (tick boxes where appropriate)

- Patient has locally advanced, non-metastatic, squamous cell cancer of the head and neck
- and  Cisplatin is contraindicated or has resulted in intolerable side effects
- and  Patient has an ECOG performance score of 0-2
- and  To be administered in combination with radiation therapy

**INITIATION – colorectal cancer, metastatic**

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

- Patient has metastatic colorectal cancer located on the left side of the colon (see Note)
- and  There is documentation confirming disease is RAS and BRAF wild-type
- and  Patient has an ECOG performance score of 0-2
- and  Patient has not received prior funded treatment with cetuximab
- and  Cetuximab is to be used in combination with chemotherapy
- or  Chemotherapy is determined to not be in the best interest of the patient based on clinician assessment

**CONTINUATION – colorectal cancer, metastatic**

Re-assessment required after 6 months

Prerequisites (tick box where appropriate)

- No evidence of disease progression

Note: Left-sided colorectal cancer comprises of the distal one-third of the transverse colon, the splenic flexure, the descending colon, the sigmoid colon, or the rectum.

I confirm that the above details are correct:

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