

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: .....

**Erlotinib**

**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

There is documentation confirming that the disease expresses activating mutations of EGFR

and

Patient is treatment naive

or

Patient has received prior treatment in the adjuvant setting and/or while awaiting EGFR results

or

The patient has discontinued osimertinib or gefitinib due to intolerance

and

The cancer did not progress while on osimertinib or gefitinib

**CONTINUATION**

Re-assessment required after 6 months

**Prerequisites** (tick box where appropriate)

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

I confirm that the above details are correct:

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