Form RS1887
July 2024

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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: ....

HOSPITAL