## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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	PATIENT:
Name:	Name:
Ward:	NHI:
Alectinib	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  O Patient has locally advanced, or metastatic, unresectable, nor and O There is documentation confirming that the patient has an AL and O Patient has an ECOG performance score of 0-2	n-small cell lung cancer K tyrosine kinase gene rearrangement using an appropriate ALK test
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  O No evidence of progressive disease according to RECIST crit and O The patient is benefitting from and tolerating treatment	eria

I confirm that the above details are correct:

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