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:  |
| Cetuximab           |  |   |
|                     | head and neck cancer, locally advanced (tick boxes where appropriate)  |   |
| and on and on and   | Patient has locally advanced, non-metastatic, squamous cell Cisplatin is contraindicated or has resulted in intolerable side Patient has an ECOG performance score of 0-2 To be administered in combination with radiation therapy   |   |
| Re-assessmer        | colorectal cancer, metastatic nt required after 6 months (tick boxes where appropriate)  Patient has metastatic colorectal cancer located on the left si There is documentation confirming disease is RAS and BRA Patient has an ECOG performance score of 0-2  Patient has not received prior funded treatment with cetuxima  Cetuximab is to be used in combination with chemother  Chemotherapy is determined to not be in the best inter | F wild-type ab  |
| Prerequisites  No e | ON – colorectal cancer, metastatic nt required after 6 months (tick box where appropriate) evidence of disease progression ed colorectal cancer comprises of the distal one-third of the tra   | ensverse colon, the splenic flexure, the descending colon, the sigmoid colon, |

I confirm that the above details are correct:

Signed: Date: