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: ....

Everolimus

INITIATION
Re-assessment required after 3 months
Prerequisites (tick boxes where appropriate)

○ Prescribed by, or recommended by a neurologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

> ○ Patient has tuberous sclerosis
>
> **and**
>
> ○ Patient has progressively enlarging sub-ependymal giant cell astrocytomas (SEGAs) that require treatment

CONTINUATION
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

○ Prescribed by, or recommended by a neurologist or oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

> ○ Documented evidence of SEGA reduction or stabilisation by MRI within the last 3 months
>
> **and**
>
> ○ The treatment remains appropriate and the patient is benefiting from treatment
>
> **and**
>
> ○ Everolimus to be discontinued at progression of SEGAs

INITIATION – renal cell carcinoma
Re-assessment required after 4 months
Prerequisites (tick boxes where appropriate)

> ○ The patient has metastatic renal cell carcinoma
>
> **and**
>
> ○ The disease is of predominant clear-cell histology
>
> **and**
>
> ○ The patient has documented disease progression following one previous line of treatment
>
> **and**
>
> ○ The patient has an ECOG performance status of 0-2
>
> **and**
>
> ○ Everolimus is to be used in combination with lenvatinib

or

> ○ Patient has received funded treatment with nivolumab for the second line treatment of metastatic renal cell carcinoma
>
> **and**
>
> ○ Patient has experienced treatment limiting toxicity from treatment with nivolumab
>
> **and**
>
> ○ Everolimus is to be used in combination with lenvatinib
>
> **and**
>
> ○ There is no evidence of disease progression

CONTINUATION – renal cell carcinoma
Re-assessment required after 4 months
Prerequisites (tick box where appropriate)

○ There is no evidence of disease progression

I confirm that the above details are correct:

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