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: .....

## Niraparib

**INITIATION**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ Patient has advanced high-grade serous* epithelial ovarian, fallopian tube, or primary peritoneal cancer

**and**

- ○ Patient has received at least one line** of treatment with platinum-based chemotherapy

**and**

- ○ Patient has experienced a partial or complete response to the preceding treatment with platinum-based chemotherapy

**and**

- ○ Patient has not previously received funded treatment with a PARP inhibitor

**and**

- ○ Treatment will be commenced within 12 weeks of the patient's last dose of the preceding platinum-based regimen

**or**

- ○ Patient commenced treatment with niraparib prior to 1 May 2024

**and**

- ○ Treatment to be administered as maintenance treatment

**and**

- ○ Treatment not to be administered in combination with other chemotherapy

**CONTINUATION**
Re-assessment required after 6 months
**Prerequisites** (tick boxes where appropriate)

- ○ No evidence of progressive disease

**and**

- ○ Treatment to be administered as maintenance treatment

**and**

- ○ Treatment not to be administered in combination with other chemotherapy

**and**

- ○ Treatment with niraparib to cease after a total duration of 36 months from commencement

**or**

- ○ Treatment with niraparib is being used in the second-line or later maintenance setting

Note: * "high-grade serous" includes tumours with high-grade serous features or a high-grade serous component.
**A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments



I confirm that the above details are correct:

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