# 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**

- ○ Patient has received prior treatment in the adjuvant setting and/or while awaiting EGFR results

**or**

- ○ The patient has discontinued osimertinib or erlotinib due to intolerance

**and**

- ○ The cancer did not progress whilst on osimertinib or erlotinib

**and**

- ○ There is documentation confirming that disease expresses activating mutations of EGFR

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

- ○ Radiological assessment (preferably including CT scan) indicates NSCLC has not progressed



I confirm that the above details are correct:

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