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: ....

Pazopanib

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

- ◯ The patient has metastatic renal cell carcinoma of predominantly clear cell histology
- **and**
  - ◯ The patient is treatment naive
  - **or**
  - ◯ The patient has only received prior cytokine treatment
- **and**
- ◯ The patient has an ECOG performance score of 0-2
- **and**
- **The patient has intermediate or poor prognosis defined as:**
  - ◯ Lactate dehydrogenase level > 1.5 times upper limit of normal
  - **or**
  - ◯ Haemoglobin level < lower limit of normal
  - **or**
  - ◯ Corrected serum calcium level > 10 mg/dL (2.5 mmol/L)
  - **or**
  - ◯ Interval of < 1 year from original diagnosis to the start of systemic therapy
  - **or**
  - ◯ Karnofsky performance score of less than or equal to 70
  - **or**
  - ◯ 2 or more sites of organ metastasis

or

- ◯ The patient has metastatic renal cell carcinoma
- **and**
- ◯ The patient has discontinued sunitinib within 3 months of starting treatment due to intolerance
- **and**
- ◯ The cancer did not progress whilst on sunitinib
- **and**
- ◯ Pazopanib to be used for a maximum of 3 months

CONTINUATION
Re-assessment required after 3 months
Prerequisites (tick box where appropriate)

- ◯ No evidence of disease progression

HOSPITAL

I confirm that the above details are correct:

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