

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: .....