Form RS2079
April 2025

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: ....

HOSPITAL