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.

PRESC	RIBER	PATIENT:
Name:		Name:
Ward:		NHI:
. .		

Olaparib

		~		_					
			arian cancer equired after 12 months						
Flelequ	Prerequisites (tick boxes where appropriate)								
and		scribe spital.	bed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health N	Z					
	C	Pat	atient has a high-grade serous* epithelial ovarian, fallopian tube, or primary peritoneal cancer						
a	$\overset{C}{{}_{nd}}$	The	nere is documentation confirming pathogenic germline BRCA1 or BRCA2 gene mutation						
			O Patient has newly diagnosed, advanced disease						
			O Patient has received one line** of previous treatment with platinum-based chemotherapy and						
			O Patient's disease must have experienced a partial or complete response to the first-line platinum-based regimen						
	c	or _							
		a	O Patient has received at least two lines** of previous treatment with platinum-based chemotherapy and						
			O Patient has platinum sensitive disease defined as disease progression occurring at least 6 months after the last dose of the penultimate line** of platinum-based chemotherapy						
		8	and O Patient's disease must have experienced a partial or complete response to treatment with the immediately preceding						
			platinum-based regimen						
		ſ	And O Patient has not previously received funded olaparib treatment						
a	nd)					
	С nd	Tre	eatment will be commenced within 12 weeks of the patient's last dose of the immediately preceding platinum-based regimen						
u.	С	Tre	eatment to be administered as maintenance treatment						
a	nd_{\frown}								
	C	Tre	eatment not to be administered in combination with other chemotherapy	,					

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PRESCRIBER			PATIENT:
Name	:		Name:
Ward:			NHI:
Olapa	arib	- co	ntinued
Re-as Prere	ssessi equisi	men i tes	N – Ovarian cancer t required after 12 months (tick boxes where appropriate) ribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ ital.
and	(and	С	Treatment remains clinically appropriate and patient is benefitting from treatment
		or	 No evidence of progressive disease Evidence of residual (not progressive) disease and the patient would continue to benefit from treatment in the clinician's opinion
	and and (and	С С	Treatment to be administered as maintenance treatment Treatment not to be administered in combination with other chemotherapy
		or	 Patient has received one line** of previous treatment with platinum-based chemotherapy Documentation confirming that the patient has been informed and acknowledges that the funded treatment period of olaparib will not be continued beyond 2 years if the patient experiences a complete response to treatment and there is no radiological evidence of disease at 2 years
		or	O Patient has received at least two lines** of previous treatment with platinum-based chemotherapy

Note: *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.