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: .....

## Cetuximab

**INITIATION – head and neck cancer, locally advanced**

**Prerequisites** (tick boxes where appropriate)

- ○ Patient has locally advanced, non-metastatic, squamous cell cancer of the head and neck

**and**

- ○ Cisplatin is contraindicated or has resulted in intolerable side effects

**and**

- ○ Patient has an ECOG performance score of 0-2

**and**

- ○ To be administered in combination with radiation therapy

**INITIATION – colorectal cancer, metastatic**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- ○ Patient has metastatic colorectal cancer located on the left side of the colon (see Note)

**and**

- ○ There is documentation confirming disease is RAS and BRAF wild-type

**and**

- ○ Patient has an ECOG performance score of 0-2

**and**

- ○ Patient has not received prior funded treatment with cetuximab

**and**

- ○ Cetuximab is to be used in combination with chemotherapy

**or**

- ○ Chemotherapy is determined to not be in the best interest of the patient based on clinician assessment

**CONTINUATION – colorectal cancer, metastatic**

Re-assessment required after 6 months

**Prerequisites** (tick box where appropriate)

- ○ No evidence of disease progression

Note: Left-sided colorectal cancer comprises of the distal one-third of the transverse colon, the splenic flexure, the descending colon, the sigmoid colon, or the rectum.



I confirm that the above details are correct:

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