

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:

Erlotinib

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
☐ There is documentation confirming that the disease expresses activating mutations of EGFR
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 gefitinib due to intolerance
and
☐ The cancer did not progress while on osimertinib or gefitinib

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: