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	PATIENT:
Name:	Name:
Ward:	NHI:
Gefitinib	
INITIATION Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) O Patient has locally advanced, or metastatic, unresectable, non and	n-squamous Non Small Cell Lung Cancer (NSCLC)
O Patient is treatment naive Or Patient has received prior treatment in the adjuvant settion Or The patient has discontinued osimertinib or erlotine and Or The cancer did not progress whilst on osimertinib	hib due to intolerance
There is documentation confirming that disease expresses act	tivating mutations of EGFR
CONTINUATION Re-assessment required after 6 months Prerequisites (tick box where appropriate) Continuation Re-assessment (preferably including CT scan) indicates Note that the continuation is a second of the continuation of t	SCLC has not progressed

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