

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: .....

**Pazopanib**

**INITIATION**

Re-assessment required after 3 months

**Prerequisites** (tick boxes where appropriate)

☐ The patient has metastatic renal cell carcinoma of predominantly clear cell histology  
**and**

- ☐ The patient is treatment naive  
**or**  
☐ The patient has only received prior cytokine treatment

**and**  
☐ The patient has an ECOG performance score of 0-2  
**and**

**The patient has intermediate or poor prognosis defined as:**

- ☐ Lactate dehydrogenase level > 1.5 times upper limit of normal  
**or**  
☐ Haemoglobin level < lower limit of normal  
**or**  
☐ Corrected serum calcium level > 10 mg/dL (2.5 mmol/L)  
**or**  
☐ Interval of < 1 year from original diagnosis to the start of systemic therapy  
**or**  
☐ Karnofsky performance score of less than or equal to 70  
**or**  
☐ 2 or more sites of organ metastasis

**or**

- ☐ The patient has metastatic renal cell carcinoma  
**and**  
☐ The patient has discontinued sunitinib within 3 months of starting treatment due to intolerance  
**and**  
☐ The cancer did not progress whilst on sunitinib  
**and**  
☐ Pazopanib to be used for a maximum of 3 months

**CONTINUATION**

Re-assessment required after 3 months

**Prerequisites** (tick box where appropriate)

- ☐ No evidence of disease progression

I confirm that the above details are correct:

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