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

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Axitinib

INITIATION
Re-assessment required after 4 months
Prerequisites (tick boxes where appropriate)

- ○ The patient has metastatic renal cell carcinoma

and

- ○ The disease is of predominant clear cell histology

and

- ○ The patient has documented disease progression following one previous line of treatment

and

- ○ The patient has ECOG performance status of 0-2

CONTINUATION
Re-assessment required after 4 months
Prerequisites (tick box where appropriate)

- ○ No evidence of disease progression.

HOSPITAL

I confirm that the above details are correct:

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