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:
Crizotinib	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate) O Patient has locally advanced or metastatic, unresectable, non-and O There is documentation confirming that the patient has a ROS and O Patient has ECOG performance score of 0-3 and O Baseline measurement of overall tumour burden is documented.	rearrangement using an appropriate ROS1 test
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
Response to treatment has been determined by comparable rained. No evidence of disease progression.	adiological assessment following the most recent treatment period

C:	D-1	
Signed.	Date:	
Oigilica.	 Duic.	