

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:

Alectinib

INITIATION

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

- ☐ Patient has locally advanced, or metastatic, unresectable, non-small cell lung cancer
and ☐ There is documentation confirming that the patient has an ALK tyrosine kinase gene rearrangement using an appropriate ALK test
and ☐ Patient has an ECOG performance score of 0-2

CONTINUATION

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

- ☐ No evidence of progressive disease according to RECIST criteria
and ☐ The patient is benefitting from and tolerating treatment

I confirm that the above details are correct:

Signed: Date: