

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: .....

**Cetuximab**

**INITIATION – head and neck cancer, locally advanced**

**Prerequisites** (tick boxes where appropriate)

- ☐ Patient has locally advanced, non-metastatic, squamous cell cancer of the head and neck  
**and**  
☐ Cisplatin is contraindicated or has resulted in intolerable side effects  
**and**  
☐ Patient has an ECOG performance score of 0-2  
**and**  
☐ To be administered in combination with radiation therapy

**INITIATION – colorectal cancer, metastatic**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- ☐ Patient has metastatic colorectal cancer located on the left side of the colon (see Note)  
**and**  
☐ There is documentation confirming disease is RAS and BRAF wild-type  
**and**  
☐ Patient has an ECOG performance score of 0-2  
**and**  
☐ Patient has not received prior funded treatment with cetuximab  
**and**  
☐ Cetuximab is to be used in combination with chemotherapy  
**or**  
☐ Chemotherapy is determined to not be in the best interest of the patient based on clinician assessment

**CONTINUATION – colorectal cancer, metastatic**

Re-assessment required after 6 months

**Prerequisites** (tick box where appropriate)

- ☐ No evidence of disease progression

Note: Left-sided colorectal cancer comprises of the distal one-third of the transverse colon, the splenic flexure, the descending colon, the sigmoid colon, or the rectum.

I confirm that the above details are correct:

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