HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:
Gefitinib	
INITIATION Re-assessment required after 4 months Prerequisites (tick boxes where appropriate) Patient has locally advanced, or metastatic, unresectable, non and	-squamous Non Small Cell Lung Cancer (NSCLC)
Patient is treatment naive Patient has received prior treatment in the adjuvant setti The patient has discontinued osimertinib or erlotin and The cancer did not progress whilst on osimertinib	ib due to intolerance
and There is documentation confirming that disease expresses act	ivating mutations of EGFR
CONTINUATION Re-assessment required after 6 months Prerequisites (tick box where appropriate) Radiological assessment (preferably including CT scan) indicates NS	SCLC has not progressed

I confirm that the above details are correct:

C:	D-1	
Signed.	Date:	
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