

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: .....

**Durvalumab**

**INITIATION – Non-small cell lung cancer**

Re-assessment required after 4 months

**Prerequisites** (tick boxes where appropriate)

- ☐ Patient has histologically or cytologically documented stage III, locally advanced, unresectable non-small cell lung cancer (NSCLC)
- or
- ☐ Patient has histologically or cytologically documented stage IIb (T1N2a only), locally advanced, unresectable non-small cell lung cancer (NSCLC)

and

- ☐ Patient has received two or more cycles of platinum-based chemotherapy concurrently with definitive radiation therapy

and

- ☐ Patient has no disease progression following the second or subsequent cycle of platinum-based chemotherapy with definitive radiation therapy treatment

and

- ☐ Patient has a ECOG performance status of 0 or 1

and

- ☐ Patient has completed last radiation dose within 8 weeks of starting treatment with durvalumab

and

- ☐ Patient must not have received prior PD-1 or PD-L1 inhibitor therapy for this condition

and

- ☐ Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks
- or
- ☐ Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks

and

- ☐ Treatment with durvalumab to cease upon signs of disease progression

**CONTINUATION – Non-small cell lung cancer**

Re-assessment required after 4 months

**Prerequisites** (tick boxes where appropriate)

- ☐ The treatment remains clinically appropriate and the patient is benefitting from treatment

and

- ☐ Durvalumab is to be used at a maximum dose of no greater than 10 mg/kg every 2 weeks
- or
- ☐ Durvalumab is to be used at a flat dose of 1500 mg every 4 weeks

and

- ☐ Treatment with durvalumab to cease upon signs of disease progression

and

- ☐ Total continuous treatment duration must not exceed 12 months

I confirm that the above details are correct:

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