HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

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: .....

Pazopanib

INITIATION
Re-assessment required after 3 months
Prerequisites (tick boxes where appropriate)

- ○ The patient has metastatic renal cell carcinoma of predominantly clear cell histology

and

- ○ The patient is treatment naive

or

- ○ The patient has only received prior cytokine treatment

and

- ○ The patient has an ECOG performance score of 0-2

and

The patient has intermediate or poor prognosis defined as:

- ○ Lactate dehydrogenase level > 1.5 times upper limit of normal

or

- ○ Haemoglobin level < lower limit of normal

or

- ○ Corrected serum calcium level > 10 mg/dL (2.5 mmol/L)

or

- ○ Interval of < 1 year from original diagnosis to the start of systemic therapy

or

- ○ Karnofsky performance score of less than or equal to 70

or

- ○ 2 or more sites of organ metastasis

or

- ○ The patient has metastatic renal cell carcinoma

and

- ○ The patient has discontinued sunitinib within 3 months of starting treatment due to intolerance

and

- ○ The cancer did not progress whilst on sunitinib

and

- ○ Pazopanib to be used for a maximum of 3 months

CONTINUATION
Re-assessment required after 3 months
Prerequisites (tick box where appropriate)

- ○ No evidence of disease progression

I confirm that the above details are correct:

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