## 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	PATIEN	т:		
Name:		Name:		
Ward:	NHI:			
Atezolizumab	b			
INITIATION – no Re-assessment r Prerequisites (ti  Prescri accorda and  F and F and F and F F F F F F F F F F F F F F F F F F F	on-small cell lung cancer second line monotherapy required after 4 months (tick boxes where appropriate)  ribed by, or recommended by a medical oncologist or any relevant pract dance with a protocol or guideline that has been endorsed by the Health  Patient has locally advanced or metastatic non-small cell lung cancer  Patient has not received prior funded treatment with an immune checkp  For patients with non-squamous histology there is documentation confire EGFR or ALK tyrosine kinase unless not possible to ascertain	NZ Hospital.  oint inhibitor for NSCLC		
and F	Patient has an ECOG 0-2  Patient has documented disease progression following treatment with a Atezolizumab is to be used as monotherapy at a dose of 1200 mg every Baseline measurement of overall tumour burden is documented clinical	three weeks (or equivalent) for a maximum of 16 weeks		
Prerequisites (ti	required after 4 months (tick boxes where appropriate)  ribed by, or recommended by a medical oncologist or any relevant pract dance with a protocol or guideline that has been endorsed by the Health  Patient's disease has had a complete response to treatment  Patient has stable disease			
and tr and T and A and T	Response to treatment in target lesions has been determined by compating treatment period  No evidence of disease progression  The treatment remains clinically appropriate and patient is benefitting for Atezolizumab to be used at a maximum dose of 1200 mg every three w  Treatment with atezolizumab to cease after a total duration of 24 month 3 weeks)	om treatment eeks (or equivalent)		

I confirm that the above details are correct:

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Signeg	 Date	

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Atezolizumab - continued	
INITIATION – unresectable hepatocellular carcinoma Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)  O Patient is currently on treatment with atezolizumab and met all or  Patient has locally advanced or metastatic, unresectable and O Patient has preserved liver function (Child-Pugh A) and O Transarterial chemoembolisation (TACE) is unsuitable and O Patient has not received prior systemic therapy for or O Patient received funded lenvatinib before 1 March or O Patient has experienced treatment-limiting to and O No disease progression since initiation of ler	the treatment of hepatocellular carcinoma  2025  exicity from treatment with lenvatinib
Patient has an ECOG performance status of 0-2 and To be given in combination with bevacizumab	
CONTINUATION – unresectable hepatocellular carcinoma Re-assessment required after 6 months Prerequisites (tick box where appropriate)  O No evidence of disease progression	

I confirm that the above details are correct:

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Signed.	Date:	
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