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: .....

Crizotinib

INITIATION
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

- ○ Individual has locally advanced or metastatic, unresectable, non-squamous non-small cell lung cancer

and

- ○ The individual has not received entrectinib

or

- ○ The individual has received treatment with entrectinib and has discontinued entrectinib due to intolerance

and

- ○ The cancer did not progress while the individual was on entrectinib

and

- ○ There is documentation confirming that the patient has a ROS1 rearrangement using an appropriate ROS1 test

and

- ○ Individual has ECOG performance score of 0-3

and

- ○ Baseline measurement of overall tumour burden is documented clinically and radiologically

CONTINUATION
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

- ○ Response to treatment has been determined by comparable radiological assessment following the most recent treatment period

and

- ○ No evidence of disease progression

I confirm that the above details are correct:

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