

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: ..... NHI: .....

**Alectinib**

**INITIATION**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

Patient has locally advanced, or metastatic, unresectable, non-small cell lung cancer  
and  
 There is documentation confirming that the patient has an ALK tyrosine kinase gene rearrangement using an appropriate ALK test  
and  
 Patient has an ECOG performance score of 0-2

**CONTINUATION**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

No evidence of progressive disease according to RECIST criteria  
and  
 The patient is benefitting from and tolerating treatment

I confirm that the above details are correct:

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