

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:

Axitinib

INITIATION

Re-assessment required after 4 months

Prerequisites (tick boxes where appropriate)

- The patient has metastatic renal cell carcinoma
- and**
- The disease is of predominant clear cell histology
- and**
- The patient has documented disease progression following one previous line of treatment
- and**
- The patient has ECOG performance status of 0-2

CONTINUATION

Re-assessment required after 4 months

Prerequisites (tick box where appropriate)

- No evidence of disease progression.

I confirm that the above details are correct:

Signed: Date: