

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:

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: