

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:

Entrectinib

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 crizotinib
- or
- ☐ The individual has received an initial Special Authority approval for crizotinib and has discontinued crizotinib due to intolerance
- and
- ☐ The cancer did not progress while the individual was on crizotinib
- 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: