

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: .....