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: .....

Erlotinib

INITIATION
Re-assessment required after 4 months
Prerequisites (tick boxes where appropriate)

- ○ Patient has locally advanced or metastatic, unresectable, non-squamous Non Small Cell Lung Cancer (NSCLC)

and

- ○ There is documentation confirming that the disease expresses activating mutations of EGFR

and

- ○ Patient is treatment naive

or

- ○ Patient has received prior treatment in the adjuvant setting and/or while awaiting EGFR results

or

- ○ The patient has discontinued osimertinib or getitinib due to intolerance

and

- ○ The cancer did not progress while on osimertinib or gefitinib

CONTINUATION
Re-assessment required after 6 months
Prerequisites (tick box where appropriate)

- ○ Radiological assessment (preferably including CT scan) indicates NSCLC has not progressed

I confirm that the above details are correct:

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