

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

PATIENT:

Name:

Name:

Ward:

NHI:

Ipilimumab

INITIATION – renal cell carcinoma

Re-assessment required after 4 months

Prerequisites (tick boxes where appropriate)

The patient is currently on treatment with ipilimumab and met all remaining criteria prior to commencing treatment

or

The patient has metastatic renal cell carcinoma

and

The patient is treatment naive

and

The patient has ECOG performance status 0-2

and

The disease is predominantly of clear cell histology

and

The patient has sarcomatoid histology

or

Haemoglobin levels less than the lower limit of normal

or

Corrected serum calcium level greater than 10 mg/dL (2.5 mmol/L)

or

Neutrophils greater than the upper limit of normal

or

Platelets greater than the upper limit of normal

or

Interval of less than 1 year from original diagnosis to the start of systemic therapy

or

Karnofsky performance score of less than or equal to 70

and

Ipilimumab is to be used at a maximum dose of 1 mg/kg for up to four cycles in combination with nivolumab

I confirm that the above details are correct:

Signed: Date: