

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: .....

**Olaparib**

**INITIATION – Ovarian cancer**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

Patient has a high-grade serous\* epithelial ovarian, fallopian tube, or primary peritoneal cancer

and

There is documentation confirming pathogenic germline BRCA1 or BRCA2 gene mutation

and

Patient has newly diagnosed, advanced disease

and

Patient has received one line\*\* of previous treatment with platinum-based chemotherapy

and

Patient's disease must have experienced a partial or complete response to the first-line platinum-based regimen

or

Patient has received at least two lines\*\* of previous treatment with platinum-based chemotherapy

and

Patient has platinum sensitive disease defined as disease progression occurring at least 6 months after the last dose of the penultimate line\*\* of platinum-based chemotherapy

and

Patient's disease must have experienced a partial or complete response to treatment with the immediately preceding platinum-based regimen

and

Patient has not previously received funded olaparib treatment

and

Treatment will be commenced within 12 weeks of the patient's last dose of the immediately preceding platinum-based regimen

and

Treatment to be administered as maintenance treatment

and

Treatment not to be administered in combination with other chemotherapy

I confirm that the above details are correct:

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

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**PRESCRIBER**

**PATIENT:**

Name: .....

Ward: ..... NHI: .....

**Olaparib - continued**

**CONTINUATION – Ovarian cancer**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

Treatment remains clinically appropriate and patient is benefitting from treatment

and

No evidence of progressive disease

or

Evidence of residual (not progressive) disease and the patient would continue to benefit from treatment in the clinician's opinion

and

Treatment to be administered as maintenance treatment

and

Treatment not to be administered in combination with other chemotherapy

and

Patient has received one line\*\* of previous treatment with platinum-based chemotherapy

and

Documentation confirming that the patient has been informed and acknowledges that the funded treatment period of olaparib will not be continued beyond 2 years if the patient experiences a complete response to treatment and there is no radiological evidence of disease at 2 years

or

Patient has received at least two lines\*\* of previous treatment with platinum-based chemotherapy

Note: \*Note "high-grade serous" includes tumours with high-grade serous features or a high-grade serous component.  
\*\*A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments.

I confirm that the above details are correct:

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