

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:

Ward: NHI:

Gefitinib

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

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 erlotinib due to intolerance

and

The cancer did not progress whilst on osimertinib or erlotinib

and

There is documentation confirming that disease expresses activating mutations of EGFR

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: