

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: .....

**Pazopanib**

**INITIATION**

Re-assessment required after 3 months

**Prerequisites** (tick boxes where appropriate)

The patient has metastatic renal cell carcinoma of predominantly clear cell histology

and

The patient is treatment naive

or

The patient has only received prior cytokine treatment

and

The patient has an ECOG performance score of 0-2

and

**The patient has intermediate or poor prognosis defined as:**

Lactate dehydrogenase level > 1.5 times upper limit of normal

or

Haemoglobin level < lower limit of normal

or

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

or

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

or

Karnofsky performance score of less than or equal to 70

or

2 or more sites of organ metastasis

or

The patient has metastatic renal cell carcinoma

and

The patient has discontinued sunitinib within 3 months of starting treatment due to intolerance

and

The cancer did not progress whilst on sunitinib

and

Pazopanib to be used for a maximum of 3 months

**CONTINUATION**

Re-assessment required after 3 months

**Prerequisites** (tick box where appropriate)

No evidence of disease progression

I confirm that the above details are correct:

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