

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: .....

**Axitinib**

**INITIATION**

Re-assessment required after 4 months

**Prerequisites** (tick boxes where appropriate)

- The patient has metastatic renal cell carcinoma
- and  The disease is of predominant clear cell histology
- and  The patient has documented disease progression following one previous line of treatment
- and  The patient has ECOG performance status of 0-2

**CONTINUATION**

Re-assessment required after 4 months

**Prerequisites** (tick box where appropriate)

- No evidence of disease progression.

I confirm that the above details are correct:

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