

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:

Everolimus

INITIATION

Re-assessment required after 3 months

Prerequisites (tick boxes where appropriate)

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

and

- Patient has tuberous sclerosis

and

- Patient has progressively enlarging sub-ependymal giant cell astrocytomas (SEGAs) that require treatment

CONTINUATION

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

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

and

- Documented evidence of SEGA reduction or stabilisation by MRI within the last 3 months

and

- The treatment remains appropriate and the patient is benefiting from treatment

and

- Everolimus to be discontinued at progression of SEGAs

INITIATION – renal cell carcinoma

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 an ECOG performance status of 0-2
- and
- Everolimus is to be used in combination with lenvatinib

or

- Patient has received funded treatment with nivolumab for the second line treatment of metastatic renal cell carcinoma
- and
- Patient has experienced treatment limiting toxicity from treatment with nivolumab
- and
- Everolimus is to be used in combination with lenvatinib
- and
- There is no evidence of disease progression

CONTINUATION – renal cell carcinoma

Re-assessment required after 4 months

Prerequisites (tick box where appropriate)

- There is no evidence of disease progression

I confirm that the above details are correct:

Signed: Date: