

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:

Erlotinib

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
 There is documentation confirming that the disease expresses activating mutations of EGFR
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 gefitinib due to intolerance
and
 The cancer did not progress while on osimertinib or gefitinib

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: