

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: .....