Gemcitabine - Non-Small Cell Lung Cancer (NSCLC)

(This form must be completed before the first dose is dispensed.)
1. **Patient Profile**

- Surname: .................................................................
- Given Name: ...........................................................
- OHIN: ................................................................. Chart Number: ..........................................................
- Postal Code: .........................................................
- Height (cm): _______  Weight (kg): __________
- BSA (m²): __________ Gender: □ Male □ Female □ Other
- Date of Birth: __________ __________ __________
  Day  Month  Year
- Site:
- Attending Physician (MRP - Most Responsible Physician): .................................................................

  Requested Prior Approval  □ Yes  □ Patient on Clinical Trial  □ Yes  □ No

Other (specify): ..........................................................

Specify Arm:
□ Standard of care arm □ Experimental arm
□ Blinded / Unknown

**Request prior approval for enrolment**

- Justification for Funding

2. **Eligibility Criteria**

  Patient must meet criteria a and b

  a. The patient has locally advanced or metastatic non-small cell lung cancer.  □ Yes
b. Please select one of the following:
   - The drug will be administered as first line (or induction) treatment
   - The patient has received either EGFR- or ALK-targeted therapy as their initial treatment and a non-pemetrexed platinum doublet is used as the next line of chemotherapy option (induction)
   - The patient has experienced excessive toxicity with another first line agent for NSCLC doses and needs to be switched to a different first line drug

3. Notes

   a. The NDFP will fund **up to 6 cycles**, based on evidence that chemotherapy given for longer than 3 to 4 cycles is not associated with improvement in overall survival, but rather may lead to worsened toxicity and a possible worsening of quality of life.

4. Supporting Documents

   To ensure reimbursement of your claim, both the completed enrolment form and a copy of the required documentation (where applicable) must be submitted through CCO e-Claims.

   Signature of Attending Physician (MRP-Most Responsible Physician): ..........................

   .......................... .......................... ..........................
   Day   Month   Year