Paclitaxel - 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

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**Request prior approval for enrolment**

- Justification for Funding

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2. **Eligibility Criteria**

Patient must meet criteria a and b

a. The patient has locally advanced or metastatic non-small cell lung cancer.  Yes
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.

b. Funding for weekly paclitaxel with a platinum agent may be considered for patients with neuropathy, since there is no evidence of equivalent survival benefit when compared to q3 week paclitaxel/platinum, though there is suggestion of less neuropathy.

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