Pemetrexed - Non-Small Cell Lung Cancer (Second or Subsequent Line)

(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

a. The patient must meet the following criteria:
   - Pemetrexed is used as monotherapy for the second (or subsequent) line of treatment of locally advanced or metastatic nonsquamous non-small cell lung cancer in patients who
      ☐ Yes
3. Funded Dose

- 500 mg/m² on day 1 - repeat every 21 days until disease progression.

4. Notes

a. Patients whose disease has progressed following treatment with pemetrexed (maintenance and/or prior lines of therapy) are not eligible for pemetrexed funding in the second or subsequent line setting.
b. Patients who have previously used erlotinib are not eligible for pemetrexed funding.
c. Funding of pemetrexed will be discontinued if there is evidence of disease progression.
d. Vitamin supplementation is mandatory starting at least 1 week prior to the first dose of pemetrexed and continuing until 3 weeks after the last dose of pemetrexed.
   i. Vitamin B₁₂ 1000 mcg IM every 9 weeks
   ii. Folic acid 0.4 – 1 mg po daily

5. 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