Eligibility Form

Topotecan - Platinum - Resistant Ovarian, Fallopian Tube, or Primary Peritoneal Cancer

(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

Date of Anticipated Treatment: Day Month Year
2. Eligibility Criteria

The patient must meet the following criteria:

a. Patient has previously been treated with platinum-containing chemotherapy with or without paclitaxel
   ☐ Yes

b. Please select one:
   ☐ Disease has relapsed less than 6 months following therapy
   ☐ Tumour has progressed during therapy or not responding to therapy

C. Patient has reasonable performance status with symptoms that are likely to be alleviated if response is achieved
   ☐ Yes

3. Funded Dose

Please select one of the following regimens:

☐ Topotecan 1.5 mg/m² IV for 5 days q21 days, until progression
☐ Topotecan 4 mg/m² IV weekly Days 1, 8, 15 every 28 days, until progression
☐ Topotecan 1.25 mg/m² Days 1 to 5 every 3 weeks (if used with bevacizumab 15 mg/kg every 3 weeks)

4. Notes

1. Patients are eligible for treatment with either topotecan or liposomal doxorubicin. Patients having already received one of these drugs are not eligible to receive funding for the other.
2. Patients with primary platinum refractory disease (i.e., disease that has progressed while on front-line platinum-based chemotherapy) are not eligible for bevacizumab in the platinum-resistant setting.

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): .................................................................

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