

GUIDELINE SUMMARY **OPEN ACCESS**

Program Guidelines for the National Lung Cancer Screening Program: Targeted Lung Cancer Screening in High-Risk Individuals in Australia

Nicole M. Rankin^{1,2} | Rebecca Zosel¹ | Lisa J. Whop³  | Raglan Maddox³  | Annette McWilliams^{4,5} | Miranda Siemienowicz^{6,7} | Jon Emery⁸  | Maria A. R. Lantin¹  | Georgia Bartlett¹ | Mikayla Wolfe³  | Abbey Diaz³ | Katrina Anderson⁹ | Lillian Liu⁹ | Cindy Toms⁹ | Sarah McDermott¹⁰ | Peter Bligh¹⁰ | Jeremy Chalke¹⁰ | Stephen Melsom^{11,12} | Claire E. Nightingale¹ | Alison Brown¹  | Sam Pope^{3,13} | Julia Brotherton¹  | Anne Fidler^{14,15} | Michel Ite^{14,15} | Mark Brooke¹⁴ | Diane M. Pascoe^{16,17} | Fraser Brims^{18,19}  | Tracy L. Leong^{20,21} | Emily Stone^{22,23} | Dorothy Keefe⁹ | Vivienne Milch^{9,24}

¹Melbourne School of Population and Global Health, The University of Melbourne, Melbourne, Victoria, Australia | ²Sydney School of Public Health, Faculty of Medicine and Health, The University of Sydney, Sydney, New South Wales, Australia | ³Yardhura Walani, National Centre for Aboriginal and Torres Strait Islander Wellbeing Research, Australian National University, Acton, Australian Capital Territory, Australia | ⁴Department of Respiratory Medicine, Fiona Stanley Hospital, Murdoch, Western Australia, Australia | ⁵School of Medicine, The University of Western Australia, Perth, Western Australia, Australia | ⁶Northern Imaging, Victoria Northern Health NCHER, Epping, Victoria, Australia | ⁷Central Clinical School, Monash University, Melbourne, Victoria, Australia | ⁸Population and Global Health, Lee Kong Chian School of Medicine, Nanyang Technological University, Singapore | ⁹Cancer Australia, Sydney, New South Wales, Australia | ¹⁰National Aboriginal Community Controlled Health Organisation, Canberra, Australian Capital Territory, Australia | ¹¹Department of Medical Imaging, Fiona Stanley Hospital, Murdoch, Western Australia, Australia | ¹²Perth Radiological Clinic, Perth, Western Australia, Australia | ¹³Institute for Urban Indigenous Health, Brisbane, Queensland, Australia | ¹⁴Lung Foundation Australia, Milton, Queensland, Australia | ¹⁵International Association for the Study of Lung Cancer, Denver, Colorado, USA | ¹⁶Department of Medical Imaging, The Royal Melbourne Hospital, Melbourne, Victoria, Australia | ¹⁷Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne, Melbourne, Victoria, Australia | ¹⁸Curtin Medical School, Curtin University, Perth, Western Australia, Australia | ¹⁹Department of Respiratory Medicine, Sir Charles Gairdner Hospital, Nedlands, Western Australia, Australia | ²⁰Department of Respiratory and Sleep Medicine, Austin Health, Heidelberg, Victoria, Australia | ²¹Olivia Newton-John Cancer Research Institute, Heidelberg, Victoria, Australia | ²²Department of Thoracic Medicine and Lung Transplantation, St Vincent's Hospital Sydney, Darlinghurst, New South Wales, Australia | ²³School of Clinical Medicine, Faculty of Medicine and Health, The University of New South Wales, Sydney, New South Wales, Australia | ²⁴Caring Futures Institute, College of Nursing and Health Sciences, Flinders University, Bedford Park, South Australia, Australia

Correspondence: Nicole M. Rankin (nicole.rankin@unimelb.edu.au)

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ABSTRACT

Introduction: Lung cancer is the leading cause of cancer mortality in Australia. In July 2025, the Australian Government launched the National Lung Cancer Screening Program (the Program). The Program has been designed in accordance with the Medical Services Advisory Committee's recommendations. This article summarises the program guidelines, outlining Program parameters and delivery requirements. The screening and assessment pathway defines the Program structure. The purpose of the guidelines is to ensure safe, effective and high-quality Program delivery, detailing key steps for clinical practice and information for participating healthcare providers.

Main Recommendations: The guidelines provide recommendations for the delivery of targeted low-dose CT screening for lung cancer in the Australian context.

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- Program eligibility is assessed using risk-based eligibility criteria recommended by the Medical Services Advisory Committee, targeting people between 50 and 70 years of age with a history of tobacco cigarette smoking.
- Smoking cessation supports are to be offered to all potential participants by healthcare providers across the lung cancer screening and assessment pathway.
- Low-dose CT scan assessment and reporting follow the National Lung Cancer Screening Program's nodule management protocol.

Changes in Management as a Result of the Guideline: This guideline provides recommendations for the delivery of targeted low-dose CT screening for lung cancer in the Australian context. Content includes: guidance on assessing Program eligibility; enrolling eligible participants in the National Cancer Screening Register; completing and fulfilling low-dose CT scan requests; assessing and reporting low-dose CT scan results; managing scan outcomes and actionable additional findings; and communicating scan results. The full guideline is available at <https://www.health.gov.au/resources/publications/nlcsp-guidelines>.

JEL Classification: Environment and public health, Neoplasms, General medicine

1 | Background

The National Lung Cancer Screening Program (hereafter referred to as the Program) is Australia's first targeted cancer screening program. The Program uses low-dose computed tomography (CT) scans to look for lung cancer in people at high risk of lung cancer, targeting those who: are aged 50–70 years; have no signs or symptoms suggestive of lung cancer; currently smoke or quit within the past 10 years; and have a history of tobacco cigarette smoking of at least 30 pack-years. Two mandatory bulk-billing Medicare Benefit Schedule (MBS) items have been created for low-dose CT scans, covering the cost of 2-yearly scans and any follow-up low-dose CT scans that may be required.

Lung cancer is the leading cause of cancer death in Australia [1], claiming more lives than breast and prostate cancers combined [2]. Australia has among the best survival rates for cancer in the world [3, 4], yet most people with lung cancer are diagnosed with late-stage disease (stage IV) (>42%) [5], meaning that curative treatment is not an option. Only 26% of people with lung cancer survive 5 years post-diagnosis [2]. Lung cancer disproportionately affects priority populations, including Aboriginal and Torres Strait Islander peoples who experience significantly higher rates of disease and significantly poorer outcomes. The 5-year survival rate for Aboriginal and Torres Strait Islander peoples is 11% [6].

Such disparities in lung cancer incidence, mortality and survival rates across the Australian community are directly influenced by socio-structural health determinants. Intersecting factors such as gender, geography, Indigeneity, ethnicity, socio-economic status and disability increase the likelihood of adverse lung cancer outcomes due to unequal access to care, higher smoking prevalence, and experiences of discrimination and stigma [7, 8]. These inequities are produced by structural determinants, including colonisation, racism and commercial determinants of health. Program materials avoid vague labels (e.g., 'vulnerable') and instead name the specific structural drivers to be addressed (e.g., access to culturally safe care, targeted marketing and financial/geospatial barriers).

The Program's guidelines were developed in the context of robust international evidence demonstrating the clinical effectiveness and population-level benefits of low-dose CT screening

for lung cancer [9–14], with program parameters defined by the Medical Services Advisory Committee (MSAC) [15]. MSAC considered the strength of available evidence in relation to comparative safety, clinical effectiveness, cost-effectiveness and total cost, and recommended implementation of the Program [15]. Work to assess the early design and feasibility of lung cancer screening in Australia was conducted before the Program was funded [16, 17].

Guidance was needed to support the implementation and standardised delivery of low-dose CT screening for lung cancer suitable for the Australian context. The Program's guidelines are firmly grounded in best practice evidence [18]. The guidelines aim to guide delivery of a safe, effective and high-quality screening program for all Australians, helping to address current inequities and ensuring that the Program does not entrench further inequity [19].

Cancer Australia is the Australian Government's lead cancer control agency, who commissioned The University of Melbourne in partnership with Yardhura Walani, the National Centre for Aboriginal and Torres Strait Islander Wellbeing Research at the Australian National University and the Lung Foundation Australia to develop the Program's guidelines. This article summarises key recommendations in the guidelines; detailed guidance is available in the original document [19].

2 | Methods

The Australian Government Department of Health, Disability and Ageing and Cancer Australia undertook a feasibility assessment to inform a fully costed proposal for the design, development and implementation of a nationwide lung cancer screening program. Based on consideration of available evidence on safety, clinical effectiveness, cost-effectiveness and total cost, MSAC recommended the establishment of the Program using low-dose CT, and outlined core Program requirements (e.g., biennial screening), as detailed in Cancer Australia's *Report on the Lung Cancer Screening enquiry* [9] and MSAC's public summary document for the Program [15]. The Program's guidelines were developed in a rigorous manner, including:

- An expert multidisciplinary working group of 21 members comprised of a broad range of healthcare providers (primary care, nursing, radiology, subspecialty physicians, Aboriginal and Torres Strait Islander health workers and practitioners), health program experts (smoking cessation, care coordination, cancer education), cancer screening experts and consumer representatives. This included an expert Aboriginal and Torres Strait Islander-specific group consisting of seven members comprising Aboriginal and Torres Strait Islander health workers, general practitioners, cessation specialists, and community-controlled health and workforce peak body representation.
- An iterative and collaborative process of development was undertaken with the Program's implementation partners: Cancer Australia, the Department of Health, Disability and Ageing, and the National Aboriginal Community Controlled Health Organisation.
- Advice from key advisory groups, including the National Lung Cancer Screening Program Advisory Group and National Lung Cancer Screening Program Expert Advisory Committee.
- Desktop review of international guidelines and protocols for lung cancer screening.
- Consultation with 74 stakeholders across Australian states and territories, geographic areas and healthcare settings, including healthcare providers, health program and policy professionals, peak bodies and advocacy organisations representing priority populations and consumers.
- Indigenous-led consultation with 102 Aboriginal and Torres Strait Islander community members, health professionals, service providers and organisations across 25 sessions.
- Public consultation on the draft guidelines, with a total of 91 submissions received, to gather feedback.

Current clinical best practice, expert opinion and consensus, stakeholder feedback and insights, and the Program's guiding principles informed the development of the practice points outlined in the guidelines. Details on the stakeholder consultation and guideline development processes are beyond the scope of this guideline summary and will be reported separately. The reporting of these guidelines was informed by the Appraisal of Guidelines for Research and Evaluation tool. A completed reporting checklist is provided in the [Supporting Information](#). This project has ethics approval from the University of Melbourne Human Research Ethics Committee (reference number 2024-29045-52,425-3) and the Australian Institute of Aboriginal and Torres Strait Islander Studies Research Ethics Committee (reference number REC-0299).

3 | Program Overview

The full guidelines for the Program [19] are available at <https://www.health.gov.au/resources/publications/nlcsp-guidelines>. The lung cancer screening and assessment pathway is presented in Figure 1.

3.1 | Program Considerations

The Program strives towards equitable and safe delivery, particularly for populations disproportionately affected by structural factors such as targeted tobacco marketing, systemic healthcare access barriers and unequal access to cessation supports, which contributes to increased risk of lung cancer related to smoking prevalence [1, 20–22]. Participation rates and significant rates of positive results requiring further investigation indicate that other cancer screening programs are not equitably meeting the needs of Aboriginal and Torres Strait Islander people [21, 23, 24]. To help ensure the Program is culturally safe, the Australian Government is committed to working in partnership with Aboriginal and Torres Strait Islander peoples, communities and organisations [25–27]. Stigma related to smoking can negatively impact how people who smoke or have a history of smoking engage with lung cancer screening, underscoring the importance of culturally safe, empathic and non-judgemental care and communication—everyone deserves care, support and understanding [28]. Given tobacco use is the single greatest avoidable risk factor for lung cancer [29], smoking cessation is an important component of any effective and equitable lung cancer screening program.

3.2 | Roles and Responsibilities Across the Program

The Program is delivered across primary and tertiary care settings. All healthcare providers and health support workers may contribute to Program delivery. Healthcare providers authorised to request low-dose CT scans as part of the Program include general practitioners, medical specialists and nurse practitioners, and are referred to as 'requesting practitioners'. Nurse practitioners are permitted to request program-specific MBS items where state or territory legislation allows, following amendments to the *Health Insurance Act 1973* (Cth) [30]. Radiology providers are responsible for reading and reporting the low-dose CT scans, and communicating scan outcomes to requesting practitioners and the National Cancer Screening Register (NCSR).

The NCSR provides a single electronic record for individuals participating in the lung, cervical and bowel cancer screening programs. The NCSR supports healthcare providers to manage a participant's journey through the lung cancer screening and assessment pathway.

4 | Recommendations

The Program's guidelines comprise eight evidence-based recommendations and 74 practice points for program delivery [19]. Recommendations are those supported by the MSAC expert advice on lung cancer screening, and additional items supported by evidence from systematic reviews and randomised controlled trials. Practice points provide guidance on delivery and implementation at each step of the screening and assessment pathway where issues are not addressed by other standards or guidelines, or where evidence is limited.

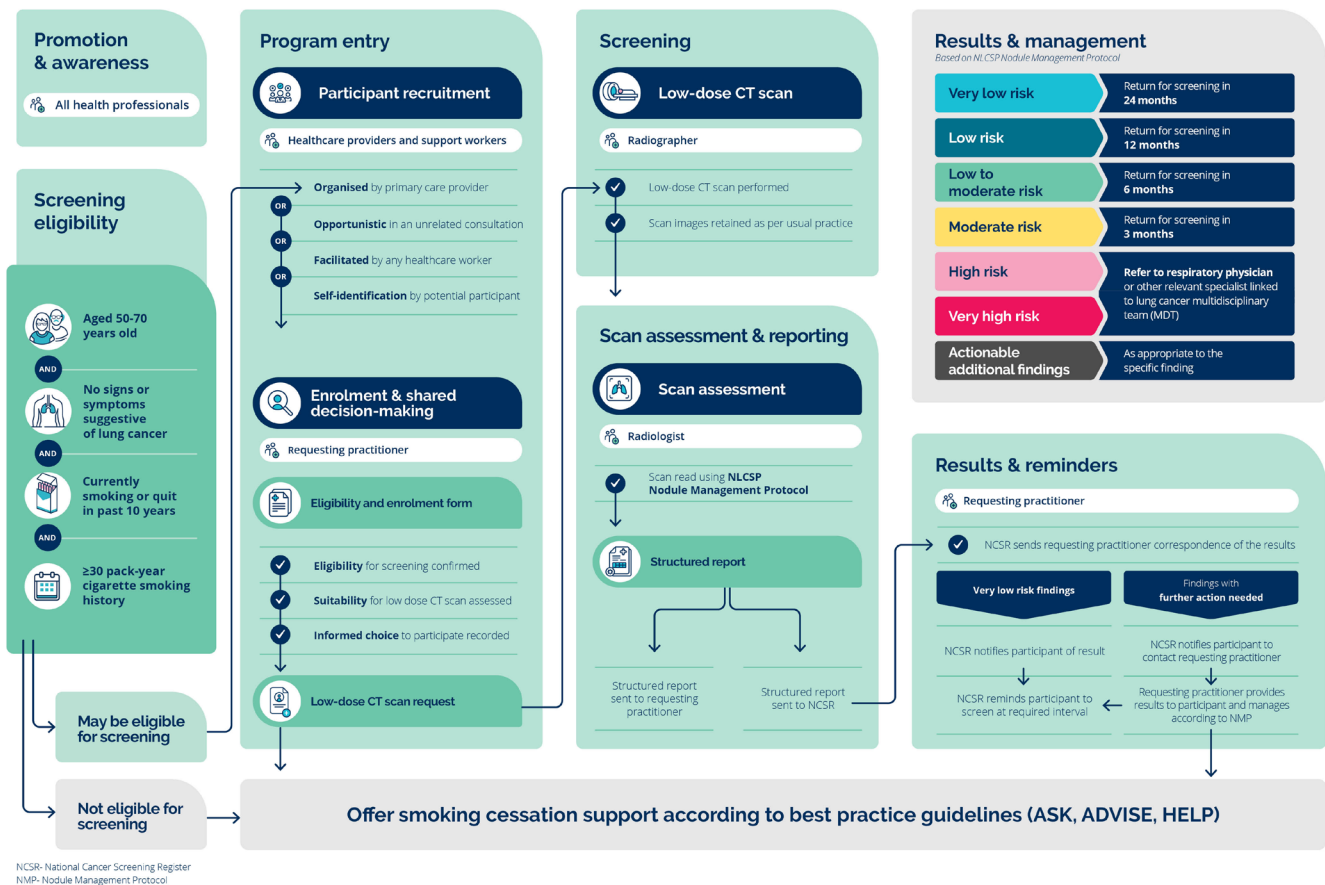


FIGURE 1 | National Lung Cancer Screening Program screening and assessment pathway. CT, computed tomography; NCSR, National Cancer Screening Register; NLCSP, National Lung Cancer Screening Program; NMP, nodule management protocol. *Source:* Australian Government Department of Health, Disability and Ageing. National Lung Cancer Screening Program guidelines, 2025; reproduced with permission [19].

4.1 | Target Population and Eligibility Criteria

The Program targets individuals at high risk of lung cancer to ensure the program is safe and effective. Eligibility is based on risk criteria recommended by MSAC [15]. To participate, individuals must meet all four criteria:

- Aged 50 to 70 years;
- Asymptomatic (no signs or symptoms suggestive of lung cancer);
- Currently smoke or have quit smoking within the past 10 years; and
- Have a history of at least 30 pack-years of tobacco cigarette smoking.

4.2 | Smoking Cessation

Smoking cessation supports are to be offered, where appropriate, to all potential participants by healthcare providers across the screening and assessment pathway; this includes follow-up and maintenance support. Evidence from trials demonstrate that lung cancer screening participants have higher quit rates than rates expected in the general smoking population [31].

Support to quit smoking or maintain cessation is strongly recommended to be delivered using the three-step brief intervention model 'Ask, Advise, Help' [32, 33]. People who smoke may choose brief advice, pharmacotherapy, referral to local services, Quitline or no further support at this time. Cessation medicines, including varenicline and bupropion, are subsidised on the Pharmaceutical Benefits Scheme, and can be accessed with a prescription. The requesting practitioner can help to arrange a referral to multi-session behavioural interventions. All options should be offered without pressure or stigma. People who smoke do not have to quit smoking to participate in the Program.

4.3 | Low-Dose CT Scan Assessment and Reporting

The Program uses a nationally standardised approach for scan assessment and reporting. Baseline screening scans and follow-up scans are read and reported using the Program's nodule management protocol [34], developed by the Australian Government in collaboration with the Australian and New Zealand Society of Thoracic Radiology (ANZSTR, for the Royal Australian and New Zealand College of Radiologists [RANZCR]) and the Thoracic Society of Australia and New Zealand. The protocol was developed to support MSAC's recommendation to use the Pan-Canadian Early Detection of Lung

Cancer Study (PanCan) nodule malignancy risk calculator [35] and the Lung CT Screening Reporting and Data System (Lung-RADS) [36], adapted for the Australian context with a biennial screening interval.

Radiologists are required to report all Program low-dose CT scan results to the NCSR using the Program's structured clinical radiology report.

5 | Summary of the Lung Cancer Screening and Assessment Pathway

The lung cancer screening and assessment pathway defines clinical and policy parameters and maps the participant journey. Key components of the pathway (Figure 1) are summarised in the following paragraphs.

5.1 | Promotion and Awareness

Widespread, repeated promotion is important to maximise participation in the Program. Governments, service providers and healthcare professionals share responsibility for proactively raising awareness among eligible individuals and the broader community. Healthcare providers play a key role in recommending screening and disseminating information. International evidence shows that lack of awareness and understanding of screening benefits are major barriers to participation [37–39].

Practice points emphasise promoting the Program in culturally safe, appropriate and accessible ways that consider varying levels of literacy and health literacy and address stigma.

5.2 | Program Entry and Recruitment

Recruitment involves identifying and engaging individuals at high risk of lung cancer to participate in the Program, occurring across multiple settings. Unlike population-based cancer screening programs for bowel, breast and cervical cancer, the Program does not issue invitations to potential participants. As a targeted screening program with risk-based eligibility criteria, eligibility cannot be determined solely by age, and information about smoking history is not contained in government registers such as Medicare.

Potential participants may enrol in the Program via four routes: organised, opportunistic, facilitated or self-identified entry. Each route requires eligibility assessment and a low-dose CT scan request by a requesting practitioner. Enrolled participants receive a welcome pack from the NCSR.

Practice points highlight strategies to optimise access and support recruitment by leveraging electronic medical records (EMRs) to facilitate participant recruitment, such as updating smoking history records, conducting EMR audits and using EMR-based prompts.

5.3 | Eligibility and Low-Dose CT Scan Request

A wide range of healthcare providers may discuss and check if people are eligible to participate in the Program. Eligibility should be confirmed by a requesting practitioner.

There are no program-specific MBS items for the eligibility assessment. Existing MBS items for short and long consultations can be used.

Participants must be aged between 50 and 70 years, and have no signs or symptoms suggestive of lung cancer, to remain eligible. Enrolled participants do not need their smoking history eligibility criteria reassessed for subsequent scan requests.

Practice points guide healthcare providers in calculating smoking pack-year history, enrolling eligible individuals into the Program and reassessing eligibility for those who may become eligible over time due to ageing or increased pack-years of smoking.

5.3.1 | Suitability for Low-Dose CT

Requesting practitioners must check suitability for low-dose CT before completing each low-dose CT scan request. Requesting practitioners should consider an individual's general health and ability to physically use CT scanners. If an eligible person has health reasons that make low-dose CT clinically inappropriate, these should be managed as per usual care arrangements.

Reasons people may be unsuitable for low-dose CT include weight restrictions of scanners, being unable to lie flat for a minimum of 5 min, having a symptomatic lung infection within the previous 12 weeks or having undergone a full chest CT scan within the previous 12 months or having one planned in the next 3 months.

Practice points guide timely reassessment of suitability for low-dose CT if an eligible person is temporarily unsuitable for screening.

5.3.2 | Shared Decision-Making and Informed Choice

Shared decision-making enables people to make an informed choice about lung cancer screening and is an integral component of the Program. Healthcare providers should support people to make an informed choice about lung cancer screening, even if they decide not to take part.

Discussions about the Program should be inclusive and tailored to each individual's and their families' values, preferences, circumstances and information needs. This includes consideration of the benefits (e.g., finding lung cancer early, peace of mind, an opportunity to quit smoking) and potential harms (e.g., false-positive results, overdiagnosis, exposure to radiation) of screening. Shared decision-making resources can be found on the Program website [40]. Shared decision-making guidance for Aboriginal and Torres Strait Islander peoples can be found

on the National Aboriginal Community Controlled Health Organisation website [41].

Practice points emphasise conducting shared decision-making discussions that are safe, culturally appropriate and respectful, to ensure people feel safe to ask questions and discuss diverse experiences and needs. Consistent with the Australian Health Practitioner Regulation Agency cultural safety regulations, health professionals are required to create environments where Aboriginal and Torres Strait Islander peoples feel respected, valued and safe to engage in lung screening programs [42].

5.3.3 | Enrolment in the NCSR

Healthcare providers are responsible for sending the NCSR participant enrolment information through NCSR forms. Practice staff and nurses can be given delegate access to fill in these forms. Individuals can choose to opt out of the NCSR and still have a free low-dose CT scan. In such cases, radiologists will still be able to receive the Medicare rebate, and requesting practitioners will be responsible for notifying patients of repeat or interval scans. Practice points guide requesting practitioners on how to enrol participants in the NCSR and in understanding the implications of opting out.

5.3.4 | Low-Dose CT Scan Request

Requesting practitioners are required to complete a low-dose CT request. The Program-specific request form [43] is preferred, but requesting practitioners can use a usual practice form for radiology imaging requests. If using a usual practice form, the low-dose CT scan request must identify that it is for lung cancer screening and include family history of lung cancer in any first-degree relative (i.e., parent, sibling or child), details of any previous chest CT scan (if known) and history of any cancer. This is required to ensure the patient is bulk-billed for the scan and that the radiologist reads and reports on the scans using the Program's nodule management protocol. A new low-dose CT scan request is needed for every scan.

Participants should be advised when to book a low-dose CT scan appointment—either as soon as possible (at Program entry) or as close to the required screening timepoint as possible. Practice points highlight strategies to support participant access to low-dose CT scans, including mobile screening, the patient travel support service for the Program and interpreter services.

5.4 | Low-Dose CT Scan

Low-dose CT scans for the Program are available through public, private and mobile [44] radiology services, with participation open to all radiology services. Two MBS items [45] cover low-dose CT scans under the program: the screening low-dose CT scans undertaken at baseline and every 2 years (Item 57,410); and the interval low-dose CT scans requested for any follow-up

needed during the 2-yearly screening period based on screening results (Item 57,413) [46]. Both MBS items are mandatory bulk-billing items with mandatory reporting requirements, ensuring participants incur no out-of-pocket costs for low-dose CT scans under the Program. Low-dose CT scans are performed by radiographers following the *National Lung Cancer Screening Program low-dose CT acquisition guidelines* published by RANZCR [47].

5.5 | Low-Dose CT Scan Assessment and Reporting

Radiologists must use the most recent version of the Program's nodule management protocol at the time of reporting. ANZSTR has developed education modules on use of the Program's nodule management protocol [48] on behalf of RANZCR.

Structured radiology reporting ensures radiologists accurately and consistently report Program low-dose CT scan results. Low-dose CT scan reports are sent to the NCSR, and it is mandatory for radiologists to report within 30 days of performing a scan. Radiology providers need to register their practice to integrate with the NCSR to access and submit reports. Radiology providers are required to share low-dose CT scan reports to My Health Record and with requesting practitioners through usual care arrangements for imaging reporting processes. Requesting practitioners are also notified by the NCSR once the results report is available.

5.6 | Results and Next Steps

5.6.1 | Scan Outcomes

The scan outcome category determines the participant's journey through the screening and assessment pathway (Figure 2). The investigation of screen-detected abnormalities falls outside of the program and is part of usual care and according to existing clinical guidance, including the optimal care pathway for people with lung cancer [49]. If lung cancer is diagnosed, specialists should update the NCSR with test findings using the diagnosis form. If diagnosis data are not entered within 4 weeks of specialist referral, the NCSR will follow up with the specialist or the nominated healthcare provider. Histopathology reports are automatically transmitted from integrated laboratories to the NCSR.

5.6.2 | Actionable Additional Findings

The low-dose CT scan is an opportunity to detect and manage actionable additional findings beyond lung cancer which may be of benefit for the participant. Actionable additional findings for the Program are defined in the *National Lung Cancer Screening Program additional findings guidelines* published by RANZCR and ANZSTR [50]. Radiologists should record actionable additional findings alongside the scan outcome category in the structured clinical radiology report. Requesting practitioners will be informed of actionable additional findings, with further recommended action required and will be responsible for managing these findings according to relevant clinical guidelines and best practice.

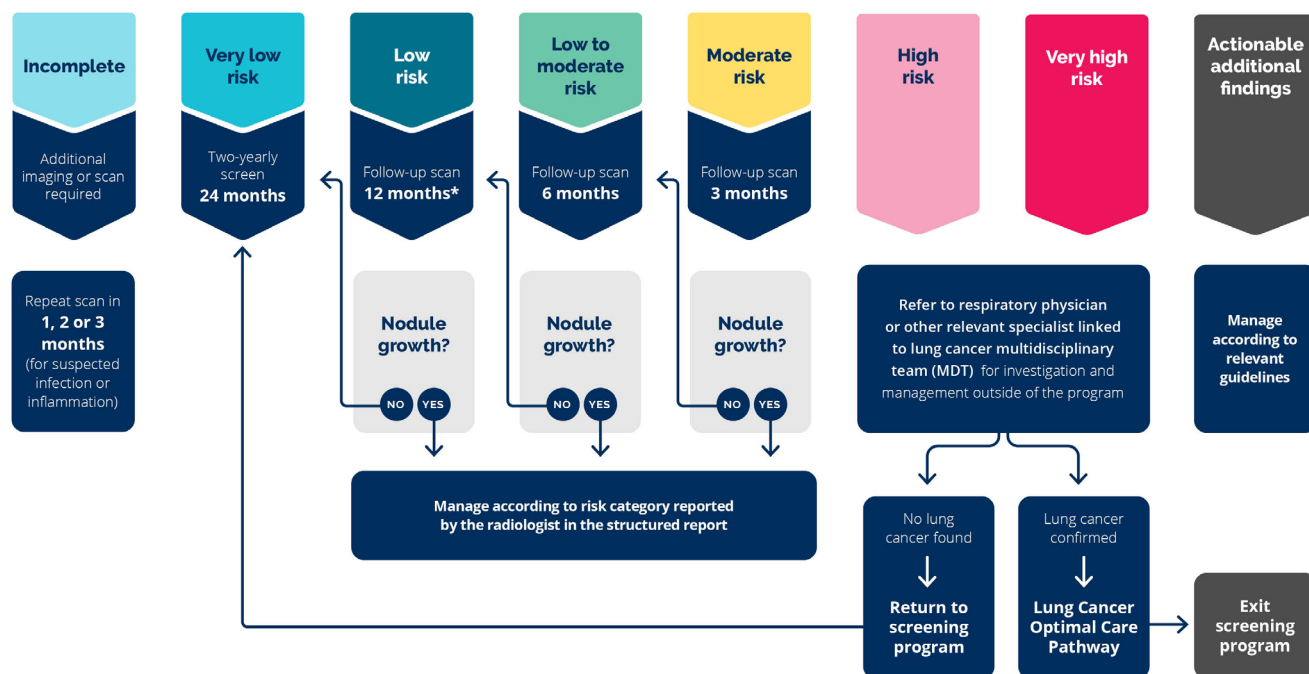


FIGURE 2 | Simplified National Lung Cancer Screening Program nodule management protocol flowchart. *Source:* Australian Government Department of Health, Disability and Ageing. National Lung Cancer Screening Program guidelines, 2025; reproduced with permission [19].

5.6.3 | Results Communication

Requesting practitioners are responsible for communicating screening results to participants. Participants without a regular general practitioner may nominate an alternative recipient for their communication.

The NCSR supports the process of results communication through direct correspondence to participants and requesting practitioners. The NCSR will notify participants registered with the NCSR and their requesting practitioners when results are available. NCSR communication does not replace duty of care responsibilities that healthcare providers have for communicating with and managing participant results. If a participant opts out of communication with the NCSR, the requesting practitioner will be responsible for all communication of results.

Healthcare providers are to accommodate participants' communication preferences regarding how and when is appropriate to discuss their results and ensure culturally safe care. Practice points emphasise communicating results in a sensitive, clear and culturally safe manner to help participants understand their results and access appropriate psychosocial and smoking cessation supports.

5.6.4 | Screening Reminders

The NCSR will issue screening reminders for 2-yearly and interval scans directly to participants and requesting practitioners. Healthcare providers are encouraged to send tailored reminders to participants whose participation is recorded in their EMR

system. Requesting practitioners are responsible for sending screening reminders and follow-up notifications to participants who have opted out of NCSR communication.

5.6.5 | Program Exit and Re-Entry

Participants may exit the Program upon reaching its upper age limit of 71 years of age (age ineligibility), having a lung cancer diagnosis, becoming unable to undergo a low-dose CT scan or actively opting out of the Program. Upon Program exit, participants' existing information will remain in the NCSR but participants will not receive further communications. Eligible participants may re-enter the Program, including those successfully treated for lung cancer, where clinical judgement deems it appropriate. Healthcare providers should discuss broader options for managing any concerns about lung health with participants who have turned 71 years of age and exited the program.

6 | Conclusion

Lung cancer screening saves lives by helping to detect cancer at an earlier, treatable stage. The National Lung Cancer Screening Program's guidelines provide step-by-step guidance for clinical delivery and Program navigation, supporting healthcare providers to deliver the Program safely and effectively. The recommendations and practice points detailed in the Program's guidelines are grounded in best practice evidence and were developed in consultation with experts, consumers and the public to ensure the delivery of a culturally safe and equitable program for the Australian community.

Author Contributions

Conceptualisation: Nicole M. Rankin, Lisa J. Whop, Raglan Maddox, Katrina Anderson, Cindy Toms, Vivienne Milch, Claire E. Nightingale, Alison Brown, Fraser Brims, Annette McWilliams, Emily Stone, Mark Brooke, Jon Emery, Michel Itel. Formal analysis: Rebecca Zosel, Lisa J. Whop, Raglan Maddox, Maria A. R. Lantin, Georgia Bartlett, Mikayla Wolfe, Abbey Diaz, Claire E. Nightingale, Alison Brown, Sam Pope. Funding acquisition: Nicole M. Rankin, Lisa J. Whop, Raglan Maddox, Claire E. Nightingale, Alison Brown, Jon Emery. Investigation: Rebecca Zosel, Lisa J. Whop, Raglan Maddox, Annette McWilliams, Miranda Siemienowicz, Jon Emery, Maria A. R. Lantin, Georgia Bartlett, Mikayla Wolfe, Abbey Diaz, Stephen Melsom, Claire E. Nightingale, Alison Brown, Sam Pope. Methodology: Nicole M. Rankin, Rebecca Zosel, Lisa J. Whop, Raglan Maddox, Katrina Anderson, Cindy Toms, Maria A. R. Lantin, Georgia Bartlett. Project administration: Rebecca Zosel, Maria A. R. Lantin, Georgia Bartlett, Mikayla Wolfe, Katrina Anderson, Lillian Liu, Cindy Toms, Sam Pope. Supervision: Nicole M. Rankin, Lisa J. Whop, Raglan Maddox, Annette McWilliams, Jon Emery, Katrina Anderson, Cindy Toms, Mark Brooke, Dorothy Keefe, Vivienne Milch. Visualisation: Nicole M. Rankin, Rebecca Zosel, Lisa J. Whop, Georgia Bartlett, Katrina Anderson, Miranda Siemienowicz, Diane M. Pascoe. Writing – original draft: Maria A. R. Lantin, Rebecca Zosel, Georgia Bartlett, Nicole M. Rankin. Writing – review and editing: Nicole M. Rankin, Lisa J. Whop, Raglan Maddox, Annette McWilliams, Jon Emery, Maria A. R. Lantin, Georgia Bartlett, Mikayla Wolfe, Abbey Diaz, Katrina Anderson, Lillian Liu, Cindy Toms, Sarah McDermott, Peter Bligh, Jeremy Chalke, Stephen Melsom, Claire E. Nightingale, Alison Brown, Sam Pope, Julia Brotherton, Anne Fidler, Michel Itel, Diane M. Pascoe, Fraser Brims, Tracy L. Leong, Emily Stone, Dorothy Keefe, Vivienne Milch.

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Disclosure

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Conflicts of Interest

Members of the National Lung Cancer Screening Program Clinical Materials Multidisciplinary Working Group were required to complete and submit a confidentiality agreement ahead of the first working group meeting and declare any conflicts of interest throughout the development of the National Lung Cancer Screening Program guidelines. The authors declare no competing interests.

Data Availability Statement

This article includes no original data.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Data S1:** mja270234-sup-0001-supinfo.pdf.