

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT NHI:</b> .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
.....	Address: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

**Trastuzumab emtansine**

**Initial application**

Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
<b>and</b>	<input type="checkbox"/>
<input type="checkbox"/>	Patient has previously received trastuzumab and chemotherapy, separately or in combination
<b>and</b>	<input type="checkbox"/>
<input type="checkbox"/>	The patient has received prior therapy for metastatic disease*
<b>or</b>	<input type="checkbox"/>
<input type="checkbox"/>	The patient developed disease recurrence during, or within six months of completing adjuvant therapy*
<b>and</b>	<input type="checkbox"/>
<input type="checkbox"/>	Patient has a good performance status (ECOG 0-1)
<b>and</b>	<input type="checkbox"/>
<input type="checkbox"/>	Patient does not have symptomatic brain metastases
<b>or</b>	<input type="checkbox"/>
<input type="checkbox"/>	Patient has brain metastases and has received prior local CNS therapy
<b>and</b>	<input type="checkbox"/>
<input type="checkbox"/>	Treatment to be discontinued at disease progression

**Renewal**

Current approval Number (if known):.....

Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab emtansine
<b>and</b>	<input type="checkbox"/>
<input type="checkbox"/>	Treatment to be discontinued at disease progression

Note: \*Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy, biological drugs, or endocrine therapy.

**I confirm the above details are correct and that in signing this form I understand I may be audited.**

Signed: ..... Date: .....

Post application to Ministry of Health, Private Bag 3015, Wanganui – email: [customerservice@health.govt.nz](mailto:customerservice@health.govt.nz)