HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.

PRESCRIBER

Name: ....

Ward: ....

PATIENT:

Name: ....

NHI: ....

Pertuzumab

INITIATION
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ◯ The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)

and

- ◯ Patient is chemotherapy treatment naive

  or

- ◯ Patient has not received prior treatment for their metastatic disease and has had a treatment free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer

and

- ◯ The patient has good performance status (ECOG grade 0-1)

and

- ◯ Pertuzumab to be administered in combination with trastuzumab

and

- ◯ Pertuzumab maximum first dose of 840 mg, followed by maximum of 420 mg every 3 weeks

and

- ◯ Pertuzumab to be discontinued at disease progression

CONTINUATION
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ◯ The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)

and

- ◯ The cancer has not progressed at any time point during the previous 12 months whilst on pertuzumab and trastuzumab

HOSPITAL

I confirm that the above details are correct:

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