

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: .....

**Fulvestrant**

**INITIATION**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

Patient has oestrogen-receptor positive locally advanced or metastatic breast cancer

and

Patient has disease progression following prior treatment with an aromatase inhibitor or tamoxifen for their locally advanced or metastatic disease

and

Treatment to be given at a dose of 500 mg monthly following loading doses

and

Treatment to be discontinued at disease progression

**CONTINUATION**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

Treatment remains appropriate and patient is benefitting from treatment

and

Treatment to be given at a dose of 500 mg monthly

and

No evidence of disease progression

I confirm that the above details are correct:

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