

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER** Reg No:

Reg No: First Names: First Names:

Name: Surname: Surname:

Address: DOB: Address:

..... Address:

.....

Fax Number: Fax Number:

Trastuzumab emtansine

Initial application — early breast cancer

Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

- Patient has early breast cancer expressing HER2 IHC3+ or ISH+
- and Documentation of pathological invasive residual disease in the breast and/or auxiliary lymph nodes following completion of surgery
- and Patient has completed systemic neoadjuvant therapy with trastuzumab and chemotherapy prior to surgery
- and Disease has not progressed during neoadjuvant therapy
- and Patient has left ventricular ejection fraction of 45% or greater
- and Adjuvant treatment with trastuzumab emtansine to be commenced within 12 weeks of surgery
- and Trastuzumab emtansine to be discontinued at disease progression
- and Total adjuvant treatment duration must not exceed 42 weeks (14 cycles)

Initial application — metastatic breast cancer

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)

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

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

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

Trastuzumab emtansine - *continued*

Renewal — metastatic breast cancer

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
and	
<input type="checkbox"/>	Treatment to be discontinued at disease progression

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