

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:

Trastuzumab emtansine

INITIATION – early breast cancer

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 axillary 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)

INITIATION – metastatic breast cancer

Re-assessment required after 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 or trastuzumab deruxtecan treatment
- or Patient has discontinued trastuzumab deruxtecan due to intolerance
- and The cancer did not progress while on trastuzumab deruxtecan
- and Treatment to be discontinued at disease progression

I confirm that the above details are correct:

Signed: Date:

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PRESCRIBER

PATIENT:

Name:

Name:

Ward:

NHI:

Trastuzumab emtansine - *continued*

CONTINUATION – metastatic breast cancer

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

- The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab emtansine
and
 Treatment to be discontinued at disease progression

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



I confirm that the above details are correct:

Signed: Date: