

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 (Herceptin)

CONTINUATION – Metastatic breast cancer

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 trastuzumab
and ☐ Trastuzumab not to be given in combination with lapatinib
and ☐ Trastuzumab to be discontinued at disease progression

I confirm that the above details are correct:

Signed: Date: