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	PATIENT:	
Name:	Name:	
Ward:	NHI:	

Trastuzumab deruxtecan

INITIATION Re-assessment required after 6 months				
	Prerequisites (tick boxes where appropriate)			
		Ο	Patient has metastatic breast cancer expressing HER-2 IHC3+ or ISH+ (including FISH or other current technology)	
	and and	0	Patient has previously received trastuzumab and chemotherapy, separately or in combination	
		or	O The patient has received prior therapy for metastatic disease	
			O The patient developed disease recurrence during, or within six months of completing adjuvant therapy	
	and and	0	Patient has a good performance status (ECOG 0-1)	
	and	Ο	Patient has not received prior funded trastuzumab deruxtecan treatment	
		0	Treatment to be discontinued at disease progression	
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)				
	and	0	The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab deruxtecan	
	and	Ο	Treatment to be discontinued at disease progression	

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

I confirm that the above details are correct: