Enquiries to Ministry of Health 0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)	ple) PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Pertuzumab		
Initial application — metastatic breast cancer Applications from any relevant practitioner. Approvals valid for 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		
Patient is chemotherapy treatment naïve		
Patient has not received prior treatment for their metastatic disease and has had a treatment free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer		
and		
The patient has good performance status (ECOG grade 0-1) and		
Pertuzumab to be administered in combination with trastuzumab and		
Pertuzumab maximum first dose of 840 mg, followed by maximum of 420 mg every 3 weeks		
Pertuzumab to be discontinued at disease progression		
Parameter water static horsest conserve		
Renewal — metastatic breast cancel Current approval Number (if known):		
Applications from any relevant practition Prerequisites (tick boxes where appropriate to the content of the co	oner. Approvals valid for 12 months.	
The patient has and	metastatic breast cancer expressing HER-2 IH	C 3+ or ISH+ (including FISH or other current technology)
The cancer has	not progressed at any time point during the pre	vious 12 months whilst on pertuzumab and trastuzumab
or		
Patient has previ disease progress and		and trastuzumab for reasons other than severe toxicity or
Patient has signs	s of disease progression	
and Disease has not	progressed during previous treatment with per	tuzumab and trastuzumab

I confirm the above details are correct and that in signing this form I understand I may be audited.