

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:

Pertuzumab

INITIATION

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

Patient is chemotherapy treatment naive

or

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

and

Pertuzumab to be discontinued at disease progression

CONTINUATION

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 pertuzumab and trastuzumab

or

Patient has previously discontinued treatment with pertuzumab and trastuzumab for reasons other than severe toxicity or disease progression

and

Patient has signs of disease progression

and

Disease has not progressed during previous treatment with pertuzumab and trastuzumab

I confirm that the above details are correct:

Signed: Date: