## 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:
Lapatinib	
INITIATION Prerequisites (tick box where appropriate) O For continuation use only	
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
O The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology) and O The cancer has not progressed at any time point during the previous 12 months whilst on lapatinib	
and C Lapatinib not to be given in combination with trastuzumab and C Lapatinib to be discontinued at disease progression	

I confirm that the above details are correct: