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:
Pertuzumab					
	ssess	smen		nired after 12 months poxes where appropriate)	
	and	0	The	patient has metastatic breast cancer expressing HER-2 IH	IC 3+ or ISH+ (including FISH or other current technology)
		or	O O	Patient is chemotherapy treatment naive Patient has not received prior treatment for their metasta between prior (neo)adjuvant chemotherapy treatment an	tic disease and has had a treatment free interval of at least 12 months
	and (and and and	OOOO	Pertu Pertu	patient has good performance status (ECOG grade 0-1) Izumab to be administered in combination with trastuzuma Izumab maximum first dose of 840 mg, followed by maximum be discontinued at disease progression	
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)					
	or	and	0		R-2 IHC 3+ or ISH+ (including FISH or other current technology) the previous 12 months whilst on pertuzumab and trastuzumab
		and	0	Patient has previously discontinued treatment with pertudisease progression Patient has signs of disease progression Disease has not progressed during previous treatment with pertudisease progression	zumab and trastuzumab for reasons other than severe toxicity or
				Sissass has not progressed during previous treatment w	nur portazantab ana nabiazantab

Signed: Date: