**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

Name: ....

Ward: ....

PATIENT:

Name: ....

NHI: ....

Palbociclib (Ibrance)

INITIATION
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

- ◯ Patient has unresectable locally advanced or metastatic breast cancer
- **and** ◯ There is documentation confirming disease is hormone-receptor positive and HER2-negative
- **and** ◯ Patient has an ECOG performance score of 0-2
- **and**
  - ◯ Disease has relapsed or progressed during prior endocrine therapy
  - **or**
    - ◯ Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state
    - **and** ◯ Patient has not received prior systemic treatment for metastatic disease
- **and** ◯ Treatment must be used in combination with an endocrine partner
- **and** ◯ Patient has not received prior funded treatment with a CDK4/6 inhibitor

or

- ◯ Patient has an active Special Authority approval for ribociclib
- **and** ◯ Patient has experienced a grade 3 or 4 adverse reaction to ribociclib that cannot be managed by dose reductions and requires treatment discontinuation
- **and** ◯ Treatment must be used in combination with an endocrine partner
- **and** ◯ There is no evidence of progressive disease since initiation of ribociclib

CONTINUATION
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ◯ Treatment must be used in combination with an endocrine partner
- **and** ◯ There is no evidence of progressive disease since initiation of palbociclib

HOSPITAL

I confirm that the above details are correct:

Signed: .... Date: ....