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.

PRE	SCRIE	ER	PATIENT:
Nam	e:		Name:
Ward	l:		NHI:
Palbociclib (Ibrance)			
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)			
		and or and and or and	Patient has unresectable locally advanced or metastatic breast cancer There is documentation confirming disease is hormone-receptor positive and HER2-negative Patient has an ECOG performance score of 0-2 O Disease has relapsed or progressed during prior endocrine therapy O Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state O Patient has not received prior systemic treatment for metastatic disease Treatment must be used in combination with an endocrine partner
	or	and and and	Patient has not received prior funded treatment with a CDK4/6 inhibitor Patient has an active Special Authority approval for ribociclib Patient has experienced a grade 3 or 4 adverse reaction to ribociclib that cannot be managed by dose reductions and requires treatment discontinuation Treatment must be used in combination with an endocrine partner There is no evidence of progressive disease since initiation of ribociclib
Re-a	assess	ites (tick t	uired after 12 months poxes where appropriate) timent must be used in combination with an endocrine partner e is no evidence of progressive disease since initiation of palbociclib

I confirm that the above details are correct:

Signed: Date: