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: .....

Trastuzumab deruxtecan

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

- ○ Patient has metastatic breast cancer expressing HER-2 IHC3+ or ISH+ (including FISH or other current technology)

and

- ○ Patient has previously received trastuzumab and chemotherapy, separately or in combination

and

- ○ The patient has received prior therapy for metastatic disease

or

- ○ The patient developed disease recurrence during, or within six months of completing adjuvant therapy

and

- ○ Patient has a good performance status (ECOG 0-1)

and

- ○ Patient has not received prior funded trastuzumab deruxtecan treatment

and

- ○ Treatment to be discontinued at disease progression

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

- ○ The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab deruxtecan

and

- ○ Treatment to be discontinued at disease progression

Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy, biological drugs, or endocrine therapy.

I confirm that the above details are correct:

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