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:
Trastuzumab deruxtecan	
INITIATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
Patient has metastatic breast cancer expressing HER-2 IHC and Patient has previously received trastuzumab and chemother	
The patient has received prior therapy for metastatic domain. The patient developed disease recurrence during, or w	
and O Patient has a good performance status (ECOG 0-1) and O Patient has not received prior funded trastuzumab deruxteca and O Treatment to be discontinued at disease progression	an treatment
CONTINUATION Re-assessment required after 6 months Prerequisites (tick boxes where appropriate)	
The cancer has not progressed at any time point during the and Treatment to be discontinued at disease progression	previous approval period whilst on trastuzumab deruxtecan
Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy,	biological drugs, or endocrine therapy.

I confirm that the above details are correct:

C:	D-1	
Signed.	Date:	
Oigilica.	 Duic.	