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



I confirm that the above details are correct:

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