

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: