

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:

Lapatinib

INITIATION

Prerequisites (tick box where appropriate)

☐ For continuation use only

CONTINUATION

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

- ☐ The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
and
☐ The cancer has not progressed at any time point during the previous 12 months whilst on lapatinib
and
☐ Lapatinib not to be given in combination with trastuzumab
and
☐ Lapatinib to be discontinued at disease progression

I confirm that the above details are correct:

Signed: Date: