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	:			
Ward:			NHI:	
Pertuzumab				
	ssess	men	nt required after 12 months (tick boxes where appropriate)	
	and	O	The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)	
		or	O Patient is chemotherapy treatment naive	
			O Patient has not received prior treatment for their metastatic disease and has had a treatment free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer	
	and (and and	0	The patient has good performance status (ECOG grade 0-1)	
		$\circ$	Pertuzumab to be administered in combination with trastuzumab	
		$\circ$	Pertuzumab maximum first dose of 840 mg, followed by maximum of 420 mg every 3 weeks	
	and (	0	Pertuzumab to be discontinued at disease progression	
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)				
		an		
	or		The cancer has not progressed at any time point during the previous 12 months whilst on pertuzumab and trastuzumab	
		an	O Patient has previously discontinued treatment with pertuzumab and trastuzumab for reasons other than severe toxicity or disease progression	
		an	O Patient has signs of disease progression	
			O Disease has not progressed during previous treatment with pertuzumab and trastuzumab	

I confirm that the above details are correct:	

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