HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

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: .....

Pertuzumab with trastuzumab

INITIATION
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ○ The individual has received an initial Special Authority approval for intravenous pertuzumab and trastuzumab for metastatic breast cancer
- **and**
- ○ Pertuzumab with trastuzumab to be administered subcutaneously at a maximum dose of 600 mg pertuzumab with 600 mg trastuzumab every three weeks (or equivalent)

or

- ○ The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
- **and**
- ○ Patient is chemotherapy treatment naïve
- **or**
- ○ 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**
- ○ The patient has good performance status (ECOG grade 0-1)
- **and**
- ○ Loading dose of pertuzumab with trastuzumab to be administered subcutaneously at a maximum dose of 1200 mg pertuzumab with 600 mg trastuzumab, respectively
- **and**
- ○ Maintenance doses of pertuzumab with trastuzumab to be administered subcutaneously at a maximum dose of 600 mg pertuzumab with 600 mg trastuzumab every three weeks (or equivalent)
- **and**
- ○ Pertuzumab with trastuzumab to be discontinued at disease progression

CONTINUATION
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ○ The individual 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 pertuzumab and trastuzumab

or

- ○ Individual has previously discontinued treatment with pertuzumab with trastuzumab for reasons other than severe toxicity or disease progression
- **and**
- ○ Individual has signs of disease progression
- **and**
- ○ Disease has not progressed during previous treatment with pertuzumab with trastuzumab

HOSPITAL

I confirm that the above details are correct:

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