

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:

Fulvestrant

INITIATION

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

- ☐ Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ☐ Patient has oestrogen-receptor positive locally advanced or metastatic breast cancer
- and
- ☐ Patient has disease progression following prior treatment with an aromatase inhibitor or tamoxifen for their locally advanced or metastatic disease
- and
- ☐ Treatment to be given at a dose of 500 mg monthly following loading doses
- and
- ☐ Treatment to be discontinued at disease progression

CONTINUATION

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

- ☐ Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ☐ Treatment remains appropriate and patient is benefitting from treatment
- and
- ☐ Treatment to be given at a dose of 500 mg monthly
- and
- ☐ No evidence of disease progression

I confirm that the above details are correct:

Signed: Date: