

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: ..... Name: .....

Ward: ..... 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: .....