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: .....

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: .....