

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:

Palbociclib (Ibrance)

INITIATION

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

- ☐ Patient has unresectable locally advanced or metastatic breast cancer

and

☐ There is documentation confirming disease is hormone-receptor positive and HER2-negative

and

☐ Patient has an ECOG performance score of 0-2

and

☐ Disease has relapsed or progressed during prior endocrine therapy

or

☐ Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state

and

☐ Patient has not received prior systemic treatment for metastatic disease

and

☐ Treatment must be used in combination with an endocrine partner

and

☐ Patient has not received prior funded treatment with a CDK4/6 inhibitor
- or
- ☐ Patient has an active Special Authority approval for ribociclib

and

☐ Patient has experienced a grade 3 or 4 adverse reaction to ribociclib that cannot be managed by dose reductions and requires treatment discontinuation

and

☐ Treatment must be used in combination with an endocrine partner

and

☐ There is no evidence of progressive disease since initiation of ribociclib

CONTINUATION

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

- ☐ Treatment must be used in combination with an endocrine partner
- and
- ☐ There is no evidence of progressive disease since initiation of palbociclib

I confirm that the above details are correct:

Signed: Date: