

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: ..... NHI: .....

**Trastuzumab deruxtecan**

**INITIATION**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

and  Patient has metastatic breast cancer expressing HER-2 IHC3+ or ISH+ (including FISH or other current technology)

and  Patient has previously received trastuzumab and chemotherapy, separately or in combination

and  The patient has received prior therapy for metastatic disease  
or  The patient developed disease recurrence during, or within six months of completing adjuvant therapy

and  Patient has a good performance status (ECOG 0-1)

and  Patient has not received prior funded trastuzumab deruxtecan treatment

and  Treatment to be discontinued at disease progression

**CONTINUATION**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

and  The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab deruxtecan

and  Treatment to be discontinued at disease progression

Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy, biological drugs, or endocrine therapy.

I confirm that the above details are correct:

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