

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: .....

**Trastuzumab emtansine**

**INITIATION – early breast cancer**

**Prerequisites** (tick boxes where appropriate)

- Patient has early breast cancer expressing HER2 IHC3+ or ISH+
- and  Documentation of pathological invasive residual disease in the breast and/or axillary lymph nodes following completion of surgery
- and  Patient has completed systemic neoadjuvant therapy with trastuzumab and chemotherapy prior to surgery
- and  Disease has not progressed during neoadjuvant therapy
- and  Patient has left ventricular ejection fraction of 45% or greater
- and  Adjuvant treatment with trastuzumab emtansine to be commenced within 12 weeks of surgery
- and  Trastuzumab emtansine to be discontinued at disease progression
- and  Total adjuvant treatment duration must not exceed 42 weeks (14 cycles)

**INITIATION – metastatic breast cancer**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- Patient has metastatic breast cancer expressing HER-2 IHC 3+ 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 does not have symptomatic brain metastases
- or  Patient has brain metastases and has received prior local CNS therapy
- and  Patient has not received prior funded trastuzumab emtansine or trastuzumab deruxtecan treatment
- or  Patient has discontinued trastuzumab deruxtecan due to intolerance
- and  The cancer did not progress while on trastuzumab deruxtecan
- and  Treatment to be discontinued at disease progression

I confirm that the above details are correct:

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

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**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

**Trastuzumab emtansine** - *continued*

**CONTINUATION – metastatic breast cancer**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab emtansine  
**and**  
 Treatment to be discontinued at disease progression

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



I confirm that the above details are correct:

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