

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:

Ribociclib

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 endocrine treatment for metastatic disease
and
 Treatment to 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 palbociclib
and
 Patient has experienced a grade 3 or 4 adverse reaction to palbociclib 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 palbociclib

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 ribociclib

I confirm that the above details are correct:

Signed: Date: