

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: .....

**Pertuzumab**

**INITIATION**

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
- Patient is chemotherapy treatment naive
- or
- Patient has not received prior treatment for their metastatic disease and has had a treatment free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer
- and
- The patient has good performance status (ECOG grade 0-1)
- and
- Pertuzumab to be administered in combination with trastuzumab
- and
- Pertuzumab maximum first dose of 840 mg, followed by maximum of 420 mg every 3 weeks
- and
- Pertuzumab to be discontinued at disease progression

**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 pertuzumab and trastuzumab
- or
- Patient has previously discontinued treatment with pertuzumab and trastuzumab for reasons other than severe toxicity or disease progression
- and
- Patient has signs of disease progression
- and
- Disease has not progressed during previous treatment with pertuzumab and trastuzumab

I confirm that the above details are correct:

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