

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 deruxtecan**

**INITIATION**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- 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)

- 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: .....