

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: .....

**Lapatinib**

**INITIATION**

**Prerequisites** (tick box where appropriate)

For continuation use only

**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 lapatinib
- and  Lapatinib not to be given in combination with trastuzumab
- and  Lapatinib to be discontinued at disease progression

I confirm that the above details are correct:

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