

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: .....

**Palbociclib (Ibrance)**

**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 treatment for metastatic disease  
**and**  
☐ Treatment must 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 ribociclib  
**and**  
☐ Patient has experienced a grade 3 or 4 adverse reaction to ribociclib 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 ribociclib

**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 palbociclib

I confirm that the above details are correct:

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