

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 emtansine

INITIATION – early breast cancer

Prerequisites (tick boxes where appropriate)

- ☐ Patient has early breast cancer expressing HER2 IHC3+ or ISH+
- and ☐ Documentation of pathological invasive residual disease in the breast and/or axillary lymph nodes following completion of surgery
- and ☐ Patient has completed systemic neoadjuvant therapy with trastuzumab and chemotherapy prior to surgery
- and ☐ Disease has not progressed during neoadjuvant therapy
- and ☐ Patient has left ventricular ejection fraction of 45% or greater
- and ☐ Adjuvant treatment with trastuzumab emtansine to be commenced within 12 weeks of surgery
- and ☐ Trastuzumab emtansine to be discontinued at disease progression
- and ☐ Total adjuvant treatment duration must not exceed 42 weeks (14 cycles)

INITIATION – metastatic breast cancer

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

- ☐ Patient has metastatic breast cancer expressing HER-2 IHC 3+ 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 does not have symptomatic brain metastases
 - or ☐ Patient has brain metastases and has received prior local CNS therapy
- and

- ☐ Patient has not received prior funded trastuzumab emtansine or trastuzumab deruxtecan treatment
 - or

- ☐ Patient has discontinued trastuzumab deruxtecan due to intolerance
 - and ☐ The cancer did not progress while on trastuzumab deruxtecan
- and ☐ Treatment to be discontinued at disease progression

I confirm that the above details are correct:

Signed: Date:

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 emtansine - continued

CONTINUATION – metastatic breast cancer

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 emtansine
and
☐ Treatment to be discontinued at disease progression

Note: *Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy, biological drugs, or endocrine therapy.

I confirm that the above details are correct:

Signed: Date: