Enquiries to Ministry of Health 0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)				sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:					First Names:	First Names:
Name:					Surname:	Surname:
Address:					DOB:	Address:
					Address:	
Fax N	lumbei	r:				Fax Number:
Ribociclib						
Initial application Applications from any relevant practitioner. Approvals valid for 6 months. Prerequisites(tick boxes where appropriate)						
	a	and [and and and	or	There is documentation core Patient has an ECOG perform Disease has relapsed Patient is amer without menstrue and Patient has not Patient comme and There is no evice Treatment to be used in core	cally advanced or metastatic breast cancer ifirming disease is hormone-receptor positive and HE irmance score of 0-2 If or progressed during prior endocrine therapy inorrhoeic, either naturally or induced, with endocrine least-potential state received prior systemic endocrine treatment for meta inced treatment with ribociclib in combination with an endocrine of progressive disease inbination with an endocrine partner or funded treatment with a CDK4/6 inhibitor	evels consistent with a postmenopausal or
	or					
		and		Patient has an active Specia	al Authority approval for palbociclib	
		and		Patient has experienced a gardenest discontinuation	grade 3 or 4 adverse reaction to palbociclib that cannot	ot be managed by dose reductions and requires
		and		Treatment must be used in	combination with an endocrine partner	
		[There is no evidence of pro-	gressive disease since initiation of palbociclib	
Renewal Current approval Number (if known):						
	There is no evidence of progressive disease since initiation of ribociclib					

I confirm the above details are correct and that in signing this form I understand I may be audited.