

**APPLICANT** (stamp or sticker acceptable)      **PATIENT NHI:** .....      **REFERRER** Reg No: .....

Reg No: .....      First Names: .....      First Names: .....

Name: .....      Surname: .....      Surname: .....

Address: .....      DOB: .....      Address: .....

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Fax Number: .....      Fax Number: .....

**Trastuzumab emtansine**

**Initial application — early breast cancer**

Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

**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)

**Initial application — metastatic breast cancer**

Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 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 the above details are correct and that in signing this form I understand I may be audited.

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

Post application to Ministry of Health, Private Bag 3015, Wanganui – email: [customerservice@health.govt.nz](mailto:customerservice@health.govt.nz)

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**Trastuzumab emtansine** - *continued*

**Renewal — metastatic breast cancer**

Current approval Number (if known):.....

Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

<b>and</b>	<input type="checkbox"/> The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab emtansine
	<input type="checkbox"/> Treatment to be discontinued at disease progression

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

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

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

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