APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
	Surname:	
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:

Pertuzumab

Appl	ication	ication — metastatic breast cancer s from any relevant practitioner. Approvals valid for 12 months. tes(tick boxes where appropriate)		
	and	The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)		
		Patient is chemotherapy treatment naïve		
		Patient has not received prior treatment for their metastatic disease and has had a treatment free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer		
	and The patient has good performance status (ECOG grade 0-1)			
	and [and	Pertuzumab to be administered in combination with trastuzumab		
	and	Pertuzumab maximum first dose of 840 mg, followed by maximum of 420 mg every 3 weeks		
		Pertuzumab to be discontinued at disease progression		
Renewal — metastatic breast cancer				
Current approval Number (if known):				
Applications from any relevant practitioner. Approvals valid for 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)		
		The cancer has not progressed at any time point during the previous 12 months whilst on pertuzumab and trastuzumab		
	or			
		Patient has previously discontinued treatment with pertuzumab and trastuzumab for reasons other than severe toxicity or disease progression		
		and Patient has signs of disease progression		
		Disease has not progressed during previous treatment with pertuzumab and trastuzumab		

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