Enquiries to Ministry of Health 0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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Name: Surname: Surname: Surname: Address: DOB: Address: Address: DOB: Address: Fax Number: Fax Numb	APPLICANT (stamp or sticker acceptable)		PATIENT NHI:	REFERRER Reg No:	
Address: Fax Number: Fax Number: Fax Number: Pertuzumab Initial application — metastatic breast cancer 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) and The 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 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 and 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) and The patient has previously discontinued treatment with pertuzumab and trastuzumab for reasons other than severe toxicity or disease progression Patient has signs of disease progression	Reg No: .		First Names:	First Names:	
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I confirm the above details are correct and that in signing this form I understand I may be audited.