

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT NHI:</b> .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
.....	Address: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

### Trastuzumab (Herzuma)

#### Initial application — early breast cancer

Applications from any relevant practitioner. Approvals valid for 15 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has early breast cancer expressing HER-2 IHC 3+ or ISH + (including FISH or other current technology)
- and
- ☐ Maximum cumulative dose of 106 mg/kg (12 months' treatment)

#### Renewal — early 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 received prior adjuvant trastuzumab treatment for early breast cancer
- and
- ☐ The patient has not previously received lapatinib treatment for HER-2 positive metastatic breast cancer

or

☐ The patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst on lapatinib

or

☐ The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab
- and
- ☐ Trastuzumab will not be given in combination with pertuzumab

or

☐ Trastuzumab to be administered in combination with pertuzumab

and

☐ 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
- ☐ Trastuzumab to be discontinued at disease progression
- or
- ☐ Patient has previously discontinued treatment with trastuzumab in the metastatic setting for reasons other than severe toxicity or disease progression

and

☐ Patient has signs of disease progression

and

☐ Disease has not progressed during previous treatment with trastuzumab

Note: \* For patients with relapsed HER-2 positive disease who have previously received adjuvant trastuzumab for early breast cancer

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

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

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

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT</b> NHI: .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
.....	Address: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

**Trastuzumab (Herzuma) - continued**

**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 previously received lapatinib treatment for HER-2 positive metastatic breast cancer
- or
- ☐ The patient discontinued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst on lapatinib
- and
- ☐ Trastuzumab will not be given in combination with pertuzumab
- or
- ☐ Trastuzumab to be administered in combination with pertuzumab

and

☐ 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
- ☐ Trastuzumab 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 cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab
- and
- ☐ Trastuzumab to be discontinued at disease progression
- or
- ☐ Patient has previously discontinued treatment with trastuzumab for reasons other than severe toxicity or disease progression
- and
- ☐ Patient has signs of disease progression
- and
- ☐ Disease has not progressed during previous treatment with trastuzumab

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

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

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

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT</b> NHI: .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
.....	Address: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

**Trastuzumab (Herzuma) - continued**

**Initial application — gastric, gastro-oesophageal junction and oesophageal cancer**

Applications from any relevant practitioner. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has locally advanced or metastatic gastric, gastro-oesophageal junction or oesophageal cancer expressing HER-2 IHC 2+ FISH+ or IHC3+ (or other current technology)
- and
- ☐ Patient has an ECOG score of 0-2

**Renewal — gastric, gastro-oesophageal junction and oesophageal cancer**

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

Applications from any relevant practitioner. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab
- and
- ☐ Trastuzumab 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 Health New Zealand, Private Bag 3015, Wanganui – email: [customerservice@health.govt.nz](mailto:customerservice@health.govt.nz)