

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

### Trastuzumab deruxtecan

#### Initial application

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 is currently on treatment with trastuzumab deruxtecan and met all remaining criteria prior to commencing treatment
- or
- ☐ Patient has metastatic breast cancer expressing HER-2 IHC3+ 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 has not received prior funded trastuzumab deruxtecan treatment

and

☐ Treatment to be discontinued at disease progression

#### Renewal

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

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)

- ☐ The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab deruxtecan
- and
- ☐ 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: .....

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