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|------------------------------------------------|---------------------------|-------------------------------|
| <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 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 Health New Zealand, Private Bag 3015, Wanganui – email: [customerservice@health.govt.nz](mailto:customerservice@health.govt.nz)

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

**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)

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

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