

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER** Reg No:

Reg No: First Names: First Names:

Name: Surname: Surname:

Address: DOB: Address:

..... Address:

.....

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