

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:

Pertuzumab with trastuzumab

Initial application — metastatic breast cancer

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

Prerequisites(tick boxes where appropriate)

The individual has received an initial Special Authority approval for intravenous pertuzumab and trastuzumab for metastatic breast cancer

and

Pertuzumab with trastuzumab to be administered subcutaneously at a maximum dose of 600 mg pertuzumab with 600 mg trastuzumab every three weeks (or equivalent)

or

The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)

and

Patient is chemotherapy treatment naïve

or

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

Loading dose of pertuzumab with trastuzumab to be administered subcutaneously at a maximum dose of 1200 mg pertuzumab with 600 mg trastuzumab, respectively

and

Maintenance doses of pertuzumab with trastuzumab to be administered subcutaneously at a maximum dose of 600 mg pertuzumab with 600 mg trastuzumab every three weeks (or equivalent)

and

Pertuzumab with 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 individual 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 pertuzumab and trastuzumab

or

Individual has previously discontinued treatment with pertuzumab with trastuzumab for reasons other than severe toxicity or disease progression

and

Individual has signs of disease progression

and

Disease has not progressed during previous treatment with pertuzumab 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