

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
.....	Address:	
.....		
.....		

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