

# Crohn's disease paediatric – continuing authority application

## When to use this form

Use this form to apply for **continuing** PBS-subsidised biological medicines for paediatric patients 6 to 17 years inclusive, with Crohn's disease.

This form can also be used for demonstrating a patient's response to a PBS-subsidised biological medicine before temporarily stopping treatment.

## Important information

**Continuing** authority applications must be in writing and must include sufficient information to determine the patient's eligibility according to the PBS criteria.

Applications for **balance of supply** can be made in real time using the **Online PBS Authorities** system or by phone. Call 1800 700 270 Monday to Friday, 8 am to 5 pm, local time.

Under no circumstances will phone approvals be granted for paediatric Crohn's disease **continuing** authority applications.

Where the term 'biological medicine' appears, it refers to adalimumab or infliximab.

A copy of the Paediatric Crohn's Disease Activity Index is provided for your convenience, but is not required to be submitted with this application.

The information in this form is correct at the time of publishing and may be subject to change.

## Continuing treatment

This form is **ONLY** for **continuing** treatment.

After a written authority application for the **first continuing** treatment has been approved, **subsequent continuing** treatments with PBS-subsidised biosimilar brands of biological medicines are **Authority Required (STREAMLINED)** and do not require authority approval from Services Australia for the listed quantity and repeats.

## Section 100 arrangements for infliximab

This item is available to a patient who is attending:

- an approved private hospital, **or**
- a public hospital

**and** is a:

- day admitted patient
- non-admitted patient, **or**
- patient on discharge.

This item is not available as a PBS benefit for in-patients of a public hospital.

The hospital name and provider number must be included in this authority form.

## Treatment specifics

The assessment of the patient's response to the course of treatment must be conducted within the time frame specified in the restriction. Where a demonstration of response is not conducted within the required time frame, the patient will be deemed to have failed treatment with that particular PBS-subsidised biological medicine.

A patient who has experienced a serious adverse reaction of a severity necessitating permanent treatment withdrawal is not considered to have failed treatment with that particular PBS-subsidised biological medicine.

## For more information

Go to [servicesaustralia.gov.au/healthprofessionals](https://servicesaustralia.gov.au/healthprofessionals)



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## Patient's details

- Medicare card number  

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Ref no.   
**or**  
 Department of Veterans' Affairs card number  

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- Mr  Miss  Other   
 Family name  
  
 First given name
- Date of birth (DD MM YYYY)  

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- Patient's weight  
 kg
- Patient's height  
 cm

## Prescriber's details

- Prescriber number
- Dr  Mr  Mrs  Miss  Ms  Other   
 Family name  
  
 First given name
- Business phone number (including area code)  

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 Alternative phone number (including area code)  

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## Hospital details

- Hospital name
- This hospital is a:  
 public hospital  
 private hospital
- Hospital provider number

## Conditions and criteria

To qualify for PBS authority approval, the following conditions must be met.

- The patient, between 6 and 17 years, is being treated by a:  
 gastroenterologist  
 consultant physician (internal medicine specialising in gastroenterology)  
 consultant physician (general medicine specialising in gastroenterology)  
 paediatrician  
 specialist paediatric gastroenterologist.
- This application for:  
 adalimumab  
 infliximab  
▶ **Go to 13**
- or**  
 **demonstrating a response** to the current PBS-subsidised treatment before temporarily stopping treatment with this biological medicine.  
▶ **Go to 15**
- Does the patient have a documented history of severe Crohn's disease?  
 No   
 Yes
- Has the patient received this drug as their most recent course of PBS-subsidised biological medicine treatment for this condition?  
 No   
 Yes



MCA0PB161 2407

**15** The patient has demonstrated an adequate response to treatment with this drug by:

a reduction in Paediatric Crohn's Disease Activity Index (PCDAI) score by at least 15 points from baseline

**and**

a PCDAI score  $\leq$  30 for moderate to severe disease (infliximab only)

**or**

a PCDAI score  $\leq$  40 for severe disease (adalimumab only).

PCDAI score

Date of assessment (DD MM YYYY)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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### Checklist

**16**  The relevant attachments need to be provided with this form.

Details of the proposed prescription(s).

### Privacy notice

**17** Personal information is protected by law (including the *Privacy Act 1988*) and is collected by Services Australia for the purposes of assessing and processing this authority application.

Personal information may be used by Services Australia, or given to other parties where the individual has agreed to this, or where it is required or authorised by law (including for the purpose of research or conducting investigations).

More information about the way in which Services Australia manages personal information, including our privacy policy, can be found at [servicesaustralia.gov.au/privacypolicy](http://servicesaustralia.gov.au/privacypolicy)

### Prescriber's declaration

You do not need to **sign** the declaration if you complete this form using Adobe Acrobat Reader and return this form through Health Professional Online Services (HPOS) at [servicesaustralia.gov.au/hpos](http://servicesaustralia.gov.au/hpos)

### 18 I declare that:

- I am aware that this patient must meet the criteria listed in the current Schedule of Pharmaceutical Benefits to be eligible for this medicine.
- I have informed the patient that their personal information (including health information) will be disclosed to Services Australia for the purposes of assessing and processing this authority application.
- I have provided details of the proposed prescription(s) and the relevant attachments as specified in the Pharmaceutical Benefits Scheme restriction.
- the information I have provided in this form is complete and correct.

### I understand that:

- giving false or misleading information is a serious offence.

I have read, understood and agree to the above.

Date (DD MM YYYY) (you **must** date this declaration)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Prescriber's signature (**only** required if returning by post)


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### Returning this form

Return this form, details of the proposed prescription(s) and any relevant attachments:

- **online** (no signature required), upload through HPOS at [servicesaustralia.gov.au/hpos](http://servicesaustralia.gov.au/hpos)  
**or**
- by post (signature required) to  
Services Australia  
Complex Drugs Programs  
Reply Paid 9826  
HOBART TAS 7001

Week ending (DD MM YYYY)

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Each parameter in this table must be assigned a value.

		Score	Subtotal
<b>Abdominal pain</b>	No abdominal pain	0	
	Mild; no interference with Activities of Daily Living (ADL)	5	
	Moderate/severe; daily, nocturnal, interferes with ADL	10	
<b>Stools/day</b>	0–1 liquid, no blood	0	
	≤ 2 semi-formed + small blood or 2–5 liquid	5	
	≥ 6 liquid stools, gross blood, or nocturnal diarrhoea	10	
<b>General function</b>	Well, no limitations of activities	0	
	Below par, occasional difficulty with activities	5	
	Very poor, frequent limitation of activities	10	
<b>Examination</b>			
<b>Weight</b>	Weight gain (or voluntarily stable/reduction)	0	
	Weight loss < 10% (or involuntarily stable)	5	
	Weight loss ≥ 10%	10	
<b>Height† (at diagnosis)</b>	< 1 channel decrease from previous percentile	0	
	1 to < 2 channel decrease from previous percentile	5	
	≥ 2 channel decrease from previous percentile	10	
<b>or</b>			
<b>Height velocity††</b>	≤ -1 standard deviation from normal	0	
	-1 to < -2 standard deviation from normal	5	
	≥ -2 standard deviation from normal	10	
<b>Abdomen</b>	No tenderness or mass	0	
	Tenderness, or mass without tenderness	5	
	Tenderness, involuntary guarding, definite mass	10	
<b>Peri-rectal disease</b>	None, asymptomatic tags	0	
	1–2 indolent fistula, scant drainage, non-tender	5	
	Active fistula, drainage, tenderness, or abscess	10	
<b>Extra-intestinal†††</b>	None	0	
	1 manifestation	5	
	≥ 2 manifestations	10	
<b>Laboratory</b>			
<b>Haematocrit (%)</b> M = Male F = Female	M/F 6–10 years: ≥ 33	0	
	M 11–14 years: ≥ 35		
	F 11–19 years: ≥ 34		
	M 15–19 years: ≥ 37		
	M/F 6–10 years: 28–32	2.5	
	M 11–14 years: 30–34		
	F 11–19 years: 29–33		
	M 15–19 years: 32–36	5	
	M/F 6–10 years: < 28		
	M 11–14 years: < 30		
	F 11–19 years: < 29		
	M 15–19 years: < 32		
<b>ESR (mm / hr)</b>	< 20	0	
	20–50	2.5	
	> 50	5	
<b>Albumin (g / L)</b>	≥ 35	0	
	31–34	5	
	≤ 30	10	

† Height-channel represents lines on the standard percentile chart eg 10 – > 25 – > 50 percentile is 2 channels difference

†† Height velocity is calculated from measurements over last 6–12 months in cm / year compared to standard deviation below (minus to) normal

††† Extra-intestinal implies fever of > 38.5°C over 3 days over last week, arthritis, uveitis, Erythema nodosum or Pyoderma gangrenosum

**TOTAL  
PCDAI SCORE**

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