

Narcolepsy without cataplexy – armodafinil or modafinil – initial authority application

Online PBS Authorities



You do not need to complete this form if you use the **Online PBS Authorities** system.

For more information and how to access the **Online PBS Authorities** system, go to servicesaustralia.gov.au/hppbsauthorities

When to use this form

Use this form to apply for **initial** PBS-subsidised armodafinil or modafinil for patients with narcolepsy without cataplexy.

Important information

Initial applications to start PBS-subsidised treatment can be made using the **Online PBS Authorities** system or in writing and must include sufficient information to determine the patient's eligibility according to the PBS criteria.

Under no circumstances will phone approvals be granted for narcolepsy without cataplexy **initial** authority applications.

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 **initial** treatment.

After an authority application for **initial** treatment has been approved, applications for **continuing** or **changing** treatment 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.

Treatment specifics

Armodafinil and modafinil are not PBS-subsidised when used in combination with each other or with PBS-subsidised dexamfetamine sulfate.

For more information

Go to servicesaustralia.gov.au/healthprofessionals



medicare



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Patient's details

1 Medicare card number Ref no.

or

Department of Veterans' Affairs card number

2 Dr Mr Mrs Miss Ms Other

Family name

First given name

3 Date of birth (DD MM YYYY)

Prescriber's details

4 Prescriber number

5 Dr Mr Mrs Miss Ms Other

Family name

First given name

6 Business phone number (including area code)

Alternative phone number (including area code)

Conditions and criteria

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

- 7 This application is for:
 armodafinil
or
 modafinil
- 8 Is the patient being treated by a qualified sleep medicine practitioner or neurologist?
No
Yes
- 9 Has the patient had excessive daytime sleepiness, recurrent naps or lapses into sleep occurring almost daily for at least 3 months?
No
Yes
- 10 Does the patient have any medical or psychiatric disorder that could otherwise account for the hypersomnia?
No
Yes



MCA0PB104 2408

- 11** The patient is unable to receive therapy with dexamfetamine sulfate for this condition due to:
- a psychiatric disorder
 - a cardiovascular disorder
 - a history of substance abuse
 - glaucoma
 - any other absolute contraindication as specified in the Therapeutic Goods Administration (TGA) approved Product Information

Provide details of the absolute contraindication posed with dexamfetamine therapy

- the development of an intolerance with a severity to necessitate treatment withdrawal

Provide details of the intolerance

- 12** The patient has:

- a mean sleep latency ≤ 10 minutes on a Multiple Sleep Latency Test (MSLT) with at least 6 hours of sleep prior to the test

MSLT result

min

Date of the MSLT (DD MM YYYY)

▶ **Go to 13**

or

- an electroencephalographic (EEG) recording showing the pathologically rapid development of Rapid Eye Movement (REM) sleep

Date of the EEG (DD MM YYYY)

▶ **Go to 14**

- 13** Has the patient had a polysomnography test conducted prior to the MSLT test?

No

Yes ▶ Provide details

Date of the polysomnography test (DD MM YYYY)

Length of sleep (in minutes) prior to the MSLT (must be at least 360 minutes)

min

Checklist

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

Details of the proposed prescription(s).

The polysomnography, MSLT or EEG test report.

Privacy notice

- 15** 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

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

- 16** 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)

Prescriber's signature (**only** required if returning by post)

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
- or
- by post (signature required) to
 Services Australia
 Complex Drugs Programs
 Reply Paid 9826
 HOBART TAS 7001