

#### medicare



## Hereditary transthyretin amyloidosis – patisiran – continuing authority application

#### **Online PBS Authorities**

Requesting PBS Authorities online provides an immediate assessment in real time.

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 **continuing** PBS-subsidised patisiran for patients with hereditary transthyretin amyloidosis.

#### **Important information**

**Continuing** authority applications can be made in real time 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 hereditary transthyretin amyloidosis **continuing** 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 **continuing** treatment.

The patient remains eligible to receive **continuing** treatment providing they continue to demonstrate clinical benefit.

### Section 100 arrangements for patisiran

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.

#### For more information

Go to servicesaustralia.gov.au/healthprofessionals

PB368.2408 1 of 3







# Hereditary transthyretin amyloidosis – patisiran – continuing authority application

0	nline PBS Authorities	Hos	spital details
	You do not need to complete this form if you use the Online PBS Authorities system.	7	Hospital name
Pa	Go to servicesaustralia.gov.au/hppbsauthorities		This hospital is a:  public hospital
1	Medicare card number  Ref no.  Or  Department of Veterans' Affairs card number	8 Co	private hospital  Hospital provider number  Inditions and criteria
2	Dr Mr Mrs Miss Ms Other		qualify for PBS authority approval, the following conditions set be met.
_	Family name  First given name	9	Does the patient continue to demonstrate a clinical benefit with this drug for this condition?
3	Date of birth (DD MM YYYY)	10	Yes
Pr	escriber's details	Cho	ecklist
4	Prescriber number	11	The relevant attachments need to be provided with this form.
5	Dr Mr Mrs Miss Ms Other  Family name		Details of the proposed prescription(s).
	First given name		
6	Business phone number (including area code)  Alternative phone number (including area code)		



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#### **Privacy notice**

**12** 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

#### 13 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 <b>must</b> date this declaration)			
Prescriber's signature ( <b>only</b> required if returning by post)			
L			

#### **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