Australian Government
Services Australia

medicare

PBS

Chronic rhinosinusitis with nasal polyps – mepolizumab – 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 mepolizumab for patients 18 years or over with chronic rhinosinusitis with nasal polyps (CRSwNP).

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 CRSwNP **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** 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.

Section 100 arrangements for mepolizumab

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**

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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)

Hospital details

7 Hospital name

This hospital is a:

☐ public hospital

☐ private hospital

8 Hospital provider number

Conditions and criteria

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

9 The patient, 18 years or over, is being treated by a medical practitioner who is:

☐ a respiratory physician

☐ a clinical immunologist

☐ an allergist

☐ an ear nose and throat specialist

☐ a general physician experienced in the management of CRSwNP

10 The patient has:

☐ not received PBS-subsidised treatment with a biological medicine for this condition

or

☐ had a 12 month break in PBS-subsidised treatment with a biological medicine for this condition

11 Will this treatment be used in combination with and within 4 weeks of another PBS-subsidised biological medicine prescribed for either nasal polyps, uncontrolled severe allergic asthma or uncontrolled severe asthma?

Yes ☐

No ☐

MCA0PB348 2410

12 The patient has a diagnosis of CRSwNP:

☐ confirmed by nasal endoscopy

or

☐ confirmed by computed tomography (CT) scan

or

☐ from at least 2 physicians of the above mentioned prescriber types

13 The patient has:

☐ undergone surgery for the removal of nasal polyps

Date of surgery (DD MM YYYY)

or

☐ written advice from at least 2 physicians of the above mentioned prescriber types demonstrating inappropriateness for surgery

Provide details of surgical exception including serious comorbid disease (for example, cardiovascular, stroke) making the risk of surgery unacceptable

14 The patient has:

☐ failed to achieve adequate control with optimised nasal polyp therapy, including adherence to intranasal corticosteroid therapy for at least 2 months

Prior intranasal corticosteroid therapy

From (DD MM YYYY)

To (DD MM YYYY)

and if required,

☐ Nasal irrigation with saline

or

☐ a contraindication or intolerance to intranasal corticosteroid therapy with reasons documented in the medical file

15 The patient had, despite optimised nasal polyp therapy, **at least 2** of the following (measured within the past 12 months):

☐ bilateral endoscopic nasal polyp score of at least 5 (out of a maximum score of 8, with a minimum score of 2 in each nasal cavity)

Baseline score

Date (DD MM YYYY)

and/or

☐ nasal obstruction visual analogue scale (VAS) score greater than 5 (out of a maximum score of 10)

Baseline score

Date (DD MM YYYY)

and/or

☐ overall symptom VAS score greater than 7 (out of a maximum score of 10).

Baseline score

Date (DD MM YYYY)

16 Has the patient had a blood eosinophil count of at least 300 cells/microlitre in the last 12 months?

Yes ☐

No ☐

17 Provide baseline eosinophil details

Blood eosinophil count cells/microlitre

Date (DD MM YYYY)

Checklist

18 The relevant attachments need to be provided with this form.

☐ Details of the proposed prescription(s).

Privacy notice

19 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**

20 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)

If returning by post, print and sign by hand.

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

Reset form