Australian Government
Services Australia

medicare

PBS

Growth hormone deficiency – late onset 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 somatropin for patients with late onset growth hormone deficiency.

Important information

Initial applications to start PBS-subsidised treatment 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 late onset growth hormone deficiency **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.

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)

Conditions and criteria

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

7 Is the patient being treated by an endocrinologist?

Yes ☐

No ☐

8 The patient has late onset of growth hormone (GH) deficiency:

☐ secondary to organic hypothalamic or pituitary disease diagnosed at chronological age of 18 years or older

or

☐ diagnosed after skeletal maturity (bone age ≥ 15.5 years in males or ≥ 13.5 years in females) and before chronological age of 18 years.

9 The patient has a:

☐ diagnostic insulin tolerance test with maximum serum GH < 2.5 µg/L ▶ ***Go to 10***

or

☐ diagnostic arginine infusion test with maximum serum GH < 0.4 µg/L ▶ ***Go to 10***

or

☐ diagnostic glucagon provocation test with maximum serum GH < 3 µg/L ▶ ***Go to 10***

or

☐ chronological age of 18 years or older with established hypothalamic-pituitary disease

and

☐ at least three documented pituitary hormone deficiencies

and

☐ an IGF-1 concentration lower than the sex- and age-specific lower limit of normal

▶ ***Go to 11***

MCA0PB248 2501

10 Provide results of the corresponding GH simulation test

Date of testing (DD MM YYYY)

Peak GH concentration level

Laboratory reference range for age and gender (for peak GH)

11 Provide the patient's somatropin dose per day

mg/day

Checklist

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

☐ Details of the proposed prescription(s).

Privacy notice

13 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**

14 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