



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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PBS

Growth hormone deficiency – late onset initial authority application

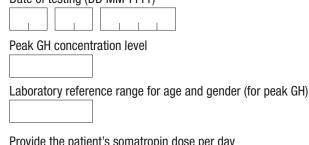
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0	nline PBS Authorities	Co	onditions and criteria				
	You do not need to complete this form if you use the Online PBS Authorities system. Go to servicesaustralia.gov.au/hppbsauthorities	To qualify for PBS authority approval, the following conditions must be met.					
Pa	tient's details	7 Is the patient being treated by an endocrinologist? Yes No					
1	Medicare card number	8	The patient has late onset of growth hormone (GH) deficiency:				
	or Ref no.		 secondary to organic hypothalamic or pituitary disease diagnosed at chronological age of 18 years or older 				
	Department of Veterans' Affairs card number		or				
			diagnosed after skeletal maturity (bone age \geq 15.5 years in males or \geq 13.5 years in females) and before chronological age of 18 years.				
2	Dr 🗌 Mr 🗌 Mrs 🗌 Miss 🗌 Ms 🗌 Other 📖	9	The patient has a:				
	Family name		diagnostic insulin tolerance test with maximum serum $GH < 2.5 \ \mu g/L$ Go to 10				
	First given name		or				
			diagnostic arginine infusion test with $Go to 10$				
3	Date of birth (DD MM YYYY)		maximum serum GH < 0.4 μ g/L Go to 10 or				
			diagnostic glucagon provocation test with maximum serum GH < 3 μg/L Go to 10				
Pr	escriber's details		or				
4	Prescriber number		chronological age of 18 years or older with established hypothalamic-pituitary disease				
5	Dr 🗌 Mr 🗌 Mrs 🗌 Miss 🗌 Ms 🗌 Other		and at least three documented pituitary hormone				
•	Family name		deficiencies and				
			an IGF-1 concentration lower than the sex- and age-specific lower limit of normal				
	First given name		Go to 11				
6	Business phone number (including area code)						
	Alternative phone number (including area code)						



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10 Provide results of the corresponding GH simulation test Date of testing (DD MM YYYY)



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)

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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
 or
- by post (signature required) to

Services Australia Complex Drugs Programs Reply Paid 9826 HOBART TAS 7001