Australian Government
Services Australia

medicare

PBS

Psoriatic arthritis – continuing authority application

When to use this form

Use this form to apply for **continuing** PBS-subsidised biological medicines for patients 18 years or over with severe psoriatic arthritis.

Important information

Continuing authority applications must be in writing and must include sufficient information to determine the patient's eligibility according to the PBS criteria.

Applications for **balance of supply** 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.

Under no circumstances will phone approvals be granted for psoriatic arthritis **continuing** authority applications.

Where the term 'biological medicine' appears, it refers to adalimumab, bimekizumab, certolizumab pegol, etanercept, golimumab, guselkumab, infliximab, ixekizumab, risankizumab, secukinumab, tofacitinib, upadacitinib and ustekinumab.

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 sustain a response to treatment.

After a written authority application for the **first continuing** treatment has been approved, **subsequent continuing** treatments with PBS-subsidised biosimilar brands of biological medicines are **Authority Required (STREAMLINED)** and do not require authority approval from Services Australia for the listed quantity and repeats.

Section 100 arrangements for infliximab i.v.

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.

Treatment specifics

The assessment of the patient's response to the course of treatment must be conducted within the time frame specified in the restriction. Where a demonstration of response is not conducted within the required time frame, the patient will be deemed to have failed treatment with that particular PBS-subsidised biological medicine.

A patient who has experienced a serious adverse reaction of a severity necessitating permanent treatment withdrawal is not considered to have failed treatment with that particular PBS-subsidised biological medicine.

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)

4 Patient's weight

kg

Prescriber's details

5 Prescriber number

6 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name

First given name

7 Business phone number (including area code)

Alternative phone number (including area code)

Hospital details

8 Hospital name

This hospital is a:

☐ public hospital

☐ private hospital

9 Hospital provider number

Conditions and criteria

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

10 The patient is being treated by a:

☐ rheumatologist

☐ clinical immunologist with expertise in the management of psoriatic arthritis

11 This application is for:

☐ adalimumab

☐ bimekizumab

☐ certolizumab pegol

☐ etanercept

☐ golimumab

☐ guselkumab

☐ infliximab i.v.

☐ infliximab s.c.

☐ ixekizumab

☐ risankizumab

☐ secukinumab

☐ tofacitinib

☐ upadacitinib

☐ ustekinumab

MCA0PB106 2503

12 Has the patient previously received this biological medicine (regardless of formulation) as their most recent course of PBS-subsidised treatment for this condition?

No ☐

Yes ☐ Dates of the most recent treatment course

From (DD MM YYYY)

To (DD MM YYYY)

13 The patient has demonstrated an adequate response to treatment evidenced by:

☐ an erythrocyte sedimentation rate (ESR) level ≤ 25 mm/hr or reduced by at least 20% from baseline

Current ESR level mm/hr

Date of test (no more than 4 weeks old) (DD MM YYYY)

and/or

☐ a C-reactive protein (CRP) level ≤ 15mg/L or reduced by at least 20% from baseline

Current CRP level mg/L

Date of test (no more than 4 weeks old) (DD MM YYYY)

Where only one marker (ESR or CRP) has been provided at baseline, the same marker must be used for assessment for all continuing applications.

and

☐ where baseline is at least 20 active (swollen and tender) joints, a reduction by at least 50% from baseline

Current total active joint count

Date of assessment (DD MM YYYY)

or

☐ where a baseline is at least 4 major joints (elbow, wrist, knee, ankle, shoulder and/or hip), a reduction by at least 50% from baseline

Current major joint count

Date of assessment (DD MM YYYY)

Checklist

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

☐ Details of the proposed prescription(s).

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)

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