Australian Government
Services Australia

medicare

PBS

Acute lymphoblastic leukaemia – blinatumomab – initial (induction) authority application

When to use this form

Use this form to apply for **initial (induction)** PBS-subsidised blinatumomab for patients with acute lymphoblastic leukaemia.

Important information

Initial (induction) applications to start PBS-subsidised treatment 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 acute lymphoblastic leukaemia **initial (induction)** authority applications.

The information in this form is correct at the time of publishing and may be subject to change.

Continuing/consolidation treatment

This form is ONLY for **initial (induction)** treatment.

After a written authority application for **initial (induction)** treatment has been approved, applications for **continuing/consolidation** 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 blinatumomab

This item is available to a patient who is attending:

- an approved private hospital, **or**
- a public participating 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.

Treatment specifics

The patient cannot receive more than **2 treatment cycles** under the **initial (induction)** restriction in a lifetime.

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 condition present in the central nervous system or testis?

Yes ☐

No ☐

8 This is for:

☐ the initial treatment of Precursor B-cell acute lymphoblastic leukaemia (Pre-B-cell ALL) in complete haematological remission

▶ *Go to 9*

or

☐ the induction treatment of relapsed or refractory B-precursor cell ALL

▶ *Go to 15*

9 Is the patient being treated by a physician experienced in the treatment of haematological malignancies?

Yes ☐

No ☐

10 Does the patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 1 or less?

Yes ☐

No ☐

11 The patient has achieved complete remission following intensive combination chemotherapy:

☐ for initial treatment of ALL and does not have measurable residual disease (MRD)

▶ *Go to 13*

or

☐ and has MRD documented after the last course of systemic chemotherapy

▶ *Go to 12*

MCA0PB210 2503

12 The intensive combination chemotherapy treatment was:

☐ the initial treatment of ALL

or

☐ subsequent salvage therapy

13 Date of most recent chemotherapy (DD MM YYYY)

14 Provide the percentage blasts in bone marrow count (no more than 4 weeks old), measured using flow cytometry/molecular methods:

%

Go to 26

15 Does the patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 2 or less?

Yes ☐

No ☐

16 The patient has received intensive combination chemotherapy for:

☐ the initial treatment of ALL ***Go to 17***

or

☐ subsequent salvage therapy ***Go to 18***

17 Date of most recent chemotherapy (DD MM YYYY)

Go to 20

18 Date of most recent chemotherapy (DD MM YYYY)

19 Provide the line of salvage therapy

20 Has the patient received more than 1 line of salvage therapy?

Yes ☐

No ☐

21 Does the patient have more than 5% blasts in bone marrow?

Yes ☐

No ☐

22 Provide the percentage blasts in bone marrow count (no more than 4 weeks old)

%

23 Is the condition Philadelphia chromosome positive?

Yes ☐ ***Go to 24***

No ☐ ***Go to 25***

24 Has the patient previously received a tyrosine kinase inhibitor (TKI)?

Yes ☐

No ☐

25 The patient:

☐ is untreated with blinatumomab for Pre-B-cell ALL

or

☐ had a relapse-free period of at least six months following completion of treatment with blinatumomab for Pre-B-cell ALL

Date of completion of blinatumomab treatment (DD MM YYYY)

Date of subsequent relapse (DD MM YYYY)

26 Will this approval exceed the maximum of 2 treatment cycles under this restriction in a lifetime?

Yes ☐

No ☐

27 Is this request for an in-patient in a public hospital setting?

Yes ☐

No ☐

Checklist

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

☐ Details of the proposed prescription(s).

Privacy notice

29 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

30 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