

Neuromyelitis optica spectrum disorder - ravulizumab - initial grandfather 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 grandfather** PBS-subsidised ravulizumab for patients with neuromyelitis optica spectrum disorder (NMOSD) who have received non-PBS-subsidised treatment with ravulizumab for the same condition prior to **1 April 2025**.

Important information

Initial grandfather 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 NMOSD **initial grandfather** 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 grandfather** treatment.

A patient may only qualify for PBS-subsidised treatment under this restriction once in a lifetime.

After an authority application for **initial grandfather** 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 ravulizumab

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

Dose and dosing frequency must not exceed that specified in the Therapeutic Goods Administration (TGA) approved Product Information. An appropriate amount of drug (maximum quantity in units) may require prescribing both strengths. A separate authority prescription form must be completed for each strength requested.

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 Family name

First given name

3 Date of birth (DD MM YYYY)

4 Patient's weight

 kg

Prescriber's details

5 Prescriber number

6 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:

☐ neurologist

☐ medical practitioner in consultation with a neurologist

11 Has the patient previously received non-PBS-subsidised treatment with this drug for this condition prior to 1 April 2025?

Yes ☐

No ☐

12 Prior to commencing treatment with this drug, did the patient have a confirmed diagnosis of neuromyelitis optica spectrum disorder (NMOSD) with aquaporin-4 immunoglobulin G auto-antibody (AQP4-IgG)?

Yes ☐

No ☐

13 Prior to commencing treatment with this drug, did the patient have a recorded baseline Expanded Disability Status Scale (EDSS) score of 7 or less?

No ☐

Yes ☐ Provide baseline EDSS score

14 Does the patient have a current EDSS score of 7 or less?

No ☐

Yes ☐ Provide current EDSS score



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15 In the 12 months prior to commencing treatment with this drug for this condition, did the patient have at least one relapse?

Yes ☐

No ☐

16 Has the patient experienced a relapse while receiving treatment with this drug for this condition?

Yes ☐

No ☐

17 Prior to commencing treatment with ravulizumab, the patient had:

☐ received treatment with rituximab immediately prior to the most recent relapse

Provide details of prior rituximab therapy including dosage and frequency

From (DD MM YYYY)

To (DD MM YYYY)

or

☐ a documented intolerance to rituximab of a severity necessitating permanent treatment withdrawal

Provide details of intolerance

or

☐ a documented contraindication to rituximab therapy

Provide details of contraindication

18 Will the patient receive more than 24 weeks of treatment under this grandfather restriction?

Yes ☐

No ☐

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

Yes ☐

No ☐

Checklist

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

☐ Details of the proposed prescription(s).

Privacy notice

21 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

22 I declare that:

- I am aware 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 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)



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