

medicare



Retinal vein occlusion – initial authority application

Online services

Requesting PBS Authorities online provides an immediate assessment in real time.

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 aflibercept, dexamethasone intravitreal implant or ranibizumab for patients with branched retinal vein occlusion (BRVO) or central retinal vein occlusion

(CRVO) with macular oedema.

Important information

Initial applications to start PBS-subsidised treatment for each eye 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.

Where both eyes are affected by the condition, a quantity of 2 units can be requested through the same

authority application.

Authority approval for initial treatment of each eye must be sought.

Under no circumstances will phone approvals be granted for **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 with the same drug for the same eye as per the PBS restriction is Authority Required (Streamlined) and does not require prior authority approval from Services Australia for the listed quantity

and repeats.

For more information

Go to servicesaustralia.gov.au/healthprofessionals

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medicare



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Online services

You do not need to complete this form if you use the **Online PBS Authorities** system.

Go to servicesaustralia.gov.au/hppbsauthorities
tient's details
Medicare card number Ref no. Department of Veterans' Affairs card number
Dr Mr Mrs Miss Ms Other Family name
First given name
Date of birth (DD MM YYYY)
pointment details
Scheduled appointment Date (DD MM YYYY) Time . am/pm
escriber's details
Prescriber number
Dr Mr Mrs Miss Ms Other Family name
First given name
Business phone number (including area code) Alternative phone number (including area code)

Coı	nditions and criteria
	qualify for PBS authority approval, the following conditions ust be met.
8	The patient is being treated by either an: ophthalmologist
	or accredited ophthalmology registrar in consultation with an ophthalmologist.
9	The patient has visual impairment due to retinal vein occlusion in:
	right eye left eye both eyes
10	Is this treatment the sole PBS-subsidised therapy for this condition? No
	For aflibercept and ranibizumab Go to 12
	For dexamethasone Go to 11
11	The patient: has a contraindication to vascular endothelial growth factor (VEGF) inhibitors
	or
	has failed prior treatment with VEGF inhibitors.
12	The patient has visual impairment due to macular oedema secondary to:
	branched retinal vein occlusion (BRVO)
	or central retinal vein occlusion (CRVO) Go to 14
13	Does the patient have a best-corrected visual acuity (BCVA) score based on the early treatment diabetic retinopathy study (ETDRS) chart of between 73 and 20 letters administered at a distance of 4 metres (approximate Snellen equivalent 20/40 to 20/400) in the eye(s) proposed for treatment? No

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14	Does the patient have a best-corrected visual acuity (BCVA) score based on the early treatment diabetic retinopathy study (ETDRS) chart of between 73 and 24 letters administered at a distance of 4 metres (approximate Snellen equivalent 20/40 to 20/320) in the eye(s) proposed for treatment? No Yes
15	The patient has been diagnosed by either:
	optical coherence tomography
	or
	fluorescein angiography.
16	Provide details of the optical coherence tomography or fluorescein angiogram report
	Date of the report (DD MM YYYY)
	Unique identifying number/code or provider number
Ch	ecklist
17	The relevant attachments need to be provided with this form.
	The completed authority prescription form(s).
D	
Pri	vacy notice

18 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/privacy

Prescriber's declaration

19 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 the completed authority prescription form(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.

Prescriber's signature	
Date (DD MM YYYY)	

Returning this form

Return this form and any supporting documents:

- online, upload this form, the authority prescription form(s) and any relevant attachments through Health Professional Online Services (HPOS) at servicesaustralia.gov.au/hpos
- by post, send this form, the authority prescription form(s) and any relevant attachments to:

Services Australia **Complex Drugs Programs** Reply Paid 9826 HOBART TAS 7001