

Subfoveal choroidal neovascularisation – faricimab – initial grandfather 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 grandfather** PBS-subsidised faricimab for patients with subfoveal choroidal neovascularisation who have received non-PBS-subsidised treatment with faricimab for the same condition prior to 1 January 2023.

Important information

Initial grandfather 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 grandfather** treatment of each eye must be sought.

Under no circumstances will phone approvals be granted for **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.

After an authority application for **initial grandfather** treatment has been approved, applications for **continuing** treatment with faricimab 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



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

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)

Appointment details

4 Scheduled appointment

Date (DD MM YYYY)

Time

 am/pm

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)

Conditions and criteria

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

8 Has the patient received non-PBS subsidised treatment with this drug for this PBS indication prior to 1 January 2023?

No

Yes

9 The patient is being treated by either an:

ophthalmologist

or

accredited ophthalmology registrar in consultation with an ophthalmologist

10 The patient has subfoveal choroidal neovascularisation (CNV) due to age-related macular degeneration (AMD) in:

right eye

left eye

both eyes

11 Is this treatment the sole PBS-subsidised therapy for this condition?

No

Yes

12 The patient has been diagnosed by either:

optical coherence tomography

or

fluorescein angiography.


13 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



Checklist

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

The completed authority prescription form(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/privacy

Prescriber's declaration

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 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)

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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
- **or**
- 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