

Subfoveal choroidal neovascularisation – initial authority application

Online PBS Authorities



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, brolucizumab, faricimab or ranibizumab for patients with subfoveal choroidal neovascularisation.

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 subfoveal choroidal neovascularisation **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 aflibercept, faricimab or ranibizumab 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.

After an authority application for **initial** treatment has been approved, applications for **continuing** treatment with brolucizumab for the same eye 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.

For more information

Go to servicesaustralia.gov.au/healthprofessionals



medicare



Subfoveal choroidal neovascularisation – initial authority application

Online PBS Authorities



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 The patient is being treated by either an:

☐ ophthalmologist

or

☐ accredited ophthalmology registrar in consultation with an
ophthalmologist

9 The patient has subfoveal choroidal neovascularisation (CNV) in:

☐ right eye ☐ left eye ☐ both eyes

10 The patient has subfoveal CNV due to:

☐ age-related macular degeneration

or

☐ pathologic myopia (aflibercept and ranibizumab only)

or

☐ causes other than age-related macular degeneration or
pathologic myopia (ranibizumab only).

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

No ☐

Yes ☐

For brolocizumab

► **Go to 14**

For aflibercept, faricimab and ranibizumab

► **Go to 12**

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

► **Go to 17**



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- 14** Has the patient previously received PBS-subsidised treatment with this drug for this condition for the same eye?
- No ☐
- Yes ☐
- 15** Does the patient have persistent macular exudation, despite at least 6 months of treatment with aflibercept, faricimab and/or ranibizumab?
- No ☐
- Yes ☐ – as determined clinically ► **Go to 17**
- Yes ☐ – as determined by optical coherence tomography or fluorescein angiography ► **Go to 16**

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

Checklist

- 17**  The relevant attachments need to be provided with this form.
- ☐ Details of the proposed prescription(s).

Privacy 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/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**

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 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