

Cystic fibrosis – elexacaftor+tezacaftor+ivacaftor – initial 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** PBS-subsidised elexacaftor+tezacaftor+ivacaftor for patients 2 years or over with cystic fibrosis.

Important information

Initial 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 cystic fibrosis **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.

Applications for **continuing** 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.

Section 100 arrangements for elexacaftor+tezacaftor +ivacaftor

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.

For more information

Go to servicesaustralia.gov.au/healthprofessionals

12 Does the patient have at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene?

Yes

No

13 Provide details of the pathology report substantiating at least one F508del mutation:

Name of the pathology report provider

Date of the pathology report (DD MM YYYY)

Unique identifying number/code

14 Prior to initiating treatment with this drug, the patient has:

chronic sinopulmonary disease

or

gastrointestinal and nutritional abnormalities.

15 Will the treatment be given concomitantly with standard therapy for this condition?

Yes

No


16 Is the patient currently receiving one of the strong CYP3A4 inducers outlined in the Product Information?

Yes

No

17 Provide current CYP3A4 inhibitors, CYP3A4 inducers and IV antibiotics, if applicable

Checklist

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

Details of the proposed prescription(s).

Privacy notice

19 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

20 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