

# Acute lymphoblastic leukaemia – blinatumomab – initial (induction) authority application

## When to use this form

Use this form to apply for **initial (induction)** PBS-subsidised blinatumomab for patients with acute lymphoblastic leukaemia.

## Important information

**Initial (induction)** applications to start PBS-subsidised treatment must be in writing and must include sufficient information to determine the patient's eligibility according to the PBS criteria.

Applications for **balance of supply** 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.

Under no circumstances will phone approvals be granted for acute lymphoblastic leukaemia **initial (induction)** authority applications.

The information in this form is correct at the time of publishing and may be subject to change.

## Continuing/consolidation treatment

This form is ONLY for **initial (induction)** treatment.

After a written authority application for **initial (induction)** treatment has been approved, applications for **continuing/consolidation** 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 blinatumomab

This item is available to a patient who is attending:

- an approved private hospital, **or**
- a public participating 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.

## Treatment specifics

The patient cannot receive more than **2 treatment cycles** under the **initial (induction)** restriction in a lifetime.

## For more information

Go to [servicesaustralia.gov.au/healthprofessionals](https://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)

## Prescriber's details

**4** Prescriber number

**5** Family name

First given name

**6** 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.

**7** Is the condition present in the central nervous system or testis?

Yes ☐

No ☐

**8** This is for:

☐ the initial treatment of Precursor B-cell acute lymphoblastic leukaemia (Pre-B-cell ALL) in complete haematological remission

► **Go to 9**

**or**

☐ the induction treatment of relapsed or refractory B-precursor cell ALL

► **Go to 15**

**9** Is the patient being treated by a physician experienced in the treatment of haematological malignancies?

Yes ☐

No ☐

**10** Does the patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 1 or less?

Yes ☐

No ☐

**11** The patient has achieved complete remission following intensive combination chemotherapy:

☐ for initial treatment of ALL and does not have measurable residual disease (MRD)

► **Go to 13**

**or**

☐ and has MRD documented after the last course of systemic chemotherapy

► **Go to 12**



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## 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**

### 30 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)

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Prescriber's signature (**only** required if returning by post)


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## 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