

Multiple myeloma dual therapy – pomalidomide – 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 pomalidomide for patients with multiple myeloma.

Important information

Initial applications to start PBS-subsidised treatment 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.

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 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 pomalidomide

This item is available to a patient who is attending:

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

and is:

- a day admitted patient
- a non-admitted patient, **or**
- a 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.

Treatment specifics

Patients receiving pomalidomide under the PBS listing must be registered in the risk management program relevant for the brand of pomalidomide being prescribed and dispensed.

For more information

Go to servicesaustralia.gov.au/healthprofessionals

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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 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)

Hospital details

7 Hospital name

This hospital is a:

☐ public hospital

☐ private hospital

8 Hospital provider number

Conditions and criteria

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

9 Has the patient undergone or is ineligible for a primary stem cell transplant?

No ☐

Yes ☐

10 Does this treatment form part of dual combination therapy limited to this drug and dexamethasone?

No ☐

Yes ☐



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11 The patient has:

- ☐ experienced treatment failure with bortezomib, as confirmed by:
- ☐ failure to achieve at least a partial response during treatment or within 6 months of discontinuing treatment with bortezomib

Provide dates of treatment

From (DD MM YYYY)

To (DD MM YYYY)

or

- ☐ progressive disease during treatment or within 6 months of discontinuing treatment with bortezomib

Provide dates of treatment

From (DD MM YYYY)

To (DD MM YYYY)

Provide details of the pathology report(s) demonstrating treatment failure with bortezomib

- a) Date of report (DD MM YYYY)

Unique identifying number/code or provider number

- b) Date of report (DD MM YYYY)

Unique identifying number/code or provider number

or

- ☐ a contraindication or experienced an intolerance to treatment with bortezomib according to the Therapeutic Goods Administration (TGA) approved Product Information (PI).

Provide details of contraindication or intolerance including nature and severity of intolerance.

12 The patient has:

- ☐ experienced treatment failure with lenalidomide, as confirmed by progressive disease during treatment or within 6 months of discontinuing treatment with lenalidomide

Provide dates of treatment

From (DD MM YYYY)

To (DD MM YYYY)

Provide details of the pathology report(s) demonstrating treatment failure with lenalidomide

- a) Date of report (DD MM YYYY)

Unique identifying number/code or provider number

- b) Date of report (DD MM YYYY)

Unique identifying number/code or provider number

or

- ☐ a contraindication or experienced an intolerance to treatment with lenalidomide according to the TGA approved PI.

Provide details of contraindication or intolerance including nature and severity of intolerance.

Checklist

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The relevant attachments need to be provided with this form.

- ☐ Details of the proposed prescription(s).

Privacy notice

- 14** 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 servicessaustralia.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**

15 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)



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