

# Symptomatic obstructive hypertrophic cardiomyopathy – mavacamten – 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](https://servicesaustralia.gov.au/hppbsauthorities)

## When to use this form

Use this form to apply for **initial** PBS-subsidised mavacamten for patients 18 years or over with symptomatic obstructive hypertrophic cardiomyopathy (HCM).

## 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 symptomatic obstructive HCM **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 the **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.

## Treatment specifics

Initial treatment covers the first 12 weeks of therapy. First continuing treatment continues until at least 6 months on optimal dose is achieved.

The assessment of response must be conducted after at least 6 months on optimal dose to determine the patient's eligibility for maintenance treatment. Where an assessment is not undertaken, the patient will not be eligible for ongoing treatment.

## 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** The patient, 18 years or over, is being treated by a:

☐ cardiologist

or

☐ consultant physician with experience in the management of hypertrophic cardiomyopathy

**8** Does the patient have left ventricular hypertrophy due to hypertrophic cardiomyopathy (HCM) confirmed by echocardiogram (ECHO) and/or cardiac magnetic resonance imaging (MRI)?

Yes ☐

No ☐

**9** Provide details of the ECHO or MRI report

Date of the report (DD MM YYYY)

Unique identifying number/code or provider number

**10** The patient is symptomatic with:

☐ New York Heart Association (NYHA) class II heart failure

or

☐ NYHA class III heart failure

**11** The patient has maximal end-diastolic left ventricular wall thickness which is:

☐ at least 15 mm

Left ventricular wall thickness

► **Go to 16**

or

☐ at least 13 mm if the patient has familial HCM (at least one first degree relative with a diagnosis of HCM)

Left ventricular wall thickness



MCA0PB360 2506



**22** The patient is undergoing concomitant treatment with:

☐ a beta-blocker

Name

**and/or**

☐ a non-dihydropyridine CCB

☐ diltiazem

**or**

☐ verapamil

**or**

☐ neither of them due to a previously stated intolerance or contraindication listed in the TGA approved PI

## Checklist

**23**  The relevant attachments need to be provided with this form.

☐ Details of the proposed prescription(s).

## Privacy notice

**24** 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](https://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](https://servicesaustralia.gov.au/hpos)

### 25 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)

<input type="text"/>	<input type="text"/>	<input type="text"/>
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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](https://servicesaustralia.gov.au/hpos)  
**or**
- by post (signature required) to  
Services Australia  
Complex Drugs Programs  
Reply Paid 9826  
HOBART TAS 7001