

Acute lymphoblastic leukaemia – blinatumomab – initial grandfather authority application



When to use this form

Use this form to apply for **initial grandfather** PBS-subsidised blinatumomab for patients with acute lymphoblastic leukaemia who have received non-PBS-subsidised treatment with blinatumomab for the same condition prior to **1 March 2025**.

Important information

Initial grandfather 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.

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

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

Consolidation treatment

This form is ONLY for **initial grandfather** treatment.

After an authority application for **initial grandfather** 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 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 treatment must not be more than **4 treatment cycles** of therapy (**non-PBS** and **PBS**) under this restriction in a lifetime.

For more information

Go to servicesaustralia.gov.au/healthprofessionals

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Patient's details		Conditions and criteria	
1	Medicare card number Ref no.		qualify for PBS authority approval, the following conditions ust be met.
2	Or Department of Veterans' Affairs card number	7	Is the patient being treated by a physician experienced in the treatment of haematological malignancies? Yes No
2	Family name First given name Date of birth (DD MM YYYY)	8	Has the patient previously received at least one treatment cycle of non-PBS-subsidised treatment with this drug for Precursor B-cell acute lymphoblastic leukaemia (Pre-B-cell ALL) prior to 1 March 2025? Yes
o Pr	escriber's details	9	No
4 5	Prescriber number Family name	10	Prior to commencing non-PBS-subsidised treatment with this drug, did the patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 1 or less? Yes
J	ramily name		No 🗌
	First given name	11	Prior to commencing non-PBS-subsidised treatment with this drug, the patient had achieved complete remission following intensive combination chemotherapy:
6	Business phone number (including area code)		for initial treatment of ALL and did not have measurable residual disease (MRD)
			Go to 12
	Alternative phone number (including area code)		or
			and had MRD documented after the last course of systemic chemotherapy
			Go to 14
		12	Date of most recent chemotherapy (DD MM YYYY)
		13	Provide the percentage blasts in bone marrow count (no more than 4 weeks old), measured using flow cytometry/molecular methods
			Go to 17



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or sub	ensive combination chemotherapy treatment was: e initial treatment of ALL bsequent salvage therapy most recent chemotherapy (DD MM YYYY)	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	
16 Provide than 4 variety treatments. 17 Has the treatment Yes No 18 Including approved restricting Yes No 10 No	the percentage blasts in bone marrow count (no more weeks old at the time of initiating non-PBS-subsidised ent), measured using flow cytometry/molecular methods % patient developed disease progression while receiving ent with this drug for this condition? In g non-PBS and PBS-subsidised treatment, will this all exceed the maximum of 4 treatment cycles under this ion in a lifetime? Request for an in-patient in a public hospital setting?	 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)	
Checklist		Prescriber's signature (only required if returning by post)	
20	The relevant attachments need to be provided with this form.		
De	tails of the proposed prescription(s).	Returning this form	
Privacy notice		Return this form, details of the proposed prescription(s) and any relevant attachments:	
Privacy purpose Persona given to where i	al information is protected by law (including the Act 1988) and is collected by Services Australia for the es of assessing and processing this authority application. al information may be used by Services Australia, or other parties where the individual has agreed to this, or it is required or authorised by law (including for the e of research or conducting investigations).	 online (no signature required), upload through HPOS at servicesaustralia.gov.au/hpos by post (signature required) to Services Australia Complex Drugs Programs Reply Paid 9826 HOBART TAS 7001 	

manages personal information, including our privacy policy, can be found at **servicesaustralia.gov.au/privacypolicy**

More information about the way in which Services Australia