Australian Government
Services Australia

medicare

PBS

Chronic obstructive pulmonary disease – mepolizumab – initial or recommencement after a 12-month break 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 mepolizumab for patients with uncontrolled chronic obstructive pulmonary disease (COPD).

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 COPD **initial** or **recommencement** 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** or **recommencing** treatment.

After an authority application for **initial** or **recommencing** 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 mepolizumab

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**

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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)

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 The patient is being treated by a medical practitioner who is a:

- ☐ respiratory physician
- ☐ general physician experienced in the management of patients with uncontrolled chronic obstructive pulmonary disease (COPD)

10 The patient:

- ☐ has not received PBS-subsidised treatment with a biological medicine for this condition
- ☐ had at least a 12-month break from the most recently approved PBS-subsidised biological medicine for this condition

11 Will this treatment be used in combination with and **within 4 weeks** of another PBS-subsidised biological medicine prescribed for nasal polyps, uncontrolled severe allergic asthma, uncontrolled severe asthma or uncontrolled COPD?

- Yes ☐
- No ☐

12 Will this treatment be used in combination with an optimised triple inhaler therapy that includes **all** of the following: a long-acting muscarinic antagonist (LAMA), a long-acting beta-2 agonist (LABA) and an inhaled corticosteroid (ICS)?

- Yes ☐
- No ☐

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13 Has the patient been unable to achieve adequate control with at least 3 months of optimised triple inhaler therapy consisting of a LAMA, a LABA and an ICS, despite formal assessment of and adherence to correct inhaler technique which has been documented in the patient's medical records?

Yes ☐
No ☐

14 Provide details of the optimised triple inhaler therapy with the combination of:

☐ LAMA

Name of LAMA

Dose

From (DD MM YYYY)

To (DD MM YYYY)

and

☐ LABA

Name of LABA

Dose

From (DD MM YYYY)

To (DD MM YYYY)

and

☐ ICS

Name of ICS

Dose

From (DD MM YYYY)

To (DD MM YYYY)

15 In the 12 months prior to commencing treatment with this drug in this treatment cycle, the patient experienced at least:

☐ **one severe** COPD exacerbation

Number of severe exacerbation(s) which required hospitalisation

and/or

☐ **two moderate** COPD exacerbations of which at least:

☐ one moderate exacerbation required treatment with systemic corticosteroids

and

☐ one other moderate exacerbation required treatment with systemic corticosteroids or antibiotics

Total number of moderate exacerbation(s) requiring treatment with systemic corticosteroids

Number of moderate exacerbation(s) requiring treatment with antibiotics

16 Did the patient experience at least one of the moderate or severe exacerbations while taking all of LAMA, LABA and ICS in an optimised triple inhaler therapy?

Yes ☐
No ☐

17 In the 12 months prior to commencing treatment with this drug in this treatment cycle, did the patient have a blood eosinophil count of at least 300 cells per microlitre?

Yes ☐
No ☐

18 Provide details of blood eosinophil count

Baseline blood eosinophil count

cells/microlitre

Date (DD MM YYYY)

Checklist

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

☐ Details of the proposed prescription(s).

Privacy notice

20 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**

21 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)

If returning by post, print and sign by hand.

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**
- by post (signature required) to

  Services Australia
  Complex Drugs Programs
  Reply Paid 9826
  HOBART TAS 7001

Reset form