

Chronic obstructive pulmonary disease – mepolizumab – initial grandfather 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 grandfather** PBS-subsidised mepolizumab for patients with uncontrolled chronic obstructive pulmonary disease (COPD) who have received non-PBS-subsidised treatment with mepolizumab for the same condition prior to **1 September 2026**.

Important information

Initial grandfather 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 grandfather** 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 grandfather** treatment.

A patient may qualify for PBS-subsidised treatment under this restriction once only. For continuing PBS-subsidised treatment, a grandfathered patient must qualify under the continuing treatment criteria.

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 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

Chronic obstructive pulmonary disease – mepolizumab – initial grandfather authority application

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 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 Has the patient previously received non-PBS-subsidised treatment with this biological medicine for this condition prior to **1 September 2026**?

Yes ☐

No ☐

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 ☐



MCA0PB404 2609

- 13** Prior to commencing non-PBS-subsidised treatment with this drug for this condition, was the patient 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 non-PBS-subsidised treatment with this drug for this condition, the patient experienced at least:

☐ **one severe** COPD exacerbation

Baseline 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

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

Baseline 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 non-PBS-subsidised treatment with this drug for this condition, 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)

- 19** Has the patient received at least 24 weeks of non-PBS-subsidised treatment with this drug for this condition?

Yes ☐ **Go to 20**
No ☐ **Go to 21**

- 20** The patient has achieved and sustained an adequate response to this drug, evidenced by maintenance (that is, no change) or a reduction in the number of:

☐ severe exacerbation(s) compared to the baseline levels
Current number of severe exacerbation(s) which required hospitalisation

and/or

☐ moderate exacerbations compared to the baseline levels
Current total number of moderate exacerbation(s) requiring treatment with systemic corticosteroids

Current number of moderate exacerbation(s) requiring treatment with antibiotics

Checklist

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

☐ Details of the proposed prescription(s).

Privacy notice

22 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

23 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)



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