

Chronic myeloid leukaemia – asciminib – continuing 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 **continuing** PBS-subsidised asciminib for patients with chronic myeloid leukaemia (CML) expressing the T315I mutation.

Important information

Continuing authority applications 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.

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 **continuing** treatment with asciminib for CML patients with T315I mutation.

For more information

Go to **servicesaustralia.gov.au/healthprofessionals**

Chronic myeloid leukaemia – asciminib – continuing 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)

Conditions and criteria

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

- 7** The patient is being treated by a:
- ☐ medical practitioner
- ☐ nurse practitioner where patient care is being shared with a medical practitioner and the prescription continues existing therapy with this medicine
- 8** Is this the sole PBS-subsidised therapy for this condition?
- Yes ☐
- No ☐
- 9** The patient is undergoing:
- ☐ **first continuing** treatment with this drug and has demonstrated a response in the preceding 18 months
- or
- ☐ **subsequent continuing** treatment with this drug and has demonstrated a response in the preceding 12 months.
- 10** Confirmed by a pathology report from an Approved Pathology Authority, the patient has demonstrated a:
- ☐ major cytogenetic response
- or
- ☐ peripheral blood level of BCR-ABL of < 1% on the international scale.
- 11** Provide details of the pathology report
- Date of pathology report (DD MM YYYY)
-
- Unique identifying number/code or provider number
-



MCA0PB084 2610

Checklist

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

☐ Details of the proposed prescription(s)

Privacy notice

- 13 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

14 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)

 If returning by post, print and sign by hand.

Reset form

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