Australian Government
Services Australia

medicare

PBS

Crohn's disease adult – continuing authority application

When to use this form

Use this form to apply for **continuing** PBS-subsidised biological agents for a patient aged 18 years or older with severe Crohn's disease.

Important information

Continuing authority applications must be in writing and must include sufficient information to determine the patient's eligibility according to the PBS criteria.

Applications for **balance of supply** 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.

Call charges may apply.

Under no circumstances will phone approvals be granted for severe Crohn's disease **continuing** authority applications.

Where the term 'biological agent' appears, it refers to adalimumab, infliximab, ustekinumab or vedolizumab.

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.

After a written authority application for the **first continuing** treatment has been approved, **subsequent continuing** treatment with PBS-subsidised biosimilar brands of biological agents are Authority Required (Streamlined) and do not require authority approval from Services Australia for the listed quantity and repeats.

Section 100 arrangements for infliximab i.v. and vedolizumab i.v.

These items are available to a patient who is attending:

- an approved private hospital
- a public participating hospital, **or**
- a public hospital

and is:

- a day admitted patient
- a non-admitted patient, **or**
- a patient on discharge.

These items are not available as a PBS benefit for in-patients of a hospital.

The hospital name and provider number must be included in this authority form.

Treatment specifics

The assessment of the patient's response to the course of treatment must be conducted within the time frame specified in the restriction. Where a demonstration of response is not conducted within the required time frame, the patient will be deemed to have failed treatment with that particular PBS-subsidised biological agent.

A patient who has experienced a serious adverse reaction of a severity resulting in the necessity for permanent withdrawal of treatment is not considered to have failed treatment with that particular PBS-subsidised biological agent.

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 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name

First given name

3 Date of birth (DD MM YYYY)

4 Patient's weight

kg

5 Patient's height

cm

Prescriber's details

6 Prescriber number

7 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name

First given name

8 Business phone number (including area code)

Alternative phone number (including area code)

Hospital details for infliximab i.v. and vedolizumab i.v.

9 Hospital name

This hospital is a:

☐ public hospital

☐ private hospital

10 Hospital provider number

Conditions and criteria

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

11 The patient is being treated by:

☐ a gastroenterologist

☐ a consultant physician specialising in gastroenterology (either general medicine or internal medicine).

12 This application is for:

☐ adalimumab

☐ infliximab i.v.

☐ infliximab s.c.

☐ ustekinumab

☐ vedolizumab i.v.
(and the patient has been assessed for the risk of developing progressive multifocal leukoencephalopathy while on this treatment)

☐ vedolizumab s.c.
(and the patient has been assessed for the risk of developing progressive multifocal leukoencephalopathy while on this treatment)

13 Has the patient previously received this biological agent (in any form) as their most recent course of PBS-subsidised treatment for this condition?

No ☐

Yes ☐ Dates of the most recent treatment course

From (DD MM YYYY)

To (DD MM YYYY)

MCA0PB088 2208

14 The patient has demonstrated or sustained an adequate response to treatment with this drug, defined as:

☐ a reduction in the Crohn's Disease Activity Index (CDAI) Score to a level ≤ 150 if assessed by CDAI or if affected by extensive small intestine disease

CDAI Score

Date of assessment (no more than 4 weeks old) (DD MM YYYY)

or

☐ an improvement of intestinal inflammation as demonstrated by at least one of the following:

- ☐ blood: normalisation of the platelet count
- ☐ blood: erythrocyte sedimentation rate (ESR) ≤ 25 mm/hour
- ☐ blood: C-reactive protein (CRP) ≤ 15 mg/L
- ☐ faeces: normalisation of lactoferrin or calprotectin level
- ☐ evidence of mucosal healing, as demonstrated by diagnostic imaging findings, compared to the baseline assessment

or

☐ reversal of high faecal output state

or

☐ avoidance of the need for surgery or total parenteral nutrition (TPN) if affected by short gut syndrome, extensive small intestine disease or is an ostomy patient.

Checklist

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

☐ The completed authority prescription form(s).

☐ The relevant pathology reports, diagnostic imaging test(s) and/or the completed CDAI calculation sheet.

Privacy notice

16 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/privacy**

Prescriber's declaration

17 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 the completed authority prescription form(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.

Prescriber's signature

On completion, print and sign by hand.

Date (DD MM YYYY)

Returning this form

Return this form and any supporting documents:

- **online**, upload this form, the authority prescription form(s) and any relevant attachments through Health Professional Online Services (HPOS) at **servicesaustralia.gov.au/hpos**

  or

- by post, send this form, the authority prescription form(s) and any relevant attachments to:

  Services Australia
  Complex Drugs Programs
  Reply Paid 9826
  HOBART TAS 7001

Australian Government
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Adult Crohn's Disease Activity Index

1 Week ending (DD MM YYYY)

Patient's full name

Gender Male ☐ Female ☐

Each parameter in this table must be assigned a value.

			Factor	Subtotal
Liquid stools (cumulative total over the last 7 days)	Number of liquid or soft stools over the last 7 days	sum =	x 2	
Abdominal pain † (cumulative total over the last 7 days)	Daily assessment †	sum =	x 5	
General well being ‡ (cumulative total over the last 7 days)	Daily assessment ‡	sum =	x 7	
Extra-intestinal				
Arthritis/arthralgia	None = 0 Yes = 1	score =	x 20	
Iritis/uveitis	None = 0 Yes = 1	score =	x 20	
Skin/mouth lesions	None = 0 Yes = 1	score =	x 20	
Peri-anal disease	None = 0 Yes = 1	score =	x 20	
Other fistula	None = 0 Yes = 1	score =	x 20	
Fever > 37.8ºC	None = 0 Yes = 1	score =	x 20	
Anti-diarrhoeals	None = 0 Yes = 1	score =	x 30	
Abdominal mass	None = 0 Questionable = 2 Definite = 5	score =	x 10	
Haematocrit (Hct)	Males (47 – Hct)	score =	x 6	
	Females (42 – Hct)	score =	x 6	
Weight (Maximum deduction of -10 for overweight patients)	Standard kg Current kg	kg kg	$100 \times \left(1 - \frac{\text{current}}{\text{standard}}\right)$	
			TOTAL CDAI SCORE	

† **Abdominal pain**	None = 0
	Intermediate = 1 or 2
	Severe = 3
‡ **General well being**	Well = 0
	Intermediate = 1, 2 or 3
	Terrible = 4

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Prescriber's declaration

3 I declare that the information I have provided in this form is complete and correct.
I understand that giving false or misleading information is a serious offence.

Prescriber's full name (Print in BLOCK LETTERS)

Prescriber's signature — On completion, print and sign by hand.

Date (DD MM YYYY)

Reset form Print form