Australian Government
Services Australia

medicare

PBS

Narcolepsy without cataplexy – armodafinil or modafinil initial authority application

When to use this form

Use this authority application form to apply for **initial** Pharmaceutical Benefits Scheme (PBS) subsidised armodafinil or modafinil treatment for patients with narcolepsy without cataplexy.

Important information

Initial applications to start PBS subsidised treatment must be in writing and must include sufficient supporting information to determine the patient's eligibility according to the PBS criteria.

Under no circumstances will phone approvals be granted for **initial** 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** treatment.

Applications for **continuing** or **changing** 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.

Call charges may apply.

Treatment specifics

Armodafinil and modafinil are not PBS subsidised when used in combination with each other or with PBS subsidised dexamfetamine sulfate.

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)

Prescriber's details

4 Prescriber number

5 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name

First given name

6 Business phone number (including area code)

Alternative phone number (including area code)

Conditions and criteria

The following information must be supplied to establish eligibility for PBS authority approval.

For restriction information, go to **pbs.gov.au**

7 This application is for:

☐ armodafinil

or

☐ modafinil

8 Is the patient being treated by a qualified sleep medicine practitioner or neurologist?

No ☐

Yes ☐

9 Has the patient had excessive daytime sleepiness, recurrent naps or lapses into sleep that occur almost daily for at least 3 months?

No ☐

Yes ☐

10 Does the patient have any medical or psychiatric disorder that could otherwise account for the hypersomnia?

No ☐

Yes ☐

11 Is the patient unable to receive therapy with dexamfetamine sulfate for this condition due to an unacceptable medical risk, as indicated by either:

☐ a psychiatric disorder

☐ a cardiovascular disorder

☐ a history of substance abuse

☐ glaucoma

☐ other absolute contraindication as specified in the Therapeutic Goods Administration (TGA) approved Product Information

or

☐ has resulted in the development of an intolerance with a severity to necessitate treatment withdrawal.

Provide details of intolerance or contraindication

MCA0PB104 2204

12 Has the patient had an electroencephalographic (EEG) recording showing the pathological rapid development of Rapid Eye Movement (REM) sleep?

No ☐

Yes ☐ Test date (DD MM YYYY)

or

Does the patient have a mean sleep latency ≤ 10 minutes on a Multiple Sleep Latency Test (MSLT)?

No ☐

Yes ☐ Give details

MSLT date (DD MM YYYY)

MSLT results

min

(Sleep prior to the MSLT test must be at least 6 hours in duration).

13 Has the patient had a polysomnography test conducted prior to the MSLT test?

No ☐

Yes ☐ Give details

Polysomnography test date (DD MM YYYY)

Polysomnography total sleep time

min

Checklist

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

☐ The completed authority prescription form(s).

☐ The polysomnography, MSLT or EEG test report.

Privacy notice

15 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

16 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

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