Australian Government
Services Australia

medicare

PBS

Severe allergic asthma – paediatric initial PBS authority application

When to use this form

Use this authority application form (this form) to apply for **initial** Pharmaceutical Benefits Scheme (PBS) subsidised omalizumab for a paediatric patient aged 6 to less than 12 years old, with uncontrolled severe allergic asthma.

Important information

Initial 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 may be made by contacting Services Australia on **1800 700 270** Monday to Friday, 8 am to 5 pm, Australian Eastern Standard Time.

Note: Call charges may apply.

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.

The assessment of the patient's response to an initial course of treatment must be made at **22 to 26 weeks** after the first dose and should be completed, where possible, by the same physician who initiated treatment with omalizumab.

Section 100 arrangements

This item is 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.

This item is not available as a PBS benefit for in-patients of a hospital.

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

Treatment specifics

Initial treatment authorisations will be limited to provide a **maximum of 28 weeks** of therapy.

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

[/ /]

4 Patient's current weight

[ ] kg

Prescriber's details

5 Prescriber number

[ ]

6 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other [ ]

Family name

[ ]

First given name

[ ]

7 Business phone number

[( )]

Alternative phone number

[ ]

Fax number

[( )]

Hospital details

8 Hospital name

[ ]

This hospital is a:

☐ public hospital

☐ private hospital

9 Hospital provider number

[ ][ ][ ][ ][ ][ ][ ][ ]

Conditions, criteria and prior treatment

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

10 Has the patient, aged 6 to less than 12 years, been under the care of the same physician for at least 6 months?

No ☐

Yes ☐

11 Is the patient being treated by a paediatric respiratory physician, clinical immunologist, allergist; or paediatrician or general physician experienced in the management of patients with severe asthma, in consultation with a respiratory physician?

No ☐

Yes ☐

12 The patient has a diagnosis of severe allergic asthma, as confirmed and documented by the treating prescriber confirmed above indicated by the following standard clinical features:

☐ forced expiratory volume (FEV1) reversibility

or

☐ airway hyperresponsiveness

or

☐ peak expiratory flow (PEF) variability.

13 Does the patient have past or current evidence of atopy, documented by skin prick testing or in vitro measure of specific Immunoglobulin E (IgE)?

No ☐

Yes ☐

14 What is the patient's total serum human IgE?

IgE value [ ] IU/mL

and

Date of IgE test [/ /]

The initial IgE assessment must be **no more than 12 months old** at the time of application.

15 Has the patient had asthma for at least 1 year?

No ☐

Yes ☐

16 The patient has received optimised asthma therapy including:

☐ adherence to high dose inhaled corticosteroid (ICS) for at least 6 months

Name

Dose

From / / to / /

and

☐ adherence to long-acting beta-2 agonist (LABA) therapy for at least 6 months

Name

Dose

From / / to / /

or

☐ if LABA therapy is contraindicated, not tolerated or not effective, montelukast, cromoglycate or nedocromil may be used as an alternative

Name

Dose

From / / to / /

and

☐ treatment with at least 2 courses of oral or IV corticosteroids (daily or alternate day maintenance treatment courses, or 3 to 5 day exacerbation treatment courses) in the previous 12 months.

Name

Dose

From / / to / /

Name

Dose

From / / to / /

17 If applicable, provide details of contraindications or intolerances to any of the prior therapies including the degree of toxicity.

For details of the toxicity criteria, go to **servicesaustralia.gov.au/healthprofessionals**

Intolerance must be of a severity to necessitate permanent treatment withdrawal.

Prior therapy contraindication or toxicity and grade

Inhaled corticosteroid

Inhaled long-acting beta-2 agonist therapy

Oral or IV corticosteroids

18 The patient:

☐ has failed to achieve adequate control despite formal assessment of and adherence to correct inhaler technique, including:

☐ an Asthma Control Questionnaire (ACQ-5 or ACQ-IA) score, assessed in the previous month:

Current ACQ-5 or ACQ-IA score

and while receiving optimised asthma therapy in the previous 12 months, has experienced:

☐ at least one admission to hospital for a severe asthma exacerbation

Provide date of exacerbation

/ /

or

☐ at least one severe asthma exacerbation, requiring documented use of systemic corticosteroids prescribed or supervised by a physician, either:

☐ oral corticosteroids initiated or increased for at least 3 days

or

☐ parenteral corticosteroids.

Provide date of exacerbation

/ /

Checklist

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

☐ The completed authority prescription form(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/privacy**

Prescriber's declaration

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 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

/ /

Reset form Print form

Returning your form

You can 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**
- **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