Australian Government
Services Australia

medicare

PBS

Acromegaly – pegvisomant 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 pegvisomant for acromegaly.

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 publication and is subject to change.

Continuing treatment

This form is ONLY for **initial** treatment.

After a written authority application for initial treatment has been approved, application for **continuing** treatment can be made by phone. Call **1800 700 270** Monday to Friday, 8 am to 5 pm, Australian Eastern Standard Time.

Note: Call charges may apply.

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.

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

[/ /]

Prescriber's details

4 Prescriber number

[ ]

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

Family name

[ ]

First given name

[ ]

6 Business phone number

[( )]

Alternative phone number

[ ]

Fax number

[( )]

Hospital details

7 Hospital name

[ ]

This hospital is a:

☐ public hospital

☐ private hospital

8 Hospital provider number

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

Conditions and criteria

9 Has the patient previously received PBS subsidised treatment with pegvisomant for acromegaly?

No ☐

Yes ☐

10 Will the patient receive pegvisomant treatment concomitantly with a PBS subsidised somatostatin analogue?

No ☐

Yes ☐

11 Does the patient have an age and sex adjusted insulin-like growth factor 1 (IGF-1) level greater than the upper limit of normal (ULN)?

No ☐

Yes ☐ Provide details

IGF-1 level [ ]

Date of assessment [/ /]

12 Has the patient failed to achieve biochemical control with maximum indicated dose of 30 mg octreotide LAR or 120 mg lanreotide ATG every 28 days for 24 weeks?

No ☐ ***Go to 14***

Yes ☐

13 Demonstration of failure to achieve biochemical control after completion of a prior therapy with either octreotide or lanreotide is demonstrated by:

☐ growth hormone level greater than 1mcg/L or 3mIU/L

or

☐ IGF-1 level greater than the age and sex adjusted ULN.

14 Is treatment with octreotide or lanreotide contraindicated or not tolerated?

No ☐

Yes ☐ Provide details

[ ]

15 Has the patient been previously treated with radiotherapy for acromegaly?

No ☐

Yes ☐ Provide details

Date of completion of radiotherapy / /

IGF-1 level

Date of assessment / /

Checklist

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

☐ The completed authority prescription form(s).

Privacy notice

17 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

18 **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 mail**, send this form, the authority prescription form(s) and any relevant attachments to:

Services Australia
Complex Drugs Programs
Reply Paid 9826
HOBART TAS 7001