Australian Government
Department of Human Services

medicare

PBS

Short bowel syndrome with intestinal failure recommencement of treatment PBS authority application

When to use this form

Use this authority application form (this form) for **recommencement of treatment** after a trial cessation period Pharmaceutical Benefits Scheme (PBS) subsidised teduglutide for patients with type III short bowel syndrome with intestinal failure.

Important information

Authority applications 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 **recommencement of treatment** authority applications.

The information on this form is correct at the time of publishing and may be subject to change.

Continuing treatment

This form is ONLY for **recommencement of treatment**.

Applications for all **subsequent continuing** treatments must be made in writing and must include a subsequent continuing treatment authority application form that provides sufficient supporting information to determine the patient's eligibility according to the PBS criteria.

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

Patients who demonstrate a stable frequency of mean days per week of parenteral support over a 6 month period commencing after the initial 12 months of treatment with this drug for this condition are required to undertake a trial of treatment cessation.

Patients who have recommenced after a trial cessation period are exempt from further trial cessation.

For more information

Go to **humanservices.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

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

9 Is the patient being treated by a gastroenterologist or a specialist within a multidisciplinary intestinal rehabilitation unit?

☐ No

☐ Yes

10 Has the patient received PBS subsidised treatment with this drug for this condition?

☐ No

☐ Yes

11 Has the patient undertaken a trial cessation period due to experiencing a stable parenteral support regimen in the first continuing or subsequent continuing treatment phase, and not due to a treatment failure?

☐ No

☐ Yes ▶ Provide the current mean number of days per week of parenteral support over the preceding 4 week period

[days per week]

12 Has the patient experienced deterioration during a trial cessation period?

☐ No

☐ Yes ▶ Provide details of the reason for recommencement after trial cessation

[ ]

13 Provide dates of the trial cessation period

Trial cessation start date

[/ /]

Trial cessation end date

[/ /]

Checklist

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

☐ The completed authority prescription form(s).

Privacy notice

15 Personal information is protected by law (including the *Privacy Act 1988*) and is collected by the Australian Government Department of Human Services for the purposes of assessing and processing this authority application.

Personal information may be used by the department, 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 the department manages personal information, including our privacy policy, can be found at **humanservices.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 the Australian Government Department of Human Services 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

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 **humanservices.gov.au/hpos**
- **by post**, send this form, the authority prescription form(s) and any relevant attachments to:

  Department of Human Services
  Complex Drugs Programs
  Reply Paid 9826
  HOBART TAS 7001