



Australian Government

Department of Health



Schedule of Pharmaceutical Benefits

Effective 1 June 2015 – 30 June 2015

This Schedule is also available at www.pbs.gov.au



This work is copyright. Apart from any use as permitted under the *Copyright Act 1968*, no part may be reproduced by any process without prior written permission from the Commonwealth. Requests and inquiries concerning reproduction and rights should be addressed to the Commonwealth Copyright Administration, Attorney General's Department, Robert Garran Offices, National Circuit, Barton ACT 2600 or posted at <http://www.ag.gov.au/cca>

This Schedule provides information on the arrangements for the prescribing and supply of pharmaceutical benefits. These arrangements operate under the *National Health Act 1953*. However, at the time of printing, the relevant legislation giving authority for the changes included in this issue of the Schedule may still be subject to the usual Parliamentary scrutiny. This book is not a legal document, and, in cases of discrepancy, the legislation will be the source document for payment for the supply of pharmaceutical benefits. The legislation is available from the Federal Register of Legislative Instruments website at <http://www.frli.gov.au>.

The information is not intended to give or replace any legal, medical, dental or optometrical advice. This document is not a legal document and does not constitute legal advice. Neither the information nor this document can be relied upon without first seeking and obtaining independent legal, medical, dental or optometrical advice beforehand. To the extent permitted by law, the Commonwealth of Australia will not be held responsible, nor accept any liability (whether arising out of negligence or otherwise), for any injury, damages, costs, expenses and losses suffered or incurred by a person where such a person has relied on this document or used the information in it as legal, medical, dental or optometrical advice.

Contents

Fees, Patient Contributions and Safety Net Thresholds	4
Summary of Changes	5
About the Schedule	14
Symbols Used in the Schedule	14
Restricted Benefits	14
Pharmaceutical Benefits Schedules	17
Prescriber Bag	19
General Pharmaceutical Benefits	25
Palliative Care	587
Highly Specialised Drugs Program (Private Hospital)	605
Highly Specialised Drugs Program (Public Hospital).....	793
Botulinum Toxin Program.....	983
Growth Hormone Program	989
IVF Treatment Program.....	995
Opiate Dependence Treatment Program	1001
Repatriation Pharmaceutical Benefits Scheme	1005
Index of Manufacturers' Code.....	1059
Generic/Proprietary Index	1062

Fees, Patient Contributions and Safety Net Thresholds

The following fees, patient contributions and safety net thresholds apply as at 1 June 2015 and are included, where applicable, in prices published in the Schedule —

Dispensing Fees:	Ready-prepared	\$6.76
	Dangerous drug fee	\$2.71
	Extemporaneously-prepared	\$8.80
	Allowable additional patient charge*	\$4.27
Additional Fees (for safety net prices):	Ready-prepared	\$1.15
	Extemporaneously-prepared	\$1.50
Patient Co-payments:	General	\$37.70
	Concessional	\$6.10
Safety Net Thresholds:	General	\$1453.90
	Concessional	\$366.00
Safety Net Card Issue Fee:		\$9.47

* The allowable additional patient charge is a discretionary charge to general patients if a pharmaceutical item has a dispensed price for maximum quantity less than the general patient co-payment. The pharmacist may charge general patients the allowable additional fee but the fee cannot take the cost of the prescription above the general patient co-payment for the medicine. This fee does not count towards the Safety Net threshold.

Summary of Changes

These changes to the Schedule of Pharmaceutical Benefits are effective from 1 June 2015. The Schedule is updated on the first day of each month and is available on the internet at www.pbs.gov.au.

General Pharmaceutical Benefits

Additions

Addition – Item

- 10258X **AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT PHENYLALANINE**, amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 30 x 36 g sachets (*PKU Anamix Junior*)
- 10260B **AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT PHENYLALANINE AND TYROSINE**, amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid: powder for, 30 x 36 g sachets (*TYR Anamix Junior*)
- 10259Y **AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT VALINE, LEUCINE AND ISOLEUCINE**, amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 30 x 36 g sachets (*MSUD Anamix Junior*)
- 10261C **DIPHTHERIA TOXOID + TETANUS TOXOID**, diphtheria toxoid 2 Lf/0.5 mL + tetanus toxoid 2 Lf/0.5 mL injection, 10 x 0.5 mL vials (*MassBiologics tetanus and diphtheria toxoids adsorbed*)

Addition – Brand

- 1003T *Aciclovir Sandoz, HX* – **ACICLOVIR**, aciclovir 200 mg tablet, 25
- 1007B *Aciclovir Sandoz, HX* – **ACICLOVIR**, aciclovir 200 mg tablet, 90
- 1081X *Atenolol RBX, RA* – **ATENOLOL**, atenolol 50 mg tablet, 30
- 8382E *Diasp SR, QA* – **DIPYRIDAMOLE + ASPIRIN**, dipyridamole 200 mg + aspirin 25 mg capsule: modified release, 60 capsules
- 9155W *Depreta 30, DO* – **DULOXETINE**, duloxetine 30 mg capsule: enteric, 28
- 9156X *Depreta 60, DO* – **DULOXETINE**, duloxetine 60 mg capsule: enteric, 28
- 2414C *Frusemide RBX, RA* – **FRUSEMIDE**, frusemide 20 mg tablet, 100
- 2412Y *Frusemide RBX, RA* – **FRUSEMIDE**, frusemide 40 mg tablet, 100
- 1834M *Gabapentin GH, GQ* – **GABAPENTIN**, gabapentin 300 mg capsule, 100
- 1835N *Gabapentin GH, GQ* – **GABAPENTIN**, gabapentin 400 mg capsule, 100
- 1512N *Hydroxychloroquine RBX, RA* – **HYDROXYCHLOROQUINE**, hydroxychloroquine sulfate 200 mg tablet, 100
- 2848X *Logem, AL* – **LAMOTRIGINE**, lamotrigine 25 mg tablet, 56
- 2849Y *Logem, AL* – **LAMOTRIGINE**, lamotrigine 50 mg tablet, 56
- 2850B *Logem, AL* – **LAMOTRIGINE**, lamotrigine 100 mg tablet, 56
- 2851C *Logem, AL* – **LAMOTRIGINE**, lamotrigine 200 mg tablet, 56
- 9331D *APO-Lansoprazole ODT, TX* – **LANSOPRAZOLE**, lansoprazole 15 mg tablet: orally disintegrating, 28 tablets
- 9477T *APO-Lansoprazole ODT, TX* – **LANSOPRAZOLE**, lansoprazole 30 mg tablet: orally disintegrating, 28 tablets
- 9478W *APO-Lansoprazole ODT, TX* – **LANSOPRAZOLE**, lansoprazole 30 mg tablet: orally disintegrating, 28 tablets
- 5264C *Solu-Medrol, PF* – **METHYLPREDNISOLONE**, methylprednisolone Powder for injection 1 g (as sodium succinate), 1

1207M	<i>Metoclopramide RBX, RA</i> – METOCLOPRAMIDE , metoclopramide hydrochloride 10 mg tablet, 25
5151D	<i>Metoclopramide RBX, RA</i> – METOCLOPRAMIDE , metoclopramide hydrochloride 10 mg tablet, 25 (Dental)
1324Q	<i>Metoprolol RBX, RA</i> – METOPROLOL TARTRATE , METOPROLOL TARTRATE Tablet 50 mg, 100
1325R	<i>Metoprolol RBX, RA</i> – METOPROLOL TARTRATE , METOPROLOL TARTRATE Tablet 100 mg, 60
1594X	<i>Ondansetron SZ, HX</i> – ONDANSETRON , ondansetron 4 mg tablet, 10
8224W	<i>Ondansetron SZ, HX</i> – ONDANSETRON , ondansetron 4 mg tablet, 4
5470X	<i>Ondansetron SZ ODT, HX</i> – ONDANSETRON , ONDANSETRON Tablet (orally disintegrating) 4 mg, 4
5472B	<i>Ondansetron SZ ODT, HX</i> – ONDANSETRON , ONDANSETRON Tablet (orally disintegrating) 4 mg, 10
1595Y	<i>Ondansetron SZ, HX</i> – ONDANSETRON , ondansetron 8 mg tablet, 10
8225X	<i>Ondansetron SZ, HX</i> – ONDANSETRON , ondansetron 8 mg tablet, 4
5471Y	<i>Ondansetron SZ ODT, HX</i> – ONDANSETRON , ONDANSETRON Tablet (orally disintegrating) 8 mg, 4
5473C	<i>Ondansetron SZ ODT, HX</i> – ONDANSETRON , ONDANSETRON Tablet (orally disintegrating) 8 mg, 10
2242B	<i>Paroxetine GH, GQ</i> – PAROXETINE , paroxetine 20 mg tablet, 30
8508T	<i>Zabep, AL</i> – RABEPRAZOLE , rabeprazole sodium 20 mg tablet: enteric, 30
8509W	<i>Zabep, AL</i> – RABEPRAZOLE , rabeprazole sodium 20 mg tablet: enteric, 30
1978D	<i>Ranitidine GH, GQ</i> – RANITIDINE , ranitidine 150 mg tablet, 60

Deletions

Deletion – Item

2080L	CALCIPOTRIOL , calcipotriol 0.005% cream, 30 g (<i>Daivonex</i>)
1172Q	CHLORAMPHENICOL , chloramphenicol 0.5% ear drops, 5 mL (<i>Chloromycetin</i>)

Deletion – Brand

1210Q	<i>Ciproxin 750, BN</i> – CIPROFLOXACIN , ciprofloxacin 750 mg tablet, 14
8505P	<i>Gabatine 100, QA</i> – GABAPENTIN , gabapentin 100 mg capsule, 100
1834M	<i>Gabatine 300, QA</i> – GABAPENTIN , gabapentin 300 mg capsule, 100
1835N	<i>Gabatine 400, QA</i> – GABAPENTIN , gabapentin 400 mg capsule, 100
8559L	<i>Gabatine 600, QA</i> – GABAPENTIN , gabapentin 600 mg tablet, 100
8389M	<i>Gabatine 800, QA</i> – GABAPENTIN , gabapentin 800 mg tablet, 100
1596B	<i>Ondaz, SZ</i> – ONDANSETRON , ondansetron 4 mg/2 mL injection, 1 x 2 mL ampoule
8226Y	<i>Ondaz, SZ</i> – ONDANSETRON , ondansetron 4 mg/2 mL injection, 1 x 2 mL ampoule
1597C	<i>Ondaz, SZ</i> – ONDANSETRON , ondansetron 8 mg/4 mL injection, 1 x 4 mL ampoule
8227B	<i>Ondaz, SZ</i> – ONDANSETRON , ondansetron 8 mg/4 mL injection, 1 x 4 mL ampoule
9372G	<i>Dilart HCT 80/12.5, AF</i> – VALSARTAN + HYDROCHLOROTHIAZIDE , valsartan 80 mg + hydrochlorothiazide 12.5 mg tablet, 28

Deletion – Equivalence Indicator

9372G	<i>Co-Diovan 80/12.5, NV</i> – VALSARTAN + HYDROCHLOROTHIAZIDE , valsartan 80 mg + hydrochlorothiazide 12.5 mg tablet, 28
-------	--

Alterations

Alteration – Brand Name

From

9012H	<i>FonatPlus, AF</i> – ALENDRONATE + COLECALCIFEROL , alendronate 70 mg + colecalciferol 70 microgram tablet, 4
-------	--

To

9012H	<i>FonatPLUS, AF</i> – ALENDRONATE + COLECALCIFEROL , alendronate 70 mg + colecalciferol 70 microgram tablet, 4
-------	--

From

9183H	<i>Fonat Plus, AF</i> – ALENDRONATE + COLECALCIFEROL , alendronate 70 mg + colecalciferol 140 microgram
-------	--

	tablet, 4
To	
9183H	<i>FonatPLUS, AF</i> – ALENDRONATE + COLECALCIFEROL , alendronate 70 mg + colecalciferol 140 microgram tablet, 4
From	
2687K	<i>Thioprine, AF</i> – AZATHIOPRINE , azathioprine 50 mg tablet, 100
To	
2687K	<i>Thioprine 50, AF</i> – AZATHIOPRINE , azathioprine 50 mg tablet, 100
Alteration – Restriction	
The following items have additions, deletions or alterations to restrictions and/or notes.	
8048N	ABCIXIMAB , abciximab 10 mg/5 mL injection, 1 x 5 mL vial (<i>ReoPro</i>)
8954G	ADAPALENE + BENZOYL PEROXIDE , adapalene 0.1% + benzoyl peroxide 2.5% gel, 30 g (<i>Epiduo</i>)
8955H	ADAPALENE + BENZOYL PEROXIDE , adapalene 0.1% + benzoyl peroxide 2.5% gel, 30 g (<i>Epiduo</i>)
3408J	ADRENALINE , adrenaline 150 microgram/0.3 mL injection, 1 x 0.3 mL syringe (<i>Anapen Junior</i>)
3409K	ADRENALINE , adrenaline 300 microgram/0.3 mL injection, 1 x 0.3 mL syringe (<i>Anapen</i>)
8697R	ADRENALINE , adrenaline 150 microgram/0.3 mL injection, 1 x 0.3 mL syringe (<i>EpiPen Jr.</i>)
8698T	ADRENALINE , adrenaline 300 microgram/0.3 mL injection, 1 x 0.3 mL syringe (<i>EpiPen</i>)
8083K	APRACLONIDINE , apraclonidine 0.5% eye drops, 10 mL (<i>Iopidine 0.5%</i>)
1115Q	BETAMETHASONE DIPROPIONATE , betamethasone (as dipropionate) 0.05% cream, 15 g (<i>Diprosone, Eleuphrat</i>)
1119X	BETAMETHASONE DIPROPIONATE , betamethasone (as dipropionate) 0.05% ointment, 15 g (<i>Diprosone, Eleuphrat</i>)
2812B	BETAMETHASONE VALERATE , betamethasone (as valerate) 0.02% (200 microgram/g) cream, 100 g (<i>Antroquoril, Betnovate 1/5, Celestone-M, Cortival 1/5</i>)
2813C	BETAMETHASONE VALERATE , betamethasone (as valerate) 0.05% (500 microgram/g) cream, 15 g (<i>Betnovate 1/2, Cortival 1/2</i>)
8844L	BIVALIRUDIN , bivalirudin 250 mg injection, 1 x 250 mg vial (<i>Angiomax</i>)
8865N	BUPRENORPHINE , buprenorphine 5 microgram/hour patch, 2 (<i>Norspan</i>)
8866P	BUPRENORPHINE , buprenorphine 10 microgram/hour patch, 2 (<i>Norspan</i>)
8867Q	BUPRENORPHINE , buprenorphine 20 microgram/hour patch, 2 (<i>Norspan</i>)
8760C	CAPTOPRIL , captopril 5 mg/mL oral liquid, 95 mL (<i>Capoten</i>)
8439E	CELECOXIB , celecoxib 100 mg capsule, 60 (<i>APO-Celecoxib, Blooms the Chemist Celecoxib, Celaxib, Celebrex, Celecoxib Actavis, Celecoxib GH, Celecoxib RBX, Celecoxib Sandoz, Celecoxib AN, Celexi, Chem mart Celecoxib, Kudeq, Terry White Chemists Celecoxib</i>)
8440F	CELECOXIB , celecoxib 200 mg capsule, 30 (<i>APO-Celecoxib, Blooms the Chemist Celecoxib, Celaxib, Celebrex, Celecoxib AN, Celecoxib GH, Celecoxib RBX, Celecoxib Sandoz, Celecoxib Actavis, Celexi, Chem mart Celecoxib, Kudeq, Terry White Chemists Celecoxib</i>)
8132B	CLODRONATE , clodronate sodium 400 mg capsule, 100 (<i>Bonefos</i>)
8265B	CLODRONATE , clodronate sodium 800 mg tablet, 60 (<i>Bonefos 800 mg</i>)
1229Q	DALTEPARIN SODIUM , dalteparin sodium 10 000 anti-Xa international units/mL injection, 10 x 1 mL syringes (<i>Fragmin</i>)
1296F	DALTEPARIN SODIUM , dalteparin sodium 12 500 anti-Xa international units/0.5 mL injection, 10 x 0.5 mL syringes (<i>Fragmin</i>)
8641T	DALTEPARIN SODIUM , dalteparin sodium 2500 anti-Xa international units/0.2 mL injection, 10 x 0.2 mL syringes (<i>Fragmin</i>)
8642W	DALTEPARIN SODIUM , dalteparin sodium 5000 anti-Xa international units/0.2 mL injection, 10 x 0.2 mL syringes (<i>Fragmin</i>)
8643X	DALTEPARIN SODIUM , dalteparin sodium 7500 anti-Xa international units/0.75 mL injection, 10 x 0.75 mL syringes (<i>Fragmin</i>)
8956J	DALTEPARIN SODIUM , dalteparin sodium 7500 anti-Xa international units/0.75 mL injection, 10 x 0.75 mL

	syringes (<i>Fragmin</i>)
8957K	DALTEPARIN SODIUM , dalteparin sodium 10 000 anti-Xa international units/mL injection, 10 x 1 mL syringes (<i>Fragmin</i>)
8958L	DALTEPARIN SODIUM , dalteparin sodium 12 500 anti-Xa international units/0.5 mL injection, 10 x 0.5 mL syringes (<i>Fragmin</i>)
8959M	DALTEPARIN SODIUM , DALTEPARIN SODIUM (Low Molecular Weight Heparin Sodium-porcine mucous) Injection 15,000 units (anti-Xa) in 0.6 mL single dose pre-filled syringe, 10 (<i>Fragmin</i>)
8960N	DALTEPARIN SODIUM , DALTEPARIN SODIUM (Low Molecular Weight Heparin Sodium-porcine mucous) Injection 18,000 units (anti-Xa) in 0.72 mL single dose pre-filled syringe, 10 (<i>Fragmin</i>)
9196B	ENOXAPARIN SODIUM , enoxaparin sodium 40 mg/0.4 mL injection, 10 x 0.4 mL ampoules (<i>Clexane</i>)
8879H	EPLERENONE , eplerenone 25 mg tablet, 30 (<i>Inspira</i>)
8880J	EPLERENONE , eplerenone 50 mg tablet, 30 (<i>Inspira</i>)
9329B	ESSENTIAL AMINO ACIDS FORMULA , essential amino acids formula oral liquid: powder for, 2 x 200 g cans (<i>Essential Amino Acid Mix</i>)
2027Q	ESSENTIAL AMINO ACIDS FORMULA WITH MINERALS AND VITAMIN C , essential amino acids formula with minerals and vitamin C oral liquid: powder for, 400 g (<i>Dialamine</i>)
9385Y	ESSENTIAL AMINO ACIDS FORMULA WITH VITAMINS AND MINERALS , essential amino acids formula with vitamins and minerals oral liquid: powder for, 50 x 12.5 g sachets (<i>EAA Supplement</i>)
8748K	ETHACRYNIC ACID , ethacrynic acid 25 mg tablet, 100 (<i>Edecrin</i>)
5265D	FENTANYL , fentanyl 12 microgram/hour patch, 5 (<i>Denpax</i>)
5277R	FENTANYL , fentanyl 25 microgram/hour patch, 5 (<i>Denpax</i>)
5278T	FENTANYL , fentanyl 50 microgram/hour patch, 5 (<i>Denpax</i>)
5279W	FENTANYL , fentanyl 75 microgram/hour patch, 5 (<i>Denpax</i>)
5280X	FENTANYL , fentanyl 100 microgram/hour patch, 5 (<i>Denpax</i>)
5437E	FENTANYL , fentanyl 12 microgram/hour patch, 5 (<i>Dutran 12, Fenpatch 12</i>)
5438F	FENTANYL , fentanyl 25 microgram/hour patch, 5 (<i>Dutran 25, Fenpatch 25</i>)
5439G	FENTANYL , fentanyl 50 microgram/hour patch, 5 (<i>Dutran 50, Fenpatch 50</i>)
5440H	FENTANYL , fentanyl 75 microgram/hour patch, 5 (<i>Dutran 75, Fenpatch 75</i>)
5441J	FENTANYL , fentanyl 100 microgram/hour patch, 5 (<i>Dutran 100, Fenpatch 100</i>)
8878G	FENTANYL , fentanyl 12 microgram/hour patch, 5 (<i>Durogesic 12, Fentanyl Sandoz</i>)
8891Y	FENTANYL , fentanyl 25 microgram/hour patch, 5 (<i>Durogesic 25, Fentanyl Sandoz</i>)
8892B	FENTANYL , fentanyl 50 microgram/hour patch, 5 (<i>Durogesic 50, Fentanyl Sandoz</i>)
8893C	FENTANYL , fentanyl 75 microgram/hour patch, 5 (<i>Durogesic 75, Fentanyl Sandoz</i>)
8894D	FENTANYL , fentanyl 100 microgram/hour patch, 5 (<i>Durogesic 100, Fentanyl Sandoz</i>)
8430Q	FLUTICASONE + SALMETEROL , fluticasone propionate 100 microgram/actuation + salmeterol 50 microgram/actuation inhalation: powder for, 60 actuations (<i>Seretide Accuhaler 100/50</i>)
8431R	FLUTICASONE + SALMETEROL , fluticasone propionate 250 microgram/actuation + salmeterol 50 microgram/actuation inhalation: powder for, 60 actuations (<i>Seretide Accuhaler 250/50</i>)
8432T	FLUTICASONE + SALMETEROL , fluticasone propionate 500 microgram/actuation + salmeterol 50 microgram/actuation inhalation: powder for, 60 actuations (<i>Seretide Accuhaler 500/50</i>)
8517G	FLUTICASONE + SALMETEROL , fluticasone propionate 50 microgram/actuation + salmeterol 25 microgram/actuation inhalation: pressurised, 120 actuations (<i>Seretide MDI 50/25</i>)
8518H	FLUTICASONE + SALMETEROL , fluticasone propionate 125 microgram/actuation + salmeterol 25 microgram/actuation inhalation: pressurised, 120 actuations (<i>Seretide MDI 125/25</i>)
8519J	FLUTICASONE + SALMETEROL , fluticasone propionate 250 microgram/actuation + salmeterol 25 microgram/actuation inhalation: pressurised, 120 actuations (<i>Seretide MDI 250/25</i>)
2312Q	FUSIDATE , fusidate sodium 250 mg tablet, 36 (<i>Fucidin</i>)
2881P	HYDROCORTISONE ACETATE , hydrocortisone acetate 1% (10 mg/g) cream, 50 g (<i>Cortic-DS 1%, Sigmacort</i>)
2882Q	HYDROCORTISONE ACETATE , hydrocortisone acetate 1% (10 mg/g) ointment, 50 g (<i>Cortic-DS 1%, Sigmacort</i>)

2887Y	HYDROCORTISONE ACETATE , hydrocortisone acetate 1% (10 mg/g) cream, 30 g (<i>Cortic-DS 1%, Sigmacort</i>)
2888B	HYDROCORTISONE ACETATE , hydrocortisone acetate 1% (10 mg/g) ointment, 30 g (<i>Cortic-DS 1%, Sigmacort</i>)
5111B	HYDROCORTISONE ACETATE , hydrocortisone acetate 1% (10 mg/g) cream, 30 g (<i>Cortic-DS 1%, Sigmacort</i>)(Dental)
5112C	HYDROCORTISONE ACETATE , hydrocortisone acetate 1% (10 mg/g) ointment, 30 g (<i>Cortic-DS 1%, Sigmacort</i>)(Dental)
5113D	HYDROCORTISONE ACETATE , hydrocortisone acetate 1% (10 mg/g) cream, 50 g (<i>Cortic-DS 1%, Sigmacort</i>)(Dental)
5114E	HYDROCORTISONE ACETATE , hydrocortisone acetate 1% (10 mg/g) ointment, 50 g (<i>Cortic-DS 1%, Sigmacort</i>)(Dental)
5115F	HYDROMORPHONE , hydromorphone hydrochloride 2 mg tablet, 20 (<i>Dilaudid</i>)(Dental)
5116G	HYDROMORPHONE , hydromorphone hydrochloride 4 mg tablet, 20 (<i>Dilaudid</i>)(Dental)
5117H	HYDROMORPHONE , hydromorphone hydrochloride 8 mg tablet, 20 (<i>Dilaudid</i>)(Dental)
5132D	HYDROMORPHONE , hydromorphone hydrochloride 1 mg/mL oral liquid, 473 mL (<i>Dilaudid</i>)(Dental)
8424J	HYDROMORPHONE , hydromorphone hydrochloride 1 mg/mL oral liquid, 473 mL (<i>Dilaudid</i>)
8541M	HYDROMORPHONE , hydromorphone hydrochloride 2 mg tablet, 20 (<i>Dilaudid</i>)
8542N	HYDROMORPHONE , hydromorphone hydrochloride 4 mg tablet, 20 (<i>Dilaudid</i>)
8543P	HYDROMORPHONE , hydromorphone hydrochloride 8 mg tablet, 20 (<i>Dilaudid</i>)
9299K	HYDROMORPHONE , hydromorphone hydrochloride 4 mg tablet: modified release, 14 tablets (<i>Jurnista</i>)
9406C	HYDROMORPHONE , hydromorphone hydrochloride 8 mg tablet: modified release, 14 tablets (<i>Jurnista</i>)
9407D	HYDROMORPHONE , hydromorphone hydrochloride 16 mg tablet: modified release, 14 tablets (<i>Jurnista</i>)
9408E	HYDROMORPHONE , hydromorphone hydrochloride 32 mg tablet: modified release, 14 tablets (<i>Jurnista</i>)
9409F	HYDROMORPHONE , hydromorphone hydrochloride 64 mg tablet: modified release, 14 tablets (<i>Jurnista</i>)
9357L	IBANDRONIC ACID , ibandronic acid 50 mg tablet, 28 (<i>Bondronat</i>)
1976B	ICATIBANT , ICATIBANT Injection 30 mg (as acetate) in 3 mL single use pre-filled syringe, 1 (<i>Firazyr</i>)
1606M	METHADONE , methadone hydrochloride 10 mg/mL injection, 5 x 1 mL ampoules (<i>Physeptone</i>)
1609Q	METHADONE , methadone hydrochloride 10 mg tablet, 20 (<i>Physeptone</i>)
1621H	METRONIDAZOLE , metronidazole 400 mg tablet, 21 (<i>Flagyl, Metrogyl 400, Metronide 400</i>)
2313R	MINOXIDIL , minoxidil 10 mg tablet, 100 (<i>Loniten</i>)
1646P	MORPHINE , morphine sulfate 30 mg tablet, 20 (<i>Anamorph</i>)
1653B	MORPHINE , morphine sulfate 10 mg tablet: modified release, 28 tablets (<i>MORPHINE MR APOTEX, MS Contin, Momex SR 10</i>)
1654C	MORPHINE , morphine sulfate 30 mg tablet: modified release, 28 tablets (<i>MORPHINE MR APOTEX, MS Contin, Momex SR 30</i>)
1655D	MORPHINE , morphine sulfate 60 mg tablet: modified release, 28 tablets (<i>MORPHINE MR APOTEX, MS Contin, Momex SR 60</i>)
1656E	MORPHINE , morphine sulfate 100 mg tablet: modified release, 28 tablets (<i>APOTEX-MORPHINE MR, MS Contin, Momex SR 100</i>)
2122Q	MORPHINE , morphine hydrochloride 2 mg/mL oral liquid, 200 mL (<i>Ordine 2</i>)
2123R	MORPHINE , morphine hydrochloride 5 mg/mL oral liquid, 200 mL (<i>Ordine 5</i>)
2124T	MORPHINE , morphine hydrochloride 10 mg/mL oral liquid, 200 mL (<i>Ordine 10</i>)
2839K	MORPHINE , morphine Capsule 20 mg (containing sustained release pellets), 28 (<i>Kapanol</i>)
2840L	MORPHINE , morphine Capsule 50 mg (containing sustained release pellets), 28 (<i>Kapanol</i>)
2841M	MORPHINE , morphine Capsule 100 mg (containing sustained release pellets), 28 (<i>Kapanol</i>)
5163R	MORPHINE , morphine sulfate 30 mg tablet, 20 (<i>Anamorph</i>)(Dental)
5237P	MORPHINE , morphine hydrochloride 2 mg/mL oral liquid, 200 mL (<i>Ordine 2</i>)(Dental)
5238Q	MORPHINE , morphine hydrochloride 5 mg/mL oral liquid, 200 mL (<i>Ordine 5</i>)(Dental)

5239R	MORPHINE , morphine hydrochloride 10 mg/mL oral liquid, 200 mL (<i>Ordine 10</i>)(Dental)
8035X	MORPHINE , morphine sulfate 5 mg tablet: modified release, 28 tablets (<i>MS Contin</i>)
8146R	MORPHINE , morphine Sachet containing controlled release granules for oral suspension, 30 mg per sachet, 28 (<i>MS Contin Suspension 30 mg</i>)
8305D	MORPHINE , morphine Sachet containing controlled release granules for oral suspension, 60 mg per sachet, 28 (<i>MS Contin Suspension 60 mg</i>)
8306E	MORPHINE , morphine sulfate 100 mg granules: modified release, 28 sachets (<i>MS Contin Suspension 100 mg</i>)
8349K	MORPHINE , morphine Capsule 10 mg (containing sustained release pellets), 28 (<i>Kapanol</i>)
8453X	MORPHINE , morphine sulfate 200 mg tablet: modified release, 28 tablets (<i>MS Contin</i>)
8454Y	MORPHINE , morphine sulfate 200 mg granules: modified release, 28 sachets (<i>MS Contin Suspension 200 mg</i>)
8489T	MORPHINE , morphine sulfate 15 mg tablet: modified release, 28 tablets (<i>MS Contin</i>)
8490W	MORPHINE , morphine sulfate 20 mg granules: modified release, 28 sachets (<i>MS Contin Suspension 20 mg</i>)
8491X	MORPHINE , morphine sulfate 30 mg capsule: modified release, 14 capsules (<i>MS Mono</i>)
8492Y	MORPHINE , morphine sulfate 60 mg capsule: modified release, 14 capsules (<i>MS Mono</i>)
8493B	MORPHINE , morphine sulfate 90 mg capsule: modified release, 14 capsules (<i>MS Mono</i>)
8494C	MORPHINE , morphine sulfate 120 mg capsule: modified release, 14 capsules (<i>MS Mono</i>)
8669G	MORPHINE , morphine sulfate 10 mg tablet, 20 (<i>Sevredol</i>)
8670H	MORPHINE , morphine sulfate 20 mg tablet, 20 (<i>Sevredol</i>)
9019Q	MOXONIDINE , moxonidine 200 microgram tablet, 30 (<i>Physiotens</i>)
9020R	MOXONIDINE , moxonidine 400 microgram tablet, 30 (<i>Physiotens</i>)
2481N	OXYCODONE , oxycodone 30 mg suppository, 12 (<i>Proladone</i>)
2622B	OXYCODONE , oxycodone hydrochloride 5 mg tablet, 20 (<i>Endone</i>)
5190E	OXYCODONE , oxycodone hydrochloride 5 mg/5 mL oral liquid, 250 mL (<i>OxyNorm Liquid 5mg/5mL</i>)(Dental)
5191F	OXYCODONE , oxycodone hydrochloride 5 mg capsule, 20 (<i>OxyNorm</i>)(Dental)
5194J	OXYCODONE , oxycodone 30 mg suppository, 12 (<i>Proladone</i>)(Dental)
5195K	OXYCODONE , oxycodone hydrochloride 5 mg tablet, 20 (<i>Endone</i>)(Dental)
5197M	OXYCODONE , oxycodone hydrochloride 10 mg capsule, 20 (<i>OxyNorm</i>)(Dental)
8464L	OXYCODONE , oxycodone hydrochloride 5 mg capsule, 20 (<i>OxyNorm</i>)
8501K	OXYCODONE , oxycodone hydrochloride 10 mg capsule, 20 (<i>OxyNorm</i>)
8502L	OXYCODONE , oxycodone hydrochloride 20 mg capsule, 20 (<i>OxyNorm</i>)
8644Y	OXYCODONE , oxycodone hydrochloride 5 mg/5 mL oral liquid, 250 mL (<i>OxyNorm Liquid 5mg/5mL</i>)
8000C	OXYCODONE + NALOXONE , oxycodone hydrochloride 5 mg + naloxone hydrochloride 2.5 mg tablet: modified release, 28 tablets (<i>Targin 5/2.5mg</i>)
8934F	OXYCODONE + NALOXONE , oxycodone hydrochloride 10 mg + naloxone hydrochloride 5 mg tablet: modified release, 28 tablets (<i>Targin 10/5mg</i>)
8935G	OXYCODONE + NALOXONE , oxycodone hydrochloride 20 mg + naloxone hydrochloride 10 mg tablet: modified release, 28 tablets (<i>Targin 20/10mg</i>)
8936H	OXYCODONE + NALOXONE , oxycodone hydrochloride 40 mg + naloxone hydrochloride 20 mg tablet: modified release, 28 tablets (<i>Targin 40/20mg</i>)
5224Y	PARACETAMOL , paracetamol 500 mg tablet, 100 (<i>APO-Paracetamol, Febridol, Generic Health Pty Ltd, Panamax, Paracetamol (Sandoz), Paralgin, Parapane</i>)(Dental)
8784H	PARACETAMOL , paracetamol 500 mg tablet, 100 (<i>APO-Paracetamol, Febridol, Generic Health Pty Ltd, Panamax, Paracetamol (Sandoz), Paralgin, Parapane</i>)
8814X	PARACETAMOL , paracetamol 665 mg tablet: modified release, 96 tablets (<i>Osteomol 665 Paracetamol, Panadol Osteo</i>)
1215Y	PARACETAMOL + CODEINE , CODEINE PHOSPHATE with PARACETAMOL Tablet 30 mg-500 mg, 20 (<i>APO-Paracetamol/Codeine 500/30, Codalgin Forte, Codapane Forte, Comfarol Forte, Panadeine Forte, Paracetamol/Codeine GH 500/30, Prodeine Forte</i>)

8785J	PARACETAMOL + CODEINE , CODEINE PHOSPHATE with PARACETAMOL Tablet 30 mg-500 mg, 20 (<i>APO-Paracetamol/Codeine 500/30, Codalgin Forte, Codapane Forte, Comfarol Forte, Panadeine Forte, Paracetamol/Codeine GH 500/30, Prodeine Forte</i>)
10212L	PEGINTERFERON BETA-1A , peginterferon beta-1a 125 microgram/0.5 mL injection, 2 x 0.5 mL injection devices (<i>Plegridy</i>)
10218T	PEGINTERFERON BETA-1A , peginterferon beta-1a 63 microgram/0.5 mL injection [0.5 mL injection device] (&) peginterferon beta-1a 94 microgram/0.5 mL injection [0.5 mL injection device], 1 pack (<i>Plegridy</i>)
10220X	PEGINTERFERON BETA-1A , peginterferon beta-1a 125 microgram/0.5 mL injection, 2 x 0.5 mL injection devices (<i>Plegridy</i>)
2997R	SALCATONIN , salcatonin 100 international units/mL injection, 5 x 1 mL ampoules (<i>Miacalcic 100</i>)
10086W	SAPROPTERIN , sapropterin dihydrochloride 100 mg tablet: soluble, 30 tablets (<i>Kuvan</i>)
8221Q	TIAGABINE , tiagabine 5 mg tablet, 50 (<i>Gabitril</i>)
8222R	TIAGABINE , tiagabine 10 mg tablet, 50 (<i>Gabitril</i>)
8223T	TIAGABINE , tiagabine 15 mg tablet, 50 (<i>Gabitril</i>)
2667J	VIGABATRIN , vigabatrin 500 mg tablet, 100 (<i>Sabril</i>)
2668K	VIGABATRIN , vigabatrin 500 mg oral liquid: powder for, 60 x 500 mg sachets (<i>Sabril</i>)
9328Y	VITAMINS, MINERALS AND TRACE ELEMENTS WITH CARBOHYDRATE , vitamins, minerals and trace elements with carbohydrate oral liquid: powder for, 200 g (<i>Paediatric Seravit</i>)
8587Y	WHEY PROTEIN FORMULA SUPPLEMENTED WITH AMINO ACIDS, VITAMINS AND MINERALS, AND LOW IN PROTEIN, PHOSPHATE, POTASSIUM AND LACTOSE , whey protein formula supplemented with amino acids, vitamins and minerals, and low in protein, phosphate, potassium and lactose oral liquid: powder for, 400 g (<i>Kindergen</i>)

Alteration – Restriction Level

		From	To
10212L	PEGINTERFERON BETA-1A , peginterferon beta-1a 125 microgram/0.5 mL injection, 2 x 0.5 mL injection devices (<i>Plegridy</i>)	authority-required	streamlined
10218T	PEGINTERFERON BETA-1A , peginterferon beta-1a 63 microgram/0.5 mL injection [0.5 mL injection device] (&) peginterferon beta-1a 94 microgram/0.5 mL injection [0.5 mL injection device], 1 pack (<i>Plegridy</i>)	authority-required	streamlined
10220X	PEGINTERFERON BETA-1A , peginterferon beta-1a 125 microgram/0.5 mL injection, 2 x 0.5 mL injection devices (<i>Plegridy</i>)	authority-required	streamlined

Advance Notices

1 July 2015

Deletion – Brand

1783W	<i>Ceftriaxone ICP, PP</i> – CEFTRIAZONE , ceftriaxone 500 mg injection, 1 x 500 mg vial
9058R	<i>Ceftriaxone ICP, PP</i> – CEFTRIAZONE , ceftriaxone 500 mg injection, 1 x 500 mg vial

1 August 2015

Deletion – Item

2873F	<i>Invokana, JC</i> – CANAGLIFLOZIN , canagliflozin 100 mg tablet, 30
2987F	<i>Invokana, JC</i> – CANAGLIFLOZIN , canagliflozin 300 mg tablet, 30
9157Y	<i>Sensipar, AN</i> – CINACALCET , cinacalcet 30 mg tablet, 28
9158B	<i>Sensipar, AN</i> – CINACALCET , cinacalcet 60 mg tablet, 28
9159C	<i>Sensipar, AN</i> – CINACALCET , cinacalcet 90 mg tablet, 28

Highly Specialised Drugs Program (Private Hospital)

Additions

Addition – Item

10263E	ANAKINRA , anakinra 100 mg/0.67 mL injection, 28 x 0.67 mL syringes (<i>Kineret</i>)
--------	---

Alterations

Alteration – Restriction

10175M **IVACAFTOR**, ivacaftor 150 mg tablet, 56 (*Kalydeco*)

Advance Notices

1 August 2015

Deletion – Item

9625N *Sensipar, AN – CINACALCET*, cinacalcet 30 mg tablet, 28

9626P *Sensipar, AN – CINACALCET*, cinacalcet 60 mg tablet, 28

9627Q *Sensipar, AN – CINACALCET*, cinacalcet 90 mg tablet, 28

Highly Specialised Drugs Program (Public Hospital) Additions

Addition – Item

10264F **ANAKINRA**, anakinra 100 mg/0.67 mL injection, 28 x 0.67 mL syringes (*Kineret*)

Alterations

Alteration – Restriction

10170G **IVACAFTOR**, ivacaftor 150 mg tablet, 56 (*Kalydeco*)

Advance Notices

1 August 2015

Deletion – Item

5621W *Sensipar, AN – CINACALCET*, cinacalcet 30 mg tablet, 28

5622X *Sensipar, AN – CINACALCET*, cinacalcet 60 mg tablet, 28

5623Y *Sensipar, AN – CINACALCET*, cinacalcet 90 mg tablet, 28

Palliative Care Alterations

Alteration – Restriction

The following items have additions, deletions or alterations to restrictions and/or notes.

5407N **FENTANYL**, FENTANYL Lozenge 200 micrograms (as citrate), 30 (*Actiq*)

5408P **FENTANYL**, FENTANYL Lozenge 400 micrograms (as citrate), 30 (*Actiq*)

5409Q **FENTANYL**, FENTANYL Lozenge 600 micrograms (as citrate), 30 (*Actiq*)

5410R **FENTANYL**, FENTANYL Lozenge 800 micrograms (as citrate), 30 (*Actiq*)

5411T **FENTANYL**, FENTANYL Lozenge 1200 micrograms (as citrate), 30 (*Actiq*)

5412W **FENTANYL**, FENTANYL Lozenge 1600 micrograms (as citrate), 30 (*Actiq*)

5399E **METHADONE**, methadone hydrochloride 5 mg/mL oral liquid, 200 mL (*Aspen Methadone Syrup*)

5400F **METHADONE**, methadone hydrochloride 5 mg/mL oral liquid, 200 mL (*Aspen Methadone Syrup*)

5391R **MORPHINE**, morphine sulfate 200 mg tablet: modified release, 28 tablets (*MS Contin*)

5392T **MORPHINE**, morphine sulfate 200 mg tablet: modified release, 28 tablets (*MS Contin*)

5393W **MORPHINE**, morphine sulfate 10 mg tablet, 20 (*Sevredol*)

5394X **MORPHINE**, morphine sulfate 20 mg tablet, 20 (*Sevredol*)

5395Y **MORPHINE**, morphine sulfate 10 mg tablet, 20 (*Sevredol*)

5396B **MORPHINE**, morphine sulfate 20 mg tablet, 20 (*Sevredol*)

5319Y **PARACETAMOL**, paracetamol 500 mg suppository, 24 (*Panadol*)

5320B **PARACETAMOL**, paracetamol 500 mg suppository, 24 (*Panadol*)

5343F **PARACETAMOL**, paracetamol 665 mg tablet: modified release, 96 tablets (*Osteomol 665 Paracetamol, Panadol Osteo*)

5344G **PARACETAMOL**, paracetamol 665 mg tablet: modified release, 96 tablets (*Osteomol 665 Paracetamol, Panadol*)

Repatriation Pharmaceutical Benefits Additions

Addition – Brand

2194L	<i>Alendronate plus D3-DRLA, RZ</i> – ALENDRONATE + COLECALCIFEROL , alendronate 70 mg + colecalciferol 70 microgram tablet, 4
2194L	<i>FonatPLUS, AF</i> – ALENDRONATE + COLECALCIFEROL , alendronate 70 mg + colecalciferol 70 microgram tablet, 4
2224C	<i>FonatPLUS, AF</i> – ALENDRONATE + COLECALCIFEROL , alendronate 70 mg + colecalciferol 140 microgram tablet, 4
4198Y	<i>Chemists' Own Laxative with Senna, AS</i> – DOCUSATE + SENNOSIDES , docusate sodium 50 mg + sennosides 11.27 mg tablet, 90
4198Y	<i>Colaxsen, QA</i> – DOCUSATE + SENNOSIDES , docusate sodium 50 mg + sennosides 11.27 mg tablet, 90
4584G	<i>Sildenafil Actavis, UA</i> – SILDENAFIL , sildenafil 25 mg tablet, 4
4584G	<i>Vedafil, AF</i> – SILDENAFIL , sildenafil 25 mg tablet, 4
4585H	<i>Sildenafil Actavis, UA</i> – SILDENAFIL , sildenafil 50 mg tablet, 4
4585H	<i>Vedafil, AF</i> – SILDENAFIL , sildenafil 50 mg tablet, 4
4586J	<i>Sildenafil Actavis, UA</i> – SILDENAFIL , sildenafil 100 mg tablet, 4
4586J	<i>Vedafil, AF</i> – SILDENAFIL , sildenafil 100 mg tablet, 4
4522B	<i>APO-Zopiclone, TX</i> – ZOPICLONE , zopiclone 7.5 mg tablet, 30
4522B	<i>Chem mart Zopiclone, CH</i> – ZOPICLONE , zopiclone 7.5 mg tablet, 30
4522B	<i>Terry White Chemists Zopiclone, TW</i> – ZOPICLONE , zopiclone 7.5 mg tablet, 30

Addition – Equivalence Indicator

2194L	<i>Fosamax Plus, MK</i> – ALENDRONATE + COLECALCIFEROL , alendronate 70 mg + colecalciferol 70 microgram tablet, 4
-------	---

Deletions

Deletion – Brand

4591P	<i>Gabatine 100, QA</i> – GABAPENTIN , gabapentin 100 mg capsule, 100
4592Q	<i>Gabatine 300, QA</i> – GABAPENTIN , gabapentin 300 mg capsule, 100
4593R	<i>Gabatine 400, QA</i> – GABAPENTIN , gabapentin 400 mg capsule, 100
4594T	<i>Gabatine 600, QA</i> – GABAPENTIN , gabapentin 600 mg tablet, 100
4595W	<i>Gabatine 800, QA</i> – GABAPENTIN , gabapentin 800 mg tablet, 100

About the Schedule

The Schedule of Pharmaceutical Benefits lists all of the ready-prepared items subsidised under the Pharmaceutical Benefits Scheme (PBS).





The Schedule is published and is effective on the first day of each month.

For detailed information about the prescribing and supply of pharmaceutical benefits go to www.pbs.gov.au

For information about the operational aspects of the PBS, such as, PBS claiming, authority applications and stationery supplies contact the Department of Human Services at www.humanservices.gov.au

The Repatriation Schedule of Pharmaceutical Benefits provides information about pharmaceutical benefits available under the Repatriation Pharmaceutical Benefits Scheme (RPBS). These may only be prescribed to Department of Veterans' Affairs (DVA) beneficiaries holding a valid repatriation health card. Queries relating to the RPBS can be made to the DVA or go to www.dva.gov.au

Symbols Used in the Schedule

*	An asterisk in the dispensed price column indicates that the manufacturer's pack does not coincide with the maximum quantity
‡	A double dagger in the maximum quantity column indicates where the maximum quantity has been determined to match the manufacturer's pack. These packs cannot be broken and the maximum quantity should be supplied and claimed
#	A gauge in the dispensed price column indicates that the product is not preconstituted and that the dispensed price therefore included a dispensing fee and where appropriate, an amount for purified water
a or b	Located immediately before brand names of an item indicates that the brands are equivalent for the purposes of substitution. These brands may be interchanged without differences in clinical effect
B	located immediately before an amount in the premium column indicates a brand premium which applies to that particular brand of the item
T	located immediately before an amount in the premium column indicates a therapeutic group premium which applies to that particular item.
S	located immediately before an amount in the premium column indicates a special patient contribution which applies to that particular item.
	Indicates that the item can be prescribed by an authorised nurse practitioner
	Indicates that the item can be prescribed by an authorised midwife
	Indicates that the item can be prescribed by an authorised optometrist
	Indicates that the item can be prescribed by an authorised dental practitioner

Restricted Benefits

All restricted items have separate headings for authority and non-authority items. In each case these items may be prescribed as pharmaceutical benefits only for use for one of the specified indications. Where more than one indication is specified for an

Authority required or Restricted pharmaceutical benefit, each indication is separated from the preceding indication by a semi-colon and commences on the next line. In the case of Authority required (STREAMLINED) items, each indication will also include a four digit streamlined authority code. The drug may be prescribed as a pharmaceutical benefit for a patient who qualifies under any of the specified indications.

Restricted benefits - above an item indicates where an item can only be prescribed for specific therapeutic uses.

Authority required benefits – above an item indicates that a prescriber must seek approval from Department of Human Services or the Department of Veterans' Affairs. The prescriber must declare the specific conditions and circumstances that justify the use of these medicines. This is usually done by phone or in writing

Authority required (STREAMLINED) – authority can be sought electronically.

Pharmaceutical Benefits Schedules

Prescriber Bag

■ ADRENALINE

adrenaline 1 in 1000 (1 mg/mL) injection, 5 x 1 mL ampoules

3451P	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	1	20.68	Link Medical Products Pty Ltd [LM]

■ ATROPINE

ATROPINE Injection 600 micrograms in 1 mL, 10

3453R	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	1	20.88	Pfizer Australia Pty Ltd [PF]

■ BENZTROPINE

benztropine mesylate 2 mg/2 mL injection, 5 x 2 mL ampoules

3457Y	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	1	103.93	Cogentin [FK]

■ BENZYL PENICILLIN

benzylpenicillin 600 mg injection, 1 x 600 mg vial

3486L	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	5	*31.96	BenPen [CS]

OR

■ PROCAINE PENICILLIN

procaine penicillin 1.5 g/3.4 mL injection, 5 x 3.4 mL syringes

3485K	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	1	92.56	Cilicaine [QA]

■ BENZYL PENICILLIN

benzylpenicillin 3 g injection, 1 x 3 g vial

3487M	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	1	15.44	BenPen [CS]

■ CHLORPROMAZINE

chlorpromazine hydrochloride 50 mg/2 mL injection, 10 x 2 mL ampoules

3455W	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	1	20.82	Largactil [SW]

OR

■ HALOPERIDOL

haloperidol 5 mg/mL injection, 10 x 1 mL ampoules

3456X	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	1	22.62	Serenace [QA]

■ CLONAZEPAM

clonazepam 2.5 mg/mL oral liquid, 10 mL

3478C	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	±1	11.07	Rivotril [RO]

■ DEXAMETHASONE SODIUM PHOSPHATE

DEXAMETHASONE SODIUM PHOSPHATE Injection equivalent to 4 mg dexamethasone phosphate in 1 mL, 5

3472R	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	17.96	^a Dexmethsone [AF]	^a Hospira Pty Limited [HH]

OR

■ HYDROCORTISONE SODIUM SUCCINATE

hydrocortisone (as sodium succinate) 100 mg injection [1 x 100 mg vial] (&) inert substance diluent [1 x 2 mL vial], 1 pack

3470P	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	2	*18.04	Solu-Cortef [PF]

OR

hydrocortisone (as sodium succinate) 250 mg injection [1 x 250 mg vial] (&) inert substance diluent [1 x 2 mL vial], 1 pack

3471Q	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	1	16.83	Solu-Cortef [PF]

■ DIAZEPAM

diazepam 10 mg/2 mL injection, 5 x 2 mL ampoules

3458B	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	1	13.68	Hospira Pty Limited [HH]

■ DIPHTHERIA TOXOID + TETANUS TOXOID

diphtheria toxoid 2 Lf/0.5 mL + tetanus toxoid 2 Lf/0.5 mL injection, 10 x 0.5 mL vials

10244E	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	1	144.59	MassBiologics tetanus and diphtheria toxoids adsorbed [CS]

OR

■ DIPHTHERIA TOXOID + TETANUS TOXOID

diphtheria toxoid 2 international units/0.5 mL + tetanus toxoid 20 international units/0.5 mL injection, 5 x 0.5 mL syringes

3463G	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	2	*144.60	ADT Booster [CS]

■ FRUSEMIDE

frusemide 20 mg/2 mL injection, 5 x 2 mL ampoules

3466K	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	8.63	^a Frusemide-Clarix [AE] ^a Lasix [SW]	^a Frusemide Sandoz [SZ]

■ GLUCAGON HYDROCHLORIDE

glucagon hydrochloride 1 mg injection [1 x 1 mg vial] (&) inert substance diluent [1 x 1 mL syringe], 1 pack

3467L	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	1	50.55	GlucaGen Hypokit [NO]

■ GLYCERYL TRINITRATE

glyceryl trinitrate 400 microgram/actuation spray, 200 actuations

3475X	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	‡1	20.47	Nitrolingual Pumpspray [SW]

■ HYOSCINE BUTYLBROMIDE

hyoscine butylbromide 20 mg/mL injection, 5 x 1 mL ampoules

3473T	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	1	24.55	Buscopan [BY]

■ LIGNOCAINE

lignocaine hydrochloride anhydrous 1% (50 mg/5 mL) injection, 5 x 5 mL ampoules

10209H	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	1	37.67	Pfizer Australia Pty Ltd [PF]

■ METHOXYFLURANE

methoxyflurane 999.9 mg/g inhalation: solution, 1 x 3 mL bottle

3489P	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
	1	45.12	Pentrox [DV]

■ METOCLOPRAMIDE

metoclopramide hydrochloride 10 mg/2 mL injection, 10 x 2 mL ampoules

3476Y	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	1	13.33	Maxolon [IA]

OR

■ PROCHLORPERAZINE

prochlorperazine mesylate 12.5 mg/mL injection, 10 x 1 mL ampoules

3477B	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	1	17.89	Stemetil [SW]

■ MIDAZOLAM

midazolam 5 mg/mL injection, 10 x 1 mL ampoules

10178Q	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	1	38.91	Pfizer Australia Pty Ltd [PF]

■ MORPHINE

morphine sulfate 15 mg/mL injection, 5 x 1 mL ampoules

3479D	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	1	17.30	Hospira Pty Limited [HH]

OR

morphine sulfate 30 mg/mL injection, 5 x 1 mL ampoules

3480E	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	1	19.43	Hospira Pty Limited [HH]

■ NALOXONE

naloxone hydrochloride 400 microgram/mL injection, 1 x 1 mL syringe

2200T	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	10	*203.56	Naloxone minijet [UC]

■ OXYTOCIN

oxytocin 10 international units/mL injection, 5 x 1 mL ampoules

10251M	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
	1	61.76	Oxytocin Sandoz [SZ]

■ PHYTOMENADIONE

phytomenadione 10 mg/mL injection, 5 x 1 mL ampoules

10213M	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
	1	22.27	Konakion MM [RO]

■ PROMETHAZINE

promethazine hydrochloride 50 mg/2 mL injection, 5 x 2 mL ampoules

3488N	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer
NP	2	*30.58	Hospira Pty Limited [HH]

■ SALBUTAMOL

salbutamol 100 microgram/actuation inhalation: pressurised, 200

3495Y	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	10.45	^a APO-Salbutamol Inhaler [TX]	^a Asmol CFC-free [AL]
		11.62	^a Ventolin CFC-free [GK]	

OR

salbutamol 2.5 mg/2.5 mL inhalation: solution, 30 x 2.5 mL ampoules

3496B	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	11.36	^a APO-Salbutamol [TX]	^a Asmol 2.5 uni-dose [AF]
			^a Butamol 2.5 [QA]	^a GenRx Salbutamol [GX]
			^a Pharmacor Salbutamol 2.5 [CR]	^a Salbutamol Actavis [UA]
			^a Salbutamol-GA [GN]	^a Salbutamol Sandoz [SZ]
		11.96	^a Ventolin Nebules [GK]	

■ SALBUTAMOL

salbutamol 5 mg/2.5 mL inhalation: solution, 30 x 2.5 mL ampoules

3497C	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	11.60	^a APO-Salbutamol [TX]	^a Asmol 5 uni-dose [AF]
			^a Butamol 5 [QA]	^a GenRx Salbutamol [GX]
			^a Pharmacor Salbutamol 5 [CR]	^a Salbutamol Actavis [UA]
			^a Salbutamol-GA [GN]	^a Salbutamol Sandoz [SZ]
		12.18	^a Ventolin Nebules [GK]	

■ TRAMADOL

tramadol hydrochloride 100 mg/2 mL injection, 5 x 2 mL ampoules

3484J	Max.Qty Packs	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	11.92	^a Tramadol ACT [GN]	^a Tramadol Sandoz [SZ]
			^a Tramal 100 [CS]	

General Pharmaceutical Benefits

ALIMENTARY TRACT AND METABOLISM.....	36
STOMATOLOGICAL PREPARATIONS	36
STOMATOLOGICAL PREPARATIONS.....	36
Antiinfectives and antiseptics for local oral treatment	36
Other agents for local oral treatment.....	36
DRUGS FOR ACID RELATED DISORDERS.....	36
ANTACIDS	36
Combinations and complexes of aluminium, calcium and magnesium compounds.....	36
DRUGS FOR PEPTIC ULCER AND GASTRO-OESOPHAGEAL REFLUX DISEASE (GORD)	36
H ₂ -receptor antagonists.....	36
Proton pump inhibitors	38
Combinations for eradication of <i>Helicobacter pylori</i>	42
Other drugs for peptic ulcer and gastro-oesophageal reflux disease (GORD)	42
DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS	42
BELLADONNA AND DERIVATIVES, PLAIN	42
Belladonna alkaloids, tertiary amines.....	42
PROPULSIVES.....	43
Propulsives	43
ANTIEMETICS AND ANTINAUSEANTS.....	43
ANTIEMETICS AND ANTINAUSEANTS	43
Serotonin (5HT ₃) antagonists	43
Other antiemetics.....	46
BILE AND LIVER THERAPY	48
BILE THERAPY	48
Bile acid preparations	48
DRUGS FOR CONSTIPATION	48
DRUGS FOR CONSTIPATION.....	48
Contact laxatives.....	48
Bulk-forming laxatives	49
Osmotically acting laxatives	49
Enemas.....	50
Other drugs for constipation.....	51
ANTIDIARRHEALS, INTESTINAL ANTIINFLAMMATORY/ANTIINFECTIVE AGENTS.....	52
INTESTINAL ANTIINFECTIVES	52
Antibiotics	52
ELECTROLYTES WITH CARBOHYDRATES	52
Oral rehydration salt formulations	52
ANTIPROPULSIVES.....	53

Antipropulsives.....	53
INTESTINAL ANTIINFLAMMATORY AGENTS.....	53
Corticosteroids acting locally.....	53
Aminosalicylic acid and similar agents.....	54
DIGESTIVES, INCL. ENZYMES.....	57
DIGESTIVES, INCL. ENZYMES.....	57
Enzyme preparations	57
DRUGS USED IN DIABETES	58
INSULINS AND ANALOGUES.....	58
Insulins and analogues for injection, fast-acting	58
Insulins and analogues for injection, intermediate-acting	59
Insulins and analogues for injection, intermediate- or long-acting combined with fast-acting	59
Insulins and analogues for injection, long-acting.....	60
BLOOD GLUCOSE LOWERING DRUGS, EXCL. INSULINS	60
Biguanides	60
Sulfonylureas	61
Combinations of oral blood glucose lowering drugs.....	62
Alpha glucosidase inhibitors	66
Thiazolidinediones	67
Dipeptidyl peptidase 4 (DPP-4) inhibitors	69
Other blood glucose lowering drugs, excl. insulins	72
VITAMINS.....	75
VITAMIN A AND D, INCL. COMBINATIONS OF THE TWO	75
Vitamin D and analogues.....	75
VITAMIN B1, PLAIN AND IN COMBINATION WITH VITAMIN B6 AND B12.....	75
Vitamin B1, plain	75
MINERAL SUPPLEMENTS	75
CALCIUM.....	75
Calcium.....	75
POTASSIUM.....	76
Potassium	76
OTHER MINERAL SUPPLEMENTS	76
Magnesium	76
ANABOLIC AGENTS FOR SYSTEMIC USE	76
ANABOLIC STEROIDS.....	76
Estren derivatives	76
OTHER ALIMENTARY TRACT AND METABOLISM PRODUCTS.....	77
OTHER ALIMENTARY TRACT AND METABOLISM PRODUCTS	77
Amino acids and derivatives	77
Various alimentary tract and metabolism products	77
BLOOD AND BLOOD FORMING ORGANS	78
ANTITHROMBOTIC AGENTS.....	78
ANTITHROMBOTIC AGENTS	78
Vitamin K antagonists	78
Heparin group	78
Platelet aggregation inhibitors excl. heparin	80
Enzymes.....	85
Direct thrombin inhibitors	85
Direct factor Xa inhibitors.....	87
Other antithrombotic agents.....	91
ANTIHEMORRHAGICS.....	92
ANTIFIBRINOLYTICS.....	92
Amino acids	92

ANTIANEMIC PREPARATIONS	92
IRON PREPARATIONS	92
Iron bivalent, oral preparations.....	92
Iron, parenteral preparations.....	92
Iron in combination with folic acid	93
VITAMIN B12 AND FOLIC ACID	93
Vitamin B12 (cyanocobalamin and analogues)	93
Folic acid and derivatives.....	93
BLOOD SUBSTITUTES AND PERFUSION SOLUTIONS	94
BLOOD AND RELATED PRODUCTS	94
Blood substitutes and plasma protein fractions.....	94
I.V. SOLUTIONS	94
Solutions for parenteral nutrition	94
Solutions affecting the electrolyte balance	94
OTHER HEMATOLOGICAL AGENTS	95
OTHER HEMATOLOGICAL AGENTS	95
Drugs used in hereditary angioedema	95
CARDIOVASCULAR SYSTEM	95
CARDIAC THERAPY	95
CARDIAC GLYCOSIDES.....	95
Digitalis glycosides.....	95
ANTIARRHYTHMICS, CLASS I AND III	96
Antiarrhythmics, class Ia	96
Antiarrhythmics, class Ib	96
Antiarrhythmics, class Ic	96
Antiarrhythmics, class III	96
CARDIAC STIMULANTS EXCL. CARDIAC GLYCOSIDES	97
Adrenergic and dopaminergic agents	97
VASODILATORS USED IN CARDIAC DISEASES	98
Organic nitrates.....	98
Other vasodilators used in cardiac diseases.....	99
OTHER CARDIAC PREPARATIONS	100
Other cardiac preparations	100
ANTIHYPERTENSIVES	100
ANTIADRENERGIC AGENTS, CENTRALLY ACTING	100
Methyldopa	100
Imidazoline receptor agonists	100
ANTIADRENERGIC AGENTS, PERIPHERALLY ACTING	101
Alpha-adrenoreceptor antagonists	101
ARTERIOLAR SMOOTH MUSCLE, AGENTS ACTING ON.....	101
Hydrazinophthalazine derivatives	101
Pyrimidine derivatives	101
DIURETICS	102
LOW-CEILING DIURETICS, THIAZIDES	102
Thiazides, plain.....	102
LOW-CEILING DIURETICS, EXCL. THIAZIDES.....	102
Sulfonamides, plain.....	102
HIGH-CEILING DIURETICS	102
Sulfonamides, plain.....	102
Aryloxyacetic acid derivatives	103
POTASSIUM-SPARING AGENTS.....	103
Aldosterone antagonists	103
DIURETICS AND POTASSIUM-SPARING AGENTS IN	
COMBINATION.....	104
Low-ceiling diuretics and potassium-sparing agents.....	104
PERIPHERAL VASODILATORS	104

PERIPHERAL VASODILATORS	104
Other peripheral vasodilators	104
BETA BLOCKING AGENTS	104
BETA BLOCKING AGENTS	104
Beta blocking agents, non-selective.....	104
Beta blocking agents, selective.....	105
Alpha and beta blocking agents	107
CALCIUM CHANNEL BLOCKERS.....	108
SELECTIVE CALCIUM CHANNEL BLOCKERS WITH MAINLY	
VASCULAR EFFECTS	108
Dihydropyridine derivatives	108
SELECTIVE CALCIUM CHANNEL BLOCKERS WITH DIRECT	
CARDIAC EFFECTS.....	110
Phenylalkylamine derivatives	110
Benzothiazepine derivatives	110
AGENTS ACTING ON THE RENIN-ANGIOTENSIN SYSTEM.....	110
ACE INHIBITORS, PLAIN.....	110
ACE inhibitors, plain.....	110
ACE INHIBITORS, COMBINATIONS	116
ACE inhibitors and diuretics	116
ACE inhibitors and calcium channel blockers	117
ANGIOTENSIN II ANTAGONISTS, PLAIN	118
Angiotensin II antagonists, plain	118
ANGIOTENSIN II ANTAGONISTS, COMBINATIONS.....	121
Angiotensin II antagonists and diuretics.....	121
Angiotensin II antagonists and calcium channel blockers	125
Angiotensin II antagonists, other combinations.....	126
LIPID MODIFYING AGENTS.....	127
LIPID MODIFYING AGENTS, PLAIN.....	127
HMG CoA reductase inhibitors.....	127
Fibrates	136
Bile acid sequestrants.....	137
Other lipid modifying agents	137
LIPID MODIFYING AGENTS, COMBINATIONS	140
HMG CoA reductase inhibitors in combination with other lipid	
modifying agents.....	140
HMG CoA reductase inhibitors, other combinations	155
DERMATOLOGICALS	156
ANTIFUNGALS FOR DERMATOLOGICAL USE	156
ANTIFUNGALS FOR TOPICAL USE.....	156
Antibiotics	156
Imidazole and triazole derivatives	156
Other antifungals for topical use	157
ANTIFUNGALS FOR SYSTEMIC USE.....	157
Antifungals for systemic use	157
ANTIPSORIATICS.....	158
ANTIPSORIATICS FOR TOPICAL USE.....	158
Tars.....	158
Other antipsoriatics for topical use.....	158
ANTIPSORIATICS FOR SYSTEMIC USE	159
Retinoids for treatment of psoriasis.....	159
ANTIBIOTICS AND CHEMOTHERAPEUTICS FOR DERMATOLOGICAL USE	159
CHEMOTHERAPEUTICS FOR TOPICAL USE.....	159
Sulfonamides	159
CORTICOSTEROIDS, DERMATOLOGICAL PREPARATIONS	160

CORTICOSTEROIDS, PLAIN	160
Corticosteroids, weak (group I)	160
Corticosteroids, moderately potent (group II)	160
Corticosteroids, potent (group III)	161
Corticosteroids, very potent (group IV)	162
ANTI-ACNE PREPARATIONS	162
ANTI-ACNE PREPARATIONS FOR TOPICAL USE	162
Retinoids for topical use in acne	162
ANTI-ACNE PREPARATIONS FOR SYSTEMIC USE	163
Retinoids for treatment of acne	163
OTHER DERMATOLOGICAL PREPARATIONS	163
OTHER DERMATOLOGICAL PREPARATIONS	163
Agents for dermatitis, excluding corticosteroids	163
Other dermatologicals	164
GENITO URINARY SYSTEM AND SEX HORMONES	165
OTHER GYNECOLOGICALS	165
CONTRACEPTIVES FOR TOPICAL USE	165
Intrauterine contraceptives	165
OTHER GYNECOLOGICALS	165
Prolactine inhibitors	165
SEX HORMONES AND MODULATORS OF THE GENITAL SYSTEM	166
HORMONAL CONTRACEPTIVES FOR SYSTEMIC USE	166
Progestogens and estrogens, fixed combinations	166
Progestogens and estrogens, sequential preparations	167
Progestogens	167
ANDROGENS	167
3-oxoandrostene (4) derivatives	167
ESTROGENS	171
Natural and semisynthetic estrogens, plain	171
PROGESTOGENS	172
Pregnen (4) derivatives	172
Estren derivatives	173
PROGESTOGENS AND ESTROGENS IN COMBINATION	173
Progestogens and estrogens, fixed combinations	173
Progestogens and estrogens, sequential preparations	173
GONADOTROPINS AND OTHER OVULATION STIMULANTS	174
Gonadotropins	174
Ovulation stimulants, synthetic	175
ANTIANDROGENS	176
Antiandrogens, plain	176
OTHER SEX HORMONES AND MODULATORS OF THE GENITAL SYSTEM	176
Antigonadotropins and similar agents	176
Progesterone receptor modulators	177
UROLOGICALS	177
UROLOGICALS	177
Drugs for urinary frequency and incontinence	177
Other urologicals	178
DRUGS USED IN BENIGN PROSTATIC HYPERTROPHY	178
Alpha-adrenoreceptor antagonists	178
Testosterone-5-alpha reductase inhibitors	178
SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS	179
PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES	179
ANTERIOR PITUITARY LOBE HORMONES AND ANALOGUES	179

ACTH	179
Thyrotropin	179
POSTERIOR PITUITARY LOBE HORMONES	179
Vasopressin and analogues	179
HYPOTHALAMIC HORMONES	180
Gonadotropin-releasing hormones	180
CORTICOSTEROIDS FOR SYSTEMIC USE	180
CORTICOSTEROIDS FOR SYSTEMIC USE, PLAIN	180
Mineralocorticoids	180
Glucocorticoids	181
THYROID THERAPY	185
THYROID PREPARATIONS	185
Thyroid hormones	185
ANTITHYROID PREPARATIONS	185
Thiouracils	185
Sulfur-containing imidazole derivatives	186
PANCREATIC HORMONES	186
GLYCOGENOLYTIC HORMONES	186
Glycogenolytic hormones	186
CALCIUM HOMEOSTASIS	186
PARATHYROID HORMONES AND ANALOGUES	186
Parathyroid hormones and analogues	186
ANTI-PARATHYROID AGENTS	187
Calcitonin preparations	187
Other anti-parathyroid agents	187
ANTIINFECTIVES FOR SYSTEMIC USE	188
ANTIBACTERIALS FOR SYSTEMIC USE	188
TETRACYCLINES	188
Tetracyclines	188
BETA-LACTAM ANTIBACTERIALS, PENICILLINS	190
Penicillins with extended spectrum	190
Beta-lactamase sensitive penicillins	192
Beta-lactamase resistant penicillins	194
Combinations of penicillins, incl. beta-lactamase inhibitors	195
OTHER BETA-LACTAM ANTIBACTERIALS	197
First-generation cephalosporins	197
Second-generation cephalosporins	200
Third-generation cephalosporins	201
Fourth-generation cephalosporins	203
SULFONAMIDES AND TRIMETHOPRIM	203
Trimethoprim and derivatives	203
Combinations of sulfonamides and trimethoprim, incl. derivatives	203
MACROLIDES, LINCOSAMIDES AND STREPTOGRAMINS	204
Macrolides	204
Lincosamides	206
AMINOGLYCOSIDE ANTIBACTERIALS	207
Other aminoglycosides	207
QUINOLONE ANTIBACTERIALS	208
Fluoroquinolones	208
OTHER ANTIBACTERIALS	209
Glycopeptide antibacterials	209
Steroid antibacterials	210
Imidazole derivatives	210
Nitrofurans derivatives	211
Other antibacterials	212
ANTIMYCOTICS FOR SYSTEMIC USE	212

ANTIMYCOTICS FOR SYSTEMIC USE.....	212
Triazole derivatives	212
ANTIMYCOBACTERIALS	216
DRUGS FOR TREATMENT OF TUBERCULOSIS.....	216
Hydrazides	216
DRUGS FOR TREATMENT OF LEPRA.....	216
Drugs for treatment of lepra	216
ANTIVIRALS FOR SYSTEMIC USE	217
DIRECT ACTING ANTIVIRALS	217
Nucleosides and nucleotides excl. reverse transcriptase inhibitors	217
VACCINES	221
BACTERIAL VACCINES.....	221
Pneumococcal vaccines	221
Tetanus vaccines	221
ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	222
ANTINEOPLASTIC AGENTS	222
ALKYLATING AGENTS	222
Nitrogen mustard analogues	222
Alkyl sulfonates	222
Nitrosoureas.....	222
Other alkylating agents	222
ANTIMETABOLITES.....	223
Folic acid analogues	223
Purine analogues	224
Pyrimidine analogues.....	224
PLANT ALKALOIDS AND OTHER NATURAL PRODUCTS	225
Vinca alkaloids and analogues.....	225
Podophyllotoxin derivatives	225
CYTOTOXIC ANTIBIOTICS AND RELATED SUBSTANCES	225
Anthracyclines and related substances.....	225
OTHER ANTINEOPLASTIC AGENTS.....	225
Protein kinase inhibitors.....	225
Other antineoplastic agents	254
ENDOCRINE THERAPY	254
HORMONES AND RELATED AGENTS	254
Progestogens.....	254
Gonadotropin releasing hormone analogues	255
HORMONE ANTAGONISTS AND RELATED AGENTS.....	257
Anti-estrogens.....	257
Anti-androgens.....	258
Aromatase inhibitors	259
Other hormone antagonists and related agents.....	261
IMMUNOSTIMULANTS	262
IMMUNOSTIMULANTS	262
Interferons.....	262
Other immunostimulants	265
IMMUNOSUPPRESSANTS.....	266
IMMUNOSUPPRESSANTS	266
Selective immunosuppressants	266
Tumor necrosis factor alpha (TNF-) inhibitors.....	278
Interleukin inhibitors	402
Calcineurin inhibitors.....	410
Other immunosuppressants.....	411

MUSCULO-SKELETAL SYSTEM.....	411
ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS.....	411
ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS, NON-STERIODS.....	411
Acetic acid derivatives and related substances.....	411
Oxicams.....	412
Propionic acid derivatives.....	414
Fenamates.....	416
Coxibs.....	416
SPECIFIC ANTIRHEUMATIC AGENTS.....	417
Quinolines.....	417
Gold preparations.....	417
Penicillamine and similar agents.....	418
MUSCLE RELAXANTS.....	418
MUSCLE RELAXANTS, CENTRALLY ACTING AGENTS.....	418
Other centrally acting agents.....	418
MUSCLE RELAXANTS, DIRECTLY ACTING AGENTS.....	418
Dantrolene and derivatives.....	418
ANTIGOUT PREPARATIONS.....	419
ANTIGOUT PREPARATIONS.....	419
Preparations inhibiting uric acid production.....	419
Preparations increasing uric acid excretion.....	419
Preparations with no effect on uric acid metabolism.....	419
DRUGS FOR TREATMENT OF BONE DISEASES.....	419
DRUGS AFFECTING BONE STRUCTURE AND MINERALIZATION.....	419
Bisphosphonates.....	419
Bisphosphonates, combinations.....	423
Other drugs affecting bone structure and mineralization.....	427
NERVOUS SYSTEM.....	430
ANALGESICS.....	430
OPIOIDS.....	430
Natural opium alkaloids.....	430
Phenylpiperidine derivatives.....	439
Diphenylpropylamine derivatives.....	440
Oripavine derivatives.....	441
Other opioids.....	441
OTHER ANALGESICS AND ANTIPYRETICS.....	444
Salicylic acid and derivatives.....	444
Anilides.....	444
Other analgesics and antipyretics.....	445
ANTIMIGRAINE PREPARATIONS.....	445
Selective serotonin (5HT ₁) agonists.....	445
Other antimigraine preparations.....	448
ANTIEPILEPTICS.....	448
ANTIEPILEPTICS.....	448
Barbiturates and derivatives.....	448
Hydantoin derivatives.....	449
Succinimide derivatives.....	449
Benzodiazepine derivatives.....	450
Carboxamide derivatives.....	451
Fatty acid derivatives.....	452
Other antiepileptics.....	453
ANTI-PARKINSON DRUGS.....	460
ANTICHOLINERGIC AGENTS.....	460
Tertiary amines.....	460

Ethers of tropine or tropine derivatives	461
DOPAMINERGIC AGENTS	461
Dopa and dopa derivatives	461
Adamantane derivatives	463
Dopamine agonists	463
Monoamine oxidase B inhibitors	466
Other dopaminergic agents.....	466
PSYCHOLEPTICS.....	466
ANTIPSYCHOTICS.....	466
Phenothiazines with aliphatic side-chain.....	466
Phenothiazines with piperazine structure.....	467
Phenothiazines with piperidine structure.....	468
Butyrophenone derivatives	468
Indole derivatives	468
Thioxanthene derivatives	469
Diazepines, oxazepines, thiazepines and oxepines.....	469
Benzamides	477
Other antipsychotics	478
ANXIOLYTICS	483
Benzodiazepine derivatives	483
HYPNOTICS AND SEDATIVES	485
Benzodiazepine derivatives	485
PSYCHOANALEPTICS	486
ANTIDEPRESSANTS	486
Non-selective monoamine reuptake inhibitors	486
Selective serotonin reuptake inhibitors	488
Monoamine oxidase inhibitors, non-selective	492
Monoamine oxidase A inhibitors	492
Other antidepressants.....	492
PSYCHOSTIMULANTS, AGENTS USED FOR ADHD AND	
NOOTROPICS	496
Centrally acting sympathomimetics.....	496
ANTI-DEMENTIA DRUGS	499
Anticholinesterases.....	499
Other anti-dementia drugs	504
OTHER NERVOUS SYSTEM DRUGS.....	506
PARASYMPATHOMIMETICS.....	506
Anticholinesterases.....	506
Choline esters	506
DRUGS USED IN ADDICTIVE DISORDERS	506
Drugs used in nicotine dependence.....	506
Drugs used in alcohol dependence.....	509
OTHER NERVOUS SYSTEM DRUGS	510
Other nervous system drugs.....	510
ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS.....	512
ANTIPROTOZOALS	512
AGENTS AGAINST AMOEBIASIS AND OTHER PROTOZOAL	
DISEASES	512
Other agents against amoebiasis and other protozoal diseases.....	512
ANTIMALARIALS.....	512
Biguanides	512
Methanolquinolines	512
Artemisinin and derivatives, combinations	512
ANTHELMINTICS	513
ANTITREMATODALS	513
Quinoline derivatives and related substances.....	513

ANTINEMATODAL AGENTS.....	513
Benzimidazole derivatives	513
Tetrahydropyrimidine derivatives	513
Avermectines	514
ECTOPARASITICIDES, INCL. SCABICIDES, INSECTICIDES AND REPELLENTS	514
ECTOPARASITICIDES, INCL. SCABICIDES.....	514
Pyrethrines, incl. synthetic compounds.....	514
RESPIRATORY SYSTEM.....	515
NASAL PREPARATIONS.....	515
DECONGESTANTS AND OTHER NASAL PREPARATIONS FOR TOPICAL USE	515
Other nasal preparations	515
DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES	515
ADRENERGICS, INHALANTS.....	515
Selective beta-2-adrenoreceptor agonists	515
Adrenergics in combination with corticosteroids or other drugs, excl. anticholinergics.....	516
Adrenergics in combination with anticholinergics.....	520
OTHER DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES, INHALANTS	521
Glucocorticoids	521
Anticholinergics.....	522
Antiallergic agents, excl. corticosteroids	523
ADRENERGICS FOR SYSTEMIC USE	523
Alpha- and beta-adrenoreceptor agonists.....	523
Selective beta-2-adrenoreceptor agonists	524
OTHER SYSTEMIC DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES	524
Xanthines.....	524
Leukotriene receptor antagonists.....	525
COUGH AND COLD PREPARATIONS.....	526
COUGH SUPPRESSANTS, EXCL. COMBINATIONS WITH EXPECTORANTS.....	526
Opium alkaloids and derivatives	526
ANTI-HISTAMINES FOR SYSTEMIC USE	526
ANTI-HISTAMINES FOR SYSTEMIC USE.....	526
Phenothiazine derivatives	526
SENSORY ORGANS	526
OPHTHALMOLOGICALS	526
ANTIINFECTIVES.....	526
Antibiotics	526
Antivirals	527
Fluoroquinolones	528
ANTIINFLAMMATORY AGENTS.....	528
Corticosteroids, plain	528
Corticosteroids and mydriatics in combination	529
Antiinflammatory agents, non-steroids.....	530
ANTIGLAUCOMA PREPARATIONS AND MIOTICS.....	530
Sympathomimetics in glaucoma therapy1)	530
Parasympathomimetics.....	531
Carbonic anhydrase inhibitors.....	531
Beta blocking agents1)	533
Prostaglandin analogues1)	534

MYDRIATICS AND CYCLOPLEGICS	537
Anticholinergics	537
DECONGESTANTS AND ANTIALLERGICS	537
Other antiallergics	537
OCULAR VASCULAR DISORDER AGENTS	538
Antineovascularisation agents	538
OTHER OPHTHALMOLOGICALS	541
Other ophthalmologicals	541
OTOLOGICALS	548
ANTIINFECTIVES	548
Antiinfectives	548
CORTICOSTEROIDS AND ANTIINFECTIVES IN COMBINATION	549
Corticosteroids and antiinfectives in combination	549
OPHTHALMOLOGICAL AND OTOLOGICAL PREPARATIONS	549
ANTIINFECTIVES	549
Antiinfectives	549
VARIOUS	549
ALLERGENS	549
ALLERGENS	549
Allergen extracts	549
ALL OTHER THERAPEUTIC PRODUCTS	550
ALL OTHER THERAPEUTIC PRODUCTS	550
Antidotes	550
Drugs for treatment of hyperkalemia and hyperphosphatemia	550
Detoxifying agents for antineoplastic treatment	551
Drugs for treatment of hypercalcemia	552
Other therapeutic products	552
DIAGNOSTIC AGENTS	553
URINE TESTS	553
OTHER DIAGNOSTIC AGENTS	553
Tests for diabetes	553
GENERAL NUTRIENTS	558
OTHER NUTRIENTS	558
Fat/carbohydrates/proteins/minerals/vitamins, combinations	559
Carbohydrates	571
Milk substitutes	571
Other combinations of nutrients	573

ALIMENTARY TRACT AND METABOLISM

STOMATOLOGICAL PREPARATIONS

STOMATOLOGICAL PREPARATIONS

Antifungives and antiseptics for local oral treatment

AMPHOTERICIN B

amphotericin B 10 mg lozenge, 20

2931G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	12.37	13.52	Fungilin [QA]

amphotericin B 10 mg lozenge, 20

3306B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	12.37	13.52	Fungilin [QA]

NYSTATIN

nystatin 100 000 international units/mL oral liquid, 24 mL

3033P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	1	..	11.48	12.63	^a Mycostatin [FM]
			^B 3.01	14.49	12.63	^a Nilstat [QA]

nystatin 100 000 international units/mL oral liquid, 24 mL

3343Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	‡1	..	..	11.48	12.63	^a Mycostatin [FM]
			^B 3.01	14.49	12.63	^a Nilstat [QA]

Other agents for local oral treatment

BENZYLAMINE

Restricted benefit

Radiation induced mucositis

benzylamine hydrochloride 0.15% mouthwash, 500 mL

1121B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	1	..	22.60	23.75	Diffiam [IA]

benzylamine hydrochloride 0.15% mouthwash, 500 mL

5032W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	‡1	..	..	22.60	23.75	Diffiam [IA]

DRUGS FOR ACID RELATED DISORDERS

ANTACIDS

Combinations and complexes of aluminium, calcium and magnesium compounds

ALUMINIUM HYDROXIDE + MAGNESIUM HYDROXIDE + MAGNESIUM TRISILICATE

aluminium hydroxide 250 mg/5 mL + magnesium hydroxide 120 mg/5 mL + magnesium trisilicate 120 mg/5 mL oral liquid, 500 mL

2159P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*18.04	19.19	Gastrogel [FM]

ALUMINIUM HYDROXIDE WITH MAGNESIUM HYDROXIDE

ALUMINIUM HYDROXIDE with MAGNESIUM HYDROXIDE Oral suspension 200 mg-200 mg per 5 mL, 500 mL, 1

2157M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*18.04	19.19	Mylanta P [JT]

DRUGS FOR PEPTIC ULCER AND GASTRO-OESOPHAGEAL REFLUX DISEASE (GORD)

H2-receptor antagonists

CIMETIDINE

Note

Helicobacter pylori eradication therapy should be considered prior to commencing initial treatment of peptic ulcer with this drug.

cimetidine 400 mg tablet, 60

1158Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	17.11	18.26	Magicul 400 [AF]

■ FAMOTIDINE**Note**

Helicobacter pylori eradication therapy should be considered prior to commencing initial treatment of peptic ulcer with this drug.

famotidine 20 mg tablet, 60

2487X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	11.80	12.95	^a Ausfam 20 [QA] ^a Famotidine AN [EA] ^a GenRx Famotidine [GX] ^a Pepzan [GN]	^a Chem mart Famotidine [CH] ^a Famotidine Sandoz [SZ] ^a Pamacid 20 [AF] ^a Terry White Chemists Famotidine [TW]

famotidine 40 mg tablet, 30

2488Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	11.80	12.95	^a Ausfam 40 [QA] ^a Famotidine AN [EA] ^a GenRx Famotidine [GX] ^a Pepzan [GN]	^a Chem mart Famotidine [CH] ^a Famotidine Sandoz [SZ] ^a Pamacid 40 [AF] ^a Terry White Chemists Famotidine [TW]

■ NIZATIDINE**Note**

Helicobacter pylori eradication therapy should be considered prior to commencing initial treatment of peptic ulcer with this drug.

nizatidine 150 mg capsule, 60

1505F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	.. ^B 5.32	18.77 24.09	19.92 19.92	^a Nizac [LN] ^a Tazac [AS]	^a Tacidine [AF]

nizatidine 300 mg capsule, 30

1504E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	.. ^B 5.32	18.77 24.09	19.92 19.92	^a Nizac [LN] ^a Tazac [AS]	^a Tacidine [AF]

■ RANITIDINE**Note**

Helicobacter pylori eradication therapy should be considered prior to commencing initial treatment of peptic ulcer with this drug.

ranitidine 150 mg tablet, 60

1978D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP MW	1	5	..	12.12	13.27	^a APO-Ranitidine [TX] ^a Chem mart Ranitidine [CH] ^a Rani 2 [AF] ^a Ranitidine GH [GQ] ^a Ranoxyl [GN] ^a Ulcaid [RA] ^a Zantac [AS]	^a Ausran [QA] ^a GenRx Ranitidine [GX] ^a Ranitidine AN [EA] ^a Ranitidine Sandoz [SZ] ^a Terry White Chemists Ranitidine [TW]
			^B 1.15	13.27	13.27		

ranitidine 150 mg tablet: effervescent, 30

1937Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*12.12	13.27	Zantac [AS]

ranitidine 150 mg/10 mL oral liquid, 300 mL

8162N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*24.86	26.01	Zantac Syrup [AS]

ranitidine 300 mg tablet, 30

1977C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.12	13.27	^a APO-Ranitidine [TX]	^a Ausran [QA]

^a Chem mart Ranitidine [CH] ^a GenRx Ranitidine [GX]
^a Rani 2 [AF] ^a Ranitidine GH [GQ]
^a Ranitidine Sandoz [SZ] ^a Ranoxyl [GN]
^a Terry White Chemists
Ranitidine [TW]
^a Zantac [AS]

^B 1.15 13.27 13.27

Proton pump inhibitors

■ ESOMEPRAZOLE

Restricted benefit

Healing of gastro-oesophageal reflux disease

Note

No applications for increased maximum quantities and/or repeats will be authorised.

esomeprazole 40 mg tablet: enteric, 30 tablets

8601Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	38.32	37.70	^a Esomeprazole Apotex [TX] ^a Esomeprazole RBX [RA]	^a Esomeprazole GxP [AF] ^a Nexium [AP]

■ ESOMEPRAZOLE

Authority required

Pathological hypersecretory conditions including Zollinger-Ellison syndrome and idiopathic hypersecretion

Authority required

Scleroderma oesophagus

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

esomeprazole 40 mg tablet: enteric, 30 tablets

3401B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	38.32	37.70	^a Esomeprazole Apotex [TX] ^a Esomeprazole RBX [RA]	^a Esomeprazole GxP [AF] ^a Nexium [AP]

■ ESOMEPRAZOLE

Restricted benefit

Initial treatment of gastric ulcer

Note

Helicobacter pylori eradication therapy should be considered.

No applications for increased maximum quantities and/or repeats will be authorised.

esomeprazole 20 mg tablet: enteric, 30 tablets

8886Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	25.37	26.52	^a Esomeprazole Apotex [TX] ^a Esomeprazole RBX [RA]	^a Esomeprazole GxP [AF] ^a Nexium [AP]

■ ESOMEPRAZOLE

Restricted benefit

Maintenance of healed gastro-oesophageal reflux disease

Restricted benefit

Scleroderma oesophagus

Restricted benefit

Pathological hypersecretory conditions including Zollinger-Ellison syndrome and idiopathic hypersecretion

Note

No applications for increased maximum quantities will be authorised.

esomeprazole 20 mg tablet: enteric, 30 tablets

8600P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	25.37	26.52	^a Esomeprazole Apotex [TX] ^a Esomeprazole RBX [RA]	^a Esomeprazole GxP [AF] ^a Nexium [AP]

■ LANSOPRAZOLE

Restricted benefit

Gastro-oesophageal reflux disease

Restricted benefit

Scleroderma oesophagus

lansoprazole 15 mg capsule: enteric, 30

8198L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	13.95	15.10	Zopral [AF]

lansoprazole 15 mg tablet: orally disintegrating, 28 tablets

9331D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.44	14.59	^a APO-Lansoprazole ODT [TX] ^a Zopral ODT [AF]	^a Lansoprazole ODT GH [GQ] ^a Zoton FasTabs [PF]

■ LANSOPRAZOLE**Restricted benefit**

Initial treatment of peptic ulcer

Note

Helicobacter pylori eradication therapy should be considered.

No applications for increased repeats will be authorised.

Pharmaceutical benefits that have the form lansoprazole capsule 30 mg and pharmaceutical benefits that have the form lansoprazole tablet 30 mg (orally disintegrating) are equivalent for the purposes of substitution.

lansoprazole 30 mg capsule: enteric, 28

2240X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	18.75	19.90	^a APO-Lansoprazole [TX] ^a Zopral [AF]	^a Lanzopran [RA]

lansoprazole 30 mg tablet: orally disintegrating, 28 tablets

9477T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	18.75	19.90	^a APO-Lansoprazole ODT [TX] ^a Zopral ODT [AF]	^a Lansoprazole ODT GH [GQ] ^a Zoton FasTabs [PF]

■ LANSOPRAZOLE**Restricted benefit**

Gastro-oesophageal reflux disease

Restricted benefit

Scleroderma oesophagus

Note

Pharmaceutical benefits that have the form lansoprazole capsule 30 mg and pharmaceutical benefits that have the form lansoprazole tablet 30 mg (orally disintegrating) are equivalent for the purposes of substitution.

lansoprazole 30 mg capsule: enteric, 28

2241Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	18.75	19.90	^a APO-Lansoprazole [TX] ^a Zopral [AF]	^a Lanzopran [RA]

lansoprazole 30 mg tablet: orally disintegrating, 28 tablets

9478W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	18.75	19.90	^a APO-Lansoprazole ODT [TX] ^a Zoton FasTabs [PF]	^a Zopral ODT [AF]

■ OMEPRAZOLE**Restricted benefit**

Gastro-oesophageal reflux disease

Restricted benefit

Scleroderma oesophagus

Restricted benefit

Zollinger-Ellison syndrome

omeprazole 10 mg tablet: enteric, 30 tablets

8332M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	11.54	12.69	Losec Tablets [AP]

■ OMEPRAZOLE**Restricted benefit**

Peptic ulcer

Treatment Phase: Initial treatment

Note

Helicobacter pylori eradication therapy should be considered.

Pharmaceutical benefits that have the forms omeprazole tablet 20 mg, omeprazole capsule 20 mg and omeprazole tablet 20 mg (as magnesium) are equivalent for the purposes of substitution.

No increase in the maximum number of repeats may be authorised.

omeprazole 20 mg capsule, 30

1326T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	13.53	14.68	^a APO-Omeprazole [TX] ^a Omeprazole Sandoz [HX] ^a Pemzo [QA] ^a Probitor [SZ]	^a Maxor [AF] ^a Omepro-GA [GN] ^a Pharmacor Omeprazole 20 [CR]

omeprazole 20 mg tablet: enteric, 30 tablets

8331L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	13.53	14.68	^a APO-Omeprazole [TX] ^a Meprazol [SZ] ^a Omeprazole-GA [GN] ^a Omeprazole RBX [RA] ^a Terry White Chemists Omeprazole [TW]	^a Chem mart Omeprazole [CH] ^a Omeprazole AN [EA] ^a Omeprazole generichealth [GQ] ^a Ozmepr [ZP]

omeprazole 20 mg tablet: enteric, 30 tablets

9109K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	13.53	14.68	^a Acimax Tablets [AL] ^a Omeprazole Sandoz [SZ] ^a Losec Tablets [AP]	^a Omepral [TX]
			^B 2.48	16.01	14.68		

■ OMEPRAZOLE

Restricted benefit

Gastro-oesophageal reflux disease

Restricted benefit

Scleroderma oesophagus

Restricted benefit

Zollinger-Ellison syndrome

Note

Pharmaceutical benefits that have the forms omeprazole tablet 20 mg, omeprazole capsule 20 mg and omeprazole tablet 20 mg (as magnesium) are equivalent for the purposes of substitution.

omeprazole 20 mg capsule, 30

1327W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.53	14.68	^a APO-Omeprazole [TX] ^a Omeprazole Sandoz [HX] ^a Pemzo [QA] ^a Probitor [SZ]	^a Maxor [AF] ^a Omepro-GA [GN] ^a Pharmacor Omeprazole 20 [CR]

omeprazole 20 mg tablet: enteric, 30 tablets

8333N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.53	14.68	^a APO-Omeprazole [TX] ^a Meprazol [SZ] ^a Omeprazole-GA [GN] ^a Omeprazole RBX [RA] ^a Terry White Chemists Omeprazole [TW]	^a Chem mart Omeprazole [CH] ^a Omeprazole AN [EA] ^a Omeprazole generichealth [GQ] ^a Ozmepr [ZP]

omeprazole 20 mg tablet: enteric, 30 tablets

9110L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.53	14.68	^a Acimax Tablets [AL] ^a Omeprazole Sandoz [SZ] ^a Losec Tablets [AP]	^a Omepral [TX]
			^B 2.48	16.01	14.68		

■ PANTOPRAZOLE

Restricted benefit

Initial treatment of peptic ulcer

Note

Helicobacter pylori eradication therapy should be considered.

No applications for increased repeats will be authorised.

pantoprazole 40 mg granules: enteric-coated, 30 sachets

9423Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	31.05	32.20	Somac [NQ]

pantoprazole 40 mg tablet: enteric, 30

8007K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	11.54	12.69	^a APO-Pantoprazole [TX] ^a I-Pantoprazole [CR] ^a Panthron [ER] ^a Pantofast 40 [RZ] ^a Pantoprazole AN [EA] ^a Pantoprazole generichealth [GQ] ^a Salpraz [AF] ^a Sozol [QA] ^a Topra 40 [DO]	^a Chem mart Pantoprazole [CH] ^a Ozpan [RA] ^a Panto [TK] ^a Pantoprazole Actavis [GN] ^a Pantoprazole-GA [UA] ^a Pantoprazole Sandoz [SZ] ^a Somac [NQ] ^a Terry White Chemists Pantoprazole [TW] ^a Torzole 40 [VN]

■ PANTOPRAZOLE

Restricted benefit

Gastro-oesophageal reflux disease

Restricted benefit

Scleroderma oesophagus

Restricted benefit

Zollinger-Ellison syndrome

pantoprazole 20 mg tablet: enteric, 30 tablets

8399C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	9.08	10.23	^a APO-Pantoprazole [TX] ^a I-Pantoprazole [CR] ^a Panthron [ER] ^a Pantofast 20 [RZ] ^a Pantoprazole-GA [GN] ^a Pantoprazole Sandoz [SZ] ^a Somac [NQ] ^a Terry White Chemists Pantoprazole [TW]	^a Chem mart Pantoprazole [CH] ^a Ozpan [RA] ^a Panto [TK] ^a Pantoprazole AN [EA] ^a Pantoprazole generichealth [GQ] ^a Salpraz [AF] ^a Sozol [QA] ^a Torzole 20 [VN]

pantoprazole 40 mg granules: enteric-coated, 30 sachets

9424B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	31.05	32.20	Somac [NQ]

pantoprazole 40 mg tablet: enteric, 30

8008L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	11.54	12.69	^a APO-Pantoprazole [TX] ^a I-Pantoprazole [CR] ^a Panthron [ER] ^a Pantofast 40 [RZ] ^a Pantoprazole AN [EA] ^a Pantoprazole generichealth [GQ] ^a Salpraz [AF] ^a Sozol [QA] ^a Topra 40 [DO]	^a Chem mart Pantoprazole [CH] ^a Ozpan [RA] ^a Panto [TK] ^a Pantoprazole Actavis [GN] ^a Pantoprazole-GA [UA] ^a Pantoprazole Sandoz [SZ] ^a Somac [NQ] ^a Terry White Chemists Pantoprazole [TW] ^a Torzole 40 [VN]

■ RABEPRAZOLE

Restricted benefit

Gastro-oesophageal reflux disease

Restricted benefit

Scleroderma oesophagus

rabeprazole sodium 10 mg tablet: enteric, 28

8507R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.10	16.25	^a APO-Rabeprazole [TX] ^a Pariet [JC]	^a Chem mart Rabeprazole [CH] ^a Parzol 10 [ZP]

^a Prabez [AF]
^a Rabeprazole-DRLA [RZ]
^a Rabeprazole generichealth [GQ]
^a Razit 10 [DO]
^a Rabeprazole AN [EA]
^a Rabeprazole-GA [GN]
^a Rabeprazole Sandoz [SZ]
^a Terry White Chemists Rabeprazole [TW]

rabeprazole sodium 20 mg tablet: enteric, 30

8508T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.10	16.25	^a APO-Rabeprazole [TX] ^a Pariet [JC] ^a Prabez [AF] ^a Rabeprazole AN [EA] ^a Rabeprazole generichealth [GQ] ^a Rabeprazole Sandoz [SZ] ^a Terry White Chemists Rabeprazole [TW]	^a Chem mart Rabeprazole [CH] ^a Parzol 20 [ZP] ^a Rabeprazole Actavis 20 [UA] ^a Rabeprazole-DRLA [RZ] ^a Rabeprazole RBX [RA] ^a Razit 20 [DO] ^a Zabep [AL]

■ RABEPRAZOLE**Restricted benefit**

Initial treatment of peptic ulcer

Note

Helicobacter pylori eradication therapy should be considered.

No applications for increased repeats will be authorised.

rabeprazole sodium 20 mg tablet: enteric, 30

8509W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	15.10	16.25	^a APO-Rabeprazole [TX] ^a Pariet [JC] ^a Prabez [AF] ^a Rabeprazole AN [EA] ^a Rabeprazole generichealth [GQ] ^a Rabeprazole Sandoz [SZ] ^a Terry White Chemists Rabeprazole [TW]	^a Chem mart Rabeprazole [CH] ^a Parzol 20 [ZP] ^a Rabeprazole Actavis 20 [UA] ^a Rabeprazole-DRLA [RZ] ^a Rabeprazole RBX [RA] ^a Razit 20 [DO] ^a Zabep [AL]

*Combinations for eradication of Helicobacter pylori***■ ESOMEPRAZOLE (&) CLARITHROMYCIN (&) AMOXYCILLIN****Restricted benefit**

Eradication of Helicobacter pylori associated with peptic ulcer disease

esomeprazole 20 mg tablet: enteric [14 tablets] (&) clarithromycin 500 mg tablet [14 tablets] (&) amoxicillin 500 mg capsule [28 capsules], 1 pack

8738X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	..	..	50.23	37.70	Nexium Hp7 [AP]

*Other drugs for peptic ulcer and gastro-oesophageal reflux disease (GORD)***■ ALGINATE SODIUM + CALCIUM CARBONATE + BICARBONATE****alginate sodium 500 mg/10 mL + calcium carbonate 160 mg/10 mL + sodium bicarbonate 267 mg/10 mL oral liquid, 500 mL**

2014B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*15.02	16.17	Gaviscon P [RC]

■ SUCRALFATE**sucralfate 1 g tablet, 120**

2055E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	23.84	24.99	^a Ulcyte [AF]
			^B 2.30	26.14	24.99	^a Carafate [AS]

■ DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS**BELLADONNA AND DERIVATIVES, PLAIN***Belladonna alkaloids, tertiary amines*

■ **ATROPINE****ATROPINE Injection 600 micrograms in 1 mL, 10**

5022H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	20.88	22.03	Pfizer Australia Pty Ltd [PF]

■ **ATROPINE****Note**

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

ATROPINE Injection 600 micrograms in 1 mL, 10

1089H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	20.88	22.03	Pfizer Australia Pty Ltd [PF]

PROPULSIVES*Propulsives*■ **DOMPERIDONE****domperidone 10 mg tablet, 25**

1347X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	9.23	10.38	Motilium [JC]

■ **METOCLOPRAMIDE****metoclopramide hydrochloride 10 mg tablet, 25**

1207M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP MW	1	..	..	8.26	9.41	Pramin [AF]	
						^a APO-Metoclopramide [TX]	^a Metoclopramide Actavis [GN]
						^a Metoclopramide AN [EA]	^a Metoclopramide RBX [RA]
			^B 2.54	10.80	9.41	^a Maxolon [IA]	

metoclopramide hydrochloride 10 mg tablet, 25

5151D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	8.26	9.41	Pramin [AF]	
						^a APO-Metoclopramide [TX]	^a Metoclopramide Actavis [GN]
						^a Metoclopramide AN [EA]	^a Metoclopramide RBX [RA]
			^B 2.54	10.80	9.41	^a Maxolon [IA]	

metoclopramide hydrochloride 10 mg/2 mL injection, 10 x 2 mL ampoules

1206L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP MW	1	..	..	13.33	14.48	Maxolon [IA]

metoclopramide hydrochloride 10 mg/2 mL injection, 10 x 2 mL ampoules

5153F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	13.33	14.48	Maxolon [IA]

■ **ANTIEMETICS AND ANTINAUSEANTS****ANTIEMETICS AND ANTINAUSEANTS***Serotonin (5HT₃) antagonists*■ **GRANISETRON****Restricted benefit**

Nausea and vomiting

Clinical criteria:

The condition must be associated with cytotoxic chemotherapy being used to treat malignancy which occurs within 48 hours of chemotherapy administration.

Increased maximum quantities will be limited to a maximum of 7 days per chemotherapy cycle.

granisetron 3 mg/3 mL injection, 1 x 3 mL ampoule

8729K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	11.68	12.83	^a Granisetron-AFT [AE]	^a Granisetron Kabi [PK]
						^a Kytril [RO]	

■ GRANISETRON

Authority required (STREAMLINED)**4092**

Nausea and vomiting

Clinical criteria:

The condition must be associated with radiotherapy being used to treat malignancy.

granisetron 3 mg/3 mL injection, 1 x 3 mL ampoule

8730L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	11.68	12.83	^a Granisetron-AFT [AE] ^a Kytril [RO]	^a Granisetron Kabi [PK]

■ GRANISETRON

Authority required (STREAMLINED)**4102**

Nausea and vomiting

Clinical criteria:

The condition must be associated with radiotherapy being used to treat malignancy.

granisetron 2 mg tablet, 5

8873B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	61.69	37.70	Kytril [RO]

■ GRANISETRON

Restricted benefit

Nausea and vomiting

Clinical criteria:

The condition must be associated with cytotoxic chemotherapy being used to treat malignancy which occurs within 48 hours of chemotherapy administration.

Increased maximum quantities will be limited to a maximum of 7 days per chemotherapy cycle.

granisetron 2 mg tablet, 1

8728J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*29.74	30.89	Kytril [RO]

■ ONDANSETRON

Authority required (STREAMLINED)**3611**

Management of nausea and vomiting associated with radiotherapy being used to treat malignancy

ondansetron 4 mg tablet, 10

1594X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	26.85	28.00	^a APO-Ondansetron [TX] ^a Ondansetron-DRLA [RZ] ^a Ondaz [SZ] ^a Zilfijim 4 [DO]	^a Ondansetron AN [EA] ^a Ondansetron SZ [HX] ^a Onsetron 4 [ZP] ^a Zofran [AS]

ondansetron 4 mg/2 mL injection, 1 x 2 mL ampoule

1596B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	7.48	8.63	^a Ondansetron Alphapharm [AF] ^a Ondansetron Kabi [PK]	^a Ondansetron-Clarix [AE] ^a Onsetron [ZP]

ondansetron 4 mg/5 mL oral liquid, 50 mL

8233H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	1	..	102.30	37.70	Zofran syrup 50 mL [AS]

ondansetron 8 mg tablet, 10

1595Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	38.22	37.70	^a APO-Ondansetron [TX] ^a Ondansetron-DRLA [RZ] ^a Ondaz [SZ] ^a Zilfijim 8 [DO]	^a Ondansetron AN [EA] ^a Ondansetron SZ [HX] ^a Onsetron 8 [ZP] ^a Zofran [AS]

ondansetron 8 mg/4 mL injection, 1 x 4 mL ampoule

1597C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	7.92	9.07	^a Ondansetron Alphapharm [AF] ^a Ondansetron Kabi [PK]	^a Ondansetron-Clarix [AE] ^a Onsetron [ZP]

■ **ONDANSETRON****Restricted benefit**

Management of nausea and vomiting associated with cytotoxic chemotherapy being used to treat malignancy which occurs within 48 hours of chemotherapy administration.

Increased maximum quantities will be limited to a maximum of 7 days per chemotherapy cycle

ondansetron 4 mg tablet, 4

8224W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	14.80	15.95	^a APO-Ondansetron [TX] ^a Ondansetron-DRLA [RZ] ^a Ondaz [SZ] ^a Zofran [AS]	^a Ondansetron AN [EA] ^a Ondansetron SZ [HX] ^a Onsetron 4 [ZP]

ondansetron 4 mg/2 mL injection, 1 x 2 mL ampoule

8226Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	7.48	8.63	^a Ondansetron Alphapharm [AF] ^a Ondansetron Kabi [PK]	^a Ondansetron-Clarix [AE] ^a Onsetron [ZP]

ondansetron 4 mg/5 mL oral liquid, 50 mL

9441X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	±1	..	..	102.30	37.70	Zofran syrup 50 mL [AS]	

ondansetron 8 mg tablet, 4

8225X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	19.35	20.50	^a APO-Ondansetron [TX] ^a Ondansetron-DRLA [RZ] ^a Ondaz [SZ] ^a Zofran [AS]	^a Ondansetron AN [EA] ^a Ondansetron SZ [HX] ^a Onsetron 8 [ZP]

ondansetron 8 mg/4 mL injection, 1 x 4 mL ampoule

8227B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	7.92	9.07	^a Ondansetron Alphapharm [AF] ^a Ondansetron Kabi [PK]	^a Ondansetron-Clarix [AE] ^a Onsetron [ZP]

■ **ONDANSETRON****Restricted benefit**

Management of nausea and vomiting associated with cytotoxic chemotherapy being used to treat malignancy which occurs within 48 hours of chemotherapy administration.

Increased maximum quantities will be limited to a maximum of 7 days per chemotherapy cycle

Note

Pharmaceutical benefits that have the form ondansetron tablet (orally disintegrating) 4 mg and pharmaceutical benefits that have the form ondansetron wafer 4 mg are equivalent for the purposes of substitution.

ONDANSETRON Tablet (orally disintegrating) 4 mg, 4

5470X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	14.80	15.95	^a Ondansetron AN ODT [EA] ^a Ondansetron SZ ODT [HX]	^a Ondansetron ODT-DRLA [RZ] ^a Onsetron ODT 4 [GN]

ondansetron 4 mg wafer, 4

8410P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	14.80	15.95	^a Ondaz Zydix [SZ]	^a Zofran Zydix [AS]

■ **ONDANSETRON****Restricted benefit**

Management of nausea and vomiting associated with cytotoxic chemotherapy being used to treat malignancy which occurs within 48 hours of chemotherapy administration.

Increased maximum quantities will be limited to a maximum of 7 days per chemotherapy cycle

Note

Pharmaceutical benefits that have the form ondansetron tablet (orally disintegrating) 8 mg and pharmaceutical benefits that have the form ondansetron wafer 8 mg are equivalent for the purposes of substitution.

ONDANSETRON Tablet (orally disintegrating) 8 mg, 4

5471Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	19.35	20.50	^a Ondansetron AN ODT [EA] ^a Ondansetron SZ ODT [HX]	^a Ondansetron ODT-DRLA [RZ] ^a Onsetron ODT 8 [GN]

ondansetron 8 mg wafer, 4

8411Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	19.35	20.50	^a Ondaz Zydis [SZ]	^a Zofran Zydis [AS]

■ ONDANSETRON**Authority required (STREAMLINED)****3611**

Management of nausea and vomiting associated with radiotherapy being used to treat malignancy

Note

Pharmaceutical benefits that have the form ondansetron tablet (orally disintegrating) 4 mg and pharmaceutical benefits that have the form ondansetron wafer 4 mg are equivalent for the purposes of substitution.

ONDANSETRON Tablet (orally disintegrating) 4 mg, 10

5472B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	26.85	28.00	^a Ondansetron AN ODT [EA] ^a Ondansetron SZ ODT [HX] ^a Zilfojim ODT 4 [DO]	^a Ondansetron ODT-DRLA [RZ] ^a Onsetron ODT 4 [GN]

ondansetron 4 mg wafer, 10

8412R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	26.85	28.00	^a Ondaz Zydis [SZ]	^a Zofran Zydis [AS]

■ ONDANSETRON**Authority required (STREAMLINED)****3611**

Management of nausea and vomiting associated with radiotherapy being used to treat malignancy

Note

Pharmaceutical benefits that have the form ondansetron tablet (orally disintegrating) 8 mg and pharmaceutical benefits that have the form ondansetron wafer 8 mg are equivalent for the purposes of substitution.

ONDANSETRON Tablet (orally disintegrating) 8 mg, 10

5473C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	38.22	37.70	^a Ondansetron AN ODT [EA] ^a Ondansetron SZ ODT [HX] ^a Zilfojim ODT 8 [DO]	^a Ondansetron ODT-DRLA [RZ] ^a Onsetron ODT 8 [GN]

ondansetron 8 mg wafer, 10

8413T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	38.22	37.70	^a Ondaz Zydis [SZ]	^a Zofran Zydis [AS]

■ PALONOSETRON**Restricted benefit**

Management of nausea and vomiting associated with cytotoxic chemotherapy being used to treat malignancy which occurs within 48 hours of chemotherapy administration

Note

No applications for increased maximum quantities will be authorised. Palonosetron is not PBS-subsidised for administration with oral 5-HT3 antagonists.

palonosetron 250 microgram/5 mL injection, 1 x 5 mL vial

5295Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	48.20	37.70	Aloxi [TS]

■ TROPISETRON**Restricted benefit**

Management of nausea and vomiting associated with cytotoxic chemotherapy being used to treat malignancy which occurs within 48 hours of chemotherapy administration.

Increased maximum quantities will be limited to a maximum of 7 days per chemotherapy cycle

tropisetron 5 mg/5 mL injection, 1 x 5 mL ampoule

2746M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	14.03	15.18	Tropisetron-AFT [AE]

*Other antiemetics***■ APREPITANT****Authority required (STREAMLINED)**

4211

Nausea and vomiting

Clinical criteria:The condition must be associated with cytotoxic chemotherapy being used to treat malignancy, **AND**The treatment must be in combination with a 5-hydroxytryptamine receptor (5HT3) antagonist and dexamethasone, **AND**

Patient must be scheduled to be administered a chemotherapy regimen that includes any 1 of the following agents:

altretamine; carmustine; cisplatin when a single dose constitutes a cycle of chemotherapy; cyclophosphamide at a dose of 1500 mg per square metre per day or greater; dacarbazine; procarbazine when a single dose constitutes a cycle of chemotherapy; streptozocin.

No more than 1 capsule of aprepitant 165 mg will be authorised per cycle of cytotoxic chemotherapy.

Authority required (STREAMLINED)**4215**

Nausea and vomiting

Clinical criteria:The condition must be associated with cytotoxic chemotherapy being used to treat breast cancer, **AND**The treatment must be in combination with a 5-hydroxytryptamine receptor (5HT3) antagonist and dexamethasone, **AND**

Patient must be scheduled to be co-administered cyclophosphamide and an anthracycline.

No more than 1 capsule of aprepitant 165 mg will be authorised per cycle of cytotoxic chemotherapy.

Authority required (STREAMLINED)**4213**

Nausea and vomiting

Clinical criteria:The condition must be associated with moderately emetogenic cytotoxic chemotherapy being used to treat malignancy, **AND**The treatment must be in combination with a 5-hydroxytryptamine receptor (5HT3) antagonist and dexamethasone on day 1 of a chemotherapy cycle, **AND**Patient must have had a prior episode of chemotherapy induced nausea or vomiting, **AND**

Patient must be scheduled to be administered a chemotherapy regimen that includes any 1 of the following intravenous chemotherapy agents: arsenic trioxide; azacitidine; carboplatin; cyclophosphamide at a dose of less than 1500 mg per square metre per day; cytarabine at a dose of greater than 1 g per square metre per day; dactinomycin; daunorubicin; doxorubicin; epirubicin; fotemustine; idarubicin; ifosfamide; irinotecan; melphalan; methotrexate at a dose of 250 mg to 1 g per square metre; oxaliplatin; raltitrexed.

No more than 1 capsule of aprepitant 165 mg will be authorised per cycle of cytotoxic chemotherapy.

Concomitant use of a 5HT3 antagonist should not occur with aprepitant on days 2 and 3 of any chemotherapy cycle.

Note

Aprepitant is not PBS-subsidised for nausea and vomiting associated with radiotherapy being used to treat malignancy.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

aprepitant 165 mg capsule, 1

2518M

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	138.13	37.70	Emend [MK]

■ PROCHLORPERAZINE**Caution**

Prochlorperazine may be associated with parkinsonism and tardive dyskinesia and should be used for short-term treatment only.

prochlorperazine maleate 25 mg suppository, 5

5208D

DP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
‡1	20.27	21.42	Stemetil [SW]

prochlorperazine maleate 5 mg tablet, 25

5205Y

DP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	8.19	9.34	^a APO-Prochlorperazine [TX]	^a Pharmacor Prozine 5 [CR]
					^a ProCalm [QA]	^a Prochlorperazine AN [EA]
					^a Prochlorperazine-GA [GN]	^a Prochlorperazine GH [GQ]
					^a Stemetil [AV]	
		^b 2.70	10.89	9.34	^a Stemetil [SW]	

prochlorperazine mesylate 12.5 mg/mL injection, 10 x 1 mL ampoules

5206B

DP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	17.89	19.04	Stemetil [SW]

■ PROCHLORPERAZINE**Caution**

Prochlorperazine may be associated with parkinsonism and tardive dyskinesia and should be used for short-term treatment only.

Note

As prochlorperazine may be associated with parkinsonism and tardive dyskinesia it should be used for short-term treatment only. However, authorities for increased maximum quantities and/or repeats of prochlorperazine tablets will be granted for the treatment of emesis associated with malignant disease.

prochlorperazine maleate 25 mg suppository, 5

2895J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	2	..	20.27	21.42	Stemetil [SW]

prochlorperazine maleate 5 mg tablet, 25

2893G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	8.19	9.34	^a APO-Prochlorperazine [TX] ^a ProCalm [QA] ^a Prochlorperazine-GA [GN] ^a Stemizine [AV]	^a Pharmacor Prozine 5 [CR] ^a Prochlorperazine AN [EA] ^a Prochlorperazine GH [GQ]
			^B 2.70	10.89	9.34	^a Stemetil [SW]	

prochlorperazine mesylate 12.5 mg/mL injection, 10 x 1 mL ampoules

2369Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	17.89	19.04	Stemetil [SW]

■ PROMETHAZINE**promethazine hydrochloride 50 mg/2 mL injection, 5 x 2 mL ampoules**

3374N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	2	..	..	*30.58	31.73	Hospira Pty Limited [HH]

■ BILE AND LIVER THERAPY**BILE THERAPY**

Bile acid preparations

■ URSODEOXYCHOLIC ACID**Authority required (STREAMLINED)**

1700

Primary biliary cirrhosis

Note

Not for use in the treatment of sclerosing cholangitis or cholelithiasis.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

ursodeoxycholic acid 250 mg capsule, 100

8448P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	2	..	*317.22	37.70	^a Ursofalk [OA]	^a Ursosan [BZ]

■ DRUGS FOR CONSTIPATION**DRUGS FOR CONSTIPATION**

Contact laxatives

■ BISACODYL**Restricted benefit**

Paraplegic and quadriplegic patients and others with severe neurogenic impairment of bowel function

Restricted benefit

Patients who are receiving long-term nursing care on account of age, infirmity or other condition in hospitals, nursing homes or residential facilities

Restricted benefit

For use by a patient who is receiving long-term nursing care and in respect of whom a Carer Allowance is payable as a disabled adult

Restricted benefit

Patients receiving palliative care

Restricted benefit

Terminal malignant neoplasia

Restricted benefit

Anorectal congenital abnormalities

Restricted benefit

Megacolon

bisacodyl 10 mg suppository, 10

1260H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*21.28	22.43	^a Petrus Bisacodyl Suppositories [PP]
			^B 1.50	*22.78	22.43	^a Dulcolax [BY]

bisacodyl 10 mg suppository, 12

1258F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	4	..	*18.67	19.82	Petrus Bisacodyl Suppositories [PP]

bisacodyl 5 mg tablet: enteric, 200 tablets

1259G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	14.45	15.60	Bisalax [AS]	Lax-Tab [AE]

Bulk-forming laxatives**■ RHAMNUS FRANGULA + STERCULIA****Restricted benefit**

Paraplegic and quadriplegic patients and others with severe neurogenic impairment of bowel function

Restricted benefit

Patients who are receiving long-term nursing care on account of age, infirmity or other condition in hospitals, nursing homes or residential facilities

Restricted benefit

For use by a patient who is receiving long-term nursing care and in respect of whom a Carer Allowance is payable as a disabled adult

Restricted benefit

Patients receiving palliative care

Restricted benefit

Terminal malignant neoplasia

Restricted benefit

Anorectal congenital abnormalities

Restricted benefit

Megacolon

ramnus frangula 80 mg/g + sterculia 620 mg/g granules, 500 g

1104D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	1	..	26.71	27.86	Normacol Plus [NE]

Osmotically acting laxatives**■ LACTULOSE****Restricted benefit**

Hepatic coma or precoma (chronic porto-systemic encephalopathy)

Restricted benefit

Constipation in patients with malignant neoplasia

LACTULOSE Mixture 3.34 g per 5 mL, 500 mL, 1

3064G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	5	..	10.70	11.85	^a Genlac [QA]	
			^B 0.89	11.59	11.85	^a Actilax [AF]	^a Dulose [FM]

■ MACROGOL-3350**Restricted benefit**

Constipation

Clinical criteria:

Patient must have malignant neoplasia.

Restricted benefit

Constipation

Clinical criteria:Patient must be paraplegic, quadriplegic or have severe neurogenic impairment of bowel function, **AND**

The condition must be unresponsive to other oral therapies.

Restricted benefit

Constipation

Clinical criteria:

Patient must be receiving palliative care.

Restricted benefit

Chronic constipation

Clinical criteria:

The condition must be inadequately controlled with first line interventions such as bulk-forming agents.

Restricted benefit

Faecal impaction

Clinical criteria:

The condition must be inadequately controlled with first line interventions such as bulk-forming agents.

Note

Pharmaceutical benefits that have the form macrogol-3350 1 g/g oral liquid: powder for, 510 g and pharmaceutical benefits that have the form macrogol-3350 1 g/g oral liquid: powder for, 30 x 17 g sachets are equivalent for the purposes of substitution.

macrogol-3350 1 g/g oral liquid: powder for, 30 x 17 g sachets

2373X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	18.57	19.72	^a Herron ClearLax [ON]

macrogol-3350 1 g/g oral liquid: powder for, 510 g

3416T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	18.57	19.72	^a OsmoLax [KY]

▪ MACROGOL-3350 + SODIUM CHLORIDE + POTASSIUM CHLORIDE + BICARBONATE**Restricted benefit**

Constipation

Clinical criteria:

Patient must have malignant neoplasia.

Restricted benefit

Constipation

Clinical criteria:

Patient must be paraplegic, quadriplegic or have severe neurogenic impairment of bowel function, **AND**

The condition must be unresponsive to other oral therapies.

Restricted benefit

Constipation

Clinical criteria:

Patient must be receiving palliative care.

Restricted benefit

Chronic constipation

Clinical criteria:

The condition must be inadequately controlled with first line interventions such as bulk-forming agents.

Restricted benefit

Faecal impaction

Clinical criteria:

The condition must be inadequately controlled with first line interventions such as bulk-forming agents.

macrogol-3350 13.12 g + sodium chloride 350.7 mg + potassium chloride 46.6 mg (0.63 mmol potassium) + sodium bicarbonate 178.5 mg solution, 30 sachets

8612G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	±1	5	..	18.57	19.72	^a APO-MACROGOL plus ELECTROLYTES [TX]	^a LaxaCon [GN]
						^a lax-sachets [AE]	^a Macrovic [QA]
						^a Molaxole [HM]	^a Movicol [NE]

macrogol-3350 13.12 g/25 mL + sodium chloride 350.7 mg/25 mL + potassium chloride 46.6 mg/25 mL (0.63 mmol/25 mL potassium) + sodium bicarbonate 178.5 mg/25 mL oral liquid, 500 mL

10126Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*22.52	23.67	Movicol Liquid [NE]

Enemas**▪ BISACODYL****Restricted benefit**

Paraplegic and quadriplegic patients and others with severe neurogenic impairment of bowel function

Restricted benefit

Patients who are receiving long-term nursing care on account of age, infirmity or other condition in hospitals, nursing homes or residential facilities

Restricted benefit

For use by a patient who is receiving long-term nursing care and in respect of whom a Carer Allowance is payable as a disabled adult

Restricted benefit

Patients receiving palliative care

Restricted benefit

Terminal malignant neoplasia

Restricted benefit

Anorectal congenital abnormalities

Restricted benefit

Megacolon

bisacodyl 10 mg/5 mL enema, 25 x 5 mL

1263L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	2	..	38.28	37.70	Bisalax [AS]

▪ SORBITOL + CITRATE + LAURYL SULFOACETATE SODIUM**Restricted benefit**

Paraplegic and quadriplegic patients and others with severe neurogenic impairment of bowel function

Restricted benefit

Patients who are receiving long-term nursing care on account of age, infirmity or other condition in hospitals, nursing homes or residential facilities

Restricted benefit

For use by a patient who is receiving long-term nursing care and in respect of whom a Carer Allowance is payable as a disabled adult

Restricted benefit

Patients receiving palliative care

Restricted benefit

Terminal malignant neoplasia

Restricted benefit

Anorectal congenital abnormalities

Restricted benefit

Megacolon

sorbitol 3.125 g/5 mL + citrate sodium dihydrate 450 mg/5 mL + lauryl sulfoacetate sodium 45 mg/5 mL enema, 12 x 5 mL

2091C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	2	..	*32.62	33.77	^a Micolette [AE]	^a Microlax [JT]

Other drugs for constipation**▪ GLYCEROL****Restricted benefit**

Paraplegic and quadriplegic patients and others with severe neurogenic impairment of bowel function

Restricted benefit

Patients who are receiving long-term nursing care on account of age, infirmity or other condition in hospitals, nursing homes or residential facilities

Restricted benefit

For use by a patient who is receiving long-term nursing care and in respect of whom a Carer Allowance is payable as a disabled adult

Restricted benefit

Patients receiving palliative care

Restricted benefit

Terminal malignant neoplasia

Restricted benefit

Anorectal congenital abnormalities

Restricted benefit

Megacolon

glycerol 1.4 g suppository, 12

2556M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*21.55	22.70	Petrus Pharmaceuticals Pty Ltd [PP]

glycerol 2.8 g suppository, 12

2557N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*22.15	23.30	Petrus Pharmaceuticals Pty Ltd [PP]

glycerol 700 mg suppository, 12

2555L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*21.10	22.25	Petrus Pharmaceuticals Pty Ltd [PP]

■ **ANTIDIARRHEALS, INTESTINAL ANTIINFLAMMATORY/ANTIINFECTIVE AGENTS****INTESTINAL ANTIINFECTIVES***Antibiotics*■ **NYSTATIN****nystatin 500 000 international units capsule, 50**

1699K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	18.32	19.47	Nilstat [QA]

nystatin 500 000 international units capsule, 50

3345C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	18.32	19.47	Nilstat [QA]

nystatin 500 000 international units tablet, 50

1696G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	18.32	19.47	Nilstat [QA]

nystatin 500 000 international units tablet, 50

3342X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	18.32	19.47	Nilstat [QA]

■ **RIFAXIMIN****Authority required**

Prevention of hepatic encephalopathy

Clinical criteria:The treatment must be in combination with lactulose, if lactulose is tolerated, **AND**

Patient must have had prior episodes of hepatic encephalopathy.

Treatment criteria:

Must be treated by a gastroenterologist or hepatologist or in consultation with a gastroenterologist or hepatologist.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

rifaximin 550 mg tablet, 56

10001J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	495.10	37.70	Xifaxan [NE]

■ **VANCOMYCIN****Authority required**

Antibiotic associated pseudomembranous colitis due to Clostridium difficile which is unresponsive to metronidazole

Authority required

Antibiotic associated pseudomembranous colitis due to Clostridium difficile where there is intolerance to metronidazole

Note

Metronidazole has similar efficacy to vancomycin but may have less selective pressure to vancomycin resistant enterococci and is therefore the preferred treatment.

vancomycin 125 mg capsule, 20

3113W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*232.60	37.70	Vancocin [AS]

vancomycin 250 mg capsule, 20

3114X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*440.38	37.70	Vancocin [AS]

ELECTROLYTES WITH CARBOHYDRATES*Oral rehydration salt formulations*

■ SODIUM CHLORIDE + POTASSIUM CHLORIDE + GLUCOSE MONOHYDRATE + CITRATE

Note

Each sachet contains sodium chloride 470 mg, potassium chloride 300 mg, sodium acid citrate 530 mg and glucose 3.56 g.

sodium chloride 470 mg + potassium chloride 300 mg + glucose monohydrate 3.56 g + sodium acid citrate 530 mg oral liquid: powder for, 10 x 4.9 g sachets

3196F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	..	..	13.25	14.40	^a O.R.S. [AS]	^a Repalyte New Formulation [SW]
						^a restore O.R.S. [GN]	

ANTIPROPULSIVES

Antipropulsives

■ DIPHENOXYLATE + ATROPINE SULFATE

diphenoxylate hydrochloride 2.5 mg + atropine sulfate 25 microgram tablet, 20

2501P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	8.81	9.96	^a Lofenoxal [IA]	
			^B 1.73	10.54	9.96	^a Lomotil [IV]	

■ LOPERAMIDE

loperamide hydrochloride 2 mg capsule, 12

1571Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	8.47	9.62	^a Gastrex [CR]	^a Gastro-Stop Loperamide [AS]
			^B 0.75	9.22	9.62	^a Imodium [JT]	

INTESTINAL ANTIINFLAMMATORY AGENTS

Corticosteroids acting locally

■ BUDESONIDE

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

budesonide 2 mg/application enema, 2 x 14 applications aerosol cans

10034D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	3	..	211.65	37.70	Budenofalk [OA]

■ HYDROCORTISONE ACETATE

Restricted benefit

Proctitis

Restricted benefit

Ulcerative colitis

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

hydrocortisone acetate 10% (100 mg/g) enema, 21.1 g

1502C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*40.78	37.70	Colifoam [HM]

■ PREDNISOLONE SODIUM PHOSPHATE

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

prednisolone (as sodium phosphate) 20 mg/100 mL enema, 7 x 100 mL

1920C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	3	..	*211.68	37.70	Predsol [QA]

▪ PREDNISOLONE SODIUM PHOSPHATE**Restricted benefit**

Proctitis

Restricted benefit

Ulcerative colitis

Note**Continuing Therapy Only:**

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

prednisolone (as sodium phosphate) 5 mg suppository, 10

2554K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	3	..	*42.04	37.70	Predsol [QA]

*Aminosalicylic acid and similar agents***▪ BALSALAZIDE****Authority required (STREAMLINED)****4824**

Ulcerative colitis

Clinical criteria:

Patient must have had a documented hypersensitivity reaction to a sulphonamide; OR

Patient must be intolerant to sulfasalazine.

Note

Not for the treatment of Crohn disease

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

balsalazide sodium 750 mg capsule, 180

8845M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	125.19	37.70	Colazide [PK]

▪ MESALAZINE**Authority required (STREAMLINED)****4824**

Ulcerative colitis

Clinical criteria:

Patient must have had a documented hypersensitivity reaction to a sulphonamide; OR

Patient must be intolerant to sulfasalazine.

Note

Not for the treatment of Crohn disease

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

mesalazine 1 g granules: modified release, 100 x 1 g sachets

8599N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	279.97	37.70	Salofalk [OA]

mesalazine 1.2 g tablet: modified release, 60 tablets

9353G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	221.33	37.70	Mezavant [ZI]

mesalazine 1.5 g granules, 60 x 1.5 g sachets

9206M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	245.26	37.70	Salofalk [OA]

mesalazine 3 g granules, 30 sachets

10257W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	245.26	37.70	Salofalk [OA]

mesalazine 4 g granules: modified release, 30 sachets

10254Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	312.64	37.70	Pentasa [FP]

mesalazine 500 mg granules, 100 x 500 mg sachets

8598M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*297.78	37.70	Salofalk [OA]

■ MESALAZINE**Authority required (STREAMLINED)****4873**

Ulcerative colitis

Clinical criteria:

Patient must have had a documented hypersensitivity reaction to a sulphonamide; OR

Patient must be intolerant to sulfasalazine.

Authority required (STREAMLINED)**4896**

Crohn disease

Clinical criteria:

Patient must have had a documented hypersensitivity reaction to a sulphonamide; OR

Patient must be intolerant to sulfasalazine.

Note**Continuing Therapy Only:**

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

mesalazine 1 g granules: modified release, 120 x 1 g sachets

2234N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	331.01	37.70	Pentasa [FP]

mesalazine 1 g tablet: modified release, 60 tablets

3413P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*331.02	37.70	Pentasa [FP]

mesalazine 2 g granules: modified release, 60 x 2 g sachets

2287J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	312.64	37.70	Pentasa [FP]

mesalazine 250 mg tablet: enteric, 100 tablets

1611T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	93.77	37.70	Mesasal [AS]

mesalazine 500 mg tablet: enteric, 100 tablets

8731M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*297.78	37.70	Salofalk [OA]

mesalazine 500 mg tablet: modified release, 100 tablets

2214M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*297.78	37.70	Pentasa [FP]

■ MESALAZINE**Restricted benefit**

Acute episode of mild to moderate ulcerative proctitis

Note

Not for the treatment of Crohn disease

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

mesalazine 1 g suppository, 30

5461K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	136.73	37.70	Salofalk [OA]

mesalazine 1 g suppository, 30

8752P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	136.73	37.70	Pentasa [FP]

■ MESALAZINE**Authority required (STREAMLINED)****4888**

Acute episode of mild to moderate ulcerative colitis

Note

Not for the treatment of Crohn disease

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

mesalazine 1 g/100 mL enema, 7 x 100 mL

8753Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	1	..	*336.56	37.70	Pentasa [FP]

mesalazine 1 g/application enema, 14 applications

8768L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	1	..	*336.56	37.70	Salofalk [OA]

mesalazine 2 g/60 mL enema, 7 x 60 mL

8616L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	1	..	*336.56	37.70	Salofalk [OA]

mesalazine 4 g/60 mL enema, 7 x 60 mL

8617M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	1	..	*446.24	37.70	Salofalk [OA]

■ OLSALAZINE**Authority required (STREAMLINED)****4824**

Ulcerative colitis

Clinical criteria:

Patient must have had a documented hypersensitivity reaction to a sulphonamide; OR

Patient must be intolerant to sulfasalazine.

Note

Not for the treatment of Crohn disease

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

olsalazine sodium 250 mg capsule, 100

1728Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	61.75	37.70	Dipentum [IX]

olsalazine sodium 500 mg tablet, 100

8086N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	103.63	37.70	Dipentum [IX]

■ SULFASALAZINE**Note**

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

SULFASALAZINE Tablet 500 mg (enteric coated), 100

2096H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*54.60	37.70	^a Pyralin EN [FZ]
			^B 2.48	*57.08	37.70	^a Salazopyrin-EN [PF]

sulfasalazine 500 mg tablet, 100

2093E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*50.62	37.70	Salazopyrin [PF]

■ SULFASALAZINE**Restricted benefit**

For use in patients who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

SULFASALAZINE Tablet 500 mg (enteric coated), 100

9209Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*54.60	37.70	^a Pyralin EN [FZ]
			^B 2.48	*57.08	37.70	^a Salazopyrin-EN [PF]

sulfasalazine 500 mg tablet, 100

9208P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*50.62	37.70	Salazopyrin [PF]

■ DIGESTIVES, INCL. ENZYMES**DIGESTIVES, INCL. ENZYMES***Enzyme preparations***■ PANCREATIC EXTRACT****Note**

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

pancreatic extract 10 000 international units capsule: modified release, 100 capsules

8020D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	5	10	..	*184.01	37.70	Creon 10,000 [GO]

pancreatic extract 25 000 international units capsule: modified release, 100 capsules

8021E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	10	..	*148.08	37.70	Creon 25,000 [GO]

pancreatic extract 40 000 international units capsule: modified release, 100 capsules

9412J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	10	..	*230.30	37.70	Creon 40,000 [GO]

pancreatic extract 5000 international units/100 mg granules: enteric-coated, 20 g

5453B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	10	..	*142.12	37.70	Creon Micro [GO]

■ PANCREATIC EXTRACT**Restricted benefit**

For use in patients with cystic fibrosis, and who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

No applications for increased maximum quantities and/or repeats will be authorised.

pancreatic extract 10 000 international units capsule: modified release, 100 capsules

9226N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	5	21	..	*184.01	37.70	Creon 10,000 [GO]

pancreatic extract 25 000 international units capsule: modified release, 100 capsules

9227P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	21	..	*148.08	37.70	Creon 25,000 [GO]

pancreatic extract 40 000 international units capsule: modified release, 100 capsules

9413K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	21	..	*230.30	37.70	Creon 40,000 [GO]

pancreatic extract 5000 international units/100 mg granules: enteric-coated, 20 g

5454C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	3	21	..	*142.12	37.70	Creon Micro [GO]

■ PANCRELIPASE**Note**

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

pancrelipase 25 000 units capsule, 100

8366H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	10	..	*138.24	37.70	Panzytrat 25000 [TM]

■ PANCRELIPASE**Restricted benefit**

For use in patients with cystic fibrosis, and who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

No applications for increased maximum quantities and/or repeats will be authorised.

pancrelipase 25 000 units capsule, 100

9229R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	21	..	*138.24	37.70	Panzytrat 25000 [TM]

■ DRUGS USED IN DIABETES**INSULINS AND ANALOGUES**

Insulins and analogues for injection, fast-acting

■ INSULIN ASPART**insulin aspart 100 international units/mL injection, 1 x 10 mL vial**

8571D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	5	2	..	*159.61	37.70	NovoRapid [NO]

insulin aspart 100 international units/mL injection, 5 x 3 mL cartridges

8435Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	1	..	*264.56	37.70	NovoRapid FlexPen [NF]	NovoRapid Penfill 3 mL [NO]

■ INSULIN GLULISINE**insulin glulisine 100 international units/mL injection, 1 x 10 mL vial**

9224L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	5	2	..	*159.61	37.70	Apidra [SW]

insulin glulisine 100 international units/mL injection, 5 x 3 mL cartridges

1921D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	1	..	*264.56	37.70	Apidra [AV]	Apidra SoloStar [SW]

■ **INSULIN LISPRO****insulin lispro 100 international units/mL injection, 1 x 10 mL vial**

8084L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
NP	5	2	..	*159.61	37.70	Humalog [LY]	

insulin lispro 100 international units/mL injection, 5 x 3 mL cartridges

8212F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	1	..	*264.56	37.70	Humalog [LY]	Humalog KwikPen [KP]

■ **INSULIN NEUTRAL BOVINE****Authority required**

Diabetes mellitus

Clinical criteria:

Patient must be intolerant to human insulin.

insulin neutral bovine 100 international units/mL injection, 1 x 10 mL vial

1713E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
NP	5	2	..	*401.06	37.70	Hypurin Neutral [AS]	

■ **INSULIN NEUTRAL HUMAN****insulin neutral human 100 international units/mL injection, 1 x 10 mL vial**

1531N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	2	..	*134.16	37.70	Actrapid [NO]	Humulin R [LY]

insulin neutral human 100 international units/mL injection, 5 x 3 mL cartridges

1762R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	1	..	*224.66	37.70	Actrapid Penfill 3 mL [NO]	Humulin R [LY]

Insulins and analogues for injection, intermediate-acting■ **INSULIN ISOPHANE BOVINE****Authority required**

Diabetes mellitus

Clinical criteria:

Patient must be intolerant to human insulin.

insulin isophane bovine 100 international units/mL injection, 1 x 10 mL vial

1711C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
NP	5	2	..	*401.06	37.70	Hypurin Isophane [AS]	

■ **INSULIN ISOPHANE HUMAN****insulin isophane human 100 international units/mL injection, 1 x 10 mL vial**

1533Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	2	..	*134.16	37.70	Humulin NPH [LY]	Protaphane [NO]

insulin isophane human 100 international units/mL injection, 5 x 3 mL cartridges

1761Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	1	..	*224.66	37.70	Humulin NPH [LY] Protaphane Penfill 3 mL [NO]	Protaphane InnoLet [NI]

Insulins and analogues for injection, intermediate- or long-acting combined with fast-acting■ **INSULIN ASPART + INSULIN ASPART PROTAMINE****insulin aspart 30 international units/mL + insulin aspart protamine 70 international units/mL injection, 5 x 3 mL syringes**

8609D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	1	..	*264.56	37.70	NovoMix 30 FlexPen [NF]	NovoMix 30 Penfill 3 mL [NO]

■ **INSULIN ISOPHANE HUMAN + INSULIN NEUTRAL HUMAN****insulin isophane human 70 international units/mL + insulin neutral human 30 international units/mL injection, 5 x 3 mL cartridges**

1763T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	1	..	*224.66	37.70	Humulin 30/70 [LY] Mixtard 30/70 Penfill 3 mL [NO]	Mixtard 30/70 InnoLet [NI]

insulin neutral human 30 international units/mL + insulin isophane human 70 international units/mL injection, 1 x 10 mL vial

1426C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	5	2	..	*134.16	37.70	Humulin 30/70 [LY]

insulin neutral human 50 international units/mL + insulin isophane human 50 international units/mL injection, 5 x 3 mL cartridges

2062M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	5	1	..	*224.66	37.70	Mixtard 50/50 Penfill 3 mL [NO]

■ INSULIN LISPRO + INSULIN LISPRO PROTAMINE**insulin lispro 25 international units/mL + insulin lispro protamine 75 international units/mL injection, 5 x 3 mL cartridges**

8390N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	1	..	*264.56	37.70	Humalog Mix25 [LY]	Humalog Mix25 KwikPen [KP]

insulin lispro 50 international units/mL + insulin lispro protamine 50 international units/mL injection, 5 x 3 mL cartridges

8874C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	1	..	*264.56	37.70	Humalog Mix50 [LY]	Humalog Mix50 KwikPen [KP]

*Insulins and analogues for injection, long-acting***■ INSULIN DETEMIR****Restricted benefit**

Type 1 diabetes

insulin detemir 100 international units/mL injection, 5 x 3 mL cartridges

9040T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	1	..	*433.06	37.70	Levemir FlexPen [NF]	Levemir Penfill [NO]

■ INSULIN GLARGINE**insulin glargine 100 international units/mL injection, 5 x 3 mL cartridges**

9039R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	1	..	*433.06	37.70	Lantus [SW]	Lantus SoloStar [AV]

BLOOD GLUCOSE LOWERING DRUGS, EXCL. INSULINS*Biguanides***■ METFORMIN****metformin hydrochloride 1 g tablet, 90**

8607B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.77	13.92	^a APO-Metformin 1000 [TX]	^a Chem mart Metformin 1000 [CH]
						^a Diaformin 1000 [AF]	^a Formet 1000 [QA]
						^a Glucobete 1000 [DO]	^a Metformin AN [EA]
						^a Metformin-GA [GN]	^a Metformin generichealth 1000 [GQ]
						^a Metformin Ranbaxy 1000 [RA]	^a Metformin Sandoz [SZ]
						^a Pharmacor Metformin 1000 [CR]	^a Terry White Chemists Metformin 1000 [TW]
			^b 2.51	15.28	13.92	^a Diabex 1000 [AL]	

metformin hydrochloride 1 g tablet: modified release, 60 tablets

3439B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.29	13.44	^a APO-Metformin XR 1000 [TX]	^a Diaformin XR 1000 [AF]
			^b 2.52	14.81	13.44	^a Diabex XR 1000 [AL]	

metformin hydrochloride 500 mg tablet, 100

2430X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	10.21	11.36	^a APO-Metformin 500 [TX]	^a Chem mart Metformin [CH]
						^a Diaformin [AF]	^a Formet Aspen 500 [AS]
						^a Glucobete 500 [DO]	^a Metformin 500 [CR]
						^a Metformin AN [EA]	^a Metformin-GA [GN]
						^a Metformin generichealth [GQ]	^a Metformin Ranbaxy [RA]

^a Metformin Sandoz [SZ]^a Terry White Chemists
Metformin [TW]^b2.52 12.73 11.36 ^a Diabex [AL]**metformin hydrochloride 500 mg tablet: modified release, 120 tablets**

9435N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.29	13.44	^a APO-Metformin XR 500 [TX] ^a Diaformin XR [AF] ^a Terry White Chemists Metformin XR 500 [TW]	^a Chem mart Metformin XR 500 [CH] ^a Metex XR [QA]
			^b 2.52	14.81	13.44	^a Diabex XR [AL]	

metformin hydrochloride 850 mg tablet, 60

1801T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	10.21	11.36	^a APO-Metformin 850 [TX] ^a Diaformin 850 [AF] ^a Glucobete 850 [DO] ^a Metformin AN [EA] ^a Metformin generichealth [GQ] ^a Metformin Sandoz [SZ]	^a Chem mart Metformin [CH] ^a Formet Aspen 850 [AS] ^a Metformin 850 [CR] ^a Metformin-GA [GN] ^a Metformin Ranbaxy [RA] ^a Terry White Chemists Metformin [TW]
			^b 0.56	10.77	11.36	^a Glucophage [MQ]	
			^b 2.52	12.73	11.36	^a Diabex 850 [AL]	

Sulfonylureas**GLIBENCLAMIDE****Caution**

Sulfonylureas may cause hypoglycaemia, particularly in the elderly.

glibenclamide 5 mg tablet, 100

2939Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	11.73	12.88	^a Glimel [AF]	
			^b 1.44	13.17	12.88	^a Daonil [SW]	

GLICLAZIDE**Caution**

Sulfonylureas may cause hypoglycaemia, particularly in the elderly.

gliclazide 30 mg tablet: modified release, 100 tablets

8535F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.69	14.84	^a APO-Gliclazide MR [TX] ^a Glyade MR [AF] ^a Terry White Chemists Gliclazide MR [TW]	^a Chem mart Gliclazide MR [CH] ^a Oziclide MR [RA]

gliclazide 60 mg tablet: modified release, 60 tablets

9302N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.09	16.24	^a ARDIX GLICLAZIDE 60mg MR [RX]	
			^b 1.94	17.03	16.24	^a Diamicon 60mg MR [SE]	

gliclazide 80 mg tablet, 100

2449X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.50	14.65	^a Chem mart Gliclazide [CH] ^a Glyade [AF] ^a Terry White Chemists Gliclazide [TW]	^a GenRx Gliclazide [GX] ^a Nidem [QA]

GLIMEPIRIDE**Caution**

Sulfonylureas may cause hypoglycaemia, particularly in the elderly.

glimepiride 1 mg tablet, 30

8450R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	8.19	9.34	^a APO-Glimepiride [TX] ^a Diapride 1 [QA] ^a Glimepiride AN [EA] ^a Glimepiride Sandoz [SZ]	^a Aylide 1 [AF] ^a Dimirel [AV] ^a Glimepiride GA 1 [GN]
			^b 2.89	11.08	9.34	^a Amaryl [SW]	

glimepiride 2 mg tablet, 30

8451T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	9.49	10.64	^a APO-Glimepiride [TX] ^a Diapride 2 [QA] ^a Glimepiride AN [EA] ^a Glimepiride Sandoz [SZ]	^a Aylide 2 [AF] ^a Dimirel [AV] ^a Glimepiride GA 2 [GN]
			^B 2.82	12.31	10.64	^a Amaryl [SW]	

glimepiride 3 mg tablet, 30

8533D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	10.22	11.37	^a APO-Glimepiride [TX] ^a Diapride 3 [QA] ^a Glimepiride AN [EA] ^a Glimepiride Sandoz [SZ]	^a Aylide 3 [AF] ^a Dimirel [AV] ^a Glimepiride GA 3 [GN]
			^B 2.84	13.06	11.37	^a Amaryl [SW]	

glimepiride 4 mg tablet, 30

8452W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	11.02	12.17	^a APO-Glimepiride [TX] ^a Diapride 4 [QA] ^a Glimepiride AN [EA] ^a Glimepiride Sandoz [SZ]	^a Aylide 4 [AF] ^a Dimirel [AV] ^a Glimepiride GA 4 [GN]
			^B 2.84	13.86	12.17	^a Amaryl [SW]	

■ GLIPIZIDE**Caution**

Sulfonylureas may cause hypoglycaemia, particularly in the elderly.

glipizide 5 mg tablet, 100

2440K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	14.60	15.75	^a Melizide [AF]
			^B 4.51	19.11	15.75	^a Minidiab [PF]

Combinations of oral blood glucose lowering drugs**■ ALOGLIPTIN + METFORMIN****Authority required (STREAMLINED)****4423**

Diabetes mellitus type 2

Clinical criteria:

Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with metformin; OR

Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with metformin.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor is initiated.

The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

- (a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or
- (b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

A patient whose diabetes was previously demonstrated unable to be controlled with metformin does not need to requalify on this criterion before being eligible for PBS-subsidised treatment with this fixed dose combination.

Authority required (STREAMLINED)**4427**

Diabetes mellitus type 2

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received and been stabilised on a PBS-subsidised regimen of oral diabetic medicines which includes metformin and alogliptin.

Note

This fixed dose combination tablet is not PBS-subsidised for use in combination with a sulfonylurea (triple oral therapy), as initial therapy or in combination with a thiazolidinedione (glitazone), a glucagon-like peptide-1 or an SGLT2 inhibitor.

alogliptin 12.5 mg + metformin hydrochloride 1 g tablet, 56

10035E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	62.77	37.70	Nesina Met 12.5/1000 [TK]

alogliptin 12.5 mg + metformin hydrochloride 500 mg tablet, 56

10033C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	61.05	37.70	Nesina Met 12.5/500 [TK]

alogliptin 12.5 mg + metformin hydrochloride 850 mg tablet, 56

10032B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	62.28	37.70	Nesina Met 12.5/850 [TK]

■ LINAGLIPTIN + METFORMIN**Authority required (STREAMLINED)****4423**

Diabetes mellitus type 2

Clinical criteria:

Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with metformin; OR

Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with metformin.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor is initiated.

The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

- (a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or
- (b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

A patient whose diabetes was previously demonstrated unable to be controlled with metformin does not need to requalify on this criterion before being eligible for PBS-subsidised treatment with this fixed dose combination.

Authority required (STREAMLINED)**4448**

Diabetes mellitus type 2

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received and been stabilised on a PBS-subsidised regimen of oral diabetic medicines which includes metformin and linagliptin.

Note

This fixed dose combination tablet is not PBS-subsidised for use in combination with a sulfonylurea (triple oral therapy), as initial therapy or in combination with a thiazolidinedione (glitazone), a glucagon-like peptide-1 or an SGLT2 inhibitor.

linagliptin 2.5 mg + metformin hydrochloride 1 g tablet, 60

10044P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	66.79	37.70	Trajentamet [BY]

linagliptin 2.5 mg + metformin hydrochloride 500 mg tablet, 60

10038H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	64.93	37.70	Trajentamet [BY]

linagliptin 2.5 mg + metformin hydrochloride 850 mg tablet, 60

10045Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	66.25	37.70	Trajentamet [BY]

■ METFORMIN + GLIBENCLAMIDE**Caution**

Sulfonylureas may cause hypoglycaemia, particularly in the elderly.

metformin hydrochloride 250 mg + glibenclamide 1.25 mg tablet, 90

8838E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	14.86	16.01	Glucovance 250mg/1.25mg [AL]

metformin hydrochloride 500 mg + glibenclamide 2.5 mg tablet, 90

8810Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	15.51	16.66	Glucovance 500mg/2.5mg [AL]

metformin hydrochloride 500 mg + glibenclamide 5 mg tablet, 90

8811R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	17.02	18.17	Glucovance 500mg/5mg [AL]

■ ROSIGLITAZONE + METFORMIN**Authority required**

Diabetes mellitus type 2

Clinical criteria:

Patient must have a contraindication to a sulfonylurea; OR

Patient must not have tolerated a sulfonylurea, **AND**

Patient must have, or have had, a HbA1c measurement greater than 7% prior to the initiation of a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor despite treatment with metformin; OR

Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor despite treatment with metformin.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor is initiated.

The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

(a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or

(b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

Note

This fixed dose combination tablet is not PBS-subsidised for use in combination with a sulfonylurea (triple oral therapy), or in combination with a dipeptidyl peptidase 4 inhibitor (gliptin), a glucagon-like peptide-1, an insulin or an SGLT2 inhibitor.

rosiglitazone 2 mg + metformin hydrochloride 1 g tablet, 56

9060W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	65.06	37.70	Avandamet [GK]

rosiglitazone 2 mg + metformin hydrochloride 500 mg tablet, 56

9059T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	63.33	37.70	Avandamet [GK]

rosiglitazone 4 mg + metformin hydrochloride 1 g tablet, 56

9062Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	94.52	37.70	Avandamet [GK]

rosiglitazone 4 mg + metformin hydrochloride 500 mg tablet, 56

9061X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	92.79	37.70	Avandamet [GK]

■ SAXAGLIPTIN + METFORMIN**Authority required (STREAMLINED)****4423**

Diabetes mellitus type 2

Clinical criteria:

Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with metformin; OR

Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with metformin.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor is initiated.

The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

(a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or

(b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

A patient whose diabetes was previously demonstrated unable to be controlled with metformin does not need to requalify on this criterion before being eligible for PBS-subsidised treatment with this fixed dose combination.

Authority required (STREAMLINED)

4451

Diabetes mellitus type 2

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received and been stabilised on a PBS-subsidised regimen of oral diabetic medicines which includes metformin and saxagliptin.

Note

This fixed dose combination tablet is not PBS-subsidised for use in combination with a sulfonylurea (triple oral therapy), as initial therapy or in combination with a thiazolidinedione (glitazone), a glucagon-like peptide-1 or an SGLT2 inhibitor.

saxagliptin 2.5 mg + metformin hydrochloride 1 g tablet: modified release, 56

10048W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	62.77	37.70	Kombiglyze XR 2.5/1000 [AP]

saxagliptin 5 mg + metformin hydrochloride 1 g tablet: modified release, 28

10051B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	61.05	37.70	Kombiglyze XR 5/1000 [AP]

saxagliptin 5 mg + metformin hydrochloride 500 mg tablet: modified release, 28

10055F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	60.12	37.70	Kombiglyze XR 5/500 [AP]

■ SITAGLIPTIN + METFORMIN

Authority required (STREAMLINED)

4423

Diabetes mellitus type 2

Clinical criteria:

Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with metformin; OR

Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with metformin.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor is initiated.

The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

- (a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or
- (b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

A patient whose diabetes was previously demonstrated unable to be controlled with metformin does not need to requalify on this criterion before being eligible for PBS-subsidised treatment with this fixed dose combination.

Authority required (STREAMLINED)

4309

Diabetes mellitus type 2

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received and been stabilised on a PBS-subsidised regimen of oral diabetic medicines which includes metformin and sitagliptin.

Note

This fixed dose combination tablet is not PBS-subsidised for use in combination with a sulfonylurea (triple oral therapy), as initial therapy or in combination with a thiazolidinedione (glitazone), a glucagon-like peptide-1 or an SGLT2 inhibitor.

sitagliptin 100 mg + metformin hydrochloride 1 g tablet: modified release, 28

10089B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	61.05	37.70	Janumet XR [MK]

sitagliptin 50 mg + metformin hydrochloride 1 g tablet, 56

9451K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	62.77	37.70	Janumet [MK]

sitagliptin 50 mg + metformin hydrochloride 1 g tablet: modified release, 56

10090C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	62.77	37.70	Janumet XR [MK]

sitagliptin 50 mg + metformin hydrochloride 500 mg tablet, 56

9449H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	61.05	37.70	Janumet [MK]

sitagliptin 50 mg + metformin hydrochloride 850 mg tablet, 56

9450J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	62.28	37.70	Janumet [MK]

■ VILDAGLIPTIN + METFORMIN**Authority required (STREAMLINED)****4423**

Diabetes mellitus type 2

Clinical criteria:

Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with metformin; OR

Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with metformin.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor is initiated.

The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

(a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or
(b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

A patient whose diabetes was previously demonstrated unable to be controlled with metformin does not need to requalify on this criterion before being eligible for PBS-subsidised treatment with this fixed dose combination.

Authority required (STREAMLINED)**4308**

Diabetes mellitus type 2

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received and been stabilised on a PBS-subsidised regimen of oral diabetic medicines which includes metformin and vildagliptin.

Note

This fixed dose combination tablet is not PBS-subsidised for use in combination with a sulfonylurea (triple oral therapy), as initial therapy or in combination with a thiazolidinedione (glitazone), a glucagon-like peptide-1 or an SGLT2 inhibitor.

vildagliptin 50 mg + metformin hydrochloride 1 g tablet, 60

5476F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	63.71	37.70	Galvumet 50/1000 [NV]

vildagliptin 50 mg + metformin hydrochloride 500 mg tablet, 60

5474D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	61.85	37.70	Galvumet 50/500 [NV]

vildagliptin 50 mg + metformin hydrochloride 850 mg tablet, 60

5475E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	63.18	37.70	Galvumet 50/850 [NV]

Alpha glucosidase inhibitors

■ ACARBOSE

acarbose 100 mg tablet, 90

8189B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	45.87	37.70	Glucobay 100 [BN]

acarbose 50 mg tablet, 90

8188Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	34.87	36.02	Glucobay 50 [BN]

Thiazolidinediones

■ PIOGLITAZONE

Authority required (STREAMLINED)**4363**

Diabetes mellitus type 2

Clinical criteria:

The treatment must be in combination with metformin; OR

The treatment must be in combination with a sulfonylurea, **AND**

Patient must have a contraindication to a combination of metformin and a sulfonylurea; OR

Patient must not have tolerated a combination of metformin and a sulfonylurea, **AND**

Patient must have, or have had, a HbA1c measurement greater than 7% prior to the initiation of a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor despite treatment with either metformin or a sulfonylurea; OR

Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor despite treatment with either metformin or a sulfonylurea.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor is initiated.

The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

(a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or

(b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

Authority required (STREAMLINED)**4388**

Diabetes mellitus type 2

Clinical criteria:The treatment must be in combination with insulin, **AND**

Patient must have, or have had, a HbA1c measurement greater than 7% prior to the initiation of a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor despite treatment with insulin and oral antidiabetic agents, or insulin alone where metformin is contraindicated; OR

Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor despite treatment with insulin and oral antidiabetic agents, or insulin alone where metformin is contraindicated.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor is initiated.

The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

(a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or

(b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

Authority required (STREAMLINED)**4364**

Diabetes mellitus type 2

Clinical criteria:The treatment must be in combination with metformin, **AND**The treatment must be in combination with a sulfonylurea, **AND**

Patient must have, or have had, a HbA1c measurement greater than 7% prior to the initiation of a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor despite treatment with maximally tolerated doses of metformin and a sulfonylurea; OR

Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor despite treatment with maximally tolerated doses of metformin and a sulfonylurea.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor is initiated.

The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

- (a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or
(b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

Note

This drug is not PBS-subsidised for use as monotherapy or in combination with a dipeptidyl peptidase 4 inhibitor (gliptin), a glucagon-like peptide-1 or an SGLT2 inhibitor.

pioglitazone 15 mg tablet, 28

8694N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	24.86	26.01	^a Acpio 15 [QA] ^a APOTEX-Pioglitazone [TX] ^a Pharmacor Pioglitazone 15 [CR] ^a Pioglitazone-GA [GN] ^a Pioglitazone Sandoz [SZ] ^a Prioten 15 [DO] ^a Vexazone [AF]	^a Actos [TK] ^a Chem mart Pioglitazone [CH] ^a Pioglitazone AN [EA] ^a Pioglitazone generichealth 15 [GQ] ^a Pizaccord [RA] ^a Terry White Chemists Pioglitazone [TW]

pioglitazone 30 mg tablet, 28

8695P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	34.60	35.75	^a Acpio 30 [QA] ^a APOTEX-Pioglitazone [TX] ^a Pharmacor Pioglitazone 30 [CR] ^a Pioglitazone-GA [GN] ^a Pioglitazone Sandoz [SZ] ^a Prioten 30 [DO] ^a Vexazone [AF]	^a Actos [TK] ^a Chem mart Pioglitazone [CH] ^a Pioglitazone AN [EA] ^a Pioglitazone generichealth 30 [GQ] ^a Pizaccord [RA] ^a Terry White Chemists Pioglitazone [TW]

pioglitazone 45 mg tablet, 28

8696Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	42.74	37.70	^a Acpio 45 [QA] ^a APOTEX-Pioglitazone [TX] ^a Pharmacor Pioglitazone 45 [CR] ^a Pioglitazone-GA [GN] ^a Pioglitazone Sandoz [SZ] ^a Prioten 45 [DO] ^a Vexazone [AF]	^a Actos [TK] ^a Chem mart Pioglitazone [CH] ^a Pioglitazone AN [EA] ^a Pioglitazone generichealth 45 [GQ] ^a Pizaccord [RA] ^a Terry White Chemists Pioglitazone [TW]

■ ROSIGLITAZONE

Authority required

Diabetes mellitus type 2

Clinical criteria:

The treatment must be in combination with metformin; OR

The treatment must be in combination with a sulfonylurea, **AND**

Patient must have a contraindication to a combination of metformin and a sulfonylurea; OR

Patient must not have tolerated a combination of metformin and a sulfonylurea, **AND**

Patient must have, or have had, a HbA1c measurement greater than 7% prior to the initiation of a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor despite treatment with either metformin or a sulfonylurea; OR

Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor despite treatment with either metformin or a sulfonylurea.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor is initiated. The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

- (a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or
- (b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

Note

This drug is not PBS-subsidised for use in combination with metformin and a sulfonylurea (triple oral therapy), as monotherapy or in combination with a dipeptidyl peptidase 4 inhibitor (gliptin), a glucagon-like peptide-1, an insulin or an SGLT2 inhibitor.

rosiglitazone 4 mg tablet, 28

8689H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	61.49	37.70	Avandia [GK]

rosiglitazone 8 mg tablet, 28

8690J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	90.94	37.70	Avandia [GK]

Dipeptidyl peptidase 4 (DPP-4) inhibitors

■ ALOGLIPTIN

Authority required (STREAMLINED)

4349

Diabetes mellitus type 2

Clinical criteria:

The treatment must be in combination with metformin; OR

The treatment must be in combination with a sulfonylurea, **AND**

Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with either metformin or a sulfonylurea; OR

Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with either metformin or a sulfonylurea.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor is initiated.

The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

- (a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or
- (b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

A patient whose diabetes was previously demonstrated unable to be controlled with metformin or a sulfonylurea does not need to requalify on this criterion before being eligible for PBS-subsidised treatment with alogliptin.

Note

Alogliptin is not PBS-subsidised for use in combination with metformin and a sulfonylurea (triple oral therapy), as monotherapy or in combination with a thiazolidinedione (glitazone), a glucagon-like peptide-1 or an SGLT2 inhibitor.

alogliptin 12.5 mg tablet, 28

2933J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	59.20	37.70	Nesina [TK]

alogliptin 25 mg tablet, 28

2986E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	59.20	37.70	Nesina [TK]

alogliptin 6.25 mg tablet, 28

2944Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	59.20	37.70	Nesina [TK]

■ LINAGLIPTIN

Authority required (STREAMLINED)

4488

Diabetes mellitus type 2

Clinical criteria:

The treatment must be in combination with metformin; OR

The treatment must be in combination with a sulfonylurea, **AND**

Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with either metformin or a sulfonylurea; OR

Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with either metformin or a sulfonylurea.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor is initiated.

The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

- (a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or
- (b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

A patient whose diabetes was previously demonstrated unable to be controlled with metformin or a sulfonylurea does not need to requalify on this criterion before being eligible for PBS-subsidised treatment with linagliptin.

Note

Linagliptin is not PBS-subsidised for use in combination with metformin and a sulfonylurea (triple oral therapy), as monotherapy or in combination with a thiazolidinedione (glitazone), a glucagon-like peptide-1 or an SGLT2 inhibitor.

linagliptin 5 mg tablet, 30

3387G

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	62.95	37.70	Trajenta [BY]

■ SAXAGLIPTIN**Authority required (STREAMLINED)****4520**

Diabetes mellitus type 2

Clinical criteria:

The treatment must be in combination with metformin; OR

The treatment must be in combination with a sulfonylurea, **AND**

Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with either metformin or a sulfonylurea; OR

Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with either metformin or a sulfonylurea.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor is initiated.

The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

- (a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or
- (b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

A patient whose diabetes was previously demonstrated unable to be controlled with metformin or a sulfonylurea does not need to requalify on this criterion before being eligible for PBS-subsidised treatment with saxagliptin.

Note

Saxagliptin is not PBS-subsidised for use in combination with metformin and a sulfonylurea (triple oral therapy), as monotherapy or in combination with a thiazolidinedione (glitazone), a glucagon-like peptide-1 or an SGLT2 inhibitor.

saxagliptin 2.5 mg tablet, 28

10128C

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	59.20	37.70	Onglyza [AP]

saxagliptin 5 mg tablet, 28

8983T

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	59.20	37.70	Onglyza [AP]

■ SITAGLIPTIN

Authority required (STREAMLINED)

4519

Diabetes mellitus type 2

Clinical criteria:

The treatment must be in combination with metformin; OR

The treatment must be in combination with a sulfonylurea, **AND**

Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with either metformin or a sulfonylurea; OR

Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with either metformin or a sulfonylurea.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor is initiated.

The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

- (a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or
- (b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

A patient whose diabetes was previously demonstrated unable to be controlled with metformin or a sulfonylurea does not need to requalify on this criterion before being eligible for PBS-subsidised treatment with sitagliptin.

Note

Sitagliptin is not PBS-subsidised for use in combination with metformin and a sulfonylurea (triple oral therapy), as monotherapy or in combination with a thiazolidinedione (glitazone), a glucagon-like peptide-1 or an SGLT2 inhibitor.

sitagliptin 100 mg tablet, 28

9182G

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	59.20	37.70	Januvia [MK]

sitagliptin 25 mg tablet, 28

9180E

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	59.20	37.70	Januvia [MK]

sitagliptin 50 mg tablet, 28

9181F

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	59.20	37.70	Januvia [MK]

■ VILDAGLIPTIN

Authority required (STREAMLINED)

4467

Diabetes mellitus type 2

Clinical criteria:

The treatment must be in combination with metformin; OR

The treatment must be in combination with a sulfonylurea, **AND**

Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with either metformin or a sulfonylurea; OR

Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with either metformin or a sulfonylurea.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor is initiated.

The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

- (a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or
- (b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

A patient whose diabetes was previously demonstrated unable to be controlled with metformin or a sulfonylurea does not need to requalify on this criterion before being eligible for PBS-subsidised treatment with vildagliptin.

Note

Vildagliptin is not PBS-subsidised for use in combination with metformin and a sulfonylurea (triple oral therapy), as monotherapy or in combination with a thiazolidinedione (glitazone), a glucagon-like peptide-1 or an SGLT2 inhibitor.

vildagliptin 50 mg tablet, 60

3415R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	62.95	37.70	Galvus [NV]

Other blood glucose lowering drugs, excl. insulins

■ CANAGLIFLOZIN

Authority required

Diabetes mellitus type 2

Clinical criteria:

The treatment must be in combination with metformin; OR

The treatment must be in combination with a sulfonylurea, **AND**

The condition must not be able to be adequately controlled by treatment with metformin and a sulfonylurea, **AND**

Patient must have, or have had, a HbA1c measurement greater than 7% prior to the initiation of a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co- transporter 2 (SGLT2) inhibitor; OR

Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor is initiated.

The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

- (a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or
- (b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

This drug is not PBS subsidised for use in combination with metformin and a sulfonylurea (triple oral therapy), as monotherapy or in combination with an insulin, a thiazolidinedione (glitazone), a dipeptidyl peptidase 4 inhibitor (gliptin) or a glucagon-like peptide-1.

canagliflozin 100 mg tablet, 30

2873F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	96.61	37.70	Invokana [JC]

canagliflozin 300 mg tablet, 30

2987F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	96.61	37.70	Invokana [JC]

■ DAPAGLIFLOZIN

Authority required (STREAMLINED)

4844

Diabetes mellitus type 2

Clinical criteria:

The treatment must be in combination with metformin; OR

The treatment must be in combination with a sulfonylurea, **AND**

Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with either metformin or a sulfonylurea; OR

Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with either metformin or a sulfonylurea.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor is initiated.

The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

- (a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or
- (b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

A patient whose diabetes was previously demonstrated unable to be controlled with metformin or a sulfonylurea does not need to requalify on this criterion before being eligible for PBS-subsidised treatment with this drug.

Authority required (STREAMLINED)

4825

Diabetes mellitus type 2

Clinical criteria:

The treatment must be in combination with insulin, **AND**

Patient must have, or have had, a HbA1c measurement greater than 7% prior to the initiation of a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor despite treatment with insulin and oral antidiabetic agents, or insulin alone where metformin is contraindicated; OR Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor despite treatment with insulin and oral antidiabetic agents, or insulin alone where metformin is contraindicated.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor is initiated.

The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

- (a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or
- (b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Dapagliflozin is not PBS subsidised for use in combination with metformin and a sulfonylurea (triple oral therapy), as monotherapy or in combination with a thiazolidinedione (glitazone), a dipeptidyl peptidase 4 inhibitor (gliptin) or a glucagon-like peptide-1.

dapagliflozin 10 mg tablet, 28

10011X

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	58.66	37.70	Forxiga [AP]

▪ **EMPAGLIFLOZIN**

Authority required (STREAMLINED)

4848

Diabetes mellitus type 2

Clinical criteria:

The treatment must be in combination with metformin; OR

The treatment must be in combination with a sulfonylurea, **AND**

Patient must have, or have had, a HbA1c measurement greater than 7% despite treatment with either metformin or a sulfonylurea; OR

Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period despite treatment with either metformin or a sulfonylurea.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor is initiated.

The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

- (a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or
- (b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

A patient whose diabetes was previously demonstrated unable to be controlled with metformin or a sulfonylurea does not need to requalify on this criterion before being eligible for PBS-subsidised treatment with this drug.

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

This drug is not PBS subsidised for use in combination with metformin and a sulfonylurea (triple oral therapy), as monotherapy or in combination with an insulin, a thiazolidinedione (glitazone), a dipeptidyl peptidase 4 inhibitor (gliptin) or a glucagon-like peptide-1.

empagliflozin 10 mg tablet, 30

10206E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	62.37	37.70	Jardiance [BY]

empagliflozin 25 mg tablet, 30

10202Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	62.37	37.70	Jardiance [BY]

■ EXENATIDE

Authority required (STREAMLINED)

4856

Diabetes mellitus type 2

Clinical criteria:

The treatment must be in combination with metformin; OR

The treatment must be in combination with a sulfonylurea, **AND**

Patient must have a contraindication to a combination of metformin and a sulfonylurea; OR

Patient must not have tolerated a combination of metformin and a sulfonylurea, **AND**

Patient must have, or have had, a HbA1c measurement greater than 7% prior to the initiation of a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor despite treatment with either metformin or a sulfonylurea; OR

Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor despite treatment with either metformin or a sulfonylurea.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor is initiated.

The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

- (a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or
- (b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

Authority required (STREAMLINED)

4857

Diabetes mellitus type 2

Clinical criteria:

The treatment must be in combination with metformin, **AND**

The treatment must be in combination with a sulfonylurea, **AND**

Patient must have, or have had, a HbA1c measurement greater than 7% prior to the initiation of a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), a glucagon-like peptide-1 or a sodium-glucose co-transporter 2 (SGLT2) inhibitor despite treatment with maximally tolerated doses of metformin and a sulfonylurea; OR

Patient must have, or have had, where HbA1c measurement is clinically inappropriate, blood glucose levels greater than 10 mmol per L in more than 20% of tests over a 2 week period prior to initiation with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor despite treatment with maximally tolerated doses of metformin and a sulfonylurea.

The date and level of the qualifying HbA1c measurement must be, or must have been, documented in the patient's medical records at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor is initiated.

The HbA1c must be no more than 4 months old at the time treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor was initiated.

Blood glucose monitoring may be used as an alternative assessment to HbA1c levels in the following circumstances:

- (a) A clinical condition with reduced red blood cell survival, including haemolytic anaemias and haemoglobinopathies; and/or
- (b) Had red cell transfusion within the previous 3 months.

The results of the blood glucose monitoring, which must be no more than 4 months old at the time of initiation of treatment with a gliptin, a glitazone, a glucagon-like peptide-1 or an SGLT2 inhibitor, must be documented in the patient's medical records.

Note

This drug is not PBS-subsidised for use as monotherapy or in combination with a dipeptidyl peptidase 4 inhibitor (gliptin), a thiazolidinedione (glitazone), an insulin or an SGLT2 inhibitor.

exenatide 10 microgram/0.04 mL injection, 60 unit doses

3424F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	97.60	37.70	Byetta 10 microgram [AP]

exenatide 5 microgram/0.02 mL injection, 60 unit doses

3423E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	70.34	37.70	Byetta 5 microgram [AP]

■ **VITAMINS****VITAMIN A AND D, INCL. COMBINATIONS OF THE TWO***Vitamin D and analogues*■ **CALCITRIOL**Authority required (STREAMLINED)**1165**

Hypocalcaemia due to renal disease

Authority required (STREAMLINED)**1166**

Hypoparathyroidism

Authority required (STREAMLINED)**1167**

Hypophosphataemic rickets

Authority required (STREAMLINED)**1467**

Vitamin D-resistant rickets

Authority required (STREAMLINED)**2636**

Treatment for established osteoporosis in patients with fracture due to minimal trauma. The fracture must have been demonstrated radiologically and the year of plain x-ray or CT-scan or MRI scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body

calcitriol 0.25 microgram capsule, 100

2502Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	30.62	31.77	^a Calciprox [ER] ^a Calcitriol-GA [UA] ^a GenRx Calcitriol [GX] ^a Rocaltrol [RO]	^a Calcitriol AN [EA] ^a Calcitriol Sandoz [SZ] ^a Kosteo [QA] ^a Sical [AF]

VITAMIN B1, PLAIN AND IN COMBINATION WITH VITAMIN B6 AND B12*Vitamin B1, plain*■ **THIAMINE**Authority required (STREAMLINED)**2384**

Prophylaxis of thiamine deficiency in an Aboriginal or a Torres Strait Islander person

thiamine hydrochloride 100 mg tablet, 100

1070H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	10.45	11.60	Betavit [PP]

■ **MINERAL SUPPLEMENTS****CALCIUM***Calcium*■ **CALCIUM**Authority required (STREAMLINED)**4586**

Hyperphosphataemia

Clinical criteria:

The condition must be associated with chronic renal failure.

CALCIUM Tablet (chewable) 500 mg (as carbonate), 60

3116B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	4	1	..	*29.24	30.39	^a Cal-500 [PP]	^a Cal-Sup [IA]

CALCIUM Tablet 600 mg (as carbonate), 240

3117C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	22.54	23.69	Calci-Tab 600 [AE]

POTASSIUM*Potassium***■ POTASSIUM CHLORIDE****Note**

For item codes 2642C and 1841X, pharmaceutical benefits that have the form tablet 600 mg (sustained release) are equivalent for the purposes of substitution.

potassium chloride 600 mg (8 mmol potassium) tablet: modified release, 100 tablets

2642C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	1	..	*13.22	14.37	^a Duro-K [NM]
			^b 2.94	*16.16	14.37	^a Slow-K [NV]

potassium chloride 600 mg (8 mmol potassium) tablet: modified release, 200 tablets

1841X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	13.21	14.36	^a Span-K [AS]

■ POTASSIUM CHLORIDE + POTASSIUM BICARBONATE + POTASSIUM CARBONATE**potassium chloride 595 mg + potassium bicarbonate 384 mg + potassium carbonate 152 mg (total potassium 14 mmol) tablet: effervescent, 60**

3012M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	15.48	16.63	Chlorvescent [AS]

OTHER MINERAL SUPPLEMENTS*Magnesium***■ MAGNESIUM ASPARTATE DIHYDRATE****Authority required**

Hypomagnesaemia in an Aboriginal or a Torres Strait Islander person

Authority required

Chronic renal disease in an Aboriginal or a Torres Strait Islander person

magnesium aspartate dihydrate 500 mg (equivalent to 37.4 mg of magnesium) tablet, 50

5146W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.04	15.19	MagMin (PBS) [BB]	Mag-Sup [PP]

■ ANABOLIC AGENTS FOR SYSTEMIC USE**ANABOLIC STEROIDS***Estren derivatives***■ NANDROLONE DECANOATE****Authority required**

Monotherapy for osteoporosis, where other treatment has failed and where specialist advice confirms that this is the only suitable treatment option for the patient. Specialist advice need only be obtained for the first authority approval

Authority required

Monotherapy for osteoporosis, where other treatment is not tolerated and where specialist advice confirms that this is the only suitable treatment option for the patient. Specialist advice need only be obtained for the first authority approval

Authority required

Monotherapy for osteoporosis, where other treatment is contraindicated and where specialist advice confirms that this is the only suitable treatment option for the patient. Specialist advice need only be obtained for the first authority approval

Authority required

Patients receiving PBS-subsidised therapy with this drug for osteoporosis prior to 1 February 2004

Authority required

Patients on long-term treatment with corticosteroids

Note

Monotherapy for the treatment of osteoporosis does not exclude calcium supplementation.

nandrolone decanoate 50 mg/mL injection, 1 x 1 mL syringe

1671Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	7	..	21.54	22.69	Deca-Durabolin [AS]

OTHER ALIMENTARY TRACT AND METABOLISM PRODUCTS

OTHER ALIMENTARY TRACT AND METABOLISM PRODUCTS

Amino acids and derivatives

■ BETAINES

Authority required

Homocystinuria

Clinical criteria:

The treatment must be as adjunctive therapy to current standard care, **AND**

The condition must be treated by or in consultation with a metabolic physician.

The name of the specialist must be included in the authority application.

betaine 1 g/g oral liquid: powder for, 180 g

10119N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	5	..	570.55	37.70	Cystadane [EU]

Various alimentary tract and metabolism products

■ SAPROPTERIN

Authority required

Hyperphenylalaninaemia

Treatment Phase: Continuing

Clinical criteria:

Patient must have hyperphenylalaninaemia (HPA) due to tetrahydrobiopterin (BH4) deficiency, **AND**

Patient must have previously been issued with an authority prescription for this drug; OR

Patient must have accessed non-PBS-subsidised treatment prior to 1 May 2014.

Patient must have documented tetrahydrobiopterin (BH4) deficiency using tests for BH4 loading and/or urine pterin metabolites, blood spot dihydropteridine reductase (DHPR) and have cerebrospinal fluid neurotransmitter metabolites measured.

The authority application must be made in writing.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

sapropterin dihydrochloride 100 mg tablet: soluble, 30 tablets

10087X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	6	5	..	*5306.74	37.70	Kuvan [SG]

■ SAPROPTERIN

Authority required

Hyperphenylalaninaemia

Treatment Phase: Initial

Clinical criteria:

Patient must have hyperphenylalaninaemia (HPA) due to tetrahydrobiopterin (BH4) deficiency.

Patient must have documented tetrahydrobiopterin (BH4) deficiency using tests for BH4 loading and/or urine pterin metabolites, blood spot dihydropteridine reductase (DHPR) and have cerebrospinal fluid neurotransmitter metabolites measured.

The authority application must be made in writing.

Note

Patients will be eligible for a maximum of one script as initial therapy to enable their response to treatment with sapropterin to be assessed.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au
Applications for authority to prescribe should be forwarded to:
Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

sapropterin dihydrochloride 100 mg tablet: soluble, 30 tablets

10086W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	6	..	..	*5306.74	37.70	Kuvan [SG]

■ BLOOD AND BLOOD FORMING ORGANS

■ ANTITHROMBOTIC AGENTS

ANTITHROMBOTIC AGENTS

Vitamin K antagonists

■ WARFARIN

Caution

The listed brands have NOT been shown to be bioequivalent and should not be interchanged.

warfarin sodium 1 mg tablet, 50

2843P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	12.75	13.90	Coumadin [QA]	Marevan [FM]

warfarin sodium 2 mg tablet, 50

2209G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	13.11	14.26	Coumadin [QA]

warfarin sodium 3 mg tablet, 50

2844Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	13.03	14.18	Marevan [FM]

warfarin sodium 5 mg tablet, 50

2211J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	14.37	15.52	Coumadin [QA]	Marevan [FM]

Heparin group

■ DALTEPARIN SODIUM

dalteparin sodium 10 000 anti-Xa international units/mL injection, 10 x 1 mL syringes

8269F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	91.33	37.70	Fragmin [PF]

dalteparin sodium 12 500 anti-Xa international units/0.5 mL injection, 10 x 0.5 mL syringes

5445N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	126.03	37.70	Fragmin [PF]

dalteparin sodium 2500 anti-Xa international units/0.2 mL injection, 10 x 0.2 mL syringes

8603T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*105.08	37.70	Fragmin [PF]

dalteparin sodium 5000 anti-Xa international units/0.2 mL injection, 10 x 0.2 mL syringes

2816F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*109.22	37.70	Fragmin [PF]

dalteparin sodium 7500 anti-Xa international units/0.75 mL injection, 10 x 0.75 mL syringes

8271H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	68.72	37.70	Fragmin [PF]

■ DALTEPARIN SODIUM

Restricted benefit

Haemodialysis

dalteparin sodium 10 000 anti-Xa international units/mL injection, 10 x 1 mL syringes

1229Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*175.90	37.70	Fragmin [PF]

dalteparin sodium 12 500 anti-Xa international units/0.5 mL injection, 10 x 0.5 mL syringes

1296F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*241.62	37.70	Fragmin [PF]

dalteparin sodium 2500 anti-Xa international units/0.2 mL injection, 10 x 0.2 mL syringes

8641T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*105.08	37.70	Fragmin [PF]

dalteparin sodium 5000 anti-Xa international units/0.2 mL injection, 10 x 0.2 mL syringes

8642W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*109.22	37.70	Fragmin [PF]

dalteparin sodium 7500 anti-Xa international units/0.75 mL injection, 10 x 0.75 mL syringes

8643X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*130.68	37.70	Fragmin [PF]

■ DALTEPARIN SODIUM**Restricted benefit**

Symptomatic venous thromboembolism

Treatment Phase: Management

Clinical criteria:

Patient must have a solid tumour(s).

Note

No applications for increased maximum quantities will be authorised.

DALTEPARIN SODIUM (Low Molecular Weight Heparin Sodium-porcine mucous) Injection 15,000 units (anti-Xa) in 0.6 mL single dose pre-filled syringe, 10

8959M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*415.09	37.70	Fragmin [PF]

DALTEPARIN SODIUM (Low Molecular Weight Heparin Sodium-porcine mucous) Injection 18,000 units (anti-Xa) in 0.72 mL single dose pre-filled syringe, 10

8960N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*493.93	37.70	Fragmin [PF]

dalteparin sodium 10 000 anti-Xa international units/mL injection, 10 x 1 mL syringes

8957K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*255.40	37.70	Fragmin [PF]

dalteparin sodium 12 500 anti-Xa international units/0.5 mL injection, 10 x 0.5 mL syringes

8958L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*350.05	37.70	Fragmin [PF]

dalteparin sodium 7500 anti-Xa international units/0.75 mL injection, 10 x 0.75 mL syringes

8956J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*192.64	37.70	Fragmin [PF]

■ ENOXAPARIN SODIUM**enoxaparin sodium 100 mg/mL injection, 10 x 1 mL syringes**

8264Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	109.42	37.70	Clexane [SW]

enoxaparin sodium 20 mg/0.2 mL injection, 10 x 0.2 mL syringes

8558K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*105.08	37.70	Clexane [SW]

enoxaparin sodium 40 mg/0.4 mL injection, 10 x 0.4 mL ampoules

9195Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*109.22	37.70	Clexane [SW]

enoxaparin sodium 40 mg/0.4 mL injection, 10 x 0.4 mL syringes

8510X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*109.22	37.70	Clexane [SW]

enoxaparin sodium 60 mg/0.6 mL injection, 10 x 0.6 mL syringes

8262W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	80.02	37.70	Clexane [SW]

enoxaparin sodium 80 mg/0.8 mL injection, 10 x 0.8 mL syringes

8263X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	91.04	37.70	Clexane [SW]

▪ ENOXAPARIN SODIUM**Restricted benefit**

Haemodialysis

enoxaparin sodium 100 mg/mL injection, 10 x 1 mL syringes

5435C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*211.42	37.70	Clexane [SW]

enoxaparin sodium 20 mg/0.2 mL injection, 10 x 0.2 mL syringes

8716R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*105.08	37.70	Clexane [SW]

enoxaparin sodium 40 mg/0.4 mL injection, 10 x 0.4 mL syringes

8639Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*109.22	37.70	Clexane [SW]

enoxaparin sodium 60 mg/0.6 mL injection, 10 x 0.6 mL syringes

8640R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*153.28	37.70	Clexane [SW]

enoxaparin sodium 80 mg/0.8 mL injection, 10 x 0.8 mL syringes

5434B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*175.32	37.70	Clexane [SW]

▪ ENOXAPARIN SODIUM**Restricted benefit**

Haemodialysis

enoxaparin sodium 40 mg/0.4 mL injection, 10 x 0.4 mL ampoules

9196B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*109.22	37.70	Clexane [SW]

▪ HEPARIN SODIUM**heparin sodium 35 000 international units/35 mL injection, 1 x 35 mL vial**

1076P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	12	5	..	*380.56	37.70	Hospira Pty Limited [HH]

heparin sodium 5000 international units/0.2 mL injection, 5 x 0.2 mL ampoules

1466E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	19.44	20.59	Hospira Pty Limited [HH]

heparin sodium 5000 international units/5 mL injection, 50 x 5 mL ampoules

1463B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	71.86	37.70	Pfizer Australia Pty Ltd [PF]

*Platelet aggregation inhibitors excl. heparin***▪ ABCIXIMAB****Authority required (STREAMLINED)****4942**

Coronary artery disease

Treatment criteria:

Patient must be undergoing percutaneous coronary balloon angioplasty.

Authority required (STREAMLINED)**4943**

Coronary artery disease

Treatment criteria:

Patient must be undergoing percutaneous coronary atherectomy.

Authority required (STREAMLINED)**4915**

Coronary artery disease

Treatment criteria:

Patient must be undergoing percutaneous coronary stent placement.

abciximab 10 mg/5 mL injection, 1 x 5 mL vial

8048N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	3	..	..	*1453.45	37.70	ReoPro [LY]

■ ASPIRIN**aspirin 100 mg tablet, 112**

8202Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	8.21	9.36	^a Mayne Pharma Aspirin [YT]	^a Spren 100 [QA]
			^b 2.32	10.53	9.36	^a Astrix [YN]	

aspirin 300 mg tablet: effervescent, 96

1010E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	8.51	9.66	Solprin [RC]

■ CLOPIDOGREL**Authority required (STREAMLINED)****4166**

Acute coronary syndrome (myocardial infarction or unstable angina)

Clinical criteria:

The treatment must be in combination with aspirin.

Authority required (STREAMLINED)**4165**

Cardiac stent insertion

Clinical criteria:The treatment must be in combination with aspirin, **AND**

The treatment must follow insertion of a cardiac stent.

Note

Not for prophylaxis of deep vein thrombosis or peripheral arterial disease.

Pharmaceutical benefits that have the forms clopidogrel tablet 75 mg (as besilate) and clopidogrel tablet 75 mg (as hydrogen sulfate) are equivalent for the purposes of substitution.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

clopidogrel 75 mg tablet, 28

2275R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.70	16.85	^a Clopidogrel-GA [GN]	^a Clovix 75 [QA]
						^a Plidogrel [FM]	

clopidogrel 75 mg tablet, 28

9317J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.70	16.85	^a APO-Clopidogrel [TX]	^a Clopidogrel AN [EA]
						^a Clopidogrel Winthrop [WA]	^a Iscover [AV]
						^a Piax [AF]	^a Plavix [SW]

■ CLOPIDOGREL**Authority required (STREAMLINED)****1723**

Prevention of recurrence of myocardial infarction or unstable angina in patients where low-dose aspirin poses an unacceptable risk of gastrointestinal bleeding

Authority required (STREAMLINED)**1724**

Prevention of recurrence of myocardial infarction or unstable angina in patients where there is a history of anaphylaxis, urticaria or asthma within 4 hours of ingestion of aspirin, other salicylates, or NSAIDs

Authority required (STREAMLINED)**1719**

Prevention of recurrence of ischaemic stroke or transient cerebral ischaemic events in patients with a history of symptomatic cerebrovascular ischaemic episodes while on therapy with low-dose aspirin

Authority required (STREAMLINED)**1720**

Prevention of recurrence of ischaemic stroke or transient cerebral ischaemic events in patients where low-dose aspirin poses an unacceptable risk of gastrointestinal bleeding

Authority required (STREAMLINED)**1721**

Prevention of recurrence of ischaemic stroke or transient cerebral ischaemic events in patients where there is a history of anaphylaxis, urticaria or asthma within 4 hours of ingestion of aspirin, other salicylates, or NSAIDs

Authority required (STREAMLINED)**1722**

Prevention of recurrence of myocardial infarction or unstable angina in patients with a history of symptomatic cardiac ischaemic events while on therapy with low-dose aspirin

Note

Not for prophylaxis of DVT or peripheral arterial disease.

Pharmaceutical benefits that have the forms clopidogrel tablet 75 mg, clopidogrel tablet 75 mg (as besilate) and clopidogrel tablet 75 mg (as hydrogen sulfate) are equivalent for the purposes of substitution.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

clopidogrel 75 mg tablet, 28

5436D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	15.70	16.85	^a Clopidogrel-DRLA [RZ]

clopidogrel 75 mg tablet, 28

8358X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.70	16.85	^a APO-Clopidogrel [TX] ^a Clopidogrel AN [EA] ^a Clopidogrel Sandoz [SZ] ^a Iscover [AV] ^a Plavacor 75 [CR] ^a Terry White Chemists Clopidogrel [TW]	^a Chem mart Clopidogrel [CH] ^a Clopidogrel RBX [RA] ^a Clopidogrel Winthrop [WA] ^a Piax [AF] ^a Plavix [SW]

■ CLOPIDOGREL**Authority required (STREAMLINED)****1719**

Prevention of recurrence of ischaemic stroke or transient cerebral ischaemic events in patients with a history of symptomatic cerebrovascular ischaemic episodes while on therapy with low-dose aspirin

Authority required (STREAMLINED)**1720**

Prevention of recurrence of ischaemic stroke or transient cerebral ischaemic events in patients where low-dose aspirin poses an unacceptable risk of gastrointestinal bleeding

Authority required (STREAMLINED)**1721**

Prevention of recurrence of ischaemic stroke or transient cerebral ischaemic events in patients where there is a history of anaphylaxis, urticaria or asthma within 4 hours of ingestion of aspirin, other salicylates, or NSAIDs

Authority required (STREAMLINED)**1722**

Prevention of recurrence of myocardial infarction or unstable angina in patients with a history of symptomatic cardiac ischaemic events while on therapy with low-dose aspirin

Authority required (STREAMLINED)**1723**

Prevention of recurrence of myocardial infarction or unstable angina in patients where low-dose aspirin poses an unacceptable risk of gastrointestinal bleeding

Authority required (STREAMLINED)**1724**

Prevention of recurrence of myocardial infarction or unstable angina in patients where there is a history of anaphylaxis, urticaria or asthma within 4 hours of ingestion of aspirin, other salicylates, or NSAIDs

Note

Not for prophylaxis of DVT or peripheral arterial disease.

Pharmaceutical benefits that have the forms clopidogrel tablet 75 mg, clopidogrel tablet 75 mg (as besilate) and clopidogrel tablet 75 mg (as hydrogen sulfate) are equivalent for the purposes of substitution.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

clopidogrel 75 mg tablet, 28

9354H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.70	16.85	^a Clopidogrel Actavis [UA] ^a Clopidogrel GH [GQ] ^a Plidogrel [FM]	^a Clopidogrel-GA [GN] ^a Clovix 75 [QA]

■ CLOPIDOGREL + ASPIRIN

Authority required (STREAMLINED)

3880

Treatment of acute coronary syndrome (myocardial infarction or unstable angina)

Authority required (STREAMLINED)

3219

Treatment following cardiac stent insertion

Authority required (STREAMLINED)

1722

Prevention of recurrence of myocardial infarction or unstable angina in patients with a history of symptomatic cardiac ischaemic events while on therapy with low-dose aspirin

Note

Not for prophylaxis of DVT or peripheral arterial disease.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

clopidogrel 75 mg + aspirin 100 mg tablet, 30

9296G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	40.56	37.70	^a APO-Clopidogrel/Aspirin 75/100 [TX] ^a Clopidogrel/Aspirin Actavis 75/100 [GN] ^a CoPlavix [SW] ^a DuoPlidogrel [GZ] ^a Terry White Chemists Clopidogrel/Aspirin 75/100 [TW]	^a Chem mart Clopidogrel/Aspirin 75/100 [CH] ^a Clopidogrel Winthrop plus aspirin [WA] ^a DuoCover [AV] ^a Piax Plus Aspirin [AF]

■ DIPYRIDAMOLE

Restricted benefit

Prevention of recurrence of ischaemic stroke or transient cerebral ischaemic events as adjunctive therapy with low-dose aspirin

Restricted benefit

Prevention of recurrence of ischaemic stroke or transient cerebral ischaemic events where low-dose aspirin poses an unacceptable risk of gastrointestinal bleeding

Restricted benefit

Prevention of recurrence of ischaemic stroke or transient cerebral ischaemic events where there is a history of anaphylaxis, urticaria or asthma within 4 hours of ingestion of aspirin, other salicylates, or NSAIDs

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

dipyridamole 200 mg capsule: modified release, 60 capsules

8335Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	37.30	37.70	Persantin SR [BY]

■ DIPYRIDAMOLE + ASPIRIN

Restricted benefit

Prevention of recurrence of ischaemic stroke or transient cerebral ischaemic events

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

dipyridamole 200 mg + aspirin 25 mg capsule: modified release, 60 capsules

8382E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	32.61	33.76	^a APO-Dipyridamole/Aspirin 200/25 [TX] ^a Diasp SR [QA]	^a Asasantin SR [BY]

■ EPTIFIBATIDE

Authority required (STREAMLINED)

1884

Patients undergoing non-urgent percutaneous intervention with intracoronary stenting

eptifibatide 20 mg/10 mL injection, 1 x 10 mL vial

8683B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*262.88	37.70	Integrilin [MK]

eptifibatide 75 mg/100 mL injection, 1 x 100 mL vial

8684C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	3	..	..	*1020.70	37.70	Integrilin [MK]

■ PRASUGREL

Authority required (STREAMLINED)

3208

Treatment of acute coronary syndrome (myocardial infarction or unstable angina) managed by percutaneous coronary intervention in combination with aspirin

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

prasugrel 10 mg tablet, 28

9496T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	106.77	37.70	Effient [LY]

prasugrel 5 mg tablet, 28

9495R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	96.77	37.70	Effient [LY]

■ TICAGRELOR

Authority required (STREAMLINED)

3879

Treatment of acute coronary syndrome (myocardial infarction or unstable angina) in combination with aspirin

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

TICAGRELOR Tablet 90 mg, 56

1418P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	149.34	37.70	Brilinta [AP]

■ TIROFIBAN

Authority required (STREAMLINED)

1729

Patients with high risk unstable angina who have new transient or persistent ST-T ischaemic changes and anginal pain lasting longer than 20 minutes

Authority required (STREAMLINED)

1730

Patients with high risk unstable angina who have new transient or persistent ST-T ischaemic changes and repetitive episodes of angina at rest or during minimal exercise in the previous 12 hours

Authority required (STREAMLINED)

1275

Patients with non-Q-wave myocardial infarction

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

tirofiban 12.5 mg/50 mL injection, 1 x 50 mL vial

8350L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	309.26	37.70	^a Aggrastat [AS]	^a Tirofiban AC [GN]

*Enzymes***▪ RETEPLASE****Restricted benefit**

Treatment of acute myocardial infarction within 6 hours of onset of attack

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

reteplase 10 units (17.4 mg) injection [2 x 10 units vials] (&) inert substance diluent [2 x 10 mL syringes], 1 pack

8253J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	..	..	2067.30	37.70	Rapilysin 10 U [GN]

▪ TENECTEPLASE**Restricted benefit**

Treatment of acute myocardial infarction within 12 hours of onset of attack

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

tenecteplase 10 000 international units (50 mg) injection [1 x 50 mg vial] (&) inert substance diluent [1 x 10 mL syringe], 1 pack

8527T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	2057.40	37.70	Metalyse [BY]

tenecteplase 8000 international units (40 mg) injection [1 x 40 mg vial] (&) inert substance diluent [1 x 8 mL syringe], 1 pack

8526R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	1961.10	37.70	Metalyse [BY]

*Direct thrombin inhibitors***▪ BIVALIRUDIN****Authority required (STREAMLINED)****4919**

Coronary artery disease

Treatment criteria:

Patient must be undergoing percutaneous coronary intervention.

bivalirudin 250 mg injection, 1 x 250 mg vial

8844L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	672.09	37.70	Angiomax [XM]

▪ DABIGATRAN**Authority required (STREAMLINED)****4402**

Prevention of venous thromboembolism

Clinical criteria:

Patient must require up to 30 days supply to complete a course of treatment.

Treatment criteria:

Patient must be undergoing total hip replacement.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

dabigatran etexilate 110 mg capsule, 60

9321N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	96.25	37.70	Pradaxa [BY]

dabigatran etexilate 75 mg capsule, 60

9320M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	121.01	37.70	Pradaxa [BY]

■ DABIGATRAN**Authority required (STREAMLINED)****4369**

Prevention of venous thromboembolism

Clinical criteria:

Patient must require up to 20 days supply to complete a course of treatment.

Treatment criteria:

Patient must be undergoing total hip replacement.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

dabigatran etexilate 110 mg capsule, 10

9319L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	1	..	*37.94	37.70	Pradaxa [BY]

dabigatran etexilate 75 mg capsule, 10

9318K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	1	..	*45.88	37.70	Pradaxa [BY]

■ DABIGATRAN**Authority required (STREAMLINED)****4381**

Prevention of venous thromboembolism

Clinical criteria:

Patient must require up to 10 days of therapy.

Treatment criteria:

Patient must be undergoing total knee replacement.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

dabigatran etexilate 110 mg capsule, 10

9323Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*37.94	37.70	Pradaxa [BY]

dabigatran etexilate 75 mg capsule, 10

9322P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*45.88	37.70	Pradaxa [BY]

■ DABIGATRAN

Authority required (STREAMLINED)

4269

Prevention of stroke or systemic embolism

Clinical criteria:

Patient must have non-valvular atrial fibrillation, **AND**

Patient must have one or more risk factors for developing stroke or systemic embolism.

Risk factors for developing stroke or systemic ischaemic embolism are:

- (i) Prior stroke (ischaemic or unknown type), transient ischaemic attack or non-central nervous system (CNS) systemic embolism;
- (ii) age 75 years or older;
- (iii) hypertension;
- (iv) diabetes mellitus;
- (v) heart failure and/or left ventricular ejection fraction 35% or less.

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

dabigatran etexilate 110 mg capsule, 60

2753X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	96.25	37.70	Pradaxa [BY]

dabigatran etexilate 150 mg capsule, 60

2769R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	96.25	37.70	Pradaxa [BY]

Direct factor Xa inhibitors

■ APIXABAN

Authority required (STREAMLINED)

4402

Prevention of venous thromboembolism

Clinical criteria:

Patient must require up to 30 days supply to complete a course of treatment.

Treatment criteria:

Patient must be undergoing total hip replacement.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

apixaban 2.5 mg tablet, 60

5061J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	101.54	37.70	Eliquis [BQ]

■ APIXABAN

Authority required (STREAMLINED)

4269

Prevention of stroke or systemic embolism

Clinical criteria:

Patient must have non-valvular atrial fibrillation, **AND**

Patient must have one or more risk factors for developing stroke or systemic embolism.

Risk factors for developing stroke or systemic ischaemic embolism are:

- (i) Prior stroke (ischaemic or unknown type), transient ischaemic attack or non-central nervous system (CNS) systemic embolism;
- (ii) age 75 years or older;
- (iii) hypertension;
- (iv) diabetes mellitus;

(v) heart failure and/or left ventricular ejection fraction 35% or less.

Note**Shared Care Model:**

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

apixaban 2.5 mg tablet, 60

2744K

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	101.54	37.70	Eliquis [BQ]

apixaban 5 mg tablet, 60

2735Y

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	101.53	37.70	Eliquis [BQ]

■ APIXABAN**Authority required (STREAMLINED)****4382**

Prevention of venous thromboembolism

Clinical criteria:

Patient must require up to 15 days of therapy.

Treatment criteria:

Patient must be undergoing total knee replacement.

Authority required (STREAMLINED)**4409**

Prevention of venous thromboembolism

Clinical criteria:

Patient must require up to 15 days supply to complete a course of treatment.

Treatment criteria:

Patient must be undergoing total hip replacement.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

apixaban 2.5 mg tablet, 30

5054B

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	54.34	37.70	Eliquis [BQ]

■ APIXABAN**Authority required (STREAMLINED)****4381**

Prevention of venous thromboembolism

Clinical criteria:

Patient must require up to 10 days of therapy.

Treatment criteria:

Patient must be undergoing total knee replacement.

Authority required (STREAMLINED)**4359**

Prevention of venous thromboembolism

Clinical criteria:

Patient must require up to 10 days supply to complete a course of treatment.

Treatment criteria:

Patient must be undergoing total hip replacement.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

apixaban 2.5 mg tablet, 20

5500L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	39.79	37.70	Eliquis [BQ]

■ RIVAROXABAN

Authority required (STREAMLINED)

4369

Prevention of venous thromboembolism

Clinical criteria:

Patient must require up to 20 days supply to complete a course of treatment.

Treatment criteria:

Patient must be undergoing total hip replacement.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

rivaroxaban 10 mg tablet, 10

9465E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	39.65	37.70	Xarelto [BN]

■ RIVAROXABAN

Authority required (STREAMLINED)

4402

Prevention of venous thromboembolism

Clinical criteria:

Patient must require up to 30 days supply to complete a course of treatment.

Treatment criteria:

Patient must be undergoing total hip replacement.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

RIVAROXABAN Tablet 10 mg, 30

9467G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	101.14	37.70	Xarelto [BN]

rivaroxaban 10 mg tablet, 15

9466F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	54.16	37.70	Xarelto [BN]

■ RIVAROXABAN

Authority required (STREAMLINED)

4381

Prevention of venous thromboembolism

Clinical criteria:

Patient must require up to 10 days of therapy.

Treatment criteria:

Patient must be undergoing total knee replacement.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

rivaroxaban 10 mg tablet, 10

9468H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	39.65	37.70	Xarelto [BN]

■ RIVAROXABAN**Authority required (STREAMLINED)****4382**

Prevention of venous thromboembolism

Clinical criteria:

Patient must require up to 15 days of therapy.

Treatment criteria:

Patient must be undergoing total knee replacement.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

rivaroxaban 10 mg tablet, 15

9469J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	54.16	37.70	Xarelto [BN]

■ RIVAROXABAN**Authority required (STREAMLINED)****4269**

Prevention of stroke or systemic embolism

Clinical criteria:Patient must have non-valvular atrial fibrillation, **AND**

Patient must have one or more risk factors for developing stroke or systemic embolism.

Risk factors for developing stroke or systemic ischaemic embolism are:

- (i) Prior stroke (ischaemic or unknown type), transient ischaemic attack or non-central nervous system (CNS) systemic embolism;
- (ii) age 75 years or older;
- (iii) hypertension;
- (iv) diabetes mellitus;
- (v) heart failure and/or left ventricular ejection fraction 35% or less.

Note**Shared Care Model:**

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

rivaroxaban 15 mg tablet, 28

2691P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	94.85	37.70	Xarelto [BN]

■ RIVAROXABAN**Authority required (STREAMLINED)****4098**

Deep vein thrombosis

Treatment Phase: Initial treatment

Clinical criteria:Patient must have confirmed acute symptomatic deep vein thrombosis, **AND**

Patient must not have symptomatic pulmonary embolism.

Authority required (STREAMLINED)**4260**

Pulmonary embolism

Treatment Phase: Initial treatment

Clinical criteria:

Patient must have confirmed acute symptomatic pulmonary embolism.

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

rivaroxaban 15 mg tablet, 42

2160Q



Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	138.89	37.70	Xarelto [BN]

▪ **RIVAROXABAN**

Authority required (STREAMLINED)

4099

Deep vein thrombosis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have confirmed acute symptomatic deep vein thrombosis, **AND**

Patient must not have symptomatic pulmonary embolism.

Authority required (STREAMLINED)

4132

Prevention of recurrent venous thromboembolism

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a history of venous thromboembolism.

Authority required (STREAMLINED)

4268

Pulmonary embolism

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have confirmed acute symptomatic pulmonary embolism.

Authority required (STREAMLINED)

4269

Prevention of stroke or systemic embolism

Clinical criteria:

Patient must have non-valvular atrial fibrillation, **AND**

Patient must have one or more risk factors for developing stroke or systemic embolism.

Risk factors for developing stroke or systemic ischaemic embolism are:

(i) Prior stroke (ischaemic or unknown type), transient ischaemic attack or non-central nervous system (CNS) systemic embolism;

(ii) age 75 years or older;

(iii) hypertension;

(iv) diabetes mellitus;

(v) heart failure and/or left ventricular ejection fraction 35% or less.

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

rivaroxaban 20 mg tablet, 28

2268J



Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	94.85	37.70	Xarelto [BN]

Other antithrombotic agents

■ FONDAPARINUX

Authority required (STREAMLINED)

2005

Prevention of venous thromboembolic events in patients undergoing major hip surgery

Authority required (STREAMLINED)

2006

Prevention of venous thromboembolic events in patients undergoing total knee replacement

Note

No applications for increased maximum quantities and/or repeats will be authorised.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

FONDAPARINUX SODIUM Injection 2.5 mg in 0.5 mL single dose pre-filled syringe, 2

8775W

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
3.5	*140.88	37.70	Arixtra [AS]

■ ANTIHEMORRHAGICS

ANTIFIBRINOLYTICS

Amino acids

■ TRANEXAMIC ACID

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

tranexamic acid 500 mg tablet, 100

2180R

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	2	..	52.02	37.70	Cyklokapron [PF]

■ ANTIANEMIC PREPARATIONS

IRON PREPARATIONS

Iron bivalent, oral preparations

■ FERROUS FUMARATE

ferrous fumarate 200 mg (equivalent to 65.7 mg of elemental iron) tablet, 60

8985X

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	1	..	11.96	13.11	Ferro-tab [AE]

■ FERROUS SULFATE

ferrous sulfate 30 mg/mL (equivalent to 6 mg/mL elemental iron) oral liquid, 250 mL

8815Y

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
‡1	2	..	19.69	20.84	Ferro-Liquid [AE]

Iron, parenteral preparations

■ IRON

iron (as ferric carboxymaltose) 500 mg/10 mL injection, 1 x 10 mL vial

10104T

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
2	1	..	*317.22	37.70	ferinject [VL]

■ IRON POLYMALTOSE

iron (as polymaltose) 100 mg/2 mL injection, 5 x 2 mL ampoules

2593L

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	31.88	33.03	^a Ferrosig [SI]	^a Ferrum H [AS]

■ IRON POLYMALTOSE

Authority required (STREAMLINED)

4302

Iron deficiency anaemia

Treatment criteria:

Patient must be undergoing chronic haemodialysis.

iron (as polymaltose) 100 mg/2 mL injection, 5 x 2 mL ampoules

2805P

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	31.88	33.03	^a Ferrosig [SI]	^a Ferrum H [AS]

■ IRON SUCROSE**iron (as sucrose) 100 mg/5 mL injection, 5 x 5 mL ampoules**

10229J

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	31.88	33.03	Venofer [AS]

■ IRON SUCROSE**Authority required (STREAMLINED)****4302**

Iron deficiency anaemia

Treatment criteria:

Patient must be undergoing chronic haemodialysis.

iron (as sucrose) 100 mg/5 mL injection, 5 x 5 mL ampoules

8807M

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	31.88	33.03	Venofer [AS]

*Iron in combination with folic acid***■ FERROUS FUMARATE + FOLIC ACID****ferrous fumarate 310 mg (equivalent to 100 mg elemental iron) + folic acid 350 microgram tablet, 60**

9011G

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	1	..	13.13	14.28	Ferro-f-tab [AE]

VITAMIN B12 AND FOLIC ACID*Vitamin B12 (cyanocobalamin and analogues)***■ HYDROXOCOBALAMIN****Restricted benefit**

Pernicious anaemia

Restricted benefit

Proven vitamin B12 deficiencies other than pernicious anaemia

Restricted benefit

Anaemias associated with vitamin B12 deficiency

Clinical criteria:Patient must have had a gastrectomy, **AND**

The treatment must be for prophylaxis.

Note

One injection of hydroxocobalamin 1 mg every three months provides appropriate maintenance therapy in vitamin B12 deficiencies.

Pharmaceutical benefits that have the form hydroxocobalamin injection 1 mg (as acetate) in 1 mL and pharmaceutical benefits that have the form hydroxocobalamin injection 1 mg (as chloride) in 1 mL are equivalent for the purposes of substitution.

hydroxocobalamin 1 mg/mL injection, 3 x 1 mL ampoules

2162T

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	11.67	12.82	^a Vita-B12 [GH]

hydroxocobalamin 1 mg/mL injection, 3 x 1 mL ampoules

9048F

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	11.67	12.82	^a Hydroxo-B12 [AS]	^a Neo-B12 [HH]

*Folic acid and derivatives***■ FOLIC ACID****folic acid 500 microgram tablet, 100**

2958Q

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
2	*11.68	12.83	^a Foltabs 500 [PP]	^a Megafol 0.5 [AF]

■ FOLIC ACID

Note

The 5 mg strength tablet should be used in malabsorption states only.

folic acid 5 mg tablet, 100

1437P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	1	..	*14.36	15.51	Megafol 5 [AF]

■ BLOOD SUBSTITUTES AND PERFUSION SOLUTIONS

BLOOD AND RELATED PRODUCTS

Blood substitutes and plasma protein fractions

■ GELATIN-SUCCINYLATED

gelatin-succinylated 20 g/500 mL injection, 1 x 500 mL bag

8444K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	..	..	*46.09	37.70	Gelofusine [BR]

■ PENTASTARCH + SODIUM CHLORIDE

HYDROXYETHYL STARCH 130/0.4 I.V. infusion 30 g per 500 mL, 500 mL, 1

9487H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	..	..	*46.09	37.70	Voluven 6% [PK]

I.V. SOLUTIONS

Solutions for parenteral nutrition

■ GLUCOSE

glucose 5% (50 g/1000 mL) injection, 1 x 1000 mL bag

2245E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	5	1	..	*15.96	17.11	Baxter Healthcare Pty Ltd [BX]

glucose 5% (50 g/1000 mL) injection, 1 x 1000 mL bag

5106R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	5	..	..	*15.96	17.11	Baxter Healthcare Pty Ltd [BX]

Solutions affecting the electrolyte balance

■ LACTATE + SODIUM CHLORIDE + POTASSIUM CHLORIDE + CALCIUM CHLORIDE DIHYDRATE

lactate sodium 0.322% (3.22 g/1000 mL) + sodium chloride 0.6% (6 g/1000 mL) + potassium chloride 0.04% (400 mg/1000 mL) + calcium chloride dihydrate 0.027% (270 mg/1000 mL) injection, 1 x 1000 mL bag

2286H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	5	1	..	*14.66	15.81	Baxter Healthcare Pty Ltd [BX]

■ SODIUM CHLORIDE

sodium chloride 0.9% (9 g/1000 mL) injection, 1 x 1000 mL bag

2264E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	5	1	..	*15.21	16.36	Baxter Healthcare Pty Ltd [BX]

sodium chloride 0.9% (9 g/1000 mL) injection, 1 x 1000 mL bag

5212H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	5	..	..	*15.21	16.36	Baxter Healthcare Pty Ltd [BX]

■ SODIUM CHLORIDE + GLUCOSE

sodium chloride 0.18% (1.8 g/1000 mL) + glucose 4% (40 g/1000 mL) injection, 1 x 1000 mL bag

2281C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	5	1	..	*23.86	25.01	Baxter Healthcare Pty Ltd [BX]

sodium chloride 0.18% (1.8 g/1000 mL) + glucose 4% (40 g/1000 mL) injection, 1 x 1000 mL bag

5214K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	5	..	..	*23.86	25.01	Baxter Healthcare Pty Ltd [BX]

■ SODIUM GLUCONATE + SODIUM CHLORIDE + POTASSIUM CHLORIDE + MAGNESIUM CHLORIDE + SODIUM ACETATE TRIHYDRATE + GLUCOSE

sodium gluconate 5.02 g/1000 mL + sodium chloride 5.26 g/1000 mL + potassium chloride 370 mg/1000 mL + magnesium chloride 300 mg/1000 mL + sodium acetate trihydrate 3.68 g/1000 mL + glucose 5% (50 g/1000 mL) injection, 1 x 1000 mL bag

3199J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	1	..	*22.30	23.45	Plasma-Lyte 148 [BX]

■ OTHER HEMATOLOGICAL AGENTS

OTHER HEMATOLOGICAL AGENTS

Drugs used in hereditary angioedema

■ ICATIBANT

Authority required

Anticipated emergency treatment of an acute attack of hereditary angioedema

Treatment Phase: Initial

Clinical criteria:

Patient must have confirmed diagnosis of C1-esterase inhibitor deficiency, **AND**

Patient must have been assessed to be at significant risk of an acute attack of hereditary angioedema, **AND**

The condition must be assessed by a clinical immunologist; OR

The condition must be assessed by a respiratory physician; OR

The condition must be assessed by a specialist allergist; OR

The condition must be assessed by a general physician experienced in the management of patients with hereditary angioedema.

The name of the specialist consulted must be provided at the time of application for initial supply.

The date of the pathology report and name of the Approved Pathology Authority must be provided at the time of application.

Authority required

Anticipated emergency treatment of an acute attack of hereditary angioedema

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously been issued with an authority prescription for this drug.

Note

Icatibant should be provided in the framework of a comprehensive hereditary angioedema prophylaxis program and an emergency Action Plan including training in recognition of the symptoms of hereditary angioedema and the self-administration of icatibant. (For further information see the Australasian Society of Clinical Immunology and Allergy website at www.allergy.org.au)

ICATIBANT Injection 30 mg (as acetate) in 3 mL single use pre-filled syringe, 1

1976B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	2571.70	37.70	Firazyr [ZI]

■ CARDIOVASCULAR SYSTEM

■ CARDIAC THERAPY

CARDIAC GLYCOSIDES

Digitalis glycosides

■ DIGOXIN

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

digoxin 250 microgram tablet, 100

1322N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	11.05	12.20	^a Sigmaxin [FM]
			^b 2.94	13.99	12.20	^a Lanoxin [QA]

digoxin 50 microgram/mL oral liquid, 60 mL

3164M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*41.46	37.70	Lanoxin [QA]

digoxin 62.5 microgram tablet, 200

2605D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	10.76	11.91	^a Sigmamax-PG [FM]
			^b 2.95	13.71	11.91	^a Lanoxin-PG [QA]

ANTIARRHYTHMICS, CLASS I AND III*Antiarrhythmics, class Ia***■ DISOPYRAMIDE****Note**

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

disopyramide 100 mg capsule, 100

2923W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	29.47	30.62	Rythmodan [SW]

disopyramide 150 mg capsule, 100

2924X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	46.85	37.70	Rythmodan [SW]

*Antiarrhythmics, class Ib***■ LIGNOCAINE****Note**

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

lignocaine hydrochloride anhydrous 500 mg/5 mL injection, 10 x 5 mL ampoules

2876J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	29.93	31.08	Xylocard 500 [AP]

*Antiarrhythmics, class Ic***■ FLECAINIDE****Caution**

Flecainide acetate should be avoided in patients with poor cardiac function.

Restricted benefit

Serious supra-ventricular cardiac arrhythmias

Restricted benefit

Serious ventricular cardiac arrhythmias where treatment is initiated in a hospital (in-patient or out-patient)

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

flecainide acetate 100 mg tablet, 60

1090J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	45.03	37.70	^a Flecatan [AF]	^a Tambacor [IA]

flecainide acetate 50 mg tablet, 60

1088G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	38.07	37.70	Tambacor [IA]

*Antiarrhythmics, class III***■ AMIODARONE****Caution**

Amiodarone hydrochloride has been reported to cause frequent and potentially serious toxicity.

Regular monitoring of hepatic and thyroid function is recommended.

Restricted benefit

Severe cardiac arrhythmias

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

amiodarone hydrochloride 100 mg tablet, 30

2344J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	11.76	12.91	^a Aratac 100 [AF]	^a Cordarone X 100 [SW]

amiodarone hydrochloride 200 mg tablet, 30

2343H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.66	16.81	^a Amiodarone Actavis [GN] ^a Aratac 200 [AF] ^a Cordarone X 200 [SW] ^a Rithmik 200 [QA]	^a Amiodarone Sandoz [SZ] ^a Chem mart Amiodarone [CH] ^a GenRx Amiodarone [GX] ^a Terry White Chemists Amiodarone [TW]

▪ **SOTALOL**

Restricted benefit

Severe cardiac arrhythmias

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

sotalol hydrochloride 160 mg tablet, 60

2043M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.81	16.96	^a APO-Sotalol [TX] ^a Chem mart Sotalol [CH] ^a Solavert [QA] ^a Terry White Chemists Sotalol [TW]	^a Cardol [AF] ^a GenRx Sotalol [GX] ^a Sotalol Sandoz [SZ]
			^B 3.32	19.13	16.96	^a Sotacor [FM]	

sotalol hydrochloride 80 mg tablet, 60

8398B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	10.98	12.13	^a APO-Sotalol [TX] ^a Solavert [QA]	^a GenRx Sotalol [GX] ^a Sotalol Sandoz [SZ]
			^B 3.31	14.29	12.13	^a Sotacor [FM]	

CARDIAC STIMULANTS EXCL. CARDIAC GLYCOSIDES

Adrenergic and dopaminergic agents

▪ **ADRENALINE**

adrenaline 1 in 1000 (1 mg/mL) injection, 5 x 1 mL ampoules

1016L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	20.68	21.83	Link Medical Products Pty Ltd [LM]

adrenaline 1 in 1000 (1 mg/mL) injection, 5 x 1 mL ampoules

5004J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	20.68	21.83	Link Medical Products Pty Ltd [LM]

▪ **ADRENALINE**

Caution

EpiPen and Anapen products have different administration techniques and should not be prescribed to the same patient without training in their use.

Authority required

Acute allergic reaction with anaphylaxis

Treatment Phase: Initial sole PBS-subsidised supply for anticipated emergency treatment

Clinical criteria:

Patient must have been assessed to be at significant risk of anaphylaxis by, or in consultation with a clinical immunologist; OR

Patient must have been assessed to be at significant risk of anaphylaxis by, or in consultation with an allergist; OR

Patient must have been assessed to be at significant risk of anaphylaxis by, or in consultation with a paediatrician; OR
 Patient must have been assessed to be at significant risk of anaphylaxis by, or in consultation with a respiratory physician.
 The name of the specialist consulted must be provided at the time of application for initial supply.

Authority required

Acute allergic reaction with anaphylaxis

Treatment Phase: Initial sole PBS-subsidised supply for anticipated emergency treatment

Clinical criteria:

Patient must have been discharged from hospital or an emergency department after treatment with adrenaline for acute allergic reaction with anaphylaxis.

Authority required

Acute allergic reaction with anaphylaxis

Treatment Phase: Continuing sole PBS-subsidised supply for anticipated emergency treatment

Clinical criteria:

Patient must have previously been issued with an authority prescription for this drug.

Note

The auto-injector should be provided in the framework of a comprehensive anaphylaxis prevention program and an emergency action plan including training in recognition of the symptoms of anaphylaxis and the use of the auto-injector device. (For further information see the Australasian Society of Clinical Immunology and Allergy website at www.allergy.org.au.)

Authority approvals will be limited to a maximum quantity of 2 auto-injectors (Anapen or EpiPen) at any one time.

No applications for repeats will be authorised.

adrenaline 150 microgram/0.3 mL injection, 1 x 0.3 mL syringe

3408J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	106.34	37.70	Anapen Junior [LM]

adrenaline 150 microgram/0.3 mL injection, 1 x 0.3 mL syringe

8697R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	106.34	37.70	EpiPen Jr. [AL]

adrenaline 300 microgram/0.3 mL injection, 1 x 0.3 mL syringe

3409K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	106.34	37.70	Anapen [LM]

adrenaline 300 microgram/0.3 mL injection, 1 x 0.3 mL syringe

8698T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	106.34	37.70	EpiPen [AL]

VASODILATORS USED IN CARDIAC DISEASES*Organic nitrates***■ GLYCERYL TRINITRATE****glyceryl trinitrate 10 mg/24 hours patch, 30**

1516T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	31.22	32.37	Transiderm-Nitro 50 [NV]

glyceryl trinitrate 10 mg/24 hours patch, 30

8011P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	31.22	32.37	Nitro-Dur 10 [MK]

glyceryl trinitrate 10 mg/24 hours patch, 30

8028M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	31.22	32.37	Minitran 10 [IA]

glyceryl trinitrate 15 mg/24 hours patch, 30

8026K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	31.22	32.37	Nitro-Dur 15 [MK]

glyceryl trinitrate 15 mg/24 hours patch, 30

8119H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	31.22	32.37	Minitran 15 [IA]

glyceryl trinitrate 5 mg/24 hours patch, 30

1515R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	25.41	26.56	Transiderm-Nitro 25 [NV]

glyceryl trinitrate 5 mg/24 hours patch, 30

8010N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	25.41	26.56	Nitro-Dur 5 [MK]

glyceryl trinitrate 5 mg/24 hours patch, 30

8027L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	25.41	26.56	Minitran 5 [IA]

glyceryl trinitrate 600 microgram tablet: sublingual, 100 tablets

1459T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	15.17	16.32	^a Lycinate [FM]
			^B 2.94	18.11	16.32	^a Anginine Stabilised [QA]

glyceryl trinitrate 600 microgram tablet: sublingual, 100 tablets

5108W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	‡1	..	..	15.17	16.32	^a Lycinate [FM]
			^B 2.94	18.11	16.32	^a Anginine Stabilised [QA]

■ GLYCERYL TRINITRATE**Note**

The spray should not be inhaled.

glyceryl trinitrate 400 microgram/actuation spray, 200 actuations

8171C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	20.47	21.62	Nitrolingual Pumpspray [SW]

■ ISOSORBIDE DINITRATE**isosorbide dinitrate 5 mg tablet: sublingual, 100**

2588F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	2	..	*14.90	16.05	Isordil Sublingual [QA]

■ ISOSORBIDE MONONITRATE**isosorbide mononitrate 120 mg tablet: modified release, 30 tablets**

8273K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	16.17	17.32	^a Monodur 120 mg [PM]
			^B 3.03	19.20	17.32	^a Imdur 120 mg [AP]

isosorbide mononitrate 60 mg tablet: modified release, 30 tablets

1558B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	10.74	11.89	^a Chem mart Isosorbide Mononitrate [CH]	^a Duride [AF]
						^a GenRx Isosorbide Mononitrate [GX]	^a Imtrate 60 mg [GN]
						^a Isomonit [SZ]	^a Isosorbide AN [EA]
						^a Terry White Chemists Isosorbide Mononitrate [TW]	
			^B 2.23	12.97	11.89	^a Monodur 60 mg [PM]	
			^B 3.05	13.79	11.89	^a Imdur Durule [AP]	

Other vasodilators used in cardiac diseases

■ NICORANDIL**Note**

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

nicorandil 10 mg tablet, 60

8228C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	5	..	22.84	23.99	^a Ikorel [SW]	^a Ikotab [QA]

nicorandil 20 mg tablet, 60

8229D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	±1	5	..	29.15	30.30	^a Ikorel [SW]	^a Ikotab [QA]

■ **PERHEXILINE****Caution**

Regular monitoring of drug serum levels is recommended.

Authority required (STREAMLINED)

1023

Angina not responding to other therapy

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

perhexiline maleate 100 mg tablet, 100

1822X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	62.96	37.70	Pexsig [QA]

OTHER CARDIAC PREPARATIONS*Other cardiac preparations*■ **IVABRADINE****Authority required**

Chronic heart failure

Clinical criteria:

Patient must be symptomatic with NYHA classes II or III, **AND**

Patient must be in sinus rhythm, **AND**

Patient must have a documented left ventricular ejection fraction (LVEF) of less than or equal to 35%, **AND**

Patient must have a resting heart rate at or above 77 bpm at the time ivabradine treatment is initiated, **AND**

Patient must receive concomitant optimal standard chronic heart failure treatment, which must include the maximum tolerated dose of a beta-blocker, unless contraindicated or not tolerated.

Resting heart rate should be measured by ECG after 5 minutes rest.

The ECG result must be documented in the patient's medical records when treatment is initiated.

Note**Continuing Therapy Only:**

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

ivabradine 5 mg tablet, 56

10012Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	56.44	37.70	Coralan [SE]

ivabradine 7.5 mg tablet, 56

2960T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	56.44	37.70	Coralan [SE]

■ **ANTIHYPERTENSIVES****ANTIADRENERGIC AGENTS, CENTRALLY ACTING***Methyldopa*■ **METHYLDOPA****methyldopa 250 mg tablet, 100**

1629R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	16.88	18.03	^a Hydopa [AF]
			^B 3.54	20.42	18.03	^a Aldomet [AS]

Imidazoline receptor agonists

■ CLONIDINE

clonidine hydrochloride 100 microgram tablet, 100

3145M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	29.22	30.37	Catapres 100 [BY]

clonidine hydrochloride 150 microgram tablet, 100

3141H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	37.78	37.70	Catapres [BY]

■ MOXONIDINE

Restricted benefit

Hypertension

Clinical criteria:

Patient must be receiving concurrent antihypertensive therapy.

moxonidine 200 microgram tablet, 30

9019Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	19.87	21.02	Physiotens [GO]

moxonidine 400 microgram tablet, 30

9020R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	29.12	30.27	Physiotens [GO]

ANTIADRENERGIC AGENTS, PERIPHERALLY ACTING

Alpha-adrenoreceptor antagonists

■ PRAZOSIN

prazosin 1 mg tablet, 100

1479W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	11.00	12.15	^a APO-Prazosin [TX] ^a Minipress [PF]	^a Chem mart Prazosin [CH] ^a Terry White Chemists Prazosin [TW]

prazosin 2 mg tablet, 100

1480X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.52	14.67	^a APO-Prazosin [TX] ^a Minipress [PF]	^a Chem mart Prazosin [CH] ^a Terry White Chemists Prazosin [TW]

prazosin 5 mg tablet, 100

1478T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	18.90	20.05	^a APO-Prazosin [TX] ^a Minipress [PF]	^a Chem mart Prazosin [CH] ^a Terry White Chemists Prazosin [TW]

ARTERIOLEAR SMOOTH MUSCLE, AGENTS ACTING ON

Hydrazinophthalazine derivatives

■ HYDRALAZINE

hydralazine hydrochloride 25 mg tablet, 100

1640H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	2	..	*17.64	18.79	Alphapress 25 [AF]

hydralazine hydrochloride 50 mg tablet, 100

1639G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	2	..	*19.36	20.51	Alphapress 50 [AF]

Pyrimidine derivatives

■ MINOXIDIL

Authority required (STREAMLINED)

4906

Severe refractory hypertension

Clinical criteria:

The treatment must be initiated by a consultant physician.

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

minoxidil 10 mg tablet, 100

2313R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	60.61	37.70	Loniten [PF]

DIURETICS**LOW-CEILING DIURETICS, THIAZIDES***Thiazides, plain***HYDROCHLOROTHIAZIDE****hydrochlorothiazide 25 mg tablet, 100**

1484D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	21.58	22.73	Dithiazide [PL]

LOW-CEILING DIURETICS, EXCL. THIAZIDES*Sulfonamides, plain***CHLORTHALIDONE****chlorthalidone 25 mg tablet, 50**

1585K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	1	..	*17.92	19.07	Hygroton 25 [LM]

INDAPAMIDE**indapamide hemihydrate 1.5 mg tablet: modified release, 90 tablets**

8532C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	19.64	20.79	^a APO-Indapamide SR [TX] ^a Natrilix SR [SE] ^a Tenaxil SR [QA]	^a Chem mart Indapamide SR [CH] ^a Odaplix SR [AF] ^a Terry White Chemists Indapamide SR [TW]

indapamide hemihydrate 2.5 mg tablet, 90

2436F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	15.59	16.74	^a Chem mart Indapamide [CH] ^a GenRx Indapamide [GX] ^a Indapamide-GA [GN] ^a Insig [QA]	^a Dapa-Tabs [AF] ^a Indapamide AN [EA] ^a Indapamide Sandoz [SZ] ^a Terry White Chemists Indapamide [TW]
			^B 4.11	19.70	16.74	^a Natrilix [SE]	

HIGH-CEILING DIURETICS*Sulfonamides, plain***FRUSEMIDE****frusemide 10 mg/mL oral liquid, 30 mL**

2411X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	3	..	25.18	26.33	Lasix [SW]

frusemide 20 mg/2 mL injection, 5 x 2 mL ampoules

2413B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	8.63	9.78	^a Frusemide-Clarix [AE] ^a Lasix [SW]	^a Frusemide Sandoz [SZ]

frusemide 40 mg tablet, 100

2412Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	8.15	9.30	Urex [FM] ^a APO-Frusemide [TX] ^a Frusax [ER] ^a Frusemide Sandoz [SZ]	^a Chem mart Frusemide [CH] ^a Frusemide RBX [RA] ^a Frusid [UA]

^a GenRx Frusemide [GX]^a Terry White Chemists
Frusemide [TW]^a Uremide [AF]^B2.13 10.28 9.30 ^a Lasix [SW]**frusemide 500 mg tablet, 50**

2415D

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	3	..	14.02	15.17	Urex-Forte [FM]

FRUSEMIDE**Note**

For item codes 2414C and 1810G, pharmaceutical benefits that have the form tablet 20 mg are equivalent for the purposes of substitution.

frusemide 20 mg tablet, 100

2414C

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	1	..	8.29	9.44	^a APO-Frusemide [TX] ^a Frusemide RBX [RA] ^a GenRx Frusemide [GX]	^a Chem mart Frusemide [CH] ^a Frusid [GN] ^a Terry White Chemists Frusemide [TW]

frusemide 20 mg tablet, 50

1810G

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
2	1	..	*8.30	9.45	^a Urex-M [FM]
		^B 1.68	*9.98	9.45	^a Lasix-M [SW]

Aryloxyacetic acid derivatives**ETHACRYNIC ACID****Restricted benefit**

Patients hypersensitive to other oral diuretics

ethacrynic acid 25 mg tablet, 100

8748K

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
2	1	..	*197.64	37.70	Edecrin [FK]

POTASSIUM-SPARING AGENTS**Aldosterone antagonists****EPLERENONE****Caution**

Serum electrolytes should be checked regularly

Authority required (STREAMLINED)**4937**

Heart failure with a left ventricular ejection fraction of 40% or less

Clinical criteria:

The condition must occur within 3 to 14 days following an acute myocardial infarction, **AND**

The treatment must be commenced within 14 days of an acute myocardial infarction.

The date of the acute myocardial infarction and the date of initiation of treatment with this drug must be documented in the patient's medical records when PBS-subsidised treatment is initiated

Note**Continuing Therapy Only:**

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

eplerenone 25 mg tablet, 30

8879H

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	113.11	37.70	Inspra [PF]

eplerenone 50 mg tablet, 30

8880J

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	113.11	37.70	Inspra [PF]

SPIRONOLACTONE**Caution**

Serum electrolytes should be checked regularly.

Appropriate contraceptive measures should be taken by women of child-bearing age in whom spironolactone therapy has been initiated.

spironolactone 100 mg tablet, 100

2340E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	29.46	30.61	^a Spiractin 100 [AF]
			^b 3.16	32.62	30.61	^a Aldactone [PF]

spironolactone 25 mg tablet, 100

2339D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	12.53	13.68	^a Spiractin 25 [AF]
			^b 2.59	15.12	13.68	^a Aldactone [PF]

DIURETICS AND POTASSIUM-SPARING AGENTS IN COMBINATION*Low-ceiling diuretics and potassium-sparing agents***■ HYDROCHLOROTHIAZIDE + AMILORIDE****Caution**

Serum electrolytes should be checked regularly.

hydrochlorothiazide 50 mg + amiloride hydrochloride 5 mg tablet, 50

1486F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	1	..	*13.84	14.99	Moduretic [AS]

■ HYDROCHLOROTHIAZIDE + TRIAMTERENE**Caution**

Serum electrolytes should be checked regularly.

hydrochlorothiazide 25 mg + triamterene 50 mg tablet, 100

1280J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	13.23	14.38	Hydrene 25/50 [AF]

■ PERIPHERAL VASODILATORS**PERIPHERAL VASODILATORS***Other peripheral vasodilators***■ PHENOXYBENZAMINE****Authority required**

Phaeochromocytoma

Authority required

Neurogenic urinary retention

Note**Continuing Therapy Only:**

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

phenoxybenzamine hydrochloride 10 mg capsule, 100

1862B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	1164.81	37.70	Dibenyline [GH]

phenoxybenzamine hydrochloride 10 mg capsule, 100

9286R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	6860.58	37.70	Dibenzyllyne [BZ]

phenoxybenzamine hydrochloride 10 mg capsule, 30

1166J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*205.24	37.70	Dibenyline [GH]

■ BETA BLOCKING AGENTS**BETA BLOCKING AGENTS***Beta blocking agents, non-selective*

■ OXPRENOLOL

oxprenolol hydrochloride 40 mg tablet, 100

3961W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	48.58	37.70	Corbeton 40 [AF]

■ PINDOLOL

pindolol 15 mg tablet, 50

3065H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	16.26	17.41	Visken 15 [NV]

pindolol 5 mg tablet, 100

3062E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	30.77	31.92	Barbloc 5 [AF]

■ PROPRANOLOL

propranolol hydrochloride 10 mg tablet, 100

2565B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	10.53	11.68	Deralin 10 [AF]
			^B 3.75	14.28	11.68	Inderal [AP]

propranolol hydrochloride 160 mg tablet, 50

2899N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	12.80	13.95	Deralin 160 [AF]

propranolol hydrochloride 40 mg tablet, 100

2566C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	10.90	12.05	Deralin 40 [AF]
			^B 3.75	14.65	12.05	Inderal [AP]

Beta blocking agents, selective

■ ATENOLOL

atenolol 50 mg tablet, 30

1081X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	8.07	9.22	^a APO-Atenolol [TX]	^a Atenolol AN [EA]
						^a Atenolol-GA [GN]	^a Atenolol GH [GQ]
						^a Atenolol RBX [RA]	^a Atenolol Sandoz [SZ]
						^a Chem mart Atenolol [CH]	^a Noten [AF]
						^a Tenolten 50 [DO]	^a Tensig [QA]
						^a Terry White Chemists Atenolol [TW]	
			^B 1.96	10.03	9.22	^a Tenormin [AP]	

■ ATENOLOL

Restricted benefit

For a patient who is unable to take a solid dose form of atenolol.

atenolol 50 mg/10 mL oral liquid, 300 mL

2243C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	27.78	28.93	Atenolol-AFT [AE]

■ BISOPROLOL

Authority required (STREAMLINED)

3234

Moderate to severe heart failure in a patient stabilised on conventional therapy which must include an ACE inhibitor or Angiotensin II antagonist, if tolerated

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

bisoprolol fumarate 10 mg tablet, 28

8606Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	33.83	34.98	^a APO-Bisoprolol [TX]	^a Beprol 10 [DO]

^a Bicard 10 [QA]
^a Bisoprolol AN [EA]
^a Bisoprolol Sandoz [SZ]
^a Chem mart Bisoprolol [CH]
^a Biso 10 [GN]
^a Bisoprolol GH [GQ]
^a Bispro 10 [AF]
^a Terry White Chemists Bisoprolol [TW]

^b2.60 36.43 34.98 ^a Bicolor [AL]

bisoprolol fumarate 2.5 mg tablet, 28

8604W

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	24.08	25.23	^a APO-Bisoprolol [TX] ^a Bicard 2.5 [QA] ^a Bisoprolol AN [EA] ^a Bisoprolol Sandoz [SZ] ^a Chem mart Bisoprolol [CH]	^a Beprol 2.5 [DO] ^a Biso 2.5 [GN] ^a Bisoprolol GH [GQ] ^a Bispro 2.5 [AF] ^a Terry White Chemists Bisoprolol [TW]
^b 2.55 26.63 25.23 ^a Bicolor [AL]						

bisoprolol fumarate 5 mg tablet, 28

8605X

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	28.41	29.56	^a APO-Bisoprolol [TX] ^a Bicard 5 [QA] ^a Bisoprolol AN [EA] ^a Bisoprolol Sandoz [SZ] ^a Chem mart Bisoprolol [CH]	^a Beprol 5 [DO] ^a Biso 5 [GN] ^a Bisoprolol GH [GQ] ^a Bispro 5 [AF] ^a Terry White Chemists Bisoprolol [TW]
^b 2.55 30.96 29.56 ^a Bicolor [AL]						

■ METOPROLOL SUCCINATE**Authority required (STREAMLINED)****3234**

Moderate to severe heart failure in a patient stabilised on conventional therapy which must include an ACE inhibitor or Angiotensin II antagonist, if tolerated

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

METOPROLOL SUCCINATE Tablet 190 mg (controlled release), 30

8735R

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	93.43	37.70	^a Metrol-XL 190 [QA] ^a Toprol-XL 190 [AP]	^a Minax XL [AF]

METOPROLOL SUCCINATE Tablet 23.75 mg (controlled release), 15

8732N

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	19.04	20.19	^a Metrol-XL 23.75 [QA] ^a Toprol-XL 23.75 [AP]	^a Minax XL [AF]

METOPROLOL SUCCINATE Tablet 47.5 mg (controlled release), 30

8733P

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	62.24	37.70	^a Metrol-XL 47.5 [QA] ^a Toprol-XL 47.5 [AP]	^a Minax XL [AF]

METOPROLOL SUCCINATE Tablet 95 mg (controlled release), 30

8734Q

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	76.09	37.70	^a Metrol-XL 95 [QA] ^a Toprol-XL 95 [AP]	^a Minax XL [AF]

■ METOPROLOL TARTRATE**METOPROLOL TARTRATE Tablet 100 mg, 60**

1325R

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	10.23	11.38	^b APO-Metoprolol [TX] ^b GenRx Metoprolol [GX] ^a Metoprolol Actavis [GN] ^a Metoprolol RBX [RA] ^b Metrol 100 [QA] ^a Mistrom [ER]	^b Chem mart Metoprolol [CH] ^a Metatar [FM] ^a Metoprolol AN [EA] ^b Metoprolol Sandoz [SZ] ^b Minax 100 [AF] ^b Terry White Chemists Metoprolol [TW]

^B 2.00	12.23	11.38	^a Lopresor 100 [NV]
^B 3.76	13.99	11.38	^b Betaloc [AP]

METOPROLOL TARTRATE Tablet 50 mg, 100

1324Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	9.49	10.64	^b APO-Metoprolol [TX]	^b Chem mart Metoprolol [CH]
						^b GenRx Metoprolol [GX]	^a Metatar [FM]
						^a Metoprolol Actavis [GN]	^a Metoprolol AN [EA]
						^a Metoprolol RBX [RA]	^b Metoprolol Sandoz [SZ]
						^b Metrol 50 [QA]	^b Minax 50 [AF]
						^a Mistrom [ER]	^b Terry White Chemists Metoprolol [TW]
		^B 2.01	11.50	10.64	^a Lopresor 50 [NV]		
		^B 3.76	13.25	10.64	^b Betaloc [AP]		

■ NEBIVOLOL

Authority required (STREAMLINED)

3234

Moderate to severe heart failure in a patient stabilised on conventional therapy which must include an ACE inhibitor or Angiotensin II antagonist, if tolerated

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

nebivolol 1.25 mg tablet, 28

9316H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*50.96	37.70	Nebilet [FK]

nebivolol 10 mg tablet, 28

9312D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	68.36	37.70	Nebilet [FK]

nebivolol 5 mg tablet, 28

9311C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	61.28	37.70	Nebilet [FK]

Alpha and beta blocking agents

■ CARVEDILOL

Authority required (STREAMLINED)

3234

Moderate to severe heart failure in a patient stabilised on conventional therapy which must include an ACE inhibitor or Angiotensin II antagonist, if tolerated

Authority required (STREAMLINED)

1735

Patients receiving this drug as a pharmaceutical benefit prior to 1 August 2002

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

carvedilol 12.5 mg tablet, 60

8257N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	25.53	26.68	^a APO-Carvedilol [TX] ^a Carvedilol generichealth [GQ] ^a Chem mart Carvedilol 12.5 mg [CH] ^a Dilatrend 12.5 [RO] ^a Terry White Chemists Carvedilol 12.5 mg [TW] ^a Volirop 12.5 [DO]	^a Carvedilol AN [EA] ^a Carvedilol Sandoz [SZ] ^a Dicarz [AF] ^a GN-Carvedilol [GN] ^a Vedilol 12.5 [QA]

carvedilol 25 mg tablet, 60

8258P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	30.23	31.38	^a APO-Carvedilol [TX]	^a Carvedilol AN [EA]

- ^a Carvedilol generichealth [GQ] ^a Carvedilol Sandoz [SZ]
^a Chem mart Carvedilol 25 mg [CH] ^a Dicarz [AF]
^a Dilatrend 25 [RO] ^a GN-Carvedilol [GN]
^a Terry White Chemists Carvedilol 25 mg [TW] ^a Vedilol 25 [QA]
^a Volirop 25 [DO]

carvedilol 3.125 mg tablet, 30

8255L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	9.93	11.08	^a APO-Carvedilol [TX] ^a Chem mart Carvedilol 3.125 mg [CH] ^a GN-Carvedilol [GN] ^a Vedilol 3.125 [QA]	^a Carvedilol AN [EA] ^a Dilatrend 3.125 [RO] ^a Terry White Chemists Carvedilol 3.125 mg [TW] ^a Volirop 3.125 [DO]

carvedilol 6.25 mg tablet, 60

8256M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	21.77	22.92	^a APO-Carvedilol [TX] ^a Carvedilol generichealth [GQ] ^a Chem mart Carvedilol 6.25 mg [CH] ^a Dilatrend 6.25 [RO] ^a Terry White Chemists Carvedilol 6.25 mg [TW] ^a Volirop 6.25 [DO]	^a Carvedilol AN [EA] ^a Carvedilol Sandoz [SZ] ^a Dicarz [AF] ^a GN-Carvedilol [GN] ^a Vedilol 6.25 [QA]

LABETALOL**labetalol hydrochloride 100 mg tablet, 100**

1566K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	.. ^B 3.13	15.62 18.75	16.77 16.77	^a Presolol 100 [AF] ^a Trandate [QA]

labetalol hydrochloride 200 mg tablet, 100

1567L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	.. ^B 3.14	21.34 24.48	22.49 22.49	^a Presolol 200 [AF] ^a Trandate [QA]

CALCIUM CHANNEL BLOCKERS**SELECTIVE CALCIUM CHANNEL BLOCKERS WITH MAINLY VASCULAR EFFECTS***Dihydropyridine derivatives***AMLODIPINE****amlodipine 10 mg tablet, 30**

2752W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	9.38	10.53	^a Amlo 10 [QA] ^a Amlodipine-DRLA [RZ] ^a Amlodipine Sandoz [SZ] ^a Auro-Amlodipine 10 [DO] ^a Nordip [AF] ^a Ozlodip [RA] ^a Terry White Chemists Amlodipine [TW] ^B 6.82	^a Amlodipine AN [EA] ^a Amlodipine generichealth [GQ] ^a APO-Amlodipine [TX] ^a Chem mart Amlodipine [CH] ^a Norvapine [GN] ^a Pharmacor Amlodipine [CR] ^a Norvasc [PF]

amlodipine 5 mg tablet, 30

2751T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	8.26	9.41	^a Amlo 5 [QA] ^a Amlodipine-DRLA [RZ] ^a Amlodipine Sandoz [SZ] ^a Auro-Amlodipine 5 [DO] ^a Nordip [AF] ^a Ozlodip [RA] ^a Terry White Chemists Amlodipine [TW] ^B 4.61	^a Amlodipine AN [EA] ^a Amlodipine generichealth [GQ] ^a APO-Amlodipine [TX] ^a Chem mart Amlodipine [CH] ^a Norvapine [GN] ^a Pharmacor Amlodipine [CR] ^a Norvasc [PF]

■ FELODIPINE

felodipine 10 mg tablet: modified release, 30 tablets

2367N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.43	17.58	^a Felodil XR 10 [QA] ^a Fendex ER [AF]	^a Felodur ER 10 mg [TX]
			^b 2.76	19.19	17.58	^a Plendil ER [GX]	

felodipine 2.5 mg tablet: modified release, 30 tablets

2361G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	10.47	11.62	^a Felodur ER 2.5 mg [TX] ^a Plendil ER [GX]	^a Fendex ER [AF]
			^b 2.75	13.22	11.62		

felodipine 5 mg tablet: modified release, 30 tablets

2366M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.10	13.25	^a Felodil XR 5 [QA] ^a Fendex ER [AF]	^a Felodur ER 5 mg [TX]
			^b 2.76	14.86	13.25	^a Plendil ER [GX]	

■ LERCANIDIPINE

lercanidipine hydrochloride 10 mg tablet, 28

8534E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	9.82	10.97	^a APO-Lercanidipine [TX] ^a Ledip [RA] ^a Lercan [QA] ^a Lercanidipine Sandoz [SZ] ^a Zircol [AF]	^a Chem mart Lercanidipine [CH] ^a Lercadip [GN] ^a Lercanidipine GH [GQ] ^a Terry White Chemists Lercanidipine [TW]
			^b 2.98	12.80	10.97	^a Zandip [GO]	

lercanidipine hydrochloride 20 mg tablet, 28

8679T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	11.85	13.00	^a APO-Lercanidipine [TX] ^a Ledip [RA] ^a Lercan [QA] ^a Lercanidipine Sandoz [SZ] ^a Zircol [AF]	^a Chem mart Lercanidipine [CH] ^a Lercadip [GN] ^a Lercanidipine GH [GQ] ^a Terry White Chemists Lercanidipine [TW]
			^b 2.97	14.82	13.00	^a Zandip [GO]	

■ NIFEDIPINE

nifedipine 10 mg tablet, 60

1694E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	13.19	14.34	^a Adefin 10 [AF]
			^b 1.84	15.03	14.34	^a Adalat 10 [BN]

nifedipine 20 mg tablet, 60

1695F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.67	15.82	^a Adefin 20 [AF]	^a GenRx Nifedipine [GX]
			^b 2.57	17.24	15.82	^a Adalat 20 [BN]	

nifedipine 20 mg tablet: modified release, 30 tablets

8610E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	14.98	16.13	Adalat Oros 20mg [BN]

nifedipine 30 mg tablet: modified release, 30 tablets

1906H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.65	16.80	^a Addos XR 30 [QA] ^a APO-Nifedipine XR [TX]	^a Adefin XL 30 [AF]
			^b 2.82	18.47	16.80	^a Adalat Oros 30 [BN]	

nifedipine 60 mg tablet: modified release, 30 tablets

1907J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	17.93	19.08	^a Addos XR 60 [QA] ^a APO-Nifedipine XR [TX]	^a Adefin XL 60 [AF]
			^b 2.99	20.92	19.08	^a Adalat Oros 60 [BN]	

SELECTIVE CALCIUM CHANNEL BLOCKERS WITH DIRECT CARDIAC EFFECTS

Phenylalkylamine derivatives

■ VERAPAMIL

Caution

The myocardial depressant effects of this drug and of beta-blocking drugs are additive.

verapamil hydrochloride 160 mg capsule: modified release, 30 capsules

2206D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	12.49	13.64	Veracaps SR [QA]

verapamil hydrochloride 180 mg tablet: modified release, 30 tablets

2208F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	13.69	14.84	^a Cordilox 180 SR [GT]
			^B 3.50	17.19	14.84	^a Isoptin 180 SR [GO]

verapamil hydrochloride 240 mg capsule: modified release, 30 capsules

2207E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	16.09	17.24	Veracaps SR [QA]

verapamil hydrochloride 240 mg tablet: modified release, 30 tablets

1241H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	16.01	17.16	^a Cordilox SR [GT]
			^B 3.50	19.51	17.16	^a Isoptin SR [GO]

verapamil hydrochloride 40 mg tablet, 100

1248Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	12.36	13.51	Anpec 40 [AF]

verapamil hydrochloride 80 mg tablet, 100

1250T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	15.35	16.50	^a Anpec 80 [AF]
			^B 3.49	18.84	16.50	^a Isoptin [GO]

Benzothiazepine derivatives

■ DILTIAZEM

Caution

The myocardial depressant effects of this drug and of beta-blocking drugs are additive.

diltiazem hydrochloride 180 mg capsule: modified release, 30 capsules

1312C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.41	16.56	^a Cardizem CD [SW] ^a Diltiazem Sandoz CD [SZ] ^a Terry White Chemists Diltiazem CD [TW]	^a Chem mart Diltiazem CD [CH] ^a GenRx Diltiazem CD [GX] ^a Vasocardol CD [AV]

diltiazem hydrochloride 240 mg capsule: modified release, 30 capsules

1313D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	18.44	19.59	^a Cardizem CD [SW] ^a Diltiazem Sandoz CD [SZ] ^a Terry White Chemists Diltiazem CD [TW]	^a Chem mart Diltiazem CD [CH] ^a GenRx Diltiazem CD [GX] ^a Vasocardol CD [AV]

diltiazem hydrochloride 360 mg capsule: modified release, 30 capsules

8480H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	22.08	23.23	^a Cardizem CD [SW] ^a Vasocardol CD [AV]	^a Diltiazem Sandoz CD [SZ]

diltiazem hydrochloride 60 mg tablet, 90

1335G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.56	15.71	^a Cardizem [SW] ^a Diltiazem AN [EA] ^a Dilzem 60 mg [GN]	^a Diltiazem Actavis [UA] ^a Diltiazem Sandoz [SZ] ^a Vasocardol [AV]

■ AGENTS ACTING ON THE RENIN-ANGIOTENSIN SYSTEM

ACE INHIBITORS, PLAIN

ACE inhibitors, plain

■ CAPTOPRIL

Caution

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

captopril 12.5 mg tablet, 90

1147J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.07	13.22	^a Captopril Sandoz [SZ] ^a Zedace [AF]	^a GenRx Captopril [GX]

captopril 25 mg tablet, 90

1148K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.45	15.60	^a Captopril Sandoz [SZ] ^a Zedace [AF]	^a GenRx Captopril [GX]
			^B 4.47	18.92	15.60	^a Capoten [QA]	

captopril 50 mg tablet, 90

1149L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	21.93	23.08	^a Captopril Sandoz [SZ] ^a Zedace [AF]	^a GenRx Captopril [GX]
			^B 3.46	25.39	23.08	^a Capoten [QA]	

■ CAPTOPRIL

Restricted benefit

Patients unable to take a solid dose form of an ACE inhibitor.

Population criteria:

Patient must not be pregnant. Use of ACE inhibitors is contraindicated during pregnancy since these drugs have been associated with foetal death in utero.

captopril 5 mg/mL oral liquid, 95 mL

8760C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	112.16	37.70	Capoten [QA]

■ ENALAPRIL

Caution

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

enalapril maleate 10 mg tablet, 30

1368B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	11.38	12.53	^a Acetec [AL] ^a Auspril [QA] ^a Enalapril Actavis [UA] ^a Enalapril-GA [GN] ^a Enalapril Sandoz [SZ] ^a Malean [FM]	^a APO-Enalapril [TX] ^a Chem mart Enalapril [CH] ^a Enalapril AN [EA] ^a Enalapril generichealth [GQ] ^a GenRx Enalapril [GX] ^a Terry White Chemists Enalapril [TW]
			^B 4.07	15.45	12.53	^a Renitec [MK]	

enalapril maleate 20 mg tablet, 30

1369C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.65	13.80	^a Acetec [AL] ^a Auspril [QA] ^a Enalapril Actavis [UA] ^a Enalapril-GA [GN] ^a Enalapril Sandoz [SZ] ^a Malean [FM]	^a APO-Enalapril [TX] ^a Chem mart Enalapril [CH] ^a Enalapril AN [EA] ^a Enalapril generichealth [GQ] ^a GenRx Enalapril [GX] ^a Terry White Chemists Enalapril [TW]
			^B 4.05	16.70	13.80	^a Renitec 20 [MK]	

enalapril maleate 5 mg tablet, 30

1370D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	9.57	10.72	^a Acetec [AL] ^a Auspril [QA] ^a Enalapril Actavis [UA] ^a Enalapril-GA [GN] ^a Enalapril Sandoz [SZ] ^a Malean [FM]	^a APO-Enalapril [TX] ^a Chem mart Enalapril [CH] ^a Enalapril AN [EA] ^a Enalapril generichealth [GQ] ^a GenRx Enalapril [GX] ^a Terry White Chemists Enalapril [TW]

■ FOSINOPRIL

Caution

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

fosinopril sodium 10 mg tablet, 30

1182F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.88	14.03	^a APO-Fosinopril [TX] ^a GenRx Fosinopril [GX] ^a Monopril [BQ]	^a Fosipril 10 [QA] ^a Monace 10 [AF]

fosinopril sodium 20 mg tablet, 30

1183G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.91	17.06	^a APO-Fosinopril [TX] ^a GenRx Fosinopril [GX] ^a Monopril [BQ]	^a Fosipril 20 [QA] ^a Monace 20 [AF]

■ LISINOPRIL

Caution

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

lisinopril 10 mg tablet, 30

2457H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	11.60	12.75	^a APO-Lisinopril [TX] ^a Chem mart Lisinopril [CH] ^a Lisinopril AN [EA] ^a Lisinopril-GA [GN] ^a Lisinopril Sandoz [SZ] ^a Zinopril 10 [AL]	^a Auro-Lisinopril 10 [DO] ^a Fibsol 10 [QA] ^a Lisinopril-DRLA [RZ] ^a Lisinopril generichealth [GQ] ^a Terry White Chemists Lisinopril [TW]
			^b 2.82	14.42	12.75	^a Zestril [AP]	
			^b 3.21	14.81	12.75	^a Prinivil 10 [MK]	

lisinopril 20 mg tablet, 30

2458J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.87	14.02	^a APO-Lisinopril [TX] ^a Chem mart Lisinopril [CH] ^a Lisinopril AN [EA] ^a Lisinopril-GA [GN] ^a Lisinopril Sandoz [SZ] ^a Zinopril 20 [AL]	^a Auro-Lisinopril 20 [DO] ^a Fibsol 20 [QA] ^a Lisinopril-DRLA [RZ] ^a Lisinopril generichealth [GQ] ^a Terry White Chemists Lisinopril [TW]
			^b 2.81	15.68	14.02	^a Zestril [AP]	
			^b 3.21	16.08	14.02	^a Prinivil 20 [MK]	

lisinopril 5 mg tablet, 30

2456G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	10.00	11.15	^a APO-Lisinopril [TX] ^a Chem mart Lisinopril [CH] ^a Lisinopril AN [EA] ^a Lisinopril-GA [GN] ^a Lisinopril Sandoz [SZ] ^a Zinopril 5 [AL]	^a Auro-Lisinopril 5 [DO] ^a Fibsol 5 [QA] ^a Lisinopril-DRLA [RZ] ^a Lisinopril generichealth [GQ] ^a Terry White Chemists Lisinopril [TW]
			^b 2.82	12.82	11.15	^a Zestril [AP]	

■ PERINDOPRIL

Caution

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

Note

Pharmaceutical benefits that have the form perindopril erbumine tablet 2 mg and pharmaceutical benefits that have the form perindopril arginine tablet 2.5 mg are equivalent for the purposes of substitution.

perindopril arginine 2.5 mg tablet, 30

9006B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	^b 1.65	11.30	10.80	^a Coversyl 2.5mg [SE]	^a PREXUM 2.5 [RX]

perindopril erbumine 2 mg tablet, 30

3050M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	9.65	10.80	^a APO-Perindopril [TX] ^a Chem mart Perindopril [CH] ^a Indopril 2 [QA] ^a Ozapace [RA] ^a Perindopril Actavis 2 [UA]	^a Blooms the Chemist Perindopril [IB] ^a Idaprex 2 [SZ] ^a Indosyl Mono 2 [FM] ^a Perindo [AF] ^a Terry White Chemists Perindopril [TW]

▪ **PERINDOPRIL**

Caution

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

Note

Pharmaceutical benefits that have the form perindopril erbumine tablet 4 mg and pharmaceutical benefits that have the form perindopril arginine tablet 5 mg are equivalent for the purposes of substitution.

perindopril arginine 5 mg tablet, 30

9007C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.14	13.29	^a Coversyl 5mg [SE]	^a PREXUM 5 [RX]

perindopril erbumine 4 mg tablet, 30

3051N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.14	13.29	^a APO-Perindopril [TX] ^a Chem mart Perindopril [CH] ^a Indopril 4 [QA] ^a Ozapace [RA] ^a Perindopril Actavis 4 [UA] ^a Perindopril generichealth [GQ]	^a Blooms the Chemist Perindopril [IB] ^a Idaprex 4 [SZ] ^a Indosyl Mono 4 [FM] ^a Perindo [AF] ^a Perindopril CH [EA] ^a Terry White Chemists Perindopril [TW]

▪ **PERINDOPRIL**

Caution

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

Note

Pharmaceutical benefits that have the form perindopril erbumine tablet 8 mg and pharmaceutical benefits that have the form perindopril arginine tablet 10 mg are equivalent for the purposes of substitution.

perindopril arginine 10 mg tablet, 30

9008D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.99	16.14	^a Coversyl 10mg [SE]	^a PREXUM 10 [RX]

perindopril erbumine 8 mg tablet, 30

8704D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.99	16.14	^a APO-Perindopril [TX] ^a Chem mart Perindopril [CH] ^a Indopril 8 [QA] ^a Ozapace [RA] ^a Perindopril Actavis 8 [UA] ^a Perindopril generichealth [GQ]	^a Blooms the Chemist Perindopril [IB] ^a Idaprex 8 [SZ] ^a Indosyl Mono 8 [FM] ^a Perindo [AF] ^a Perindopril CH [EA] ^a Terry White Chemists Perindopril [TW]

▪ **QUINAPRIL**

Caution


Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

quinapril 10 mg tablet, 30

1969P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	11.90	13.05	^a Acquin Aspen 10 [AS] ^a Aquinafil [GN]	^a APO-Quinapril [TX] ^a Qpril 10 [AF]
			^B 1.30	13.20	13.05	^a Accupril [PF]	

quinapril 20 mg tablet, 30

1970Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.12	14.27	^a Acquin Aspen 20 [AS] ^a Aquinafil [GN]	^a APO-Quinapril [TX] ^a Qpril 20 [AF]

						^a Quinapril-GA [UA]	^a Quinapril generichealth [GQ]
			^B 1.30	14.42	14.27	^a Accupril [PF]	
quinapril 5 mg tablet, 30							
1968N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	10.36	11.51	^a Acquin Aspen 5 [AS] ^a Aquinafil [GN]	^a APO-Quinapril [TX] ^a Qpril 5 [AF]
			^B 1.30	11.66	11.51	^a Accupril [PF]	

■ RAMIPRIL

Caution

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

ramipril 2.5 mg tablet [7 tablets] (&) ramipril 5 mg tablet [21 tablets] (&) ramipril 10 mg capsule [10 capsules], 1 pack

8668F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
	±1	..	..	12.15	13.30	Tritace Titration Pack [SW]	

■ RAMIPRIL


Caution

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.


Note

Pharmaceutical benefits that have the form ramipril tablet 10 mg and pharmaceutical benefits that have the form ramipril capsule 10 mg are equivalent for the purposes of substitution.

ramipril 10 mg capsule, 30

8470T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	12.56	13.71	^a APO-Ramipril [TX] ^a GenRx Ramipril [GX] ^a Prilace 10 [QA] ^a Ramipril CH [EA] ^a Ramipril generichealth [GQ] ^a Ramipril Winthrop [WA] ^a Tritace 10 mg [SW] ^a Vascalace Caps 10 [DO]	^a Chem mart Ramipril [CH] ^a Pharmacor Ramipril 10 [CR] ^a Ramace 10 mg [AV] ^a Ramipril-GA [GN] ^a Ramipril Sandoz [SZ] ^a Terry White Chemists Ramipril [TW] ^a Tryzan Caps 10 [AF]

ramipril 10 mg tablet, 30

1316G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	12.56	13.71	^a APO-Ramipril [TX] ^a Ramipril AN [EA] ^a Ramipril Sandoz [SZ] ^a Terry White Chemists Ramipril [TW] ^a Tryzan Tabs 10 [AF]	^a Chem mart Ramipril [CH] ^a Ramipril RBX Tabs [RA] ^a Ramipril Winthrop [WA] ^a Tritace [SW] ^a Vascalace 10 [DO]

■ RAMIPRIL


Caution

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.


Note

Pharmaceutical benefits that have the form ramipril tablet 1.25 mg and pharmaceutical benefits that have the form ramipril capsule 1.25 mg are equivalent for the purposes of substitution.

ramipril 1.25 mg capsule, 30

9120B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	8.55	9.70	^a APO-Ramipril [TX] ^a Ramipril-GA [GN] ^a Tryzan Caps 1.25 [AF]	^a Chem mart Ramipril [CH] ^a Terry White Chemists Ramipril [TW] ^a Vascalace Caps 1.25 [DO]

ramipril 1.25 mg tablet, 30

1944H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	8.55	9.70	^a APO-Ramipril [TX] ^a Ramace 1.25 mg [AV] ^a Ramipril Sandoz [SZ] ^a Terry White Chemists Ramipril [TW] ^a Tryzan Tabs 1.25 [AF]	^a Chem mart Ramipril [CH] ^a Ramipril AN [EA] ^a Ramipril Winthrop [WA] ^a Tritace 1.25 mg [SW] ^a Vascalace 1.25 [DO]

■ RAMIPRIL

Caution

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

Note

Pharmaceutical benefits that have the form ramipril tablet 2.5 mg and pharmaceutical benefits that have the form ramipril capsule 2.5 mg are equivalent for the purposes of substitution.

ramipril 2.5 mg capsule, 30

9121C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	9.38	10.53	^a APO-Ramipril [TX] ^a Ramipril-GA [GN] ^a Terry White Chemists Ramipril [TW] ^a Vascalace Caps 2.5 [DO]	^a Chem mart Ramipril [CH] ^a Ramipril generichealth [GQ] ^a Tryzan Caps 2.5 [AF]

ramipril 2.5 mg tablet, 30

1945J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	9.38	10.53	^a APO-Ramipril [TX] ^a Prilace 2.5 [QA] ^a Ramipril AN [EA] ^a Ramipril Sandoz [SZ] ^a Terry White Chemists Ramipril [TW] ^a Tryzan Tabs 2.5 [AF]	^a Chem mart Ramipril [CH] ^a Ramace 2.5 mg [AV] ^a Ramipril RBX Tabs [RA] ^a Ramipril Winthrop [WA] ^a Tritace 2.5 mg [SW] ^a Vascalace 2.5 [DO]

■ RAMIPRIL

Caution

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

Note

Pharmaceutical benefits that have the form ramipril tablet 5 mg and pharmaceutical benefits that have the form ramipril capsule 5 mg are equivalent for the purposes of substitution.

ramipril 5 mg capsule, 30

9122D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	10.05	11.20	^a APO-Ramipril [TX] ^a Pharmacor Ramipril 5 [CR] ^a Ramipril generichealth [GQ] ^a Tryzan Caps 5 [AF]	^a Chem mart Ramipril [CH] ^a Ramipril-GA [GN] ^a Terry White Chemists Ramipril [TW] ^a Vascalace Caps 5 [DO]

ramipril 5 mg tablet, 30

1946K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	10.05	11.20	^a APO-Ramipril [TX] ^a Prilace 5 [QA] ^a Ramipril AN [EA] ^a Ramipril Sandoz [SZ] ^a Terry White Chemists Ramipril [TW] ^a Tryzan Tabs 5 [AF]	^a Chem mart Ramipril [CH] ^a Ramace 5 mg [AV] ^a Ramipril RBX Tabs [RA] ^a Ramipril Winthrop [WA] ^a Tritace 5 mg [SW] ^a Vascalace 5 [DO]

■ TRANDOLAPRIL

Caution

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

trandolapril 1 mg capsule, 28

2792Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	11.33	12.48	^a APO-Trandolapril [TX] ^a Tranalpha [AF] ^a Gopten [GO]	^a Dolapril 1 [QA] ^a Trandolapril-DP [GN]
			^B 3.09	14.42	12.48		

trandolapril 2 mg capsule, 28

2793B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.26	13.41	^a APO-Trandolapril [TX] ^a Tranalpha [AF] ^a Gopten [GO]	^a Dolapril 2 [QA] ^a Trandolapril-DP [GN]
			^B 3.10	15.36	13.41		

trandolapril 4 mg capsule, 28

8758Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	17.10	18.25	^a APO-Trandolapril [TX] ^a Tranalpha [AF]	^a Dolapril 4 [QA] ^a Trandolapril-DP [GN]
			^B 3.10	20.20	18.25	^a Gopten [GO]	

trandolapril 500 microgram capsule, 28

2791X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	8.47	9.62	^a APO-Trandolapril [TX] ^a Tranalpha [AF]	^a Dolapril 0.5 [QA] ^a Trandolapril-DP [GN]
			^B 3.11	11.58	9.62	^a Gopten [GO]	

ACE INHIBITORS, COMBINATIONS*ACE inhibitors and diuretics***■ ENALAPRIL + HYDROCHLOROTHIAZIDE****Caution**

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

Restricted benefit

Hypertension

Clinical criteria:

The treatment must not be for the initiation of anti-hypertensive therapy, **AND**

The condition must be inadequately controlled with an ACE inhibitor; OR

The condition must be inadequately controlled with a thiazide diuretic.

enalapril maleate 20 mg + hydrochlorothiazide 6 mg tablet, 30

8477E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	27.94	29.09	^a Enalapril/HCT Sandoz [SZ]	^a Renitec Plus 20/6 [MK]

■ FOSINOPRIL + HYDROCHLOROTHIAZIDE**Caution**

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

Restricted benefit

Hypertension

Clinical criteria:

The treatment must not be for the initiation of anti-hypertensive therapy, **AND**

The condition must be inadequately controlled with an ACE inhibitor; OR

The condition must be inadequately controlled with a thiazide diuretic.

fosinopril sodium 10 mg + hydrochlorothiazide 12.5 mg tablet, 30

8400D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	21.66	22.81	^a APO-Fosinopril HCTZ 10/12.5 [TX]	^a Monoplus 10/12.5 [BQ]

fosinopril sodium 20 mg + hydrochlorothiazide 12.5 mg tablet, 30

8401E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	28.64	29.79	^a APO-Fosinopril HCTZ 20/12.5 [TX] ^a Fosinopril/HCT Actavis 20/12.5 [UA]	^a Fosetic 20/12.5 [ZP] ^a Monoplus 20/12.5 [BQ]

■ PERINDOPRIL + INDAPAMIDE**Caution**

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

perindopril arginine 2.5 mg + indapamide hemihydrate 0.625 mg tablet, 30

2190G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	12.56	13.71	Coversyl Plus LD 2.5mg/0.625mg [SE]

■ PERINDOPRIL + INDAPAMIDE**Caution**

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

Restricted benefit

Hypertension

Clinical criteria:

The treatment must not be for the initiation of anti-hypertensive therapy, **AND**

The condition must be inadequately controlled with an ACE inhibitor; OR

The condition must be inadequately controlled with a thiazide-like diuretic.

Note

Pharmaceutical benefits that have the form perindopril with indapamide hemihydrate tablet (containing 4 mg perindopril erbumine-1.25 mg indapamide hemihydrate) and pharmaceutical benefits that have the form perindopril with indapamide hemihydrate tablet (containing 5 mg perindopril arginine-1.25 mg indapamide hemihydrate) are equivalent for the purposes of substitution.

perindopril arginine 5 mg + indapamide hemihydrate 1.25 mg tablet, 30

2845R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	19.80	20.95	^a Coversyl Plus 5mg/1.25mg [SE]	^a Prexum Combi 5/1.25 [RX]

perindopril erbumine 4 mg + indapamide hemihydrate 1.25 mg tablet, 30

8449Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	19.80	20.95	^a Chem mart Perindopril/ Indapamide 4/1.25 [CH] ^a Idaprex Combi 4/1.25 [SZ] ^a Perindo Combi 4/1.25 [AF] ^a Perindopril Combi Actavis 4/1.25 [GN] ^a Terry White Chemists Perindopril/ Indapamide 4/1.25 [TW]	^a GenRx Perindopril/ Indapamide 4/1.25 [GX] ^a Indosyl Combi 4/1.25 [QA] ^a Perindopril and Indapamide CH 4/1.25 [EA] ^a Perindopril/ Indapamide GH 4/1.25 [GQ]

▪ **QUINAPRIL + HYDROCHLOROTHIAZIDE**

Caution

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

Restricted benefit

Hypertension

Clinical criteria:

The treatment must not be for the initiation of anti-hypertensive therapy, **AND**

The condition must be inadequately controlled with an ACE inhibitor; OR

The condition must be inadequately controlled with a thiazide diuretic.

quinapril 10 mg + hydrochlorothiazide 12.5 mg tablet, 30

8589C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	14.13	15.28	Accuretic 10/12.5mg [PF]

quinapril 20 mg + hydrochlorothiazide 12.5 mg tablet, 30

8590D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	15.34	16.49	Accuretic 20/12.5mg [PF]

ACE inhibitors and calcium channel blockers

▪ **LERCANIDIPINE + ENALAPRIL**

Caution

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

Restricted benefit

Hypertension

Clinical criteria:

The treatment must not be for the initiation of anti-hypertensive therapy, **AND**

The condition must be inadequately controlled with an ACE inhibitor; OR

The condition must be inadequately controlled with a dihydropyridine calcium channel blocker.

lercanidipine hydrochloride 10 mg + enalapril maleate 10 mg tablet, 28

9144G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	14.13	15.28	Zan-Extra 10/10 [GO]

lercanidipine hydrochloride 10 mg + enalapril maleate 20 mg tablet, 28

9145H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	15.30	16.45	Zan-Extra 10/20 [GO]

▪ **PERINDOPRIL + AMLODIPINE**

Caution

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

Restricted benefit

Hypertension

Clinical criteria:

The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
 The condition must be inadequately controlled with an ACE inhibitor; OR
 The condition must be inadequately controlled with a dihydropyridine calcium channel blocker.

Restricted benefit

Stable coronary heart disease

Clinical criteria:

The treatment must not be for the initiation of therapy for coronary heart disease, **AND**
 The condition must be stabilised by treatment with perindopril and amlodipine at the same doses.

perindopril arginine 10 mg + amlodipine 10 mg tablet, 30

9349C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	40.60	37.70	^a Coveram 10/10 [SE]	^a Reaptan 10/10 [RX]

perindopril arginine 10 mg + amlodipine 5 mg tablet, 30

9348B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	33.28	34.43	^a Coveram 10/5 [SE]	^a Reaptan 10/5 [RX]

perindopril arginine 5 mg + amlodipine 10 mg tablet, 30

9347Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	34.79	35.94	^a Coveram 5/10 [SE]	^a Reaptan 5/10 [RX]

perindopril arginine 5 mg + amlodipine 5 mg tablet, 30

9346X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	27.45	28.60	^a Coveram 5/5 [SE]	^a Reaptan 5/5 [RX]

■ RAMIPRIL + FELODIPINE**Caution**

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

Restricted benefit

Hypertension

Clinical criteria:

The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
 The condition must be inadequately controlled with an ACE inhibitor; OR
 The condition must be inadequately controlled with a dihydropyridine calcium channel blocker.

ramipril 2.5 mg + felodipine 2.5 mg tablet: modified release, 30 tablets

2626F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	13.10	14.25	Triasyn 2.5/2.5 [SW]

ramipril 5 mg + felodipine 5 mg tablet: modified release, 30 tablets

2629J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	15.39	16.54	Triasyn 5.0/5.0 [SW]

■ TRANDOLAPRIL + VERAPAMIL**Caution**

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.
 The myocardial depressant effects of verapamil hydrochloride and of beta-blocking drugs are additive.

Restricted benefit

Hypertension

Clinical criteria:

The treatment must not be for the initiation of anti-hypertensive therapy, **AND**
 The condition must be inadequately controlled with an ACE inhibitor; OR
 The condition must be inadequately controlled with verapamil.

trandolapril 2 mg + verapamil hydrochloride 180 mg tablet: modified release, 28 tablets

9387C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	18.74	19.89	Tarka 2/180 [GO]

trandolapril 4 mg + verapamil hydrochloride 240 mg tablet: modified release, 28 tablets

2857J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	25.72	26.87	Tarka 4/240 [GO]

ANGIOTENSIN II ANTAGONISTS, PLAIN

Angiotensin II antagonists, plain

■ CANDESARTAN

candesartan cilexetil 16 mg tablet, 30

8297Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	18.97	20.12	^a Adesan [AF] ^a Auro-Candesartan 16 [DO] ^a Candesartan Aspen 16 [QA] ^a Candesartan GH [GQ] ^a Candesartan Sandoz [SZ] ^a Pharmacor Candesartan 16 [CR]	^a APO-Candesartan [TX] ^a Candesartan AN [EA] ^a Candesartan-GA [GN] ^a Candesartan RBX [RA] ^a Chem mart Candesartan [CH] ^a Terry White Chemists Candesartan [TW]
			^B 1.59	20.56	20.12	^a Atacand [AP]	

candesartan cilexetil 32 mg tablet, 30

8889W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	21.53	22.68	^a Adesan [AF] ^a Auro-Candesartan 32 [DO] ^a Candesartan Aspen 32 [QA] ^a Candesartan GH [GQ] ^a Candesartan Sandoz [SZ] ^a Pharmacor Candesartan 32 [CR]	^a APO-Candesartan [TX] ^a Candesartan AN [EA] ^a Candesartan-GA [GN] ^a Candesartan RBX [RA] ^a Chem mart Candesartan [CH] ^a Terry White Chemists Candesartan [TW]
			^B 1.57	23.10	22.68	^a Atacand [AP]	

candesartan cilexetil 4 mg tablet, 30

8295N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	8.13	9.28	^a Adesan [AF] ^a Auro-Candesartan 4 [DO] ^a Candesartan Aspen 4 [QA] ^a Candesartan GH [GQ] ^a Candesartan Sandoz [SZ] ^a Pharmacor Candesartan 4 [CR]	^a APO-Candesartan [TX] ^a Candesartan AN [EA] ^a Candesartan-GA [GN] ^a Candesartan RBX [RA] ^a Chem mart Candesartan [CH] ^a Terry White Chemists Candesartan [TW]
			^B 1.59	9.72	9.28	^a Atacand [AP]	

candesartan cilexetil 8 mg tablet, 30

8296P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	10.84	11.99	^a Adesan [AF] ^a Auro-Candesartan 8 [DO] ^a Candesartan Aspen 8 [QA] ^a Candesartan GH [GQ] ^a Candesartan Sandoz [SZ] ^a Pharmacor Candesartan 8 [CR]	^a APO-Candesartan [TX] ^a Candesartan AN [EA] ^a Candesartan-GA [GN] ^a Candesartan RBX [RA] ^a Chem mart Candesartan [CH] ^a Terry White Chemists Candesartan [TW]
			^B 1.58	12.42	11.99	^a Atacand [AP]	

■ EPROSARTAN

eprosartan 400 mg tablet, 28

8397Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	^T 3.50	*24.48	22.13	Teveten [GO]

eprosartan 600 mg tablet, 28

8447N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	^T 3.50	28.07	25.72	Teveten [GO]

■ EPROSARTAN

Authority required

Adverse effects occurring with all of the base-priced drugs

Authority required

Drug interactions occurring with all of the base-priced drugs

Authority required

Drug interactions expected to occur with all of the base-priced drugs

Authority required

Transfer to a base-priced drug would cause patient confusion resulting in problems with compliance

eprosartan 400 mg tablet, 28

8951D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*24.48	25.63	Teveten [GO]

eprosartan 600 mg tablet, 28

5491B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	28.07	29.22	Teveten [GO]

■ IRBESARTAN**irbesartan 150 mg tablet, 30**

8247C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	11.88	13.03	^a Abisart [AF] ^a Avapro [AV] ^a Irbesartan Actavis 150 [UA] ^a Irbesartan-DRLA [RZ] ^a Irbesartan GH [GQ] ^a Irbesartan Sandoz [SZ] ^a Irprestan 150 [ZP] ^a Karvea [SW]	^a APO-Irbesartan [TX] ^a Chem mart Irbesartan [CH] ^a Irbesartan AN [EA] ^a Irbesartan-GA [GN] ^a Irbesartan RBX [RA] ^a Irbesartan Winthrop [WA] ^a Karbesat 150 [QA] ^a Terry White Chemists Irbesartan [TW]

irbesartan 300 mg tablet, 30

8248D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.98	18.13	^a Abisart [AF] ^a Avapro [AV] ^a Irbesartan Actavis 300 [UA] ^a Irbesartan-DRLA [RZ] ^a Irbesartan GH [GQ] ^a Irbesartan Sandoz [SZ] ^a Irprestan 300 [ZP] ^a Karvea [SW]	^a APO-Irbesartan [TX] ^a Chem mart Irbesartan [CH] ^a Irbesartan AN [EA] ^a Irbesartan-GA [GN] ^a Irbesartan RBX [RA] ^a Irbesartan Winthrop [WA] ^a Karbesat 300 [QA] ^a Terry White Chemists Irbesartan [TW]

irbesartan 75 mg tablet, 30

8246B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	10.35	11.50	^a Abisart [AF] ^a Avapro [AV] ^a Irbesartan Actavis 75 [UA] ^a Irbesartan-DRLA [RZ] ^a Irbesartan GH [GQ] ^a Irbesartan Sandoz [SZ] ^a Irprestan 75 [ZP] ^a Karvea [SW]	^a APO-Irbesartan [TX] ^a Chem mart Irbesartan [CH] ^a Irbesartan AN [EA] ^a Irbesartan-GA [GN] ^a Irbesartan RBX [RA] ^a Irbesartan Winthrop [WA] ^a Karbesat 75 [QA] ^a Terry White Chemists Irbesartan [TW]

■ LOSARTAN**losartan potassium 25 mg tablet, 30**

5452Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	13.05	14.20	Cozavan [AF]

losartan potassium 50 mg tablet, 30

8203R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*24.74	25.89	Cozavan [AF]

■ OLMESARTAN MEDOXOMIL**olmesartan medoxomil 20 mg tablet, 30**

2147B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	^T 3.49	19.44	17.10	Olmotec [MK]

olmesartan medoxomil 40 mg tablet, 30

2148C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	^T 3.50	29.75	27.40	Olmotec [MK]

■ OLMESARTAN MEDOXOMIL**Authority required**

Adverse effects occurring with all of the base-priced drugs

Authority required

Drug interactions occurring with all of the base-priced drugs

Authority required

Drug interactions expected to occur with all of the base-priced drugs

Authority required

Transfer to a base-priced drug would cause patient confusion resulting in problems with compliance

olmesartan medoxomil 20 mg tablet, 30

5492C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	19.44	20.59	Olmetec [MK]

olmesartan medoxomil 40 mg tablet, 30

5493D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	29.75	30.90	Olmetec [MK]

■ **TELMISARTAN**

telmisartan 40 mg tablet, 28

8355R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.28	14.43	^a APO-Telmisartan [TX] ^a Micardis [BY] ^a Pharmacor Telmisartan 40 [CR] ^a Telmisartan AN [EA] ^a Telmisartan GH [GQ] ^a Telmisartan Sandoz [SZ] ^a Terry White Chemists Telmisartan [TW]	^a Chem mart Telmisartan [CH] ^a Mizart [AF] ^a Telmigen [GN] ^a Telmisartan-DRLA [RZ] ^a Telmisartan RBX [RA] ^a Teltartan [QA]

telmisartan 80 mg tablet, 28

8356T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	25.65	26.80	^a APO-Telmisartan [TX] ^a Micardis [BY] ^a Pharmacor Telmisartan 80 [CR] ^a Telmisartan AN [EA] ^a Telmisartan GH [GQ] ^a Telmisartan Sandoz [SZ] ^a Terry White Chemists Telmisartan [TW]	^a Chem mart Telmisartan [CH] ^a Mizart [AF] ^a Telmigen [GN] ^a Telmisartan-DRLA [RZ] ^a Telmisartan RBX [RA] ^a Teltartan [QA]

■ **VALSARTAN**

valsartan 160 mg tablet, 28

9370E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	19.90	21.05	^a APO-Valsartan [TX] ^a Diovan [NV]	^a Dilart [AF]

valsartan 40 mg tablet, 28

9368C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	13.79	14.94	^a APO-Valsartan [TX] ^a Diovan [NV]	^a Dilart [AF]

valsartan 80 mg tablet, 28

9369D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	17.00	18.15	^a APO-Valsartan [TX] ^a Diovan [NV]	^a Dilart [AF]

■ **VALSARTAN**

Note

No applications for increased maximum quantities and/or repeats will be authorised for the 320 mg tablet.

valsartan 320 mg tablet, 28

9371F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	23.61	24.76	^a APO-Valsartan [TX] ^a Diovan [NV]	^a Dilart [AF]

ANGIOTENSIN II ANTAGONISTS, COMBINATIONS

Angiotensin II antagonists and diuretics

■ **CANDESARTAN + HYDROCHLOROTHIAZIDE**

Restricted benefit

Hypertension

Clinical criteria:The treatment must not be for the initiation of anti-hypertensive therapy, **AND**

The condition must be inadequately controlled with an angiotensin II antagonist; OR

The condition must be inadequately controlled with a thiazide diuretic.

candesartan cilexetil 16 mg + hydrochlorothiazide 12.5 mg tablet, 30

8504N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	22.84	23.99	^a Adesan HCT 16/12.5 [AF]	^a APO-Candesartan HCTZ 16/12.5 [TX]
						^a Candesartan Combi Aspen 16/12.5 [QA]	^a Candesartan HCT GH 16/12.5 [GQ]
						^a Candesartan/HCT Sandoz [SZ]	^a Candesartan HCTZ AN 16/12.5 [EA]
						^a Candesartan HCTZ-GA 16/12.5 [GN]	^a Candesartan HCTZ RBX 16/12.5 [RA]
						^a Chem mart Candesartan HCTZ 16/12.5 [CH]	^a Pharmacor Candesartan HCT 16/12.5 [CR]
						^a Terry White Chemists Candesartan HCTZ 16/12.5 [TW]	
			^b 2.00	24.84	23.99	^a Atacand Plus 16/12.5 [AP]	

candesartan cilexetil 32 mg + hydrochlorothiazide 12.5 mg tablet, 30

9314F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	25.88	27.03	^a Adesan HCT 32/12.5 [AF]	^a APO-Candesartan HCTZ 32/12.5 [TX]
						^a Candesartan Combi Aspen 32/12.5 [QA]	^a Candesartan HCT GH 32/12.5 [GQ]
						^a Candesartan/HCT Sandoz [SZ]	^a Candesartan HCTZ AN 32/12.5 [EA]
						^a Candesartan HCTZ-GA 32/12.5 [GN]	^a Candesartan HCTZ RBX 32/12.5 [RA]
						^a Chem mart Candesartan HCTZ 32/12.5 [CH]	^a Pharmacor Candesartan HCT 32/12.5 [CR]
						^a Terry White Chemists Candesartan HCTZ 32/12.5 [TW]	
			^b 2.02	27.90	27.03	^a Atacand Plus 32/12.5 [AP]	

candesartan cilexetil 32 mg + hydrochlorothiazide 25 mg tablet, 30

9315G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	27.33	28.48	^a Adesan HCT 32/25 [AF]	^a APO-Candesartan HCTZ 32/25 [TX]
						^a Candesartan Combi Aspen 32/25 [QA]	^a Candesartan HCT GH 32/25 [GQ]
						^a Candesartan/HCT Sandoz [SZ]	^a Candesartan HCTZ AN 32/25 [EA]
						^a Candesartan HCTZ-GA 32/25 [GN]	^a Candesartan HCTZ RBX 32/25 [RA]
						^a Chem mart Candesartan HCTZ 32/25 [CH]	^a Pharmacor Candesartan HCT 32/25 [CR]
						^a Terry White Chemists Candesartan HCTZ 32/25 [TW]	
			^b 2.00	29.33	28.48	^a Atacand Plus 32/25 [AP]	

■ EPROSARTAN + HYDROCHLOROTHIAZIDE**Restricted benefit**

Hypertension

Clinical criteria:The treatment must not be for the initiation of anti-hypertensive therapy, **AND**

The condition must be inadequately controlled with an angiotensin II antagonist; OR

The condition must be inadequately controlled with a thiazide diuretic.

eprosartan 600 mg + hydrochlorothiazide 12.5 mg tablet, 28

8624X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	26.64	27.79	Teveten Plus 600/12.5 [GO]

■ IRBESARTAN + HYDROCHLOROTHIAZIDE**Restricted benefit**

Hypertension

Clinical criteria:

The treatment must not be for the initiation of anti-hypertensive therapy, **AND**

The condition must be inadequately controlled with an angiotensin II antagonist; OR

The condition must be inadequately controlled with a thiazide diuretic.

irbesartan 150 mg + hydrochlorothiazide 12.5 mg tablet, 30

8404H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.89	15.04	^a Abisart HCT 150/12.5 [AF] ^a Avapro HCT 150/12.5 [AV] ^a Irbesartan HCT Actavis 150/12.5 [UA] ^a Irbesartan/HCT Sandoz [SZ] ^a Irbesartan HCTZ AN 150/12.5 [EA] ^a Irbesartan/HCTZ RBX 150/12.5 [RA] ^a KSART HCT 150/12.5 [QA]	^a APO-Irbesartan HCTZ [TX] ^a Chem mart Irbesartan HCTZ [CH] ^a Irbesartan HCT GH 150/12.5 [GQ] ^a Irbesartan HCT Winthrop 150/12.5 [WA] ^a Irbesartan HCTZ-GA 150/12.5 [GN] ^a Karvezide 150/12.5 [SW] ^a Terry White Chemists Irbesartan HCTZ [TW]

irbesartan 300 mg + hydrochlorothiazide 12.5 mg tablet, 30

8405J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	19.86	21.01	^a Abisart HCT 300/12.5 [AF] ^a Avapro HCT 300/12.5 [AV] ^a Irbesartan HCT Actavis 300/12.5 [UA] ^a Irbesartan/HCT Sandoz [SZ] ^a Irbesartan HCTZ AN 300/12.5 [EA] ^a Irbesartan/HCTZ RBX 300/12.5 [RA] ^a KSART HCT 300/12.5 [QA]	^a APO-Irbesartan HCTZ [TX] ^a Chem mart Irbesartan HCTZ [CH] ^a Irbesartan HCT GH 300/12.5 [GQ] ^a Irbesartan HCT Winthrop 300/12.5 [WA] ^a Irbesartan HCTZ-GA 300/12.5 [GN] ^a Karvezide 300/12.5 [SW] ^a Terry White Chemists Irbesartan HCTZ [TW]

irbesartan 300 mg + hydrochlorothiazide 25 mg tablet, 30

2136K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	21.02	22.17	^a Abisart HCT 300/25 [AF] ^a Avapro HCT 300/25 [AV] ^a Irbesartan HCT Actavis 300/25 [UA] ^a Irbesartan/HCT Sandoz [SZ] ^a Irbesartan HCTZ AN 300/25 [EA] ^a Irbesartan/HCTZ RBX 300/25 [RA] ^a KSART HCT 300/25 [QA]	^a APO-Irbesartan HCTZ [TX] ^a Chem mart Irbesartan HCTZ [CH] ^a Irbesartan HCT GH 300/25 [GQ] ^a Irbesartan HCT Winthrop 300/25 [WA] ^a Irbesartan HCTZ-GA 300/25 [GN] ^a Karvezide 300/25 [SW] ^a Terry White Chemists Irbesartan HCTZ [TW]

■ OLMESARTAN MEDOXOMIL + HYDROCHLOROTHIAZIDE**Restricted benefit**

Hypertension

Clinical criteria:

The treatment must not be for the initiation of anti-hypertensive therapy, **AND**

The condition must be inadequately controlled with an angiotensin II antagonist; OR

The condition must be inadequately controlled with a thiazide diuretic.

olmesartan medoxomil 20 mg + hydrochlorothiazide 12.5 mg tablet, 30

2161R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	18.16	19.31	Olmotec Plus [MK]

olmesartan medoxomil 40 mg + hydrochlorothiazide 12.5 mg tablet, 30

2166B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	28.46	29.61	Olmotec Plus [MK]

olmesartan medoxomil 40 mg + hydrochlorothiazide 25 mg tablet, 30

2170F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	30.70	31.85	Olmotec Plus [MK]

■ TELMISARTAN + HYDROCHLOROTHIAZIDE**Restricted benefit**

Hypertension

Clinical criteria:The treatment must not be for the initiation of anti-hypertensive therapy, **AND**

The condition must be inadequately controlled with an angiotensin II antagonist; OR

The condition must be inadequately controlled with a thiazide diuretic.

telmisartan 40 mg + hydrochlorothiazide 12.5 mg tablet, 28

8622T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.02	16.17	^a APO-Telmisartan HCTZ 40/12.5 [TX] ^a Micardis Plus 40/12.5 mg [BY] ^a Pritor Plus 40/12.5 mg [FI] ^a Telmisartan HCT GH 40/12.5 [GQ] ^a Telmisartan HCTZ AN 40/12.5 [EA] ^a Terry White Chemists Telmisartan HCTZ 40/12.5 [TW]	^a Chem mart Telmisartan HCTZ 40/12.5 [CH] ^a Mizart HCT 40/12.5 mg [AF] ^a Telmigen HCT 40/12.5 [GN] ^a Telmisartan/HCT Sandoz [SZ] ^a Teltartan HCT 40/12.5 [QA]

telmisartan 80 mg + hydrochlorothiazide 12.5 mg tablet, 28

8623W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	27.40	28.55	^a APO-Telmisartan HCTZ 80/12.5 [TX] ^a Micardis Plus 80/12.5 mg [BY] ^a Pritor Plus 80/12.5 mg [FI] ^a Telmisartan HCT GH 80/12.5 [GQ] ^a Telmisartan HCTZ AN 80/12.5 [EA] ^a Terry White Chemists Telmisartan HCTZ 80/12.5 [TW]	^a Chem mart Telmisartan HCTZ 80/12.5 [CH] ^a Mizart HCT 80/12.5 mg [AF] ^a Telmigen HCT 80/12.5 [GN] ^a Telmisartan/HCT Sandoz [SZ] ^a Teltartan HCT 80/12.5 [QA]

telmisartan 80 mg + hydrochlorothiazide 25 mg tablet, 28

9381R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	29.14	30.29	^a APO-Telmisartan HCTZ 80/25 [TX] ^a Micardis Plus 80/25 mg [BY] ^a Pritor Plus 80/25 mg [FI] ^a Telmisartan HCT GH 80/25 [GQ] ^a Telmisartan HCTZ AN 80/25 [EA] ^a Terry White Chemists Telmisartan HCTZ 80/25 [TW]	^a Chem mart Telmisartan HCTZ 80/25 [CH] ^a Mizart HCT 80/25 mg [AF] ^a Telmigen HCT 80/25 [GN] ^a Telmisartan/HCT Sandoz [SZ] ^a Teltartan HCT 80/25 [QA]

■ VALSARTAN + HYDROCHLOROTHIAZIDE**Restricted benefit**

Hypertension

Clinical criteria:The treatment must not be for the initiation of anti-hypertensive therapy, **AND**

The condition must be inadequately controlled with an angiotensin II antagonist; OR

The condition must be inadequately controlled with a thiazide diuretic.

valsartan 160 mg + hydrochlorothiazide 12.5 mg tablet, 28

9373H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	21.65	22.80	^a APO-Valsartan HCTZ 160/12.5 [TX] ^a Dilart HCT 160/12.5 [AF]	^a Co-Diovan 160/12.5 [NV]

valsartan 160 mg + hydrochlorothiazide 25 mg tablet, 28

9374J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	23.39	24.54	^a Co-Diovan 160/25 [NV]	^a Dilart HCT 160/25 [AF]

valsartan 80 mg + hydrochlorothiazide 12.5 mg tablet, 28

9372G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	18.74	19.89	Co-Diovan 80/12.5 [NV]

■ VALSARTAN + HYDROCHLOROTHIAZIDE**Restricted benefit**

Hypertension

Clinical criteria:The treatment must not be for the initiation of anti-hypertensive therapy, **AND**

The condition must be inadequately controlled with an angiotensin II antagonist; OR

The condition must be inadequately controlled with a thiazide diuretic.

Note

No applications for increased maximum quantities and/or repeats will be authorised for the tablets containing 320 mg valsartan.

valsartan 320 mg + hydrochlorothiazide 12.5 mg tablet, 28

9481B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	25.36	26.51	^a APO-Valsartan HCTZ 320/12.5 [TX] ^a Dilart HCT 320/12.5 [AF]	^a Co-Diovan 320/12.5 [NV]

valsartan 320 mg + hydrochlorothiazide 25 mg tablet, 28

9482C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	27.10	28.25	^a APO-Valsartan HCTZ 320/25 [TX] ^a Dilart HCT 320/25 [AF]	^a Co-Diovan 320/25 [NV]

Angiotensin II antagonists and calcium channel blockers**■ AMLODIPINE + VALSARTAN****Restricted benefit**

Hypertension

Clinical criteria:The treatment must not be for the initiation of anti-hypertensive therapy, **AND**

The condition must be inadequately controlled with an angiotensin II antagonist; OR

The condition must be inadequately controlled with a dihydropyridine calcium channel blocker.

amlodipine 10 mg + valsartan 160 mg tablet, 28

9377M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	28.98	30.13	Exforge 10/160 [NV]

amlodipine 10 mg + valsartan 320 mg tablet, 28

5460J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	32.81	33.96	Exforge 10/320 [NV]

amlodipine 5 mg + valsartan 160 mg tablet, 28

9376L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	25.44	26.59	Exforge 5/160 [NV]

amlodipine 5 mg + valsartan 320 mg tablet, 28

5459H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	29.28	30.43	Exforge 5/320 [NV]

amlodipine 5 mg + valsartan 80 mg tablet, 28

9375K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	22.37	23.52	^a Exforge 5/80 [NV]	^a Valsartan/Amlodipine Sandoz 80/5 [NM]

■ OLMESARTAN MEDOXOMIL + AMLODIPINE**Restricted benefit**

Hypertension

Clinical criteria:The treatment must not be for the initiation of anti-hypertensive therapy, **AND**

The condition must be inadequately controlled with an angiotensin II antagonist; OR

The condition must be inadequately controlled with a dihydropyridine calcium channel blocker.

olmesartan medoxomil 20 mg + amlodipine 5 mg tablet, 30

5292M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	17.44	18.59	Sevikar 20/5 [MK]

olmesartan medoxomil 40 mg + amlodipine 10 mg tablet, 30

5294P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	28.86	30.01	Sevikar 40/10 [MK]

olmesartan medoxomil 40 mg + amlodipine 5 mg tablet, 30

5293N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	27.75	28.90	Sevikar 40/5 [MK]

■ TELMISARTAN + AMLODIPINE**Restricted benefit**

Hypertension

Clinical criteria:The treatment must not be for the initiation of anti-hypertensive therapy, **AND**

The condition must be inadequately controlled with an angiotensin II antagonist; OR

The condition must be inadequately controlled with a dihydropyridine calcium channel blocker.

telmisartan 40 mg + amlodipine 10 mg tablet, 28

8979N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.66	17.81	^a Pritor/Amlodipine [FI]	^a Twynsta [BY]

telmisartan 40 mg + amlodipine 5 mg tablet, 28

8978M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.21	16.36	^a Pritor/Amlodipine [FI]	^a Twynsta [BY]

telmisartan 80 mg + amlodipine 10 mg tablet, 28

8981Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	29.05	30.20	^a Pritor/Amlodipine [FI]	^a Twynsta [BY]

telmisartan 80 mg + amlodipine 5 mg tablet, 28

8980P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	27.60	28.75	^a Pritor/Amlodipine [FI]	^a Twynsta [BY]

*Angiotensin II antagonists, other combinations***■ AMLODIPINE + VALSARTAN + HYDROCHLOROTHIAZIDE****Restricted benefit**

Hypertension

Clinical criteria:The treatment must not be for the initiation of anti-hypertensive therapy, **AND**

The condition must be inadequately controlled with concomitant treatment with two of the following: an angiotensin II antagonist, a dihydropyridine calcium channel blocker or a thiazide diuretic.

amlodipine 10 mg + valsartan 160 mg + hydrochlorothiazide 12.5 mg tablet, 28

5287G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	30.71	31.86	Exforge HCT 10/160/12.5 [NV]

amlodipine 10 mg + valsartan 160 mg + hydrochlorothiazide 25 mg tablet, 28

5288H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	32.45	33.60	Exforge HCT 10/160/25 [NV]

amlodipine 10 mg + valsartan 320 mg + hydrochlorothiazide 25 mg tablet, 28

5289J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	36.32	37.47	Exforge HCT 10/320/25 [NV]

amlodipine 5 mg + valsartan 160 mg + hydrochlorothiazide 12.5 mg tablet, 28

5285E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	27.17	28.32	^a Exforge HCT 5/160/12.5 [NV]	^a Valsartan/Amlodipine/HCT Sandoz 160/5/12.5 [NM]

amlodipine 5 mg + valsartan 160 mg + hydrochlorothiazide 25 mg tablet, 28

5286F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	28.92	30.07	Exforge HCT 5/160/25 [NV]

■ OLMESARTAN + AMLODIPINE + HYDROCHLOROTHIAZIDE

Restricted benefit

Hypertension

Clinical criteria:

The treatment must not be for the initiation of anti-hypertensive therapy, **AND**

The condition must be inadequately controlled with concomitant treatment with two of the following: an angiotensin II antagonist, a dihydropyridine calcium channel blocker or a thiazide diuretic.

olmesartan medoxomil 20 mg + amlodipine 5 mg + hydrochlorothiazide 12.5 mg tablet, 30

10005N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	19.67	20.82	Sevikar HCT 20/5/12.5 [MK]

olmesartan medoxomil 40 mg + amlodipine 10 mg + hydrochlorothiazide 12.5 mg tablet, 30

2836G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	31.09	32.24	Sevikar HCT 40/10/12.5 [MK]

olmesartan medoxomil 40 mg + amlodipine 10 mg + hydrochlorothiazide 25 mg tablet, 30

2953K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	33.33	34.48	Sevikar HCT 40/10/25 [MK]

olmesartan medoxomil 40 mg + amlodipine 5 mg + hydrochlorothiazide 12.5 mg tablet, 30

2880N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	29.97	31.12	Sevikar HCT 40/5/12.5 [MK]

olmesartan medoxomil 40 mg + amlodipine 5 mg + hydrochlorothiazide 25 mg tablet, 30

2864R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	32.20	33.35	Sevikar HCT 40/5/25 [MK]

■ LIPID MODIFYING AGENTS

LIPID MODIFYING AGENTS, PLAIN

HMG CoA reductase inhibitors

■ ATORVASTATIN

Restricted benefit

For use in patients that meet the criteria set out in the General Statement for Lipid-Lowering Drugs

atorvastatin 10 mg tablet, 30

8213G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	11.41	12.56	^a APO-Atorvastatin [TX] ^a Atorvastatin AN [EA] ^a Atorvastatin Pfizer [FZ] ^a Atorvastatin SCP 10 [RZ] ^a Blooms the Chemist Atorvastatin [IB] ^a Lipitor [PF] ^a Terry White Chemists Atorvastatin [TW] ^a Trovas [RA]	^a Atorvachol [GN] ^a Atorvastatin GH [GQ] ^a Atorvastatin Sandoz [SZ] ^a Atorvastatin SZ [HX] ^a Chem mart Atorvastatin [CH] ^a Lorstat 10 [AF] ^a Torvastat 10 [QA]

atorvastatin 20 mg tablet, 30

8214H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.63	14.78	^a APO-Atorvastatin [TX] ^a Atorvastatin AN [EA] ^a Atorvastatin Pfizer [FZ] ^a Atorvastatin SCP 20 [RZ] ^a Blooms the Chemist Atorvastatin [IB] ^a Lipitor [PF] ^a Terry White Chemists Atorvastatin [TW] ^a Trovas [RA]	^a Atorvachol [GN] ^a Atorvastatin GH [GQ] ^a Atorvastatin Sandoz [SZ] ^a Atorvastatin SZ [HX] ^a Chem mart Atorvastatin [CH] ^a Lorstat 20 [AF] ^a Torvastat 20 [QA]

atorvastatin 40 mg tablet, 30

8215J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.43	17.58	^a APO-Atorvastatin [TX] ^a Atorvastatin AN [EA] ^a Atorvastatin Pfizer [FZ]	^a Atorvachol [GN] ^a Atorvastatin GH [GQ] ^a Atorvastatin Sandoz [SZ]

^a Atorvastatin SCP 40 [RZ]	^a Atorvastatin SZ [HX]
^a Blooms the Chemist Atorvastatin [IB]	^a Chem mart Atorvastatin [CH]
^a Lipitor [PF]	^a Lorstat 40 [AF]
^a Terry White Chemists Atorvastatin [TW]	^a Torvastat 40 [QA]
^a Trovas [RA]	

atorvastatin 80 mg tablet, 30

8521L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	20.58	21.73	^a APO-Atorvastatin [TX] ^a Atorvastatin AN [EA] ^a Atorvastatin Pfizer [FZ] ^a Atorvastatin SCP 80 [RZ] ^a Blooms the Chemist Atorvastatin [IB] ^a Lipitor [PF] ^a Terry White Chemists Atorvastatin [TW] ^a Trovas [RA]	^a Atorvachol [GN] ^a Atorvastatin GH [GQ] ^a Atorvastatin Sandoz [SZ] ^a Atorvastatin SZ [HX] ^a Chem mart Atorvastatin [CH] ^a Lorstat 80 [AF] ^a Torvastat 80 [QA]

■ ATORVASTATIN**Restricted benefit**

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs, and who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

No applications for increased maximum quantities and/or repeats will be authorised.

atorvastatin 10 mg tablet, 30

9230T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	11.41	12.56	^a APO-Atorvastatin [TX] ^a Atorvastatin AN [EA] ^a Atorvastatin Pfizer [FZ] ^a Atorvastatin SCP 10 [RZ] ^a Blooms the Chemist Atorvastatin [IB] ^a Lipitor [PF] ^a Terry White Chemists Atorvastatin [TW] ^a Trovas [RA]	^a Atorvachol [GN] ^a Atorvastatin GH [GQ] ^a Atorvastatin Sandoz [SZ] ^a Atorvastatin SZ [HX] ^a Chem mart Atorvastatin [CH] ^a Lorstat 10 [AF] ^a Torvastat 10 [QA]

atorvastatin 20 mg tablet, 30

9231W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	13.63	14.78	^a APO-Atorvastatin [TX] ^a Atorvastatin AN [EA] ^a Atorvastatin Pfizer [FZ] ^a Atorvastatin SCP 20 [RZ] ^a Blooms the Chemist Atorvastatin [IB] ^a Lipitor [PF] ^a Terry White Chemists Atorvastatin [TW] ^a Trovas [RA]	^a Atorvachol [GN] ^a Atorvastatin GH [GQ] ^a Atorvastatin Sandoz [SZ] ^a Atorvastatin SZ [HX] ^a Chem mart Atorvastatin [CH] ^a Lorstat 20 [AF] ^a Torvastat 20 [QA]

atorvastatin 40 mg tablet, 30

9232X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	16.43	17.58	^a APO-Atorvastatin [TX] ^a Atorvastatin AN [EA] ^a Atorvastatin Pfizer [FZ] ^a Atorvastatin SCP 40 [RZ] ^a Blooms the Chemist Atorvastatin [IB] ^a Lipitor [PF] ^a Terry White Chemists Atorvastatin [TW] ^a Trovas [RA]	^a Atorvachol [GN] ^a Atorvastatin GH [GQ] ^a Atorvastatin Sandoz [SZ] ^a Atorvastatin SZ [HX] ^a Chem mart Atorvastatin [CH] ^a Lorstat 40 [AF] ^a Torvastat 40 [QA]

atorvastatin 80 mg tablet, 30

9233Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	20.58	21.73	^a APO-Atorvastatin [TX] ^a Atorvastatin AN [EA] ^a Atorvastatin Pfizer [FZ] ^a Atorvastatin SCP 80 [RZ] ^a Blooms the Chemist Atorvastatin [IB] ^a Lipitor [PF] ^a Terry White Chemists Atorvastatin [TW] ^a Trovas [RA]	^a Atorvachol [GN] ^a Atorvastatin GH [GQ] ^a Atorvastatin Sandoz [SZ] ^a Atorvastatin SZ [HX] ^a Chem mart Atorvastatin [CH] ^a Lorstat 80 [AF] ^a Torvastat 80 [QA]

▪ **FLUVASTATIN**

Restricted benefit

For use in patients that meet the criteria set out in the General Statement for Lipid-Lowering Drugs

fluvastatin 20 mg capsule, 28

8023G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	25.80	26.95	^a Lescol [NV]
			^B 3.09	28.89	26.95	^a Vastin [NM]

fluvastatin 40 mg capsule, 28

8024H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	30.11	31.26	^a Lescol [NV]
			^B 3.38	33.49	31.26	^a Vastin [NM]

fluvastatin 80 mg tablet: modified release, 28 tablets

2863Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	45.76	37.70	Lescol XL [NV]

▪ **FLUVASTATIN**

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs, and who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

No applications for increased maximum quantities and/or repeats will be authorised.

fluvastatin 20 mg capsule, 28

9234B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	11	..	25.80	26.95	^a Lescol [NV]
			^B 3.09	28.89	26.95	^a Vastin [NM]

fluvastatin 40 mg capsule, 28

9235C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	11	..	30.11	31.26	^a Lescol [NV]
			^B 3.38	33.49	31.26	^a Vastin [NM]

fluvastatin 80 mg tablet: modified release, 28 tablets

9236D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	11	..	45.76	37.70	Lescol XL [NV]

▪ **PRAVASTATIN**

Restricted benefit

For use in patients that meet the criteria set out in the General Statement for Lipid-Lowering Drugs

pravastatin sodium 10 mg tablet, 30

2833D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	9.23	10.38	^a APO-Pravastatin [TX] ^a Chem mart Pravastatin [CH] ^a Lipostat 10 [QA] ^a Pravastatin Actavis 10 [UA] ^a Pravastatin-GA 10 [GN] ^a Pravastatin Sandoz [SZ]	^a Auro-Pravastatin 10 [DO] ^a Cholstat 10 [AF] ^a Pharmacor Pravastat 10 [CR] ^a Pravastatin AN [EA] ^a Pravastatin generichealth [GQ] ^a Terry White Chemists Pravastatin [TW]
			^B 1.38	10.61	10.38	^a Pravachol [FM]	

pravastatin sodium 20 mg tablet, 30

2834E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	10.68	11.83	^a APO-Pravastatin [TX] ^a Chem mart Pravastatin [CH] ^a Cholvastin [RA] ^a Pharmacor Pravastat 20 [CR] ^a Pravastatin AN [EA] ^a Pravastatin generichealth [GQ] ^a Terry White Chemists Pravastatin [TW]	^a Auro-Pravastatin 20 [DO] ^a Cholstat 20 [AF] ^a Lipostat 20 [QA] ^a Pravastatin Actavis 20 [UA] ^a Pravastatin-GA 20 [GN] ^a Pravastatin Sandoz [SZ]
			^B 1.37	12.05	11.83	^a Pravachol [FM]	

pravastatin sodium 40 mg tablet, 30

8197K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.86	14.01	^a APO-Pravastatin [TX] ^a Chem mart Pravastatin [CH] ^a Cholvastin [RA] ^a Pharmacor Pravastat 40 [CR] ^a Pravastatin AN [EA] ^a Pravastatin generichealth [GQ] ^a Terry White Chemists Pravastatin [TW]	^a Auro-Pravastatin 40 [DO] ^a Cholstat 40 [AF] ^a Lipostat 40 [QA] ^a Pravastatin Actavis 40 [UA] ^a Pravastatin-GA 40 [GN] ^a Pravastatin Sandoz [SZ]
			^B 1.46	14.32	14.01	^a Pravachol [FM]	

pravastatin sodium 80 mg tablet, 30

8829Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.13	17.28	^a APO-Pravastatin [TX] ^a Chem mart Pravastatin [CH] ^a Pravastatin AN [EA] ^a Pravastatin generichealth [GQ] ^a Terry White Chemists Pravastatin [TW]	^a Auro-Pravastatin 80 [DO] ^a Lipostat 80 [QA] ^a Pravastatin-GA 80 [GN] ^a Pravastatin Sandoz [SZ]
			^B 1.46	17.59	17.28	^a Pravachol [FM]	

■ PRAVASTATIN**Restricted benefit**

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs, and who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

No applications for increased maximum quantities and/or repeats will be authorised.

pravastatin sodium 10 mg tablet, 30

9237E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	9.23	10.38	^a APO-Pravastatin [TX] ^a Chem mart Pravastatin [CH] ^a Lipostat 10 [QA] ^a Pharmacor Pravastat 10 [CR] ^a Pravastatin Actavis 10 [UA] ^a Pravastatin-GA 10 [GN] ^a Pravastatin Sandoz [SZ]	^a Auro-Pravastatin 10 [DO] ^a Cholstat 10 [AF] ^a Pharmacor Pravastat 10 [CR] ^a Pravastatin AN [EA] ^a Pravastatin generichealth [GQ] ^a Terry White Chemists Pravastatin [TW]
			^B 1.38	10.61	10.38	^a Pravachol [FM]	

pravastatin sodium 20 mg tablet, 30

9238F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	10.68	11.83	^a APO-Pravastatin [TX] ^a Chem mart Pravastatin [CH] ^a Cholvastin [RA] ^a Pharmacor Pravastat 20 [CR] ^a Pravastatin AN [EA] ^a Pravastatin generichealth [GQ] ^a Terry White Chemists Pravastatin [TW]	^a Auro-Pravastatin 20 [DO] ^a Cholstat 20 [AF] ^a Lipostat 20 [QA] ^a Pravastatin Actavis 20 [UA] ^a Pravastatin-GA 20 [GN] ^a Pravastatin Sandoz [SZ]
			^B 1.37	12.05	11.83	^a Pravachol [FM]	

pravastatin sodium 40 mg tablet, 30

9239G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	12.86	14.01	^a APO-Pravastatin [TX] ^a Chem mart Pravastatin [CH]	^a Auro-Pravastatin 40 [DO] ^a Cholstat 40 [AF]

^a Cholvastin [RA]	^a Lipostat 40 [QA]
^a Pharmacor Pravastat 40 [CR]	^a Pravastatin Actavis 40 [UA]
^a Pravastatin AN [EA]	^a Pravastatin-GA 40 [GN]
^a Pravastatin generichealth [GQ]	^a Pravastatin Sandoz [SZ]
^a Terry White Chemists Pravastatin [TW]	
^a Pravachol [FM]	

^B1.46 14.32 14.01

pravastatin sodium 80 mg tablet, 30


9240H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	16.13	17.28	^a APO-Pravastatin [TX] ^a Chem mart Pravastatin [CH] ^a Pravastatin AN [EA] ^a Pravastatin generichealth [GQ] ^a Terry White Chemists Pravastatin [TW]	^a Auro-Pravastatin 80 [DO] ^a Lipostat 80 [QA] ^a Pravastatin-GA 80 [GN] ^a Pravastatin Sandoz [SZ]
			^B 1.46	17.59	17.28	^a Pravachol [FM]	

■ **ROSUVASTATIN**


Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs


rosuvastatin 10 mg tablet, 30

2628H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	26.68	27.83	^a APO-Rosuvastatin [TX] ^a Cavstat [AF] ^a Crestor [AP] ^a Rosuvastatin Actavis 10 [GN] ^a Rosuvastatin GH [GQ]	^a Blooms the Chemist Rosuvastatin [IB] ^a Chem mart Rosuvastatin [CH] ^a Crosuva 10 [ZP] ^a Rosuvastatin-DRLA [RI] ^a Terry White Chemists Rosuvastatin [TW]


rosuvastatin 20 mg tablet, 30

2574L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	35.11	36.26	^a APO-Rosuvastatin [TX] ^a Cavstat [AF] ^a Crestor [AP] ^a Rosuvastatin Actavis 20 [GN] ^a Rosuvastatin GH [GQ]	^a Blooms the Chemist Rosuvastatin [IB] ^a Chem mart Rosuvastatin [CH] ^a Crosuva 20 [ZP] ^a Rosuvastatin-DRLA [RI] ^a Terry White Chemists Rosuvastatin [TW]

rosuvastatin 40 mg tablet, 30

2594M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	46.43	37.70	^a APO-Rosuvastatin [TX] ^a Cavstat [AF] ^a Crestor [AP] ^a Rosuvastatin Actavis 40 [GN] ^a Rosuvastatin GH [GQ]	^a Blooms the Chemist Rosuvastatin [IB] ^a Chem mart Rosuvastatin [CH] ^a Crosuva 40 [ZP] ^a Rosuvastatin-DRLA [RI] ^a Terry White Chemists Rosuvastatin [TW]

rosuvastatin 5 mg tablet, 30

2606E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	20.32	21.47	^a APO-Rosuvastatin [TX] ^a Cavstat [AF] ^a Crestor [AP] ^a Rosuvastatin Actavis 5 [GN] ^a Rosuvastatin GH [GQ]	^a Blooms the Chemist Rosuvastatin [IB] ^a Chem mart Rosuvastatin [CH] ^a Crosuva 5 [ZP] ^a Rosuvastatin-DRLA [RI] ^a Terry White Chemists Rosuvastatin [TW]

■ **ROSUVASTATIN**

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs

Clinical criteria:

The treatment must not be prescribed for hypercholesterolaemia if the patient has heterozygous familial hypercholesterolaemia.

rosuvastatin 10 mg tablet, 30

9043Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	26.68	27.83	^a APO-Rosuvastatin [TX]	^a Blooms the Chemist Rosuvastatin [IB]
						^a Cavstat [AF]	^a Chem mart Rosuvastatin [CH]
						^a Crestor [AP]	^a Crosuva 10 [ZP]
						^a Rostor 10 [DO]	^a Rosuvastatin Actavis 10 [GN]
						^a Rosuvastatin AN [EA]	^a Rosuvastatin-DRLA [RI]
						^a Rosuvastatin GH [GQ]	^a Rosuvastatin RBX [RA]
						^a Rosuvastatin Sandoz [SZ]	^a Terry White Chemists Rosuvastatin [TW]

rosuvastatin 20 mg tablet, 30

9044B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	35.11	36.26	^a APO-Rosuvastatin [TX]	^a Blooms the Chemist Rosuvastatin [IB]
						^a Cavstat [AF]	^a Chem mart Rosuvastatin [CH]
						^a Crestor [AP]	^a Crosuva 20 [ZP]
						^a Rostor 20 [DO]	^a Rosuvastatin Actavis 20 [GN]
						^a Rosuvastatin AN [EA]	^a Rosuvastatin-DRLA [RI]
						^a Rosuvastatin GH [GQ]	^a Rosuvastatin RBX [RA]
						^a Rosuvastatin Sandoz [SZ]	^a Terry White Chemists Rosuvastatin [TW]

rosuvastatin 40 mg tablet, 30

9045C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	46.43	37.70	^a APO-Rosuvastatin [TX]	^a Blooms the Chemist Rosuvastatin [IB]
						^a Cavstat [AF]	^a Chem mart Rosuvastatin [CH]
						^a Crestor [AP]	^a Crosuva 40 [ZP]
						^a Rostor 40 [DO]	^a Rosuvastatin Actavis 40 [GN]
						^a Rosuvastatin AN [EA]	^a Rosuvastatin-DRLA [RI]
						^a Rosuvastatin GH [GQ]	^a Rosuvastatin RBX [RA]
						^a Rosuvastatin Sandoz [SZ]	^a Terry White Chemists Rosuvastatin [TW]

rosuvastatin 5 mg tablet, 30

9042X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	20.32	21.47	^a APO-Rosuvastatin [TX]	^a Blooms the Chemist Rosuvastatin [IB]
						^a Cavstat [AF]	^a Chem mart Rosuvastatin [CH]
						^a Crestor [AP]	^a Crosuva 5 [ZP]
						^a Rostor 5 [DO]	^a Rosuvastatin Actavis 5 [GN]
						^a Rosuvastatin AN [EA]	^a Rosuvastatin-DRLA [RI]
						^a Rosuvastatin GH [GQ]	^a Rosuvastatin RBX [RA]
						^a Rosuvastatin Sandoz [SZ]	^a Terry White Chemists Rosuvastatin [TW]

■ ROSUVASTATIN**Restricted benefit**

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs

Clinical criteria:

Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

rosuvastatin 10 mg tablet, 30

2584B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	26.68	27.83	^a APO-Rosuvastatin [TX]	^a Blooms the Chemist Rosuvastatin [IB]
						^a Cavstat [AF]	^a Chem mart Rosuvastatin [CH]
						^a Crestor [AP]	^a Crosuva 10 [ZP]
						^a Rosuvastatin Actavis 10 [GN]	^a Rosuvastatin-DRLA [RI]
						^a Rosuvastatin GH [GQ]	^a Terry White Chemists Rosuvastatin [TW]

rosuvastatin 20 mg tablet, 30

2609H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	35.11	36.26	^a APO-Rosuvastatin [TX] ^a Cavstat [AF] ^a Crestor [AP] ^a Rosuvastatin Actavis 20 [GN] ^a Rosuvastatin GH [GQ]	^a Blooms the Chemist Rosuvastatin [IB] ^a Chem mart Rosuvastatin [CH] ^a Crosuva 20 [ZP] ^a Rosuvastatin-DRLA [RI] ^a Terry White Chemists Rosuvastatin [TW]

rosuvastatin 40 mg tablet, 30

2636R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	46.43	37.70	^a APO-Rosuvastatin [TX] ^a Cavstat [AF] ^a Crestor [AP] ^a Rosuvastatin Actavis 40 [GN] ^a Rosuvastatin GH [GQ]	^a Blooms the Chemist Rosuvastatin [IB] ^a Chem mart Rosuvastatin [CH] ^a Crosuva 40 [ZP] ^a Rosuvastatin-DRLA [RI] ^a Terry White Chemists Rosuvastatin [TW]

rosuvastatin 5 mg tablet, 30

2590H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	20.32	21.47	^a APO-Rosuvastatin [TX] ^a Cavstat [AF] ^a Crestor [AP] ^a Rosuvastatin Actavis 5 [GN] ^a Rosuvastatin GH [GQ]	^a Blooms the Chemist Rosuvastatin [IB] ^a Chem mart Rosuvastatin [CH] ^a Crosuva 5 [ZP] ^a Rosuvastatin-DRLA [RI] ^a Terry White Chemists Rosuvastatin [TW]

▪ ROSUVASTATIN**Restricted benefit**

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs

Clinical criteria:

Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements, **AND**

The treatment must not be prescribed for hypercholesterolaemia if the patient has heterozygous familial hypercholesterolaemia.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

rosuvastatin 10 mg tablet, 30

3403D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	26.68	27.83	^a APO-Rosuvastatin [TX] ^a Cavstat [AF] ^a Crestor [AP] ^a Rostor 10 [DO] ^a Rosuvastatin AN [EA] ^a Rosuvastatin GH [GQ] ^a Rosuvastatin Sandoz [SZ]	^a Blooms the Chemist Rosuvastatin [IB] ^a Chem mart Rosuvastatin [CH] ^a Crosuva 10 [ZP] ^a Rosuvastatin Actavis 10 [GN] ^a Rosuvastatin-DRLA [RI] ^a Rosuvastatin RBX [RA] ^a Terry White Chemists Rosuvastatin [TW]

rosuvastatin 20 mg tablet, 30

3404E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	35.11	36.26	^a APO-Rosuvastatin [TX] ^a Cavstat [AF] ^a Crestor [AP] ^a Rostor 20 [DO] ^a Rosuvastatin AN [EA] ^a Rosuvastatin GH [GQ] ^a Rosuvastatin Sandoz [SZ]	^a Blooms the Chemist Rosuvastatin [IB] ^a Chem mart Rosuvastatin [CH] ^a Crosuva 20 [ZP] ^a Rosuvastatin Actavis 20 [GN] ^a Rosuvastatin-DRLA [RI] ^a Rosuvastatin RBX [RA] ^a Terry White Chemists Rosuvastatin [TW]

rosuvastatin 40 mg tablet, 30

3405F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	46.43	37.70	^a APO-Rosuvastatin [TX]	^a Blooms the Chemist Rosuvastatin [IB]
						^a Cavstat [AF]	^a Chem mart Rosuvastatin [CH]
						^a Crestor [AP]	^a Crosuva 40 [ZP]
						^a Rostor 40 [DO]	^a Rosuvastatin Actavis 40 [GN]
						^a Rosuvastatin AN [EA]	^a Rosuvastatin-DRLA [RI]
						^a Rosuvastatin GH [GQ]	^a Rosuvastatin RBX [RA]
						^a Rosuvastatin Sandoz [SZ]	^a Terry White Chemists Rosuvastatin [TW]

rosuvastatin 5 mg tablet, 30

3402C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	20.32	21.47	^a APO-Rosuvastatin [TX]	^a Blooms the Chemist Rosuvastatin [IB]
						^a Cavstat [AF]	^a Chem mart Rosuvastatin [CH]
						^a Crestor [AP]	^a Crosuva 5 [ZP]
						^a Rostor 5 [DO]	^a Rosuvastatin Actavis 5 [GN]
						^a Rosuvastatin AN [EA]	^a Rosuvastatin-DRLA [RI]
						^a Rosuvastatin GH [GQ]	^a Rosuvastatin RBX [RA]
						^a Rosuvastatin Sandoz [SZ]	^a Terry White Chemists Rosuvastatin [TW]

■ SIMVASTATIN**Restricted benefit**

For use in patients that meet the criteria set out in the General Statement for Lipid-Lowering Drugs

simvastatin 10 mg tablet, 30

2011W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	8.95	10.10	^a APO-Simvastatin [TX]	^a Auro-Simvastatin 10 [DO]
						^a Chem mart Simvastatin [CH]	^a GenRx Simvastatin [GX]
						^a Ransim [RA]	^a Simvacor 10 [CR]
						^a Simvar 10 [QA]	^a Simvastatin AN [EA]
						^a Simvastatin-DP [UA]	^a Simvastatin-DRLA [RZ]
						^a Simvastatin-GA 10 [GN]	^a Simvastatin generichealth [GQ]
						^a Simvastatin Sandoz [SZ]	^a Terry White Chemists Simvastatin [TW]
						^a Zimstat [AF]	
			^B 3.33	12.28	10.10	^a Lipex 10 [FR]	^a Zocor [MK]

simvastatin 20 mg tablet, 30

2012X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	9.92	11.07	^a APO-Simvastatin [TX]	^a Auro-Simvastatin 20 [DO]
						^a Chem mart Simvastatin [CH]	^a Ransim [RA]
						^a Simvacor 20 [CR]	^a Simvar 20 [QA]
						^a Simvastatin AN [EA]	^a Simvastatin-DP [UA]
						^a Simvastatin-DRLA [RZ]	^a Simvastatin-GA 20 [GN]
						^a Simvastatin generichealth [GQ]	^a Simvastatin Sandoz [SZ]
						^a Terry White Chemists Simvastatin [TW]	^a Zimstat [AF]
			^B 3.33	13.25	11.07	^a Lipex 20 [FR]	^a Zocor [MK]

simvastatin 40 mg tablet, 30

8173E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	11.31	12.46	^a APO-Simvastatin [TX]	^a Auro-Simvastatin 40 [DO]
						^a Chem mart Simvastatin [CH]	^a Ransim [RA]
						^a Simvacor 40 [CR]	^a Simvar 40 [QA]
						^a Simvastatin AN [EA]	^a Simvastatin-DP [UA]
						^a Simvastatin-DRLA [RZ]	^a Simvastatin-GA 40 [GN]
						^a Simvastatin generichealth [GQ]	^a Simvastatin Sandoz [SZ]
						^a Terry White Chemists Simvastatin [TW]	^a Zimstat [AF]
			^B 3.33	14.64	12.46	^a Lipex 40 [FR]	^a Zocor [MK]

simvastatin 5 mg tablet, 30

2013Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	8.35	9.50	^a Simvastatin Sandoz [SZ]	^a Zimstat [AF]

simvastatin 80 mg tablet, 30

8313M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.29	14.44	^a APO-Simvastatin [TX] ^a Chem mart Simvastatin [CH] ^a Simvacor 80 [CR] ^a Simvastatin AN [EA] ^a Simvastatin-DRLA [RZ] ^a Simvastatin generichealth [GQ] ^a Terry White Chemists Simvastatin [TW]	^a Auro-Simvastatin 80 [DO] ^a Ransim [RA] ^a Simvar 80 [QA] ^a Simvastatin-DP [UA] ^a Simvastatin-GA 80 [GN] ^a Simvastatin Sandoz [SZ] ^a Zimstat [AF]
			^B 3.33	16.62	14.44	^a Lipex 80 [FR]	^a Zocor [MK]

▪ **SIMVASTATIN**

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs, and who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

No applications for increased maximum quantities and/or repeats will be authorised.

simvastatin 10 mg tablet, 30

9242K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	8.95	10.10	^a APO-Simvastatin [TX] ^a Chem mart Simvastatin [CH] ^a Ransim [RA] ^a Simvar 10 [QA] ^a Simvastatin-DP [UA] ^a Simvastatin-GA 10 [GN] ^a Simvastatin Sandoz [SZ] ^a Zimstat [AF]	^a Auro-Simvastatin 10 [DO] ^a GenRx Simvastatin [GX] ^a Simvacor 10 [CR] ^a Simvastatin AN [EA] ^a Simvastatin-DRLA [RZ] ^a Simvastatin generichealth [GQ] ^a Terry White Chemists Simvastatin [TW]
			^B 3.33	12.28	10.10	^a Lipex 10 [FR]	^a Zocor [MK]

simvastatin 20 mg tablet, 30

9243L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	9.92	11.07	^a APO-Simvastatin [TX] ^a Chem mart Simvastatin [CH] ^a Simvacor 20 [CR] ^a Simvastatin AN [EA] ^a Simvastatin-DRLA [RZ] ^a Simvastatin generichealth [GQ] ^a Terry White Chemists Simvastatin [TW]	^a Auro-Simvastatin 20 [DO] ^a Ransim [RA] ^a Simvar 20 [QA] ^a Simvastatin-DP [UA] ^a Simvastatin-GA 20 [GN] ^a Simvastatin Sandoz [SZ] ^a Zimstat [AF]
			^B 3.33	13.25	11.07	^a Lipex 20 [FR]	^a Zocor [MK]

simvastatin 40 mg tablet, 30

9244M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	11.31	12.46	^a APO-Simvastatin [TX] ^a Chem mart Simvastatin [CH] ^a Simvacor 40 [CR] ^a Simvastatin AN [EA] ^a Simvastatin-DRLA [RZ] ^a Simvastatin generichealth [GQ] ^a Terry White Chemists Simvastatin [TW]	^a Auro-Simvastatin 40 [DO] ^a Ransim [RA] ^a Simvar 40 [QA] ^a Simvastatin-DP [UA] ^a Simvastatin-GA 40 [GN] ^a Simvastatin Sandoz [SZ] ^a Zimstat [AF]
			^B 3.33	14.64	12.46	^a Lipex 40 [FR]	^a Zocor [MK]

simvastatin 5 mg tablet, 30

9241J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	8.35	9.50	^a Simvastatin Sandoz [SZ]	^a Zimstat [AF]

simvastatin 80 mg tablet, 30

9245N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	13.29	14.44	^a APO-Simvastatin [TX] ^a Chem mart Simvastatin [CH] ^a Simvacor 80 [CR] ^a Simvastatin AN [EA] ^a Simvastatin-DRLA [RZ] ^a Simvastatin generichealth [GQ] ^a Terry White Chemists Simvastatin [TW]	^a Auro-Simvastatin 80 [DO] ^a Ransim [RA] ^a Simvar 80 [QA] ^a Simvastatin-DP [UA] ^a Simvastatin-GA 80 [GN] ^a Simvastatin Sandoz [SZ] ^a Zimstat [AF]
			^B 3.33	16.62	14.44	^a Lipex 80 [FR]	^a Zocor [MK]

Fibrates■ **FENOFIBRATE****Restricted benefit**

For use in patients that meet the criteria set out in the General Statement for Lipid-Lowering Drugs

Note

The risk of serious muscle toxicity is increased if fenofibrate is used concomitantly with HMG CoA reductase inhibitors or other fibrates. Such combination therapy should be used with caution in patients with severe combined dyslipidaemia and high cardiovascular risk without any history of muscular disease and patients monitored closely for chronic signs of muscle toxicity.

fenofibrate 145 mg tablet, 30

9203X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	42.09	37.70	Lipidil [GO]

fenofibrate 48 mg tablet, 60

9202W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	30.39	31.54	Lipidil [GO]

■ **FENOFIBRATE****Restricted benefit**

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs, and who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

The risk of serious muscle toxicity is increased if fenofibrate is used concomitantly with HMG CoA reductase inhibitors or other fibrates. Such combination therapy should be used with caution in patients with severe combined dyslipidaemia and high cardiovascular risk without any history of muscular disease and patients monitored closely for chronic signs of muscle toxicity.

No applications for increased maximum quantities and/or repeats will be authorised.

fenofibrate 145 mg tablet, 30

9247Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	11	..	42.09	37.70	Lipidil [GO]

fenofibrate 48 mg tablet, 60

9246P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	11	..	30.39	31.54	Lipidil [GO]

■ **GEMFIBROZIL****Restricted benefit**

For use in patients that meet the criteria set out in the General Statement for Lipid-Lowering Drugs

Note

The risk of serious muscle toxicity is increased if gemfibrozil is used concomitantly with HMG CoA reductase inhibitors or other fibrates. Such combination therapy should be used with caution in patients with severe combined dyslipidaemia and high cardiovascular risk without any history of muscular disease and patients monitored closely for chronic signs of muscle toxicity.

gemfibrozil 600 mg tablet, 60

1453L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	18.15	19.30	^a Ausgem [QA] ^a Gemfibrozil-GA [UA] ^a GenRx Gemfibrozil [GX]	^a Chem mart Gemfibrozil [CH] ^a Gemhexal [SZ] ^a Jezil [GN]

^a Lipigem [AF]

^a Terry White Chemists
Gemfibrozil [TW]

■ GEMFIBROZIL

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs, and who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

The risk of serious muscle toxicity is increased if gemfibrozil is used concomitantly with HMG CoA reductase inhibitors or other fibrates. Such combination therapy should be used with caution in patients with severe combined dyslipidaemia and high cardiovascular risk without any history of muscular disease and patients monitored closely for chronic signs of muscle toxicity.

No applications for increased maximum quantities and/or repeats will be authorised.

gemfibrozil 600 mg tablet, 60

9248R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	11	..	18.15	19.30	^a Ausgem [QA] ^a Gemfibrozil-GA [UA] ^a GenRx Gemfibrozil [GX] ^a Lipigem [AF]	^a Chem mart Gemfibrozil [CH] ^a Gemhexal [SZ] ^a Jezil [GN] ^a Terry White Chemists Gemfibrozil [TW]

Bile acid sequestrants

■ CHOLESTYRAMINE

cholestyramine 4 g oral liquid: powder for, 50 x 4.7 g sachets

2967E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*72.28	37.70	Questran Lite [QA]

■ CHOLESTYRAMINE

Restricted benefit

For use in patients who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

No applications for increased maximum quantities and/or repeats will be authorised.

cholestyramine 4 g oral liquid: powder for, 50 x 4.7 g sachets

9249T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*72.28	37.70	Questran Lite [QA]

■ COLESTIPOL HYDROCHLORIDE

colestipol hydrochloride 5 g granules, 120 x 5 g sachets

1224K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	85.38	37.70	Colestid [PF]

■ COLESTIPOL HYDROCHLORIDE

Restricted benefit

For use in patients who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

No applications for increased maximum quantities and/or repeats will be authorised.

colestipol hydrochloride 5 g granules, 120 x 5 g sachets

9250W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	85.38	37.70	Colestid [PF]

Other lipid modifying agents

■ EZETIMIBE

Authority required (STREAMLINED)

3724

Treatment, in conjunction with dietary therapy and exercise, for co-administration with an HMG CoA reductase inhibitor (statin) in patients whose cholesterol levels are inadequately controlled with a statin and who have coronary heart disease. Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that

threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated

Authority required (STREAMLINED)

3725

Treatment, in conjunction with dietary therapy and exercise, for co-administration with an HMG CoA reductase inhibitor (statin) in patients whose cholesterol levels are inadequately controlled with a statin and who have diabetes mellitus. Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated

Authority required (STREAMLINED)

3726

Treatment, in conjunction with dietary therapy and exercise, for co-administration with an HMG CoA reductase inhibitor (statin) in patients whose cholesterol levels are inadequately controlled with a statin and who have peripheral vascular disease. Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated

Authority required (STREAMLINED)

3727

Treatment, in conjunction with dietary therapy and exercise, for co-administration with an HMG CoA reductase inhibitor (statin) in patients whose cholesterol levels are inadequately controlled with a statin and who have heterozygous familial hypercholesterolaemia. Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated

Authority required (STREAMLINED)

3728

Treatment, in conjunction with dietary therapy and exercise, for co-administration with an HMG CoA reductase inhibitor (statin) in patients whose cholesterol levels are inadequately controlled with a statin and who have symptomatic cerebrovascular disease. Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated

Authority required (STREAMLINED)

3729

Treatment, in conjunction with dietary therapy and exercise, for co-administration with an HMG CoA reductase inhibitor (statin) in patients whose cholesterol levels are inadequately controlled with a statin and who have family history of coronary heart disease. Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated

Authority required (STREAMLINED)

3730

Treatment, in conjunction with dietary therapy and exercise, for co-administration with an HMG CoA reductase inhibitor (statin) in patients whose cholesterol levels are inadequately controlled with a statin and who have hypertension. Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated

Authority required (STREAMLINED)

1989

Patients eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs) where treatment with an HMG CoA reductase inhibitor (statin) is contraindicated

Authority required (STREAMLINED)

3731

Patients eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs) where treatment with an HMG CoA reductase inhibitor (statin) must be discontinued or reduced because the patient developed a clinically important product-related adverse event during treatment with a statin.

A clinically important product-related adverse event is defined as follows:

- (i) Severe myalgia (muscle symptoms without creatine kinase elevation) which is proven to be temporally associated with statin treatment; or
- (ii) Myositis (clinically important creatine kinase elevation, with or without muscle symptoms) demonstrated by results twice the upper limit of normal on a single reading or a rising pattern on consecutive measurements and which is unexplained by other causes; or
- (iii) Unexplained, persistent elevations of serum transaminases (greater than 3 times the upper limit of normal) during treatment with a statin

Authority required (STREAMLINED)

1991

Homozygous sitosterolaemia

Authority required (STREAMLINED)

2438

Patients with homozygous familial hypercholesterolaemia who are eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs), in combination with an HMG CoA reductase inhibitor (statin)

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

ezetimibe 10 mg tablet, 30

8757X

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	71.31	37.70	Ezetrol [MK]

LIPID MODIFYING AGENTS, COMBINATIONS

HMG CoA reductase inhibitors in combination with other lipid modifying agents

▪ ATORVASTATIN (&) EZETIMIBE

Authority required (STREAMLINED)**4068**

Hypercholesterolaemia

Clinical criteria:The treatment must be in conjunction with dietary therapy and exercise, **AND**Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)**4085**

Hypercholesterolaemia

Clinical criteria:The treatment must be in conjunction with dietary therapy and exercise, **AND**Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have diabetes mellitus.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)**4086**

Hypercholesterolaemia

Clinical criteria:The treatment must be in conjunction with dietary therapy and exercise, **AND**Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have peripheral vascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4069

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have heterozygous familial hypercholesterolaemia.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4096

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have symptomatic cerebrovascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4120

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have a family history of coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4121

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have hypertension.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4097

Hypercholesterolaemia

Clinical criteria:

Patient must have homozygous familial hypercholesterolaemia, **AND**

Patient must be eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs).

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

atorvastatin 20 mg tablet [30] (&) ezetimibe 10 mg tablet [30], 1 pack

2874G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	77.88	37.70	Atozet Composite Pack [MK]

atorvastatin 40 mg tablet [30] (&) ezetimibe 10 mg tablet [30], 1 pack

2821L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	80.56	37.70	Atozet Composite Pack [MK]

atorvastatin 80 mg tablet [30] (&) ezetimibe 10 mg tablet [30], 1 pack

10006P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	84.54	37.70	Atozet Composite Pack [MK]

■ ATORVASTATIN (&) EZETIMIBE

Authority required (STREAMLINED)

4068

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4085

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have diabetes mellitus.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that

threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4086

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have peripheral vascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4069

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have heterozygous familial hypercholesterolaemia.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4096

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have symptomatic cerebrovascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4120

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have a family history of coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4121

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have hypertension.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4097

Hypercholesterolaemia

Clinical criteria:

Patient must have homozygous familial hypercholesterolaemia, **AND**

Patient must be eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs).

Authority required (STREAMLINED)

4353

Hypercholesterolaemia

Clinical criteria:

Patient must be eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs), **AND**

Patient must have developed a clinically important product-related adverse event during treatment with an HMG CoA reductase inhibitor (statin) necessitating a reduction in the atorvastatin dose.

A clinically important product-related adverse event is defined as follows:

- (i) Severe myalgia (muscle symptoms without creatine kinase elevation) which is proven to be temporally associated with statin treatment; or
- (ii) Myositis (clinically important creatine kinase elevation, with or without muscle symptoms) demonstrated by results twice the upper limit of normal on a single reading or a rising pattern on consecutive measurements and which is unexplained by other causes; or
- (iii) Unexplained, persistent elevations of serum transaminases (greater than 3 times the upper limit of normal) during treatment with a statin.

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

atorvastatin 10 mg tablet [30] (&) ezetimibe 10 mg tablet [30], 1 pack

10002K

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
±1	5	..	75.76	37.70	Atozet Composite Pack [MK]

■ EZETIMIBE + SIMVASTATIN

Authority required (STREAMLINED)**4068**

Hypercholesterolaemia

Clinical criteria:The treatment must be in conjunction with dietary therapy and exercise, **AND**Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)**4085**

Hypercholesterolaemia

Clinical criteria:The treatment must be in conjunction with dietary therapy and exercise, **AND**Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have diabetes mellitus.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)**4086**

Hypercholesterolaemia

Clinical criteria:The treatment must be in conjunction with dietary therapy and exercise, **AND**Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have peripheral vascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)**4069**

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
 Patient must have heterozygous familial hypercholesterolaemia.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)**4096**

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
 Patient must have symptomatic cerebrovascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)**4120**

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
 Patient must have a family history of coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)**4121**

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**
 Patient must have hypertension.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be

documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4097

Hypercholesterolaemia

Clinical criteria:

Patient must have homozygous familial hypercholesterolaemia, **AND**

Patient must be eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs).

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

ezetimibe 10 mg + simvastatin 40 mg tablet, 30

8881K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	75.66	37.70	Vytorin [MK]

ezetimibe 10 mg + simvastatin 80 mg tablet, 30

8882L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	77.56	37.70	Vytorin [MK]

■ EZETIMIBE + SIMVASTATIN

Authority required (STREAMLINED)

4068

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4085

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have diabetes mellitus.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be

documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4086

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have peripheral vascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4069

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have heterozygous familial hypercholesterolaemia.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4096

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have symptomatic cerebrovascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4120

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have a family history of coronary heart disease.

Inadequate control with a statin is defined as follows:

- (1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or
- (2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4121

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have hypertension.

Inadequate control with a statin is defined as follows:

- (1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or
- (2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4097

Hypercholesterolaemia

Clinical criteria:

Patient must have homozygous familial hypercholesterolaemia, **AND**

Patient must be eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs).

Authority required (STREAMLINED)

4147

Hypercholesterolaemia

Clinical criteria:

Patient must be eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs), **AND**

Patient must have developed a clinically important product-related adverse event during treatment with an HMG CoA reductase inhibitor (statin) necessitating a reduction in the statin dose.

A clinically important product-related adverse event is defined as follows:

- (i) Severe myalgia (muscle symptoms without creatine kinase elevation) which is proven to be temporally associated with statin treatment; or
- (ii) Myositis (clinically important creatine kinase elevation, with or without muscle symptoms) demonstrated by results twice the upper limit of normal on a single reading or a rising pattern on consecutive measurements and which is unexplained by other causes; or
- (iii) Unexplained, persistent elevations of serum transaminases (greater than 3 times the upper limit of normal) during treatment with a statin.

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

ezetimibe 10 mg + simvastatin 10 mg tablet, 30

9483D



Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	73.41	37.70	Vytorin [MK]

ezetimibe 10 mg + simvastatin 20 mg tablet, 30

9484E

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	74.34	37.70	Vytorin [MK]

■ ROSUVASTATIN (&) EZETIMIBE

Authority required (STREAMLINED)**4068**

Hypercholesterolaemia

Clinical criteria:The treatment must be in conjunction with dietary therapy and exercise, **AND**Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)**4085**

Hypercholesterolaemia

Clinical criteria:The treatment must be in conjunction with dietary therapy and exercise, **AND**Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have diabetes mellitus.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)**4086**

Hypercholesterolaemia

Clinical criteria:The treatment must be in conjunction with dietary therapy and exercise, **AND**Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have peripheral vascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)**4069**

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have heterozygous familial hypercholesterolaemia.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4096

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have symptomatic cerebrovascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4120

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have a family history of coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4121

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have hypertension.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be

documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4097

Hypercholesterolaemia

Clinical criteria:

Patient must have homozygous familial hypercholesterolaemia, **AND**

Patient must be eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs).

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

rosuvastatin 10 mg tablet [30] (&) ezetimibe 10 mg tablet [30], 1 pack

10208G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	78.54	37.70	Rosuzet Composite Pack [MK]

rosuvastatin 20 mg tablet [30] (&) ezetimibe 10 mg tablet [30], 1 pack

10201X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	81.48	37.70	Rosuzet Composite Pack [MK]

rosuvastatin 40 mg tablet [30] (&) ezetimibe 10 mg tablet [30 tablets], 1 pack

10207F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	85.86	37.70	Rosuzet Composite Pack [MK]

▪ **ROSUVASTATIN (&) EZETIMIBE**

Authority required (STREAMLINED)

4068

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4085

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have diabetes mellitus.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4086

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have peripheral vascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4069

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have heterozygous familial hypercholesterolaemia.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4096

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have symptomatic cerebrovascular disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4120

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have a family history of coronary heart disease.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4121

Hypercholesterolaemia

Clinical criteria:

The treatment must be in conjunction with dietary therapy and exercise, **AND**

Patient must have cholesterol levels that are inadequately controlled with an HMG CoA reductase inhibitor (statin), **AND**

Patient must have hypertension.

Inadequate control with a statin is defined as follows:

(1) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs includes an initial cholesterol threshold for PBS-subsidy (i.e. a patient not in a very high risk category), a cholesterol level in excess of that threshold after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated; or

(2) where the patient falls into a category for which the General Statement for Lipid-Lowering Drugs allows PBS-subsidised treatment with a statin at any cholesterol level (i.e. a very high risk category patient), a cholesterol level in excess of 4 mmol per L after at least 3 months of treatment at a maximum tolerated dose of a statin, in conjunction with dietary therapy and exercise. The dose and duration of statin treatment and the cholesterol level which shows inadequate control must be documented in the patient's medical records when ezetimibe is initiated. The cholesterol level which shows inadequate control must be no more than 2 months old when ezetimibe is initiated.

Authority required (STREAMLINED)

4097

Hypercholesterolaemia

Clinical criteria:

Patient must have homozygous familial hypercholesterolaemia, **AND**

Patient must be eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs).

Authority required (STREAMLINED)

4147

Hypercholesterolaemia

Clinical criteria:

Patient must be eligible for PBS-subsidised lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs), **AND**

Patient must have developed a clinically important product-related adverse event during treatment with an HMG CoA reductase inhibitor (statin) necessitating a reduction in the statin dose.

A clinically important product-related adverse event is defined as follows:

(i) Severe myalgia (muscle symptoms without creatine kinase elevation) which is proven to be temporally associated with statin treatment; or

(ii) Myositis (clinically important creatine kinase elevation, with or without muscle symptoms) demonstrated by results twice the upper limit of normal on a single reading or a rising pattern on consecutive measurements and which is unexplained by other causes; or

(iii) Unexplained, persistent elevations of serum transaminases (greater than 3 times the upper limit of normal) during treatment with a statin.

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

rosuvastatin 5 mg tablet [30] (&) ezetimibe 10 mg tablet [30], 1 pack

10204C



Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
±1	5	..	76.21	37.70	Rosuzet Composite Pack [MK]

HMG CoA reductase inhibitors, other combinations

■ **AMLODIPINE + ATORVASTATIN**

Restricted benefit

For use in patients who have hypertension and/or angina and who meet the criteria set out in the General Statement for Lipid-Lowering Drugs, and who are currently receiving treatment with a dihydropyridine calcium channel blocker

Restricted benefit

For use in patients who have hypertension and/or angina and who meet the criteria set out in the General Statement for Lipid-Lowering Drugs, and whose blood pressure and/or angina is inadequately controlled with other classes of antihypertensive and/or anti-anginal agent, and in whom adjunctive therapy with a dihydropyridine calcium channel blocker would be appropriate

Restricted benefit

For use in patients who have hypertension and/or angina and who meet the criteria set out in the General Statement for Lipid-Lowering Drugs, and who are intolerant of the side effects of other classes of antihypertensive and/or anti-anginal agent, and in whom replacement therapy with a dihydropyridine calcium channel blocker would be appropriate

amlodipine 10 mg + atorvastatin 10 mg tablet, 30

9053L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	45.64	37.70	^a APO-Amlodipine/Atorvastatin 10/10 [TX] ^a Cadatin 10/10 [FZ] ^a Caduet 10/10 [PF] ^a Terry White Chemists Amlodipine/Atorvastatin 10/10 [TW]	^a Blooms the Chemist Amlodipine/Atorvastatin 10/10 [IB] ^a Cadivast 10/10 [AF] ^a Chem mart Amlodipine/Atorvastatin 10/10 [CH]

amlodipine 10 mg + atorvastatin 20 mg tablet, 30

9054M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	58.54	37.70	^a APO-Amlodipine/Atorvastatin 10/20 [TX] ^a Cadatin 10/20 [FZ] ^a Caduet 10/20 [PF] ^a Terry White Chemists Amlodipine/Atorvastatin 10/20 [TW]	^a Blooms the Chemist Amlodipine/Atorvastatin 10/20 [IB] ^a Cadivast 10/20 [AF] ^a Chem mart Amlodipine/Atorvastatin 10/20 [CH]

amlodipine 10 mg + atorvastatin 40 mg tablet, 30

9055N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	76.23	37.70	^a APO-Amlodipine/Atorvastatin 10/40 [TX] ^a Cadatin 10/40 [FZ] ^a Caduet 10/40 [PF] ^a Terry White Chemists Amlodipine/Atorvastatin 10/40 [TW]	^a Blooms the Chemist Amlodipine/Atorvastatin 10/40 [IB] ^a Cadivast 10/40 [AF] ^a Chem mart Amlodipine/Atorvastatin 10/40 [CH]

amlodipine 10 mg + atorvastatin 80 mg tablet, 30

9056P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	102.43	37.70	^a APO-Amlodipine/Atorvastatin 10/80 [TX] ^a Cadatin 10/80 [FZ] ^a Caduet 10/80 [PF] ^a Terry White Chemists Amlodipine/Atorvastatin 10/80 [TW]	^a Blooms the Chemist Amlodipine/Atorvastatin 10/80 [IB] ^a Cadivast 10/80 [AF] ^a Chem mart Amlodipine/Atorvastatin 10/80 [CH]

amlodipine 5 mg + atorvastatin 10 mg tablet, 30

9049G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	42.34	37.70	^a APO-Amlodipine/Atorvastatin 5/10 [TX]	^a Blooms the Chemist Amlodipine/Atorvastatin 5/10 [IB]

^a Cadatin 5/10 [FZ]^a Caduet 5/10 [PF]^a Cadivast 5/10 [AF]^a Chem mart

Amlodipine/Atorvastatin 5/10 [CH]

^a Terry White Chemists

Amlodipine/Atorvastatin 5/10 [TW]

amlodipine 5 mg + atorvastatin 20 mg tablet, 30

9050H

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	55.03	37.70	^a APO-Amlodipine/Atorvastatin 5/20 [TX]	^a Blooms the Chemist Amlodipine/Atorvastatin 5/20 [IB]
					^a Cadatin 5/20 [FZ]	^a Cadivast 5/20 [AF]
					^a Caduet 5/20 [PF]	^a Chem mart Amlodipine/Atorvastatin 5/20 [CH]
					^a Terry White Chemists Amlodipine/Atorvastatin 5/20 [TW]	

amlodipine 5 mg + atorvastatin 40 mg tablet, 30

9051J

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	72.60	37.70	^a APO-Amlodipine/Atorvastatin 5/40 [TX]	^a Blooms the Chemist Amlodipine/Atorvastatin 5/40 [IB]
					^a Cadatin 5/40 [FZ]	^a Cadivast 5/40 [AF]
					^a Caduet 5/40 [PF]	^a Chem mart Amlodipine/Atorvastatin 5/40 [CH]
					^a Terry White Chemists Amlodipine/Atorvastatin 5/40 [TW]	

amlodipine 5 mg + atorvastatin 80 mg tablet, 30

9052K

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	98.80	37.70	^a APO-Amlodipine/Atorvastatin 5/80 [TX]	^a Blooms the Chemist Amlodipine/Atorvastatin 5/80 [IB]
					^a Cadatin 5/80 [FZ]	^a Cadivast 5/80 [AF]
					^a Caduet 5/80 [PF]	^a Chem mart Amlodipine/Atorvastatin 5/80 [CH]
					^a Terry White Chemists Amlodipine/Atorvastatin 5/80 [TW]	

■ **DERMATOLOGICALS**■ **ANTIFUNGALS FOR DERMATOLOGICAL USE****ANTIFUNGALS FOR TOPICAL USE***Antibiotics*■ **NYSTATIN**Authority required (STREAMLINED)**2354**

Treatment of a fungal or a yeast infection in an Aboriginal or a Torres Strait Islander person

nystatin 100 000 international units/g cream, 15 g

1698J

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
2	3	..	*18.90	20.05	Mycostatin [FM]

Imidazole and triazole derivatives■ **KETOCONAZOLE**Authority required (STREAMLINED)**2354**

Treatment of a fungal or a yeast infection in an Aboriginal or a Torres Strait Islander person

ketoconazole 1% (10 mg/g) shampoo, 100 mL

9025B

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
‡1	1	..	17.94	19.09	Nizoral 1% [JT]

ketoconazole 2% (20 mg/g) cream, 30 g

9024Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	2	..	23.46	24.61	Nizoral 2% Cream [JT]

ketoconazole 2% (20 mg/g) shampoo, 60 mL

1574W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	1	..	18.65	19.80	Nizoral 2% [JT]

■ MICONAZOLE**Authority required (STREAMLINED)****2354**

Treatment of a fungal or a yeast infection in an Aboriginal or a Torres Strait Islander person

miconazole 2% solution, 30 mL

9031H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	2	..	19.81	20.96	Daktarin Tincture [JT]

miconazole nitrate 2% (20 mg/g) cream, 30 g

9027D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	2	..	15.13	16.28	Daktarin [JT]

miconazole nitrate 2% (20 mg/g) cream, 70 g

9028E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	1	..	17.13	18.28	Daktarin [JT]

miconazole nitrate 2% (20 mg/g) powder: dusting, 30 g

9029F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	2	..	15.90	17.05	Daktarin [JT]

*Other antifungals for topical use***■ TERBINAFINE****Authority required (STREAMLINED)****2354**

Treatment of a fungal or a yeast infection in an Aboriginal or a Torres Strait Islander person

Authority required (STREAMLINED)**3243**

Treatment of a fungal or a yeast infection in a patient aged up to 18 years inclusive

terbinafine hydrochloride 1% cream, 15 g

9160D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*37.70	37.70	Lamisil [NC]

ANTIFUNGALS FOR SYSTEMIC USE*Antifungals for systemic use***■ GRISEOFULVIN****griseofulvin 125 mg tablet, 100**

1460W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	26.21	27.36	Grisovin [QA]

griseofulvin 500 mg tablet, 28

2982Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	27.33	28.48	Grisovin 500 [QA]

■ TERBINAFINE**Authority required**

Treatment of a dermatophyte infection in an Aboriginal or a Torres Strait Islander person where topical treatment has failed

Authority required

Treatment of a dermatophyte infection in a patient aged up to 18 years inclusive where topical treatment and griseofulvin have failed

terbinafine 250 mg tablet, 42

2285G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	38.82	37.70	^a GenRx Terbinafine [GX]	^a Lamisil (Novartis Pharmaceuticals Australia Pty Limited) [NV]
						^a Pharmacy Choice Terbinafine [RI]	^a Sebifin 250 [RA]
						^a Tamsil [QA]	^a Terbinafine Actavis [VN]
						^a Terbinafine AN [EA]	^a Terbinafine-DRLA [RZ]
						^a Terbinafine GH [GQ]	^a Terbinafine Sandoz [SZ]
						^a Tinasil [AF]	

■ TERBINAFINE**Authority required**

Proximal or extensive (greater than 80% nail involvement) onychomycosis due to dermatophyte infection where topical treatment has failed. This infection must be proven by microscopy or culture and confirmed by an Approved Pathology Authority. The date of the pathology report must be provided at the time of application and must not be more than 12 months old

Note

No applications for increased maximum quantities and/or repeats will be authorised.

terbinafine 250 mg tablet, 42

2804N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	38.82	37.70	^a GenRx Terbinafine [GX]	^a Lamisil (Novartis Pharmaceuticals Australia Pty Limited) [NV]
						^a Pharmacy Choice Terbinafine [RI]	^a Sebifin 250 [RA]
						^a Tamsil [QA]	^a Terbinafine Actavis [VN]
						^a Terbinafine AN [EA]	^a Terbinafine-DRLA [RZ]
						^a Terbinafine GH [GQ]	^a Terbinafine Sandoz [SZ]
						^a Tinasil [AF]	

■ ANTIPSORIATICS**ANTIPSORIATICS FOR TOPICAL USE***Tars***■ COAL TAR PREPARED****coal tar prepared 1% (10 mg/g) lotion, 100 mL**

8864M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	2	..	33.42	34.57	Exorex [GN]

coal tar prepared 2% foam, 100 g

10225E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	2	..	33.42	34.57	Scytera [RZ]

*Other antipsoriatics for topical use***■ CALCIPOTRIOL + BETAMETHASONE DIPROPIONATE****Authority required**

Chronic stable plaque type psoriasis vulgaris

Clinical criteria:

The condition must be on the patient's scalp, **AND**

The condition must be inadequately controlled with either a vitamin D analogue or potent topical corticosteroid as monotherapy, **AND**

Patient must require more than 30 grams of the product per month.

Note**Continuing Therapy Only:**

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

betamethasone (as dipropionate) 0.05% + calcipotriol 0.005% gel, 60 g

10075G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	1	..	74.88	37.70	Daivobet 50/500 gel [LO]

■ CALCIPOTRIOL + BETAMETHASONE DIPROPIONATE

Restricted benefit

Chronic stable plaque type psoriasis vulgaris of the scalp in a patient who is not adequately controlled with either calcipotriol or potent topical corticosteroid monotherapy

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

calcipotriol 0.005% + betamethasone (as dipropionate) 0.05% gel, 30 g

5276Q

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
±1	1	..	42.23	37.70	Daivobet 50/500 gel [LO]

■ CALCIPOTRIOL + BETAMETHASONE DIPROPIONATE

Restricted benefit

Chronic stable plaque type psoriasis vulgaris in a patient who is not adequately controlled with either calcipotriol or potent topical corticosteroid monotherapy

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

calcipotriol 0.005% + betamethasone (as dipropionate) 0.05% ointment, 30 g

9494Q

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
±1	1	..	42.23	37.70	Daivobet [LO]

ANTIPSORIATICS FOR SYSTEMIC USE

Retinoids for treatment of psoriasis

■ ACITRETIN

Caution

This drug is a potent teratogen—pregnancy should be avoided for at least two years after cessation of therapy.

Authority required (STREAMLINED)

1366

Severe intractable psoriasis

Authority required (STREAMLINED)

1363

Severe forms of disorders of keratinisation

Note

Care must be taken to comply with the provisions of State/Territory law when prescribing acitretin.

acitretin 10 mg capsule, 100

2019G

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	2	..	174.32	37.70	^a Acitretin Actavis [GN] ^a Novatin [TX]	^a Neotigason [UA]

acitretin 25 mg capsule, 100

2020H

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	2	..	334.55	37.70	^a Acitretin Actavis [GN] ^a Novatin [TX]	^a Neotigason [UA]

■ ANTIBIOTICS AND CHEMOTHERAPEUTICS FOR DERMATOLOGICAL USE

CHEMOTHERAPEUTICS FOR TOPICAL USE

Sulfonamides

■ SULFADIAZINE SILVER

Restricted benefit

Prevention and treatment of infection in partial or full skin thickness loss due to burns

Restricted benefit

Prevention and treatment of infection in partial or full skin thickness loss due to epidermolysis bullosa

Restricted benefit

Stasis ulcers

sulfadiazine silver 1% (10 mg/g) cream, 50 g

9479X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	..	..	19.49	20.64	Flamazine [SN]

■ **CORTICOSTEROIDS, DERMATOLOGICAL PREPARATIONS****CORTICOSTEROIDS, PLAIN***Corticosteroids, weak (group I)*■ **HYDROCORTISONE ACETATE**Restricted benefit

Corticosteroid-responsive dermatoses

hydrocortisone acetate 1% (10 mg/g) cream, 30 g

2887Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	1	..	9.23	10.38	^a Cortic-DS 1% [FM]
			^B 2.69	11.92	10.38	^a Sigmacort [QA]

hydrocortisone acetate 1% (10 mg/g) cream, 50 g

2881P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	1	..	8.90	10.05	^a Cortic-DS 1% [FM]
			^B 2.70	11.60	10.05	^a Sigmacort [QA]

hydrocortisone acetate 1% (10 mg/g) ointment, 30 g

2888B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	1	..	9.23	10.38	^a Cortic-DS 1% [FM]
			^B 2.69	11.92	10.38	^a Sigmacort [QA]

hydrocortisone acetate 1% (10 mg/g) ointment, 50 g

2882Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	1	..	8.90	10.05	^a Cortic-DS 1% [FM]
			^B 2.70	11.60	10.05	^a Sigmacort [QA]

■ **HYDROCORTISONE ACETATE**Restricted benefit

Corticosteroid-responsive dermatoses

hydrocortisone acetate 1% (10 mg/g) cream, 30 g

5111B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	‡1	..	..	9.23	10.38	^a Cortic-DS 1% [FM]
			^B 2.69	11.92	10.38	^a Sigmacort [QA]

hydrocortisone acetate 1% (10 mg/g) cream, 50 g

5113D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	‡1	..	..	8.90	10.05	^a Cortic-DS 1% [FM]
			^B 2.70	11.60	10.05	^a Sigmacort [QA]

hydrocortisone acetate 1% (10 mg/g) ointment, 30 g

5112C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	‡1	..	..	9.23	10.38	^a Cortic-DS 1% [FM]
			^B 2.69	11.92	10.38	^a Sigmacort [QA]

hydrocortisone acetate 1% (10 mg/g) ointment, 50 g

5114E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	‡1	..	..	8.90	10.05	^a Cortic-DS 1% [FM]
			^B 2.70	11.60	10.05	^a Sigmacort [QA]

Corticosteroids, moderately potent (group II)■ **TRIAMCINOLONE**Restricted benefit

Treatment of corticosteroid-responsive dermatoses

triamcinolone acetonide 0.02% (200 microgram/g) cream, 100 g

2117K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*14.74	15.89	^a Tricortone [FM]
			^B 3.78	*18.52	15.89	^a Aristocort 0.02% [QA]

triamcinolone acetonide 0.02% (200 microgram/g) ointment, 100 g

2118L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*14.74	15.89	^a Tricortone [FM]
			^B 3.78	*18.52	15.89	^a Aristocort 0.02% [QA]

*Corticosteroids, potent (group III)***■ BETAMETHASONE DIPROPIONATE****Restricted benefit**

Corticosteroid-responsive dermatoses

Note**Continuing Therapy Only:**

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

betamethasone (as dipropionate) 0.05% cream, 15 g

1115Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	1	..	13.48	14.63	^a Eleuphrat [FR]
			^B 2.45	15.93	14.63	^a Diprosone [MK]

betamethasone (as dipropionate) 0.05% ointment, 15 g

1119X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	1	..	13.48	14.63	^a Eleuphrat [FR]
			^B 2.45	15.93	14.63	^a Diprosone [MK]

■ BETAMETHASONE VALERATE**Restricted benefit**

Corticosteroid-responsive dermatoses

betamethasone (as valerate) 0.02% (200 microgram/g) cream, 100 g

2812B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	..	..	*24.56	25.71	^a Antroquoril [FR]	^b Cortival 1/5 [FM]
			^B 2.46	*27.02	25.71	^a Celestone-M [MK]	
			^B 6.88	*31.44	25.71	^b Betnovate 1/5 [QA]	

■ BETAMETHASONE VALERATE**Restricted benefit**

Corticosteroid-responsive dermatoses

Note**Continuing Therapy Only:**

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

betamethasone (as valerate) 0.05% (500 microgram/g) cream, 15 g

2813C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	1	..	8.75	9.90	^a Cortival 1/2 [FM]
			^B 2.94	11.69	9.90	^a Betnovate 1/2 [QA]

■ METHYLPREDNISOLONE**Restricted benefit**

Treatment of corticosteroid-responsive dermatoses

Note**Continuing Therapy Only:**

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

methylprednisolone aceponate 0.1% (1 mg/g) cream, 15 g

8054X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	..	..	14.32	15.47	Advantan [BN]

methylprednisolone aceponate 0.1% (1 mg/g) ointment, 15 g

8055Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	..	..	14.32	15.47	Advantan [BN]

methylprednisolone aceponate 0.1% (1 mg/g) ointment, 15 g

8128T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	..	..	14.32	15.47	Advantan [BN]

■ METHYLPREDNISOLONE**Restricted benefit**

Eczema

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

methylprednisolone aceponate 0.1% (1 mg/g) lotion, 20 g

8618N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	..	..	14.99	16.14	Advantan [BN]

■ MOMETASONE**Restricted benefit**

Treatment of corticosteroid-responsive dermatoses

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

mometasone furoate 0.1% (1 mg/g) cream, 15 g

1913Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	..	..	12.35	13.50	^a Momasone [QA]	^a Novasone [FR]
			^B 3.07	15.42	13.50	^a Elocon [MK]	

mometasone furoate 0.1% lotion, 30 mL

8043H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	..	..	15.58	16.73	^a Novasone [FR]	^a Zatamil [EO]
			^B 3.06	18.64	16.73	^a Elocon [MK]	

mometasone furoate 0.1% ointment, 15 g

1915T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	..	..	12.35	13.50	^a Novasone [FR]	^a Zatamil [EO]
			^B 3.07	15.42	13.50	^a Elocon [MK]	

*Corticosteroids, very potent (group IV)***■ CLOBETASOL****Authority required**

Moderate to severe scalp psoriasis

Clinical criteria:

The condition must be inadequately controlled with either a vitamin D analogue or potent topical corticosteroid as monotherapy; OR

The condition must be inadequately controlled with combination use of a vitamin D analogue and potent topical corticosteroid.

Population criteria:

Patient must be aged 18 years or older.

clobetasol propionate 0.05% shampoo, 125 mL

10080M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	48.98	37.70	Clobex [GA]

■ ANTI-ACNE PREPARATIONS**ANTI-ACNE PREPARATIONS FOR TOPICAL USE***Retinoids for topical use in acne***■ ADAPALENE + BENZOYL PEROXIDE****Restricted benefit**

Severe acne vulgaris

Treatment Phase: Acute treatment

Clinical criteria:

The treatment must in combination with an oral antibiotic.

adapalene 0.1% + benzoyl peroxide 2.5% gel, 30 g

8954G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
	±1	1	..	37.27	37.70	Epiduo [GA]	

ADAPALENE + BENZOYL PEROXIDE**Restricted benefit**

Severe acne vulgaris

Clinical criteria:

The treatment must be maintenance therapy.

Note**Continuing Therapy Only:**

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

adapalene 0.1% + benzoyl peroxide 2.5% gel, 30 g

8955H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
NP	±1	3	..	37.27	37.70	Epiduo [GA]	

ANTI-ACNE PREPARATIONS FOR SYSTEMIC USE*Retinoids for treatment of acne***ISOTRETINOIN****Caution**

This drug causes birth defects. Isotretinoin has been reported to cause other frequent and potentially serious toxicity.

Authority required (STREAMLINED)**1354**

Severe cystic acne not responsive to other therapy

Note

Care must be taken to comply with the provisions of State/Territory law when prescribing isotretinoin.

isotretinoin 10 mg capsule, 60

2591J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	3	..	43.29	37.70	^a APO-Isotretinoin [TX] ^a Isotretinoin AN [EA] ^a Oratane [GN] ^a Rocta 10 [QA]	^a Dermatane [ER] ^a Isotretinoin SCP 10 [CR] ^a Roaccutane [RO]

isotretinoin 20 mg capsule, 60

2592K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	3	..	61.66	37.70	^a APO-Isotretinoin [TX] ^a Isotretinoin AN [EA] ^a Oratane [GN] ^a Rocta 20 [QA]	^a Dermatane [ER] ^a Isotretinoin SCP 20 [CR] ^a Roaccutane [RO]

isotretinoin 40 mg capsule, 30

2549E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	3	..	56.32	37.70	^a Dermatane [ER]	^a Oratane [GN]

OTHER DERMATOLOGICAL PREPARATIONS**OTHER DERMATOLOGICAL PREPARATIONS***Agents for dermatitis, excluding corticosteroids***PIMECROLIMUS****Authority required**

Treatment of facial or eyelid atopic dermatitis in patients aged at least 3 months with 1 or more of the following contraindications to topical corticosteroids:

- (i) perioral dermatitis;
- (ii) periorbital dermatitis;
- (iii) rosacea;
- (iv) epidermal atrophy;
- (v) dermal atrophy;
- (vi) allergy to topical corticosteroids;

- (vii) cataracts;
- (viii) glaucoma;
- (ix) raised intraocular pressure

Authority required

Short-term (up to 3 weeks) intermittent treatment of atopic dermatitis of the face or eyelids in patients aged at least 3 months who fail to achieve satisfactory disease control with intermittent topical corticosteroid therapy, and where more than 3 months have passed since the initial diagnosis of atopic dermatitis.

Failure to achieve satisfactory disease control with intermittent topical corticosteroid therapy is manifest by:

- (i) failure of the facial skin to clear despite at least 2 weeks of topical hydrocortisone 1% applied every day; or
- (ii) failure of the facial skin to clear despite at least 1 week of a moderate or potent topical corticosteroid applied every day; or
- (iii) clearing of the facial skin with at least 2 weeks of topical hydrocortisone 1% applied every day, but almost immediate and significant flare in facial disease (within 48 hours) upon stopping topical corticosteroids, occurring on at least 2 consecutive occasions; or
- (iv) clearing of the facial skin with at least 1 week of a moderate or potent topical corticosteroid applied every day, but almost immediate and significant flare in facial disease (within 48 hours) upon stopping topical corticosteroids, occurring on at least 2 consecutive occasions

Note

No applications for increased maximum quantities and/or repeats will be authorised. Only 1 authority application per 6 months, per patient, will be authorised.

pimecrolimus 1% (10 mg/g) cream, 15 g

8802G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	1	..	34.13	35.28	Elidel [HM]

*Other dermatologicals***■ DAPSONE****Note**


Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

dapsone 100 mg tablet, 100

1272Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	114.18	37.70	Link Medical Products Pty Ltd [LM]

dapsone 25 mg tablet, 100

8801F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	100.92	37.70	Link Medical Products Pty Ltd [LM]

■ IMIQUIMOD**Authority required**

Superficial basal cell carcinoma

Clinical criteria:

The condition must be previously untreated, **AND**

The condition must be confirmed by biopsy, **AND**

Patient must have normal immune function, **AND**

The condition must not be suitable for treatment with surgical excision; OR

The condition must not be suitable for treatment with cryotherapy; OR

The condition must not be suitable for treatment with curettage with diathermy, **AND**

Patient must require topical drug therapy.

The date of the pathology report and name of the Approved Pathology Authority must be provided at the time of application.

Note

The patient or carer must be able to understand and administer the imiquimod dosing regimen.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Treatment of recurrent (previously treated) lesions will not be authorised.

Pharmaceutical benefits that have the form imiquimod single use sachets and pharmaceutical benefits that have the form imiquimod multi-use pump are equivalent for the purposes of substitution.

imiquimod 5% cream, 12 x 250 mg sachets

2546B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	1	..	135.72	37.70	^a Aldara [IA]	^a Aldiq [QA]

^a APO-Imiquimod [TX]**imiquimod 5% cream, 2 x 2 g pump packs**

2637T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	135.72	37.70	^a Aldara Pump [IA]

■ **GENITO URINARY SYSTEM AND SEX HORMONES**■ **OTHER GYNECOLOGICALS****CONTRACEPTIVES FOR TOPICAL USE***Intrauterine contraceptives*■ **LEVONORGESTREL****Restricted benefit**

Contraception

Restricted benefit

Idiopathic menorrhagia where oral treatments are ineffective

Restricted benefit

Idiopathic menorrhagia where oral treatments are contraindicated

levonorgestrel 52 mg drug delivery system: intrauterine, 1 system

8633J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	266.56	37.70	Mirena [BN]

OTHER GYNECOLOGICALS*Prolactine inhibitors*■ **BROMOCRIPTINE****Restricted benefit**

Prevention of the onset of lactation in the puerperium for medical reasons

bromocriptine 2.5 mg tablet, 30

1444B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	19.26	20.41	^a Krypton 2.5 [AF]	^a Parlodel [NV]

■ **BROMOCRIPTINE****Restricted benefit**

Acromegaly

Restricted benefit

Parkinson's disease

Restricted benefit

Pathological hyperprolactinaemia where surgery is not indicated

Restricted benefit

Pathological hyperprolactinaemia where surgery has already been used with incomplete resolution

Restricted benefit

Pathological hyperprolactinaemia where radiotherapy is not indicated

Restricted benefit

Pathological hyperprolactinaemia where radiotherapy has already been used with incomplete resolution

Note

Care should be taken when treating patients with advanced age and significant cognitive impairment with dopamine agonists.

For item codes 1443Y and 1559C, pharmaceutical benefits that have the form tablet 2.5 mg (base) are equivalent for the purposes of substitution.

bromocriptine 2.5 mg tablet, 30

1443Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*31.76	32.91	^a Parlodel [NV]

bromocriptine 2.5 mg tablet, 60

1559C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	31.76	32.91	^a Krypton 2.5 [AF]

■ **CABERGOLINE****Restricted benefit**

Prevention of the onset of lactation in the puerperium for medical reasons

cabergoline 500 microgram tablet, 2

8115D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	22.12	23.27	^a Dostan [GN]	^a Dostinex [PF]

■ CABERGOLINE
Authority required (STREAMLINED)
2659

Pathological hyperprolactinaemia where surgery is not indicated

Authority required (STREAMLINED)
2660

Pathological hyperprolactinaemia where surgery has already been used with incomplete resolution

Authority required (STREAMLINED)
2661

Pathological hyperprolactinaemia where radiotherapy is not indicated

Authority required (STREAMLINED)
2662

Pathological hyperprolactinaemia where radiotherapy has already been used with incomplete resolution

cabergoline 500 microgram tablet, 8

8114C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	65.57	37.70	^a Dostan [GN]	^a Dostinex [PF]

■ QUINAGOLIDE
Authority required (STREAMLINED)
2659

Pathological hyperprolactinaemia where surgery is not indicated

Authority required (STREAMLINED)
2660

Pathological hyperprolactinaemia where surgery has already been used with incomplete resolution

Authority required (STREAMLINED)
2661

Pathological hyperprolactinaemia where radiotherapy is not indicated

Authority required (STREAMLINED)
2662

Pathological hyperprolactinaemia where radiotherapy has already been used with incomplete resolution

quinagolide 25 microgram tablet [3 tablets] (&) quinagolide 50 microgram tablet [3 tablets], 6

8860H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	11.81	12.96	Norprolac [FP]

quinagolide 75 microgram tablet, 30

8822H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	55.13	37.70	Norprolac [FP]

■ SEX HORMONES AND MODULATORS OF THE GENITAL SYSTEM
HORMONAL CONTRACEPTIVES FOR SYSTEMIC USE
Progestogens and estrogens, fixed combinations
■ ETHINYLOESTRADIOL + LEVONORGESTREL
ethinyloestradiol 30 microgram + levonorgestrel 150 microgram tablet [84] (&) inert substance tablet [28], 112 [4 x 28]

1394J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	15.64	16.79	^b Eleanor 150/30 ED [EA] ^b Femme-Tab ED 30/150 [AE] ^b Micronelle 30 ED [TX]	^b Evelyn 150/30 ED [GQ] ^b Levlen ED [SY] ^a Monofeme 28 [FZ]
			^B 11.41	27.05	16.79	^b Microgynon 30 ED [BN]	
			^B 14.37	30.01	16.79	^a Nordette 28 [PF]	

ethinyloestradiol 50 microgram + levonorgestrel 125 microgram tablet [84] (&) inert substance tablet [28], 112 [4 x 28]

1456P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	15.64	16.79	Microgynon 50 ED [BN]

ethinylloestradiol 20 microgram + levonorgestrel 100 microgram tablet [84] (&) inert substance tablet [28], 112 [4 x 28]

2416E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	15.64	16.79	Femme-Tab ED 20/100 [AE]

▪ ETHINYLOESTRADIOL + NORETHISTERONE

ethinylloestradiol 35 microgram + norethisterone 1 mg tablet [84] (&) inert substance tablet [28], 112 [4 x 28]

2775C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	16.80	17.95	^a Norimin-1 28 Day [FZ]
			^B 10.67	27.47	17.95	^a Brevinor-1 [PF]

ethinylloestradiol 35 microgram + norethisterone 500 microgram tablet [84] (&) inert substance tablet [28], 112 [4 x 28]

2774B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	16.80	17.95	^a Norimin 28 Day [FZ]
			^B 10.67	27.47	17.95	^a Brevinor [PF]

▪ MESTRANOL + NORETHISTERONE

mestranol 50 microgram + norethisterone 1 mg tablet [84] (&) inert substance tablet [28], 112 [4 x 28]

3179H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	16.80	17.95	Norinyl-1/28 [PF]

Progestogens and estrogens, sequential preparations

▪ ETHINYLOESTRADIOL + LEVONORGESTREL

ethinylloestradiol 30 microgram + levonorgestrel 50 microgram tablet [24] (&) ethinylloestradiol 40 microgram + levonorgestrel 75 microgram tablet [20] (&) ethinylloestradiol 30 microgram + levonorgestrel 125 microgram tablet [40] (&) inert substance tablet [28], 112 [4 x 28]

1392G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	15.64	16.79	^b Logynon ED [SY]	^a Trifeme 28 [FZ]
			^B 11.41	27.05	16.79	^b Triquilar ED [BN]	
			^B 14.37	30.01	16.79	^a Triphasil 28 [PF]	

Progestogens

▪ ETONOGESTREL

etonogestrel 68 mg implant, 1

8487Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP MW	1	..	..	216.26	37.70	Implanon NXT [MK]

▪ LEVONORGESTREL

levonorgestrel 30 microgram tablet, 112 [4 x 28 tablets]

2913H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP MW	1	2	..	17.66	18.81	Microlut 28 [BN]

▪ MEDROXYPROGESTERONE

medroxyprogesterone acetate 150 mg/mL injection, 1 x 1 mL vial

3118D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	23.01	24.16	^a Depo-Ralovera [FZ]
			^B 6.19	29.20	24.16	^a Depo-Provera [PF]

▪ NORETHISTERONE

norethisterone 350 microgram tablet, 112 [4 x 28]

1967M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	16.80	17.95	Micronor [JC]	Noriday 28 Day [PF]

ANDROGENS

3-oxoandrosten (4) derivatives

▪ TESTOSTERONE

Authority required

Androgen deficiency

Clinical criteria:

Patient must have an established pituitary or testicular disorder.

Population criteria:

Patient must be male.

Treatment criteria:

Must be treated by a specialist paediatric endocrinologist, specialist urologist, specialist endocrinologist or a registered member of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

The name of the specialist must be included in the authority application.

Authority required

Androgen deficiency

Clinical criteria:

Patient must not have an established pituitary or testicular disorder, **AND**

The condition must not be due to age, obesity, cardiovascular diseases, infertility or drugs.

Population criteria:

Patient must be male, **AND**

Patient must be aged 40 years or older.

Treatment criteria:

Must be treated by a specialist urologist, specialist endocrinologist or a registered member of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

Androgen deficiency is defined as:

(i) testosterone level of less than 6 nmol per litre; OR

(ii) testosterone level between 6 and 15 nmol per litre with high luteinising hormone (LH) (greater than 1.5 times the upper limit of the eugonadal reference range for young men, or greater than 14 IU per litre, whichever is higher).

Androgen deficiency must be confirmed by at least two morning blood samples taken on different mornings.

The dates and levels of the qualifying testosterone and LH measurements must be, or must have been provided in the authority application when treatment with this drug is or was initiated.

The name of the specialist must be included in the authority application.

Authority required

Micropenis

Population criteria:

Patient must be male, **AND**

Patient must be under 18 years of age.

Treatment criteria:

Must be treated by a specialist paediatric endocrinologist, specialist urologist, specialist endocrinologist or a registered member of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

The name of the specialist must be included in the authority application.

Authority required

Pubertal induction

Population criteria:

Patient must be male, **AND**

Patient must be under 18 years of age.

Treatment criteria:

Must be treated by a specialist paediatric endocrinologist, specialist urologist, specialist endocrinologist or a registered member of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

The name of the specialist must be included in the authority application.

Authority required

Constitutional delay of growth or puberty

Population criteria:

Patient must be male, **AND**

Patient must be under 18 years of age.

Treatment criteria:

Must be treated by a specialist paediatric endocrinologist, specialist urologist, specialist endocrinologist or a registered member of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

The name of the specialist must be included in the authority application.

testosterone 1% (50 mg/5 g) gel, 30 x 5 g sachets

8830R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	5	..	95.46	37.70	Testogel [HB]

testosterone 2% (30 mg/1.5 mL actuation) transdermal solution, 60 actuations

2341F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	5	..	82.79	37.70	Axiron [LY]

testosterone 2.5 mg/24 hours patch, 60

8460G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	96.18	37.70	Androderm [GN]

testosterone 5 mg/24 hours patch, 30

8619P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	96.18	37.70	Androderm [GN]

■ TESTOSTERONE ENANTHATE**Authority required**

Androgen deficiency

Clinical criteria:

Patient must have an established pituitary or testicular disorder.

Population criteria:

Patient must be male.

Treatment criteria:

Must be treated by a specialist paediatric endocrinologist, specialist urologist, specialist endocrinologist or a registered member of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

The name of the specialist must be included in the authority application.

Authority required

Androgen deficiency

Clinical criteria:Patient must not have an established pituitary or testicular disorder, **AND**

The condition must not be due to age, obesity, cardiovascular diseases, infertility or drugs.

Population criteria:Patient must be male, **AND**

Patient must be aged 40 years or older.

Treatment criteria:

Must be treated by a specialist urologist, specialist endocrinologist or a registered member of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

Androgen deficiency is defined as:

(i) testosterone level of less than 6 nmol per litre; OR

(ii) testosterone level between 6 and 15 nmol per litre with high luteinising hormone (LH) (greater than 1.5 times the upper limit of the eugonadal reference range for young men, or greater than 14 IU per litre, whichever is higher).

Androgen deficiency must be confirmed by at least two morning blood samples taken on different mornings.

The dates and levels of the qualifying testosterone and LH measurements must be, or must have been provided in the authority application when treatment with this drug is or was initiated.

The name of the specialist must be included in the authority application.

Authority required

Micropenis

Population criteria:Patient must be male, **AND**

Patient must be under 18 years of age.

Treatment criteria:

Must be treated by a specialist paediatric endocrinologist, specialist urologist, specialist endocrinologist or a registered member of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

The name of the specialist must be included in the authority application.

Authority required

Pubertal induction

Population criteria:Patient must be male, **AND**

Patient must be under 18 years of age.

Treatment criteria:

Must be treated by a specialist paediatric endocrinologist, specialist urologist, specialist endocrinologist or a registered member of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

The name of the specialist must be included in the authority application.

Authority required

Constitutional delay of growth or puberty

Population criteria:Patient must be male, **AND**

Patient must be under 18 years of age.

Treatment criteria:

Must be treated by a specialist paediatric endocrinologist, specialist urologist, specialist endocrinologist or a registered member of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

The name of the specialist must be included in the authority application.

testosterone enanthate 250 mg/mL injection, 3 x 1 mL syringes

2114G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	33.82	34.97	Primoteston Depot [BN]

■ TESTOSTERONE UNDECANOATE

Authority required

Androgen deficiency

Clinical criteria:

Patient must have an established pituitary or testicular disorder.

Population criteria:

Patient must be male.

Treatment criteria:

Must be treated by a specialist paediatric endocrinologist, specialist urologist, specialist endocrinologist or a registered member of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

The name of the specialist must be included in the authority application.

Authority required

Androgen deficiency

Clinical criteria:

Patient must not have an established pituitary or testicular disorder, **AND**

The condition must not be due to age, obesity, cardiovascular diseases, infertility or drugs.

Population criteria:

Patient must be male, **AND**

Patient must be aged 40 years or older.

Treatment criteria:

Must be treated by a specialist urologist, specialist endocrinologist or a registered member of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

Androgen deficiency is defined as:

(i) testosterone level of less than 6 nmol per litre; OR

(ii) testosterone level between 6 and 15 nmol per litre with high luteinising hormone (LH) (greater than 1.5 times the upper limit of the eugonadal reference range for young men, or greater than 14 IU per litre, whichever is higher).

Androgen deficiency must be confirmed by at least two morning blood samples taken on different mornings.

The dates and levels of the qualifying testosterone and LH measurements must be, or must have been provided in the authority application when treatment with this drug is or was initiated.

The name of the specialist must be included in the authority application.

Authority required

Micropenis

Population criteria:

Patient must be male, **AND**

Patient must be under 18 years of age.

Treatment criteria:

Must be treated by a specialist paediatric endocrinologist, specialist urologist, specialist endocrinologist or a registered member of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

The name of the specialist must be included in the authority application.

Authority required

Pubertal induction

Population criteria:

Patient must be male, **AND**

Patient must be under 18 years of age.

Treatment criteria:

Must be treated by a specialist paediatric endocrinologist, specialist urologist, specialist endocrinologist or a registered member of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

The name of the specialist must be included in the authority application.

Authority required

Constitutional delay of growth or puberty

Population criteria:

Patient must be male, **AND**

Patient must be under 18 years of age.

Treatment criteria:

Must be treated by a specialist paediatric endocrinologist, specialist urologist, specialist endocrinologist or a registered member of the Australasian Chapter of Sexual Health Medicine; or in consultation with one of these specialists; or have an appointment to be assessed by one of these specialists.

The name of the specialist must be included in the authority application.

testosterone undecanoate 1 g/4 mL injection, 1 x 4 mL vial

10205D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	147.75	37.70	Reandron 1000 [BN]

testosterone undecanoate 40 mg capsule, 60

2115H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	37.87	37.70	Andriol Testocaps [MK]

ESTROGENS

Natural and semisynthetic estrogens, plain

■ OESTRADIOL

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

oestradiol 10 microgram pessary: modified release, 18

10203B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	31.20	32.35	Vagifem Low [NO]

■ OESTRADIOL

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

oestradiol 2 mg tablet, 56

8274L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	13.89	15.04	Zumenon [GO]

oestradiol valerate 1 mg tablet, 56

1663M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	12.02	13.17	Progynova [BN]

oestradiol valerate 2 mg tablet, 56

1664N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	14.24	15.39	Progynova [BN]

■ OESTRADIOL

Note

Oestradiol should be used in conjunction with an oral progestogen in women with an intact uterus.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

oestradiol 0.1% (1 mg/g) gel, 28 x 1 g sachets

8286D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	17.43	18.58	Sandrena [AS]

oestradiol 100 microgram/24 hours patch, 4

8126Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	19.47	20.62	Climara 100 [BN]

oestradiol 100 microgram/24 hours patch, 8

8312L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	19.47	20.62	Estraderm MX 100 [NV]

oestradiol 100 microgram/24 hours patch, 8

8765H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	19.47	20.62	Estradot 100 [NV]

oestradiol 25 microgram/24 hours patch, 4

8485N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	17.43	18.58	Climara 25 [BN]

oestradiol 25 microgram/24 hours patch, 8

8311K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	17.43	18.58	Estraderm MX 25 [NV]

oestradiol 25 microgram/24 hours patch, 8

8761D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	17.43	18.58	Estradot 25 [NV]

oestradiol 37.5 microgram/24 hours patch, 8

8762E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	17.43	18.58	Estradot 37.5 [NV]

oestradiol 50 microgram/24 hours patch, 4

8125P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	17.43	18.58	Climara 50 [BN]

oestradiol 50 microgram/24 hours patch, 8

8140K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	17.43	18.58	Estraderm MX 50 [NV]

oestradiol 50 microgram/24 hours patch, 8

8763F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	17.43	18.58	Estradot 50 [NV]

oestradiol 75 microgram/24 hours patch, 4

8486P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	19.47	20.62	Climara 75 [BN]

oestradiol 75 microgram/24 hours patch, 8

8764G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	19.47	20.62	Estradot 75 [NV]

■ OESTRIOL
Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

oestriol 0.1% (1 mg/g) cream, 15 g

1781R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	1	..	19.43	20.58	Ovestin [AS]

oestriol 500 microgram pessary, 15

1771F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	2	..	21.60	22.75	Ovestin Ovula [AS]

PROGESTOGENS

Pregnen (4) derivatives

■ MEDROXYPROGESTERONE
Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

medroxyprogesterone acetate 10 mg tablet, 30

2321E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	14.66	15.81	^a Ralovera [FZ]
			^b 2.46	17.12	15.81	^a Provera [PF]

medroxyprogesterone acetate 5 mg tablet, 56

2323G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	15.96	17.11	^a Ralovera [FZ]
			^b 2.59	18.55	17.11	^a Provera [PF]

■ MEDROXYPROGESTERONE**Restricted benefit**

Endometriosis

medroxyprogesterone acetate 10 mg tablet, 100

2722G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	33.10	34.25	^a Ralovera [FZ]
			^b 2.53	35.63	34.25	^a Provera [PF]

Estren derivatives**■ NORETHISTERONE****Note**

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

norethisterone 5 mg tablet, 30

2993M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	32.30	33.45	Primolut N [BN]

PROGESTOGENS AND ESTROGENS IN COMBINATION***Progestogens and estrogens, fixed combinations*****■ NORETHISTERONE ACETATE + OESTRADIOL****Note**

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

oestradiol 50 microgram/24 hours + norethisterone acetate 140 microgram/24 hours patch, 8

8427M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	19.47	20.62	Estalis continuous 50/140 [NV]

oestradiol 50 microgram/24 hours + norethisterone acetate 250 microgram/24 hours patch, 8

8428N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	19.47	20.62	Estalis continuous 50/250 [NV]

■ OESTRADIOL + DYDROGESTERONE**Note**

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

oestradiol 1 mg + dydrogesterone 5 mg tablet, 28

10142T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	19.10	20.25	Femoston-Conti [GO]

Progestogens and estrogens, sequential preparations**■ NORETHISTERONE ACETATE + OESTRADIOL (&) OESTRADIOL****Note**

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

oestradiol 50 microgram/24 hours patch [4 patches] (&) oestradiol 50 microgram/24 hours + norethisterone acetate 140 microgram/24 hours patch [4 patches], 8

8425K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	19.47	20.62	Estalis sequi 50/140 [NV]

oestradiol 50 microgram/24 hours patch [4 patches] (&) oestradiol 50 microgram/24 hours + norethisterone acetate 250 microgram/24 hours patch [4 patches], 8

8426L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	19.47	20.62	Estalis sequi 50/250 [NV]

▪ **OESTRADIOL (&) OESTRADIOL + DYDROGESTERONE**

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

oestradiol 1 mg tablet [14] (&) oestradiol 1 mg + dydrogesterone 10 mg tablet [14], 28

10146B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	19.10	20.25	Femoston 1/10 [GO]

▪ **OESTRADIOL (&) OESTRADIOL + DYDROGESTERONE**

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

oestradiol 2 mg tablet [14] (&) oestradiol 2 mg + dydrogesterone 10 mg tablet [14], 28

8244X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	19.10	20.25	Femoston 2/10 [GO]

GONADOTROPINS AND OTHER OVULATION STIMULANTS

Gonadotropins

▪ **FOLLITROPIN ALFA**

Restricted benefit

Anovulatory infertility

Restricted benefit

For the treatment of infertility in males due to hypogonadotrophic hypogonadism, following failure of 6 months' treatment with human chorionic gonadotrophin to achieve adequate spermatogenesis. Combined treatment with HCG must be given

Note

Except in cases of hypopituitarism or primary amenorrhoea, the patient should have been adequately treated with clomiphene citrate and/or gonadorelin and failed to have conceived.

Women who have had apparent ovulation induced by other agents and have failed to conceive should have laparoscopic evidence that there is no other impediment to conception.

Oligomenorrhoea should have been present for at least twelve months or amenorrhoea for at least six months prior to treatment.

Patients with hyperprolactinaemia should have had appropriate surgical or medical treatment prior to treatment.

follitropin alfa 300 international units / 0.5 mL (21.84 microgram/0.5 mL) injection, 1 x 0.5 mL cartridge

8713N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	3	5	..	*493.84	37.70	Gonal-f Pen [SG]

follitropin alfa 450 international units / 0.75 mL (32.76 microgram/0.75 mL) injection, 1 x 0.75 mL cartridge

8714P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	3	5	..	*737.41	37.70	Gonal-f Pen [SG]

follitropin alfa 900 international units / 1.5 mL (65.52 microgram/1.5 mL) injection, 1 x 1.5 mL cartridge

8715Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*980.94	37.70	Gonal-f Pen [SG]

▪ FOLLITROPIN BETA**Restricted benefit**

Anovulatory infertility

Restricted benefit

For the treatment of infertility in males due to hypogonadotrophic hypogonadism, following failure of 6 months' treatment with human chorionic gonadotrophin to achieve adequate spermatogenesis. Combined treatment with HCG must be given

Note

Except in cases of hypopituitarism or primary amenorrhoea, the patient should have been adequately treated with clomiphene citrate and/or gonadorelin and failed to have conceived.

Women who have had apparent ovulation induced by other agents and have failed to conceive should have laparoscopic evidence that there is no other impediment to conception.

Oligomenorrhoea should have been present for at least twelve months or amenorrhoea for at least six months prior to treatment.

Patients with hyperprolactinaemia should have had appropriate surgical or medical treatment prior to treatment.

follitropin beta 300 international units/0.36 mL injection, 1 x 0.36 mL cartridge

8565T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	3	5	..	*509.95	37.70	Puregon 300 IU/0.36 mL [MK]

follitropin beta 600 international units/0.72 mL injection, 1 x 0.72 mL cartridge

8566W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*661.40	37.70	Puregon 600 IU/0.72 mL [MK]

follitropin beta 900 international units/1.08 mL injection, 1 x 1.08 mL cartridge

8871X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*979.92	37.70	Puregon 900 IU/1.08 mL [MK]

▪ GONADOTROPHIN CHORIONIC HUMAN**Restricted benefit**

Anovulatory infertility

Restricted benefit

For the treatment of infertility in males due to hypogonadotrophic hypogonadism

Restricted benefit

For the treatment of infertility in males associated with isolated luteinising hormone deficiency

Restricted benefit

For the treatment of males who have combined deficiency of human growth hormone and gonadotrophins and in whom the absence of secondary sexual characteristics indicates a lag in maturation

Restricted benefit

For the treatment of boys over the age of 16 years who show clinical evidence of hypogonadism or delayed puberty. Treatment must not extend beyond 6 months

Note

Except in cases of hypopituitarism or primary amenorrhoea, the patient should have been adequately treated with clomiphene citrate and/or gonadorelin and failed to have conceived.

Women who have had apparent ovulation induced by other agents and have failed to conceive should have laparoscopic evidence that there is no other impediment to conception.

Oligomenorrhoea should have been present for at least twelve months or amenorrhoea for at least six months prior to treatment.

Patients with hyperprolactinaemia should have had appropriate surgical or medical treatment prior to treatment.

gonadotrophin chorionic human 1500 international units injection [3 x 1500 international units ampoules] (& inert substance diluent [3 x 1 mL ampoules], 1 pack

1581F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	53.81	37.70	Pregnyl [MK]

Ovulation stimulants, synthetic

▪ CLOMIPHENE**Restricted benefit**

Anovulatory infertility

Restricted benefit

Patients undergoing in-vitro fertilisation

Note

Care must be taken to comply with the provisions of State/Territory law when prescribing clomiphene citrate.

clomiphene citrate 50 mg tablet, 10

1211R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	34.85	36.00	^a Clomid [SW]	^a Serophene [SG]

ANTIANDROGENS

Antiandrogens, plain

■ CYPROTERONE

Caution

This drug should not be used during pregnancy as it may result in feminisation of the male foetus.

Authority required (STREAMLINED)

1230

Moderate to severe androgenisation in non-pregnant women (acne alone is not a sufficient indication of androgenisation)

cyproterone acetate 50 mg tablet, 20

1269T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	27.79	28.94	^a Cyprocur 50 [QA] ^a Cyprostat [SY] ^a Cyproterone Sandoz [HX] ^a Procur [GN]	^a Cyprone [AF] ^a Cyproterone AN [EA] ^a GenRx Cyproterone Acetate [GX]
			^B 2.05	29.84	28.94	^a Androcur [BN]	

■ CYPROTERONE

Authority required (STREAMLINED)

1014

Advanced carcinoma of the prostate

Authority required (STREAMLINED)

1404

To reduce drive in sexual deviations in males

cyproterone acetate 100 mg tablet, 50

8019C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	85.11	37.70	^a Cyprocur 100 [QA] ^a Cyproterone AN [EA] ^a GenRx Cyproterone Acetate [GX]	^a Cyprostat-100 [SY] ^a Cyproterone Sandoz [HX] ^a Procur 100 [GN]
			^B 0.80	85.91	37.70	^a Androcur-100 [BN]	

cyproterone acetate 50 mg tablet, 50

1270W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*107.36	37.70	^a Cyprocur 50 [QA] ^a Cyprostat [SY] ^a Cyproterone Sandoz [HX] ^a GenRx Cyproterone Acetate [GX]	^a Cyprone [AF] ^a Cyproterone AN [EA] ^a Cyrotone [ER] ^a Procur [GN]
			^B 1.88	*109.24	37.70	^a Androcur [BN]	

OTHER SEX HORMONES AND MODULATORS OF THE GENITAL SYSTEM

Antigonadotropins and similar agents

■ DANAZOL

Caution

Pregnancy must be excluded prior to administration of this drug.

Authority required (STREAMLINED)

1090

Endometriosis, visually proven

Authority required (STREAMLINED)

1151

Hereditary angio-oedema

Authority required (STREAMLINED)

2639

Short-term treatment (up to 6 months) of intractable primary menorrhagia (Treatment of this indication is limited to 6 months. See Australian Product Information)

Authority required (STREAMLINED)**2640**

Short-term treatment (up to 6 months) of severe benign (fibrocystic) breast disease or mastalgia associated with severe symptomatic benign breast disease in patients refractory to other treatments (Treatment of this indication is limited to 6 months. See Australian Product Information)

danazol 100 mg capsule, 100

1285P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	58.92	37.70	Azol 100 [AF]

danazol 200 mg capsule, 100

1287R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	87.31	37.70	Azol 200 [AF]

■ GESTRINONE**Authority required (STREAMLINED)****3652**

Short-term treatment (up to 6 months) of visually proven endometriosis (only 1 course of not more than 6 months' therapy may be prescribed)

gestrinone 2.5 mg capsule, 8

8015W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	82.15	37.70	Dimetriose [SW]

*Progesterone receptor modulators***■ MIFEPRISTONE (&) MISOPROSTOL****Authority required**

Termination of an intra-uterine pregnancy

Clinical criteria:

The condition must be an intra-uterine pregnancy of up to 63 days of gestation.

Treatment criteria:

Must be treated by a prescriber who is registered with the MS 2 Step Prescribing Program.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

mifepristone 200 mg tablet [1] (&) misoprostol 200 microgram tablet [4], 1 pack

10211K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	..	..	321.38	37.70	MS-2 Step [XH]

■ UROLOGICALS**UROLOGICALS***Drugs for urinary frequency and incontinence***■ OXYBUTYNIN****Restricted benefit**

Detrusor overactivity

oxybutynin hydrochloride 5 mg tablet, 100

8039D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.80	14.95	^a Ditropan [SW] ^a Oxybutynin Winthrop [WA]	^a Oxybutynin Sandoz [SZ]

■ OXYBUTYNIN**Restricted benefit**

Detrusor overactivity in a patient who cannot tolerate oral oxybutynin, or who cannot swallow oral oxybutynin

oxybutynin 3.9 mg/24 hours patch, 8

9454N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	35.57	36.72	Oxytrol [GN]

■ PROPANTHELINE**Restricted benefit**

Detrusor overactivity

propantheline bromide 15 mg tablet, 100

1953T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*26.80	27.95	Pro-Banthine [QA]

Other urologicals
■ BICARBONATE
sodium bicarbonate 840 mg capsule, 100

9470K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	14.34	15.49	Sodibic [AS]

■ PHENOXYBENZAMINE
Authority required

Phaeochromocytoma

Authority required

Neurogenic urinary retention

Note
Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

phenoxybenzamine hydrochloride 10 mg capsule, 100

1862B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	1164.81	37.70	Dibenyline [GH]

phenoxybenzamine hydrochloride 10 mg capsule, 100

9286R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	6860.58	37.70	Dibenzylamine [BZ]

phenoxybenzamine hydrochloride 10 mg capsule, 30

1166J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*205.24	37.70	Dibenyline [GH]

DRUGS USED IN BENIGN PROSTATIC HYPERTROPHY
Alpha-adrenoreceptor antagonists
■ DUTASTERIDE + TAMSULOSIN
Authority required (STREAMLINED)
3687

Treatment of lower urinary tract symptoms due to benign prostatic hyperplasia where treatment has been initiated by a urologist

Note
Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

dutasteride 500 microgram + tamsulosin hydrochloride 400 microgram capsule: modified release, 30

5490Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	35.63	36.78	Duodart 500ug/400ug [GK]

Testosterone-5-alpha reductase inhibitors
■ DUTASTERIDE
Authority required (STREAMLINED)
3667

Treatment, in combination with an alpha-antagonist, of lower urinary tract symptoms due to benign prostatic hyperplasia where treatment is initiated by a urologist

Note
Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

dutasteride 500 microgram capsule, 30

5468T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	30.77	31.92	Avodart [GK]

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES

ANTERIOR PITUITARY LOBE HORMONES AND ANALOGUES

ACTH

TETRACOSACTRIN

tetracosactrin 1 mg/mL injection: modified release, 1 x 1 mL ampoule

2832C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	5	5	..	*71.61	37.70	Synacthen Depot 1 mg/1 mL [NV]

Thyrotropin

THYROTROPIN ALFA

Authority required (STREAMLINED)**3193**

Ablation of thyroid remnant tissue, in combination with radioactive iodine, in a post thyroidectomy patient without known metastatic disease

thyrotropin alfa 900 microgram injection, 2 x 900 microgram vials

2700D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	1901.76	37.70	Thyrogen [GZ]

POSTERIOR PITUITARY LOBE HORMONES

Vasopressin and analogues

DESMOPRESSIN

Authority required (STREAMLINED)**1678**

Cranial diabetes insipidus

desmopressin acetate 10 microgram/actuation nasal spray, 60 actuations

8711L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*161.38	37.70	Minirin Nasal Spray [FP]

desmopressin acetate 100 microgram/mL nasal drops, 2.5 mL

2129C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	5	5	..	*161.51	37.70	Minirin [FP]

desmopressin acetate 200 microgram tablet, 30

8662X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	3	5	..	*180.25	37.70	Minirin [FP]

DESMOPRESSIN

Authority required (STREAMLINED)**2641**

Primary nocturnal enuresis in patients aged 6 years or older who are refractory to an enuresis alarm

Authority required (STREAMLINED)**2642**

Primary nocturnal enuresis in patients aged 6 years or older for whom an enuresis alarm is contraindicated. The reason that an alarm is contraindicated must be documented in the patient's medical records when treatment is initiated

Note

Not to be used in preference to enuresis alarms.

Desmopressin nasal spray may be associated with an increased risk of hyponatraemia compared to the oral formulations.

desmopressin acetate 10 microgram/actuation nasal spray, 60 actuations

8712M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	84.07	37.70	Minirin Nasal Spray [FP]

DESMOPRESSIN

Authority required (STREAMLINED)

2641

Primary nocturnal enuresis in patients aged 6 years or older who are refractory to an enuresis alarm

Authority required (STREAMLINED)**2642**

Primary nocturnal enuresis in patients aged 6 years or older for whom an enuresis alarm is contraindicated. The reason that an alarm is contraindicated must be documented in the patient's medical records when treatment is initiated

Note

Not to be used in preference to enuresis alarms.

Desmopressin nasal spray may be associated with an increased risk of hyponatraemia compared to the oral formulations.

Only one application per six months with no more than twice the maximum quantity will be authorised for the tablets.

desmopressin acetate 200 microgram tablet, 30

8663Y

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	64.59	37.70	Minirin [FP]

■ DESMOPRESSIN**Authority required (STREAMLINED)****2641**

Primary nocturnal enuresis in patients aged 6 years or older who are refractory to an enuresis alarm

Authority required (STREAMLINED)**2642**

Primary nocturnal enuresis in patients aged 6 years or older for whom an enuresis alarm is contraindicated. The reason that an alarm is contraindicated must be documented in the patient's medical records when treatment is initiated

Note

Not to be used in preference to enuresis alarms.

Desmopressin nasal spray may be associated with an increased risk of hyponatraemia compared to the oral formulations.

Only one application per six months will be authorised for the wafers. No more than twice the maximum quantity for the 120 micrograms wafers and no applications for increased maximum quantities for the 240 micrograms wafers will be authorised.

desmopressin 120 microgram wafer: sublingual, 30

9398P

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	71.19	37.70	Minirin Melt [FP]

desmopressin 240 microgram wafer: sublingual, 30

8975J

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	116.28	37.70	Minirin Melt [FP]

HYPOTHALAMIC HORMONES*Gonadotropin-releasing hormones***■ NAFARELIN****Authority required**

Initial treatment (up to 6 months) of visually proven endometriosis

Authority required

Subsequent treatment (up to 6 months) of visually proven endometriosis, where 2 years or more have elapsed since the end of the previous course and where a recent bone density assessment has been made. The date of the assessment must be provided

nafarelin 200 microgram/actuation nasal spray, 60 actuations

2962X

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
±1	5	..	132.13	37.70	Synarel [PF]

■ CORTICOSTEROIDS FOR SYSTEMIC USE**CORTICOSTEROIDS FOR SYSTEMIC USE, PLAIN***Mineralocorticoids***■ FLUDROCORTISONE ACETATE****Note**

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

fludrocortisone acetate 100 microgram tablet, 100

1433K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	1	..	*46.84	37.70	Florinef [QA]

*Glucocorticoids***■ BETAMETHASONE ACETATE + BETAMETHASONE SODIUM PHOSPHATE****Restricted benefit**

For local intra-articular or peri-articular infiltration

Restricted benefit

Keloid

Restricted benefit

Lichen planus hypertrophic

betamethasone (as acetate) 2.71 mg/mL + betamethasone (as sodium phosphate) 2.96 mg/mL injection, 5 x 1 mL ampoules

5034Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	25.34	26.49	Celestone Chronodose [MK]

■ BETAMETHASONE ACETATE + BETAMETHASONE SODIUM PHOSPHATE**Restricted benefit**

Alopecia areata

Restricted benefit

For local intra-articular or peri-articular infiltration

Restricted benefit

Granulomata, dermal

Restricted benefit

Keloid

Restricted benefit

Lichen planus hypertrophic

Restricted benefit

Lichen simplex chronicus

Restricted benefit

Lupus erythematosus, chronic discoid

Restricted benefit

Necrobiosis lipoidica

Restricted benefit

Uveitis

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

betamethasone (as acetate) 2.71 mg/mL + betamethasone (as sodium phosphate) 2.96 mg/mL injection, 5 x 1 mL ampoules

2694T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	25.34	26.49	Celestone Chronodose [MK]

■ CORTISONE**Note**

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

cortisone acetate 25 mg tablet, 60

1247P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	4	..	18.08	19.23	Cortate [AS]

cortisone acetate 5 mg tablet, 50

1246N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	4	..	15.64	16.79	Cortate [AS]

■ DEXAMETHASONE

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

DEXAMETHASONE Tablet 4 mg, 30

2507Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	4	..	12.74	13.89	Dexamethasone [AS]

DEXAMETHASONE Tablet 500 micrograms, 30

1292B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	4	..	9.18	10.33	Dexamethasone [AS]

■ DEXAMETHASONE SODIUM PHOSPHATE

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

DEXAMETHASONE SODIUM PHOSPHATE Injection equivalent to 4 mg dexamethasone phosphate in 1 mL, 5

2509C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	17.96	19.11	^a Dexamethasone [AF]	^a Hospira Pty Limited [HH]

DEXAMETHASONE SODIUM PHOSPHATE Injection equivalent to 8 mg dexamethasone phosphate in 2 mL, 5

1291Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	25.28	26.43	^a Dexamethasone [AF]	^a Hospira Pty Limited [HH]

■ HYDROCORTISONE

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

hydrocortisone 20 mg tablet, 60

1500Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	4	..	30.50	31.65	Hysone 20 [AF]

hydrocortisone 4 mg tablet, 50

1499X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	4	..	23.39	24.54	Hysone 4 [AF]

■ HYDROCORTISONE SODIUM SUCCINATE

hydrocortisone (as sodium succinate) 100 mg injection [1 x 100 mg vial] (&) inert substance diluent [1 x 2 mL vial], 1 pack

1501B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*18.04	19.19	Solu-Cortef [PF]

hydrocortisone (as sodium succinate) 250 mg injection [1 x 250 mg vial] (&) inert substance diluent [1 x 2 mL vial], 1 pack

3096Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	16.83	17.98	Solu-Cortef [PF]

■ HYDROCORTISONE SODIUM SUCCINATE

Restricted benefit

For use in a hospital

hydrocortisone (as sodium succinate) 100 mg injection [1 x 100 mg vial] (&) inert substance diluent [1 x 2 mL vial], 1 pack

1510L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	6	..	..	*40.60	37.70	Solu-Cortef [PF]

hydrocortisone (as sodium succinate) 100 mg injection [1 x 100 mg vial] (&) inert substance diluent [1 x 2 mL vial], 1 pack

5118J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	6	..	..	*40.60	37.70	Solu-Cortef [PF]

hydrocortisone (as sodium succinate) 250 mg injection [1 x 250 mg vial] (&) inert substance diluent [1 x 2 mL vial], 1 pack

1511M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	6	..	..	*64.60	37.70	Solu-Cortef [PF]

hydrocortisone (as sodium succinate) 250 mg injection [1 x 250 mg vial] (&) inert substance diluent [1 x 2 mL vial], 1 pack

5119K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	6	..	..	*64.60	37.70	Solu-Cortef [PF]

■ METHYLPREDNISOLONE

Restricted benefit

For local intra-articular or peri-articular infiltration

methylprednisolone acetate 40 mg/mL injection, 5 x 1 mL vials

1928L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	19.42	20.57	^a Depo-Nisolone [FZ]
			^B 1.08	20.50	20.57	^a Depo-Medrol [PF]

methylprednisolone acetate 40 mg/mL injection, 5 x 1 mL vials

5148Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	19.42	20.57	^a Depo-Nisolone [FZ]
			^B 1.08	20.50	20.57	^a Depo-Medrol [PF]

■ METHYLPREDNISOLONE

Note

Pharmaceutical benefits that have the form methylprednisolone powder for injection 40 mg (as sodium succinate) and pharmaceutical benefits that have the form methylprednisolone powder for injection 40 mg (as sodium succinate) with diluent are equivalent for the purposes of substitution.

methylprednisolone 40 mg injection [5 x 40 mg vials] (&) inert substance diluent [5 x 1 mL vials], 1 pack

2981X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	22.80	23.95	^a Solu-Medrol [PF]

methylprednisolone Powder for injection 40 mg (as sodium succinate), 5

5263B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	22.80	23.95	^a Methylpred [AL]

■ METHYLPREDNISOLONE

Note

Pharmaceutical benefits that have the form methylprednisolone powder for injection 1 g (as sodium succinate) and pharmaceutical benefits that have the form methylprednisolone powder for injection 1 g (as sodium succinate) with diluent are equivalent for the purposes of substitution.

methylprednisolone 1 g injection [1 x 1 g vial] (&) inert substance diluent [1 x 16 mL vial], 1 pack

8834Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	55.68	37.70	^a Solu-Medrol [PF]

methylprednisolone Powder for injection 1 g (as sodium succinate), 1

5264C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	55.68	37.70	^a Methylpred [AL]	^a Methylprednisolone Alphapharm [AF]
						^a Solu-Medrol [PF]	

■ PREDNISOLONE

prednisolone 1 mg tablet, 100

3152X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	4	..	8.67	9.82	^a Predsolone [LN]
			^B 0.82	9.49	9.82	^a Panafcortelone [AS]

prednisolone 25 mg tablet, 30

1916W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	4	..	10.47	11.62	Panafcortelone [AS]	Solone [IA]

prednisolone 5 mg tablet, 60

1917X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	4	..	8.81	9.96	Panafcortelone [AS]	Solone [IA]

▪ PREDNISOLONE SODIUM PHOSPHATE**prednisolone (as sodium phosphate) 5 mg/mL oral liquid, 30 mL**

8285C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	15.04	16.19	^a PredMix [LN]
			^B 2.70	17.74	16.19	^a Redipred [AS]

▪ PREDNISONE**prednisone 1 mg tablet, 100**

1934T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	4	..	9.20	10.35	^a Predsone [LN]
			^B 0.91	10.11	10.35	^a Panafcort [AS]

prednisone 25 mg tablet, 30

1936X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	4	..	11.75	12.90	Panafcort [AS]	Sone [IA]

prednisone 5 mg tablet, 60

1935W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	4	..	9.52	10.67	Panafcort [AS]	Sone [IA]

▪ TRIAMCINOLONE**Restricted benefit**

For local intra-articular or peri-articular infiltration

Restricted benefit

Keloid

Restricted benefit

Lichen planus hypertrophic

triamcinolone acetonide 10 mg/mL injection, 5 x 1 mL ampoules

5233K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	25.34	26.49	Kenacort-A10 [QA]

▪ TRIAMCINOLONE**Restricted benefit**

Alopecia areata

Restricted benefit

For local intra-articular or peri-articular infiltration

Restricted benefit

Granulomata, dermal

Restricted benefit

Keloid

Restricted benefit

Lichen planus hypertrophic

Restricted benefit

Lichen simplex chronicus

Restricted benefit

Lupus erythematosus, chronic discoid

Restricted benefit

Necrobiosis lipoidica

Restricted benefit

Psoriasis

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

triamcinolone acetonide 10 mg/mL injection, 5 x 1 mL ampoules

2990J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	25.34	26.49	Kenacort-A10 [QA]

■ **THYROID THERAPY****THYROID PREPARATIONS***Thyroid hormones*■ **LIOTHYRONINE**Authority required (STREAMLINED)**1219**

Management of patients with thyroid cancer

Authority required (STREAMLINED)**1858**

Replacement therapy for hypothyroid patients who have documented intolerance to thyroxine sodium

Authority required (STREAMLINED)**1859**

Replacement therapy for hypothyroid patients who have documented resistance to thyroxine sodium

Authority required (STREAMLINED)**1182**

Initiation of thyroid therapy in severely hypothyroid patients

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

liothyronine sodium 20 microgram tablet, 100

2318B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	83.87	37.70	Tertroxin [QA]

■ **THYROXINE****Note**

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

thyroxine sodium 100 microgram tablet, 200

2175L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	24.32	25.47	^a Eutroxsig [FM]
			^B 2.21	26.53	25.47	^a Oroxine [QA]

thyroxine sodium 200 microgram tablet, 200

2173J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	27.35	28.50	^a Eutroxsig [FM]
			^B 2.21	29.56	28.50	^a Oroxine [QA]

thyroxine sodium 50 microgram tablet, 200

2174K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	23.71	24.86	^a Eutroxsig [FM]
			^B 2.20	25.91	24.86	^a Oroxine [QA]

thyroxine sodium 75 microgram tablet, 200

9287T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	24.36	25.51	^a Eutroxsig [FM]
			^B 2.27	26.63	25.51	^a Oroxine [QA]

ANTITHYROID PREPARATIONS*Thiouracils*■ **PROPYLTHIOURACIL****Note**

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

propylthiouracil 50 mg tablet, 100

1955X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	2	..	*49.98	37.70	PTU [PL]

Sulfur-containing imidazole derivatives

■ CARBIMAZOLE

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

carbimazole 5 mg tablet, 100

1153Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	2	..	*31.38	32.53	Carbimazol ARISTO [PQ]	Neo-Mercazole [LM]

■ PANCREATIC HORMONES

GLYCOGENOLYTIC HORMONES

Glycogenolytic hormones

■ GLUCAGON HYDROCHLORIDE

glucagon hydrochloride 1 mg injection [1 x 1 mg vial] (&) inert substance diluent [1 x 1 mL syringe], 1 pack

1449G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	50.55	37.70	GlucaGen Hypokit [NO]

glucagon hydrochloride 1 mg injection [1 x 1 mg vial] (&) inert substance diluent [1 x 1 mL syringe], 1 pack

5105Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	50.55	37.70	GlucaGen Hypokit [NO]

■ CALCIUM HOMEOSTASIS

PARATHYROID HORMONES AND ANALOGUES

Parathyroid hormones and analogues

■ TERIPARATIDE

Authority required

Severe established osteoporosis

Treatment Phase: Initial treatment

Clinical criteria:

Patient must be at very high risk of fracture, **AND**

Patient must have a bone mineral density (BMD) T-score of -3.0 or less, **AND**

Patient must have had 2 or more fractures due to minimal trauma, **AND**

Patient must have experienced at least 1 symptomatic new fracture after at least 12 months continuous therapy with an anti-resorptive agent at adequate doses, **AND**

The treatment must be the sole PBS-subsidised agent, **AND**

The treatment must not exceed a lifetime maximum of 18 months therapy.

Treatment criteria:

Must be treated by a specialist; OR

Must be treated by a consultant physician.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

If treatment with anti-resorptive therapy is contraindicated according to the relevant TGA-approved Product Information, details of the contraindication must be documented in the patient's medical record at the time treatment with teriparatide is initiated.

If an intolerance of a severity necessitating permanent treatment withdrawal develops during the relevant period of use of one anti-resorptive agent, alternate anti-resorptive agents must be trialled so that the patient achieves the minimum requirement of 12 months continuous therapy. Details must be documented in the patient's medical record at the time treatment with teriparatide is initiated.

Anti-resorptive therapies for osteoporosis and their adequate doses which will be accepted for the purposes of administering this restriction are alendronate sodium 10 mg per day or 70 mg once weekly, risedronate sodium 5 mg per day or 35 mg

once weekly or 150 mg once monthly, raloxifene hydrochloride 60 mg per day (women only), denosumab 60 mg once every 6 months, strontium ranelate 2 g per day and zoledronic acid 5 mg per annum.

Details of prior anti-resorptive therapy, fracture history including the date(s), site(s), the symptoms associated with the fracture(s) which developed after at least 12 months continuous anti-resorptive therapy and the score of the qualifying BMD measurement must be provided at the time of application.

Note

Details of accepted toxicities including severity can be found on the Department of Human Services website at www.humanservices.gov.au.

Authority required

Severe established osteoporosis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have previously been issued with an authority prescription for this drug, **AND**

The treatment must not exceed a lifetime maximum of 18 months therapy.

Note

Up to a maximum of 18 pens will be reimbursed through the PBS.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

teriparatide 20 microgram/dose injection, 1 x 2.4 mL cartridge

9411H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	438.71	37.70	Forteo [LY]

ANTI-PARATHYROID AGENTS*Calcitonin preparations***■ SALCATONIN****Authority required (STREAMLINED)**

4938

Symptomatic Paget disease of bone

Authority required (STREAMLINED)

4918

Hypercalcaemia

Clinical criteria:

The treatment must be initiated in a hospital.

Note

The maximum quantities for salcatonin shown represent the number of individual ampoules and NOT multiples of the manufacturer's packs. The pack size for both strengths is five ampoules.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

salcatonin 100 international units/mL injection, 5 x 1 mL ampoules

2997R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*161.47	37.70	Miacalcic 100 [NV]

*Other anti-parathyroid agents***■ CINACALCET****Authority required (STREAMLINED)**

3673

Maintenance therapy, following initiation and stabilisation of treatment with cinacalcet, of a patient with chronic kidney disease on dialysis who has a decrease of at least 30% in iPTH concentrations after 6 months treatment

Authority required (STREAMLINED)

3672

Maintenance therapy, following initiation and stabilisation of treatment with cinacalcet, of a patient with chronic kidney disease on dialysis who has iPTH greater than 15 pmol per L and an (adjusted) serum calcium concentration of less than 2.6 mmol per L after 6 months treatment

Note

During the titration phase, intact PTH should be monitored 4 weekly (measured at least 12 hours post dose) and dose titrated until an appropriate iPTH concentration is achieved. During the titration phase, approval will be limited to sufficient supply for 4 weeks treatment at a time, with doses between 30 and 180 mg per day according to the patient's response and tolerability.

During the maintenance phase, approval will be limited to provide sufficient quantity for 4 weeks treatment up to a maximum of 6 months supply for doses between 30 and 180 mg per day according to the patient's response and tolerability. Intact PTH should be monitored quarterly (measured at least 12 hours post dose) and dose adjusted as necessary to maintain an appropriate iPTH concentration.

Special Pricing Arrangements apply.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

cinacalcet 30 mg tablet, 28

9157Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	232.23	37.70	Sensipar [AN]

cinacalcet 60 mg tablet, 28

9158B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	439.70	37.70	Sensipar [AN]

cinacalcet 90 mg tablet, 28

9159C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	654.07	37.70	Sensipar [AN]

ANTIINFECTIVES FOR SYSTEMIC USE

ANTIBACTERIALS FOR SYSTEMIC USE

TETRACYCLINES

Tetracyclines

DOXYCYCLINE

Note

Pharmaceutical benefits that have the forms doxycycline tablet 100 mg (as hydrochloride), doxycycline tablet 100 mg (as monohydrate) and doxycycline capsule: modified release 100 mg (as hydrochloride) are equivalent for the purposes of substitution.

doxycycline 100 mg capsule: modified release, 7 capsules

2708M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	^B 0.84	8.69	9.00	^a Mayne Pharma Doxycycline [YT]
			^B 2.00	9.85	9.00	^a Doryx [YN]

doxycycline 100 mg capsule: modified release, 7 capsules

3322W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	^B 0.84	8.69	9.00	^a Mayne Pharma Doxycycline [YT]
			^B 2.00	9.85	9.00	^a Doryx [YN]

doxycycline 100 mg tablet, 7

2709N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	7.85	9.00	^a Doxsig [QA] ^a Doxycycline AN [EA]	^a Doxy-100 [GN] ^a Doxylin 100 [AF]

doxycycline 100 mg tablet, 7

3321T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	7.85	9.00	^a Doxsig [QA] ^a Doxycycline AN [EA]	^a Doxy-100 [GN] ^a Doxylin 100 [AF]

doxycycline 100 mg tablet, 7

5082L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	7.85	9.00	^a Chem mart Doxycycline [CH] ^a GenRx Doxycycline [GX]	^a Doxycycline Sandoz [HX] ^a Terry White Chemists Doxycycline [TW]

doxycycline 100 mg tablet, 7

9105F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	7.85	9.00	^a Chem mart Doxycycline [CH] ^a GenRx Doxycycline [GX]	^a Doxycycline Sandoz [HX] ^a Terry White Chemists Doxycycline [TW]

■ DOXYCYCLINE

Restricted benefit

Urethritis

Note

Pharmaceutical benefits that have the forms doxycycline tablet 100 mg (as hydrochloride), doxycycline tablet 100 mg (as monohydrate) and doxycycline capsule: modified release 100 mg (as hydrochloride) are equivalent for the purposes of substitution.

doxycycline 100 mg capsule: modified release, 21 capsules

2715X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	^B 1.93	11.96	11.18	^a Mayne Pharma Doxycycline [YT]
			^B 4.69	14.72	11.18	^a Doryx [YN]

doxycycline 100 mg tablet, 21

10176N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	10.03	11.18	^a Doxycycline AN [EA]

doxycycline 100 mg tablet, 21

1800R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	10.03	11.18	^a GenRx Doxycycline [GX]

doxycycline 100 mg tablet, 7

2714W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	3	..	..	*10.03	11.18	^a Doxsig [QA]	^a Doxy-100 [GN]
						^a Doxycycline AN [EA]	^a Doxilyn 100 [AF]

doxycycline 100 mg tablet, 7

9108J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	3	..	..	*10.03	11.18	^a Chem mart Doxycycline [CH]	^a Doxycycline Sandoz [HX]
						^a Terry White Chemists Doxycycline [TW]	

■ DOXYCYCLINE

Restricted benefit

Pelvic inflammatory disease

Note

Pharmaceutical benefits that have the forms doxycycline tablet 100 mg (as hydrochloride), doxycycline tablet 100 mg (as monohydrate) and doxycycline capsule: modified release 100 mg (as hydrochloride) are equivalent for the purposes of substitution.

doxycycline 100 mg capsule: modified release, 7 capsules

2703G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	..	^B 3.36	*14.48	12.27	^a Mayne Pharma Doxycycline [YT]
			^B 8.00	*19.12	12.27	^a Doryx [YN]

doxycycline 100 mg tablet, 7

2702F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	4	..	..	*11.12	12.27	^a Doxsig [QA]	^a Doxy-100 [GN]
						^a Doxilyn 100 [AF]	

doxycycline 100 mg tablet, 7

9107H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	4	..	..	*11.12	12.27	^a Chem mart Doxycycline [CH]	^a Doxycycline Sandoz [HX]
						^a GenRx Doxycycline [GX]	^a Terry White Chemists Doxycycline [TW]

■ DOXYCYCLINE

Restricted benefit

Bronchiectasis

Population criteria:

Patient must be aged 8 years or older.

Restricted benefit

Chronic bronchitis

Population criteria:

Patient must be aged 8 years or older.

Restricted benefit

Severe acne

Note

Pharmaceutical benefits that have the forms doxycycline tablet 50 mg (as hydrochloride), doxycycline tablet 50 mg (as monohydrate) and doxycycline capsule: modified release 50 mg (as hydrochloride) are equivalent for the purposes of substitution.

doxycycline 50 mg capsule: modified release, 25 capsules

2707L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	^B 1.40	10.10	9.85	^a Mayne Pharma Doxycycline [YT]
			^B 3.37	12.07	9.85	^a Doryx [YN]

doxycycline 50 mg tablet, 25

2711Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	8.70	9.85	^a Doxy-50 [GN]	^a Doxycycline AN [EA]
						^a Doxylin 50 [AF]	

doxycycline 50 mg tablet, 25

9106G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	8.70	9.85	^a Chem mart Doxycycline [CH]	^a Doxycycline Sandoz [HX]
						^a Frakas [QA]	^a GenRx Doxycycline [GX]
						^a Terry White Chemists Doxycycline [TW]	

MINOCYCLINE**Caution**

There are concerns about the incidence of benign intracranial hypertension associated with this drug.

Restricted benefit

Severe acne not responding to other tetracyclines

Note

No applications for increased maximum quantities and/or repeats will be authorised.

minocycline 50 mg tablet, 60

1616C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	15.39	16.54	^a Akamin 50 [AF]
			^B 1.89	17.28	16.54	^a Minomycin-50 [QA]

BETA-LACTAM ANTIBACTERIALS, PENICILLINS

Penicillins with extended spectrum

AMOXYCILLIN**amoxycillin 100 mg/mL oral liquid: powder for, 20 mL**

1888J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	1	^S 0.61	#14.23	15.12	Amoxil [AS]

amoxycillin 100 mg/mL oral liquid: powder for, 20 mL

3310F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	±1	..	^S 0.61	#14.23	15.12	Amoxil [AS]

amoxycillin 125 mg/5 mL oral liquid: powder for, 100 mL

1886G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	±1	1	..	#10.07	11.57	^a Alphamox 125 [AF]	^a Amoxycillin Sandoz [SZ]
						^a APO-Amoxycillin [TX]	^a Bgramin [GN]
						^a Chem mart Amoxycillin [CH]	^a GenRx Amoxycillin [GX]
						^a Ranmoxy [RA]	^a Terry White Chemists Amoxycillin [TW]
			^B 2.89	#12.96	11.57	^a Amoxil [AS]	

amoxycillin 125 mg/5 mL oral liquid: powder for, 100 mL

3302T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	±1	..	..	#10.07	11.57	^a Alphamox 125 [AF]	^a Amoxycillin Sandoz [SZ]
						^a APO-Amoxycillin [TX]	^a Bgramin [GN]
						^a Chem mart Amoxycillin [CH]	^a GenRx Amoxycillin [GX]
						^a Ranmoxy [RA]	^a Terry White Chemists Amoxycillin [TW]
			^B 2.89	#12.96	11.57	^a Amoxil [AS]	

amoxycillin 250 mg capsule, 20

1884E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP MW	1	1	..	7.53	8.68	^a Alphamox 250 [AF] ^a Amoxycillin-GA [GN] ^a Amoxycillin Sandoz [SZ] ^a Chem mart Amoxycillin [CH] ^a Terry White Chemists Amoxycillin [TW]	^a Amoxycillin AN [EA] ^a Amoxycillin Ranbaxy [RA] ^a APO-Amoxycillin [TX] ^a Cilamox [QA] ^a Yomax 250 [DO]
			^B 2.89	10.42	8.68	^a Amoxil [AS]	

amoxycillin 250 mg capsule, 20

3301R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	7.53	8.68	^a Alphamox 250 [AF] ^a Amoxycillin-GA [GN] ^a Amoxycillin Sandoz [SZ] ^a Chem mart Amoxycillin [CH] ^a Terry White Chemists Amoxycillin [TW]	^a Amoxycillin AN [EA] ^a Amoxycillin Ranbaxy [RA] ^a APO-Amoxycillin [TX] ^a Cilamox [QA] ^a Yomax 250 [DO]
			^B 2.89	10.42	8.68	^a Amoxil [AS]	

amoxycillin 250 mg/5 mL oral liquid: powder for, 100 mL

1887H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	1	..	#10.38	11.88	^a Alphamox 250 [AF] ^a APO-Amoxycillin [TX] ^a Chem mart Amoxycillin [CH] ^a GenRx Amoxycillin [GX] ^a Terry White Chemists Amoxycillin [TW]	^a Amoxycillin Sandoz [SZ] ^a Bgramin [GN] ^a Cilamox [QA] ^a Ranmoxy [RA]
			^B 2.97	#13.35	11.88	^a Amoxil Forte [AS]	

amoxycillin 250 mg/5 mL oral liquid: powder for, 100 mL

3393N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	‡1	..	..	#10.38	11.88	^a Alphamox 250 [AF] ^a APO-Amoxycillin [TX] ^a Chem mart Amoxycillin [CH] ^a GenRx Amoxycillin [GX] ^a Terry White Chemists Amoxycillin [TW]	^a Amoxycillin Sandoz [SZ] ^a Bgramin [GN] ^a Cilamox [QA] ^a Ranmoxy [RA]
			^B 2.97	#13.35	11.88	^a Amoxil Forte [AS]	

amoxycillin 500 mg capsule, 20

1889K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP MW	1	1	..	8.29	9.44	^a Alphamox 500 [AF] ^a Amoxycillin-GA [GN] ^a Amoxycillin Ranbaxy [RA] ^a APO-Amoxycillin [TX] ^a Cilamox [QA] ^a Yomax 500 [DO]	^a Amoxycillin AN [EA] ^a Amoxycillin generichealth 500 [GQ] ^a Amoxycillin Sandoz [SZ] ^a Chem mart Amoxycillin [CH] ^a Terry White Chemists Amoxycillin [TW]
			^B 3.06	11.35	9.44	^a Amoxil [AS]	

amoxycillin 500 mg capsule, 20

3300Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	8.29	9.44	^a Alphamox 500 [AF] ^a Amoxycillin-GA [GN] ^a Amoxycillin Ranbaxy [RA] ^a APO-Amoxycillin [TX] ^a Cilamox [QA] ^a Yomax 500 [DO]	^a Amoxycillin AN [EA] ^a Amoxycillin generichealth 500 [GQ] ^a Amoxycillin Sandoz [SZ] ^a Chem mart Amoxycillin [CH] ^a Terry White Chemists Amoxycillin [TW]
			^B 3.06	11.35	9.44	^a Amoxil [AS]	

amoxycillin 500 mg/5 mL oral liquid: powder for, 100 mL

5225B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	‡1	..	..	#11.47	12.97	Maxamox [SZ]

amoxycillin 500 mg/5 mL oral liquid: powder for, 100 mL

8705E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	1	..	#11.47	12.97	Maxamox [SZ]

■ AMOXYCILLIN**Restricted benefit**

Acute exacerbations of chronic bronchitis

amoxycillin 1 g tablet, 14

8581P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	8.34	9.49	^a Amoxycillin Sandoz [BG]
			^B 0.41	8.75	9.49	^a Maxamox [SZ]

■ AMOXYCILLIN**Authority required**

Treatment of infections suspected or proven to be due to a susceptible organism in patients who require a liquid formulation and in whom the syrup formulations are unsuitable

amoxycillin 100 mg/mL oral liquid: powder for, 20 mL

9714G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	1	..	#14.23	15.73	Amoxil [AS]

■ AMPICILLIN**ampicillin 1 g injection, 5 x 1 g vials**

2977Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	13.22	14.37	^a Ampicyn [AF] ^a Ibimicyn [GN]	^a Austrapen [AL]

ampicillin 1 g injection, 5 x 1 g vials

3314K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	13.22	14.37	^a Ampicyn [AF] ^a Ibimicyn [GN]	^a Austrapen [AL]

ampicillin 500 mg injection, 5 x 500 mg vials

2390T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	10.69	11.84	^a Austrapen [AL]	^a Ibimicyn [GN]

ampicillin 500 mg injection, 5 x 500 mg vials

3313J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	10.69	11.84	^a Austrapen [AL]	^a Ibimicyn [GN]

*Beta-lactamase sensitive penicillins***■ BENZATHINE BENZYL PENICILLIN****BENZATHINE BENZYL PENICILLIN Injection 900 mg in 2.3 mL single use pre-filled syringe, 10**

2267H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	318.90	37.70	Bicillin L-A [PF]

BENZATHINE BENZYL PENICILLIN Injection 900 mg in 2.3 mL single use pre-filled syringe, 10

5027N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	318.90	37.70	Bicillin L-A [PF]

■ BENZYL PENICILLIN**benzylpenicillin 3 g injection, 1 x 3 g vial**

2647H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	10	..	..	*89.86	37.70	BenPen [CS]

benzylpenicillin 3 g injection, 1 x 3 g vial

3399X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	10	..	..	*89.86	37.70	BenPen [CS]

benzylpenicillin 600 mg injection, 1 x 600 mg vial

1775K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP MW	10	1	..	*55.06	37.70	BenPen [CS]

benzylpenicillin 600 mg injection, 1 x 600 mg vial

3398W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	10	..	..	*55.06	37.70	BenPen [CS]

■ PHENOXYMETHYLPENICILLIN**phenoxymethylpenicillin 125 mg/5 mL oral liquid: powder for, 100 mL**

5024K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	2	..	..	*#17.15	18.65	Phenoxymethylpenicillin-AFT [AE]

phenoxymethylpenicillin 125 mg/5 mL oral liquid: powder for, 100 mL

8976K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	1	..	*#17.15	18.65	Phenoxymethylpenicillin-AFT [AE]

phenoxymethylpenicillin 150 mg/5 mL oral liquid, 100 mL

5012T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	2	..	..	*21.94	23.09	^a Cilicaine V [FM]
			^B 1.90	*23.84	23.09	^a Abbocillin-V [QA]

phenoxymethylpenicillin 150 mg/5 mL oral liquid, 100 mL

9143F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	1	..	*21.94	23.09	^a Cilicaine V [FM]
			^B 1.90	*23.84	23.09	^a Abbocillin-V [QA]

phenoxymethylpenicillin 250 mg capsule, 50

1789E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	11.50	12.65	LPV [IA]	
						^a Cilicaine VK [FM]	^a Cilopen VK [GN]

phenoxymethylpenicillin 250 mg capsule, 50

3363B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	11.50	12.65	LPV [IA]	
						^a Cilicaine VK [FM]	^a Cilopen VK [GN]

phenoxymethylpenicillin 250 mg tablet, 25

1787C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*11.66	12.81	Abbocillin-VK Filmtab [QA]

phenoxymethylpenicillin 250 mg tablet, 25

3360W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	2	..	..	*11.66	12.81	Abbocillin-VK Filmtab [QA]

phenoxymethylpenicillin 250 mg/5 mL oral liquid: powder for, 100 mL

5029Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	2	..	..	*#19.71	21.21	Phenoxymethylpenicillin-AFT [AE]

phenoxymethylpenicillin 250 mg/5 mL oral liquid: powder for, 100 mL

8977L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	1	..	*#19.71	21.21	Phenoxymethylpenicillin-AFT [AE]

phenoxymethylpenicillin 500 mg capsule, 50

2965C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	13.81	14.96	LPV [IA]	
						^a Cilicaine VK [FM]	^a Cilopen VK [GN]

phenoxymethylpenicillin 500 mg capsule, 50

3364C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	13.81	14.96	LPV [IA]	
						^a Cilicaine VK [FM]	^a Cilopen VK [GN]

phenoxymethylpenicillin 500 mg tablet, 25

3028J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*14.00	15.15	Abbocillin-VK Filmtab [QA]

phenoxymethylpenicillin 500 mg tablet, 25

3361X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	2	..	..	*14.00	15.15	Abbocillin-VK Filmtab [QA]

■ PHENOXYMETHYLPENICILLIN**Restricted benefit**

Prophylaxis of recurrent streptococcal infections (including rheumatic fever)

phenoxymethylpenicillin 250 mg capsule, 50

1705R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	11.50	12.65	LPV [IA] ^a Cilicaine VK [FM]	^a Cilopen VK [GN]

phenoxymethylpenicillin 250 mg tablet, 25

1703P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*11.66	12.81	Abbocillin-VK Filmtab [QA]

■ PROCAINE PENICILLIN**procaine penicillin 1.5 g/3.4 mL injection, 5 x 3.4 mL syringes**

1794K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	92.56	37.70	Cilicaine [QA]

procaine penicillin 1.5 g/3.4 mL injection, 5 x 3.4 mL syringes

3371K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	92.56	37.70	Cilicaine [QA]

*Beta-lactamase resistant penicillins***■ DICLOXACILLIN****Restricted benefit**

Serious staphylococcal infections

dicloxacillin 250 mg capsule, 24

5096F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	13.10	14.25	Distaph 250 [AF]

dicloxacillin 250 mg capsule, 24

8121K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP MW	1	..	..	13.10	14.25	Distaph 250 [AF]

dicloxacillin 500 mg capsule, 24

5097G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	17.85	19.00	Distaph 500 [AF]

dicloxacillin 500 mg capsule, 24

8122L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP MW	1	..	..	17.85	19.00	Distaph 500 [AF]

■ FLUCLOXACILLIN**Caution**

Severe cholestatic hepatitis has been reported with this drug. Significant risk factors are age, particularly greater than 55 years, and duration of treatment longer than 14 days.

flucloxacillin 1 g injection, 5 x 1 g vials

1525G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	11.91	13.06	^a Flubiclox [GN] ^a Hospira Pty Limited [HH]	^a Flucil [AS]

flucloxacillin 1 g injection, 5 x 1 g vials

5095E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	11.91	13.06	^a Flubiclox [GN] ^a Hospira Pty Limited [HH]	^a Flucil [AS]

flucloxacillin 500 mg injection, 5 x 500 mg vials

1524F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	10.05	11.20	^a Flubiclox [GN]	^a Flucil [AS]

flucloxacillin 500 mg injection, 5 x 500 mg vials

5094D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	10.05	11.20	^a Flubiclox [GN]	^a Flucil [AS]

FLUCLOXACILLIN**Caution**

Severe cholestatic hepatitis has been reported with this drug. Significant risk factors are age, particularly greater than 55 years, and duration of treatment longer than 14 days.

Restricted benefit

Serious staphylococcal infections

flucloxacillin 125 mg/5 mL oral liquid: powder for, 100 mL

5257Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	‡1	..	..	#16.44	17.94	Flucil [LN]	

flucloxacillin 125 mg/5 mL oral liquid: powder for, 100 mL

9149M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	..	..	#16.44	17.94	Flucil [LN]	

flucloxacillin 250 mg capsule, 24

1526H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP MW	1	..	..	11.53	12.68	^a Flopen [AS]	^a Staphylex 250 [AF]

flucloxacillin 250 mg capsule, 24

5090X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	11.53	12.68	^a Flopen [AS]	^a Staphylex 250 [AF]

flucloxacillin 250 mg/5 mL oral liquid: powder for, 100 mL

5258R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	‡1	..	..	#19.97	21.47	Flucil [LN]	

flucloxacillin 250 mg/5 mL oral liquid: powder for, 100 mL

9150N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	..	..	#19.97	21.47	Flucil [LN]	

flucloxacillin 500 mg capsule, 24

1527J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP MW	1	..	..	16.75	17.90	^a Flopen [AS]	^a Staphylex 500 [AF]

flucloxacillin 500 mg capsule, 24

5091Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	16.75	17.90	^a Flopen [AS]	^a Staphylex 500 [AF]

Combinations of penicillins, incl. beta-lactamase inhibitors**AMOXYCILLIN + CLAVULANIC ACID****Caution**

Hepatotoxicity has been reported with this drug.

Restricted benefit

Infections where resistance to amoxycillin is suspected

Restricted benefit

Infections where resistance to amoxycillin is proven

amoxycillin 125 mg/5 mL + clavulanic acid 31.25 mg/5 mL oral liquid: powder for, 75 mL

1892N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	1	..	#10.76	12.26	^a APO-Amoxycillin and Clavulanic Acid 125/31.25 [TX]	^a Clamoxyl [AL]
						^a Curam [SZ]	^a GA-Amclav 125/31.25 [GN]
			^b 2.89	#13.65	12.26	^a Augmentin [AS]	

amoxycillin 125 mg/5 mL + clavulanic acid 31.25 mg/5 mL oral liquid: powder for, 75 mL

5009P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	‡1	..	..	#10.76	12.26	^a APO-Amoxycillin and Clavulanic Acid 125/31.25 [TX]	^a Clamoxyl [AL]
						^a Curam [SZ]	^a GA-Amclav 125/31.25 [GN]
			^b 2.89	#13.65	12.26	^a Augmentin [AS]	

amoxicillin 400 mg/5 mL + clavulanic acid 57 mg/5 mL oral liquid: powder for, 60 mL

5011R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	‡1	..	..	#11.36	12.86	^a APO-Amoxycillin and Clavulanic Acid 400/57 [TX] ^a Curam Duo [SZ]	^a Clamoxyl Duo 400 [AL] ^a GA-Amclav Forte 400/57 [GN]
			^B 4.06	#15.42	12.86	^a Augmentin Duo 400 [AS]	

amoxicillin 400 mg/5 mL + clavulanic acid 57 mg/5 mL oral liquid: powder for, 60 mL

8319W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	1	..	#11.36	12.86	^a APO-Amoxycillin and Clavulanic Acid 400/57 [TX] ^a Curam Duo [SZ]	^a Clamoxyl Duo 400 [AL] ^a GA-Amclav Forte 400/57 [GN]
			^B 4.06	#15.42	12.86	^a Augmentin Duo 400 [AS]	

amoxicillin 500 mg + clavulanic acid 125 mg tablet, 10

1891M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP MW	1	1	..	9.00	10.15	^a Amoxyclav AN 500/125 [EA] ^a Clamoxyl Duo [AL] ^a GA-Amclav 500/125 [GN] ^a Pharmacor AmoxyClav 500/125 [CR]	^a APO-Amoxycillin/ Clavulanic Acid 500/125 [TX] ^a Curam Duo 500/125 [SZ] ^a Moxiclav Duo 500/125 [QA]
			^B 4.00	13.00	10.15	^a Augmentin Duo [AS]	

amoxicillin 500 mg + clavulanic acid 125 mg tablet, 10

5008N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	9.00	10.15	^a Amoxyclav AN 500/125 [EA] ^a Clamoxyl Duo [AL] ^a GA-Amclav 500/125 [GN] ^a Pharmacor AmoxyClav 500/125 [CR]	^a APO-Amoxycillin/ Clavulanic Acid 500/125 [TX] ^a Curam Duo 500/125 [SZ] ^a Moxiclav Duo 500/125 [QA]
			^B 4.00	13.00	10.15	^a Augmentin Duo [AS]	

amoxicillin 875 mg + clavulanic acid 125 mg tablet, 10

5006L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	9.95	11.10	^a Amoxyclav AN 875/125 [EA] ^a AmoxyClav RBX 875/125 [RA] ^a Chem mart Amoxycillin and Clavulanic Acid [CH] ^a Clavam 875 mg/125 mg [NJ] ^a GA-Amclav Forte 875/125 [GN] ^a Pharmacor AmoxyClav 875/125 [CR]	^a AmoxyClav GH 875/125 [GQ] ^a APO-Amoxycillin and Clavulanic Acid [TX] ^a Clamoxyl Duo forte [AL] ^a Curam Duo Forte 875/125 [SZ] ^a Moxiclav Duo Forte 875/125 [QA] ^a Terry White Chemists Amoxycillin and Clavulanic Acid [TW]
			^B 5.12	15.07	11.10	^a Augmentin Duo forte [AS]	

amoxicillin 875 mg + clavulanic acid 125 mg tablet, 10

8254K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	9.95	11.10	^a Amoxyclav AN 875/125 [EA] ^a AmoxyClav RBX 875/125 [RA] ^a Chem mart Amoxycillin and Clavulanic Acid [CH] ^a Clavam 875 mg/125 mg [NJ] ^a GA-Amclav Forte 875/125 [GN] ^a Pharmacor AmoxyClav 875/125 [CR]	^a AmoxyClav GH 875/125 [GQ] ^a APO-Amoxycillin and Clavulanic Acid [TX] ^a Clamoxyl Duo forte [AL] ^a Curam Duo Forte 875/125 [SZ] ^a Moxiclav Duo Forte 875/125 [QA] ^a Terry White Chemists Amoxycillin and Clavulanic Acid [TW]
			^B 5.12	15.07	11.10	^a Augmentin Duo forte [AS]	

■ TICARCILLIN + CLAVULANIC ACID**Restricted benefit**

Infections where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent

ticarcillin 3 g + clavulanic acid 100 mg injection, 1 x 3.1 g vial

10125X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	10	..	..	*163.76	37.70	Timentin [AS]

■ TICARCILLIN + CLAVULANIC ACID**Restricted benefit**

Infections where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent

Restricted benefit

Septicaemia, suspected

Restricted benefit

Septicaemia, proven

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

ticarcillin 3 g + clavulanic acid 100 mg injection, 1 x 3.1 g vial

10113G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	10	..	..	*163.76	37.70	Timentin [AS]

OTHER BETA-LACTAM ANTIBACTERIALS*First-generation cephalosporins***■ CEPHALEXIN****cephalexin 125 mg/5 mL oral liquid: powder for, 100 mL**

3094W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	1	..	#10.74	12.24	^a APO-Cephalexin [TX] ^a Chem mart Cephalexin [CH] ^a Ialex [LN] ^a Terry White Chemists Cephalexin [TW]	^a Cefalexin Sandoz [SZ] ^a Cilex [GN] ^a Ibilex 125 [AF]
			^B 4.77	#15.51	12.24	^a Keflex [AS]	

cephalexin 125 mg/5 mL oral liquid: powder for, 100 mL

3319Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	‡1	..	..	#10.74	12.24	^a APO-Cephalexin [TX] ^a Chem mart Cephalexin [CH] ^a Ialex [LN] ^a Terry White Chemists Cephalexin [TW]	^a Cefalexin Sandoz [SZ] ^a Cilex [GN] ^a Ibilex 125 [AF]
			^B 4.77	#15.51	12.24	^a Keflex [AS]	

cephalexin 250 mg capsule, 20

3058Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP MW	1	1	..	7.89	9.04	^a APO-Cephalexin [TX] ^a Cephalax 250 [CR] ^a Cephalexin generichealth [GQ] ^a Cilex [GN] ^a Ialex [LN] ^a Rancef [RA]	^a Cefalexin Sandoz [SZ] ^a Cephalexin AN [EA] ^a Chem mart Cephalexin [CH] ^a GenRx Cephalexin [GX] ^a Ibilex 250 [AF] ^a Terry White Chemists Cephalexin [TW]
			^B 4.32	12.21	9.04	^a Keflex [AS]	

cephalexin 250 mg capsule, 20

3317N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	7.89	9.04	^a APO-Cephalexin [TX] ^a Cephalax 250 [CR] ^a Cephalexin generichealth [GQ] ^a Cilex [GN] ^a Ialex [LN] ^a Rancef [RA]	^a Cefalexin Sandoz [SZ] ^a Cephalexin AN [EA] ^a Chem mart Cephalexin [CH] ^a GenRx Cephalexin [GX] ^a Ibilex 250 [AF] ^a Terry White Chemists Cephalexin [TW]
			^B 4.32	12.21	9.04	^a Keflex [AS]	

cephalexin 250 mg/5 mL oral liquid: powder for, 100 mL

3095X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	1	..	#11.39	12.89	^a APO-Cephalexin [TX] ^a Chem mart Cephalexin [CH] ^a Ialex [LN] ^a Terry White Chemists Cephalexin [TW]	^a Cefalexin Sandoz [SZ] ^a Cilex [GN] ^a Ibilex 250 [AF]
			^B 6.23	#17.62	12.89	^a Keflex [AS]	

cephalexin 250 mg/5 mL oral liquid: powder for, 100 mL

3320R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	‡1	..	..	#11.39	12.89	^a APO-Cephalexin [TX] ^a Chem mart Cephalexin [CH] ^a Ialex [LN] ^a Terry White Chemists Cephalexin [TW]	^a Cefalexin Sandoz [SZ] ^a Cilex [GN] ^a Ibilex 250 [AF]
			^B 6.23	#17.62	12.89	^a Keflex [AS]	

cephalexin 500 mg capsule, 20

3119E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP MW	1	1	..	8.78	9.93	^a APO-Cephalexin [TX] ^a Cephalax 500 [NJ] ^a Cephalaxin generichealth [GQ] ^a Cilex [GN] ^a Ialex [LN] ^a Pharmacor Cephalexin 500 [CR] ^a Terry White Chemists Cephalexin [TW]	^a Cefalexin Sandoz [SZ] ^a Cephalaxin AN [EA] ^a Chem mart Cephalexin [CH] ^a GenRx Cephalexin [GX] ^a Ibilex 500 [AF] ^a Rancef [RA]
			^B 6.31	15.09	9.93	^a Keflex [AS]	

cephalexin 500 mg capsule, 20

3318P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	8.78	9.93	^a APO-Cephalexin [TX] ^a Cephalax 500 [NJ] ^a Cephalaxin generichealth [GQ] ^a Cilex [GN] ^a Ialex [LN] ^a Pharmacor Cephalexin 500 [CR] ^a Terry White Chemists Cephalexin [TW]	^a Cefalexin Sandoz [SZ] ^a Cephalaxin AN [EA] ^a Chem mart Cephalexin [CH] ^a GenRx Cephalexin [GX] ^a Ibilex 500 [AF] ^a Rancef [RA]
			^B 6.31	15.09	9.93	^a Keflex [AS]	

■ CEPHALEXIN**Authority required (STREAMLINED)****4243**

Prophylaxis of urinary tract infection

cephalexin 250 mg capsule, 20

2655R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	2	..	*9.02	10.17	^a APO-Cephalexin [TX] ^a Cephalax 250 [CR] ^a Cephalaxin generichealth [GQ] ^a Cilex [GN] ^a Ialex [LN] ^a Rancef [RA]	^a Cefalexin Sandoz [SZ] ^a Cephalaxin AN [EA] ^a Chem mart Cephalexin [CH] ^a GenRx Cephalexin [GX] ^a Ibilex 250 [AF] ^a Terry White Chemists Cephalexin [TW]
			^B 8.64	*17.66	10.17	^a Keflex [AS]	

■ CEPHALOTHIN**cephalothin 1 g injection, 10 x 1 g vials**

2964B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	19.32	20.47	Hospira Pty Limited [HH]

cephalothin 1 g injection, 10 x 1 g vials

3376Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	19.32	20.47	Hospira Pty Limited [HH]

■ CEPHAZOLIN

Restricted benefit

Cellulitis

cephazolin 2 g injection, 1 x 2 g vial

5479J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	10	..	..	*23.76	24.91	^a Cefazolin Sandoz [SZ]	^a Cephazolin Alphapharm [AF]

cephazolin 500 mg injection, 5 x 500 mg vials

5477G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	..	..	*12.38	13.53	Cefazolin-AFT [AE]	

■ CEPHAZOLIN

Restricted benefit

Cellulitis

Note

For item codes 5478H and 1799Q, pharmaceutical benefits that have the form powder for injection 1 g are equivalent for the purposes of substitution.

cephazolin 1 g injection, 10 x 1 g vials

5478H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	14.20	15.35	^a Cefazolin Sandoz [SZ]	

cephazolin 1 g injection, 5 x 1 g vials

1799Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	..	..	*14.22	15.37	^a Cefazolin-AFT [AE]	^a Hospira Cefazolin Sodium [HH]

■ CEPHAZOLIN

Restricted benefit

Infections where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent

Restricted benefit

Septicaemia, suspected

Restricted benefit

Septicaemia, proven

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

cephazolin 2 g injection, 1 x 2 g vial

9326W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	10	..	..	*23.76	24.91	^a Cefazolin Sandoz [SZ]	^a Cephazolin Alphapharm [AF]

cephazolin 500 mg injection, 5 x 500 mg vials

1256D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	..	..	*12.38	13.53	Cefazolin-AFT [AE]	

■ CEPHAZOLIN

Restricted benefit

Infections where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent

Restricted benefit

Septicaemia, suspected

Restricted benefit

Septicaemia, proven

Note

For item codes 1257E and 1797N, pharmaceutical benefits that have the form powder for injection 1 g are equivalent for the purposes of substitution.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

cephazolin 1 g injection, 10 x 1 g vials

1257E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	14.20	15.35	^a Cefazolin Sandoz [SZ]

cephazolin 1 g injection, 5 x 1 g vials

1797N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	..	..	*14.22	15.37	^a Cefazolin-AFT [AE]	^a Hospira Cefazolin Sodium [HH]

*Second-generation cephalosporins***■ CEFACLOR****Caution**

Serum sickness-like reactions have been reported with this drug, especially in children.

cefactor 125 mg/5 mL oral liquid: powder for, 100 mL

2460L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	‡1	1	..	#12.07	13.57	^a Aclor 125 [QA] ^a GenRx Cefaclor [GX]	^a APO-Cefaclor [TX] ^a Keflor [AF]
			^B 5.86	#17.93	13.57	^a Ceclor [AS]	

cefactor 125 mg/5 mL oral liquid: powder for, 100 mL

5046N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	‡1	..	..	#12.07	13.57	^a Aclor 125 [QA] ^a GenRx Cefaclor [GX]	^a APO-Cefaclor [TX] ^a Keflor [AF]
			^B 5.86	#17.93	13.57	^a Ceclor [AS]	

cefactor 250 mg/5 mL oral liquid: powder for, 75 mL

2461M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	‡1	1	..	#12.28	13.78	^a Aclor 250 [QA] ^a GenRx Cefaclor [GX]	^a APO-Cefaclor [TX] ^a Keflor [AF]
			^B 6.10	#18.38	13.78	^a Ceclor [AS]	

cefactor 250 mg/5 mL oral liquid: powder for, 75 mL

5047P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	‡1	..	..	#12.28	13.78	^a Aclor 250 [QA] ^a GenRx Cefaclor [GX]	^a APO-Cefaclor [TX] ^a Keflor [AF]
			^B 6.10	#18.38	13.78	^a Ceclor [AS]	

cefactor 375 mg tablet: modified release, 10

1169M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	1	..	10.59	11.74	^a APO-Cefaclor CD [TX] ^a Cefaclor GH [GQ] ^a GenRx Cefaclor CD [GX] ^a Keflor CD [AF] ^a Terry White Chemists Cefaclor CD [TW]	^a Cefaclor-GA [GN] ^a Chem mart Cefaclor CD [CH] ^a Karlor CD [LN] ^a Ozcef [RA]
			^B 7.20	17.79	11.74	^a Ceclor CD [AS]	

cefactor 375 mg tablet: modified release, 10

5045M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	10.59	11.74	^a APO-Cefaclor CD [TX] ^a Cefaclor GH [GQ] ^a GenRx Cefaclor CD [GX] ^a Keflor CD [AF] ^a Terry White Chemists Cefaclor CD [TW]	^a Cefaclor-GA [GN] ^a Chem mart Cefaclor CD [CH] ^a Karlor CD [LN] ^a Ozcef [RA]
			^B 7.20	17.79	11.74	^a Ceclor CD [AS]	

■ CEFUROXIME**CEFUROXIME AXETIL Powder for oral suspension 125 mg (base) per 5 mL, 70 mL, 1**

2002J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	‡1	..	..	#19.80	21.30	Zinnat [AS]

CEFUROXIME AXETIL Powder for oral suspension 125 mg (base) per 5 mL, 70 mL, 1

5499K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	#19.80	21.30	Zinnat [AS]

cefuroxime 250 mg tablet, 14

5052X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	18.96	20.11	Zinnat [AS]

cefuroxime 250 mg tablet, 14

8292K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	18.96	20.11	Zinnat [AS]

*Third-generation cephalosporins***■ CEFOTAXIME****Restricted benefit**

Infections where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent

Note

For item codes 5048Q and 1768C, pharmaceutical benefits that have the form powder for injection 1 g are equivalent for the purposes of substitution.

CEFOTAXIME Powder for injection 1 g, 10

1768C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	21.47	22.62	^a Hospira Pty Limited [HH]

cefotaxime 1 g injection, 1 x 1 g vial

5048Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	10	..	..	*21.46	22.61	^a Cefotaxime Sandoz [SZ]

■ CEFOTAXIME**Restricted benefit**

Infections where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent

Note

For item codes 5049R and 1769D, pharmaceutical benefits that have the form powder for injection 2 g are equivalent for the purposes of substitution.

CEFOTAXIME Powder for injection 2 g, 10

1769D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	33.96	35.11	^a Hospira Pty Limited [HH]

cefotaxime 2 g injection, 1 x 2 g vial

5049R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	10	..	..	*34.06	35.21	^a Cefotaxime Sandoz [SZ]

■ CEFOTAXIME**Restricted benefit**

Infections where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent

Restricted benefit

Septicaemia, suspected

Restricted benefit

Septicaemia, proven

Note

For item codes 1085D and 1758M, pharmaceutical benefits that have the form powder for injection 1 g are equivalent for the purposes of substitution.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

CEFOTAXIME Powder for injection 1 g, 10

1758M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	21.47	22.62	^a Hospira Pty Limited [HH]

cefotaxime 1 g injection, 1 x 1 g vial

1085D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	10	..	..	*21.46	22.61	^a Cefotaxime Sandoz [SZ]

■ CEFOTAXIME**Restricted benefit**

Infections where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent

Restricted benefit

Septicaemia, suspected

Restricted benefit

Septicaemia, proven

Note

For item codes 1086E and 1759N, pharmaceutical benefits that have the form powder for injection 2 g are equivalent for the purposes of substitution.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

CEFOTAXIME Powder for injection 2 g, 10

1759N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	33.96	35.11	^a Hospira Pty Limited [HH]

cefotaxime 2 g injection, 1 x 2 g vial

1086E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	10	..	..	*34.06	35.21	^a Cefotaxime Sandoz [SZ]

▪ **CEFTRIAXONE**

Restricted benefit

Gonorrhoea

ceftriaxone 500 mg injection, 1 x 500 mg vial

9058R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	7.63	8.78	^a Ceftriaxone-AFT [AE]	^a Ceftriaxone ICP [PP]

▪ **CEFTRIAXONE**

Restricted benefit

Infections where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent

Restricted benefit

Septicaemia, suspected

Restricted benefit

Septicaemia, proven

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

ceftriaxone 2 g injection, 1 x 2 g vial

1785Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	..	..	*19.56	20.71	^a Ceftriaxone-AFT [AE] ^a Ceftriaxone Sandoz [SZ]	^a Ceftriaxone Alphapharm [AF] ^a Hospira Ceftriaxone [HH]

ceftriaxone 500 mg injection, 1 x 500 mg vial

1783W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	..	..	*11.11	12.26	^a Ceftriaxone-AFT [AE]	^a Ceftriaxone ICP [PP]

▪ **CEFTRIAXONE**

Restricted benefit

Infections where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent

Restricted benefit

Septicaemia, suspected

Restricted benefit

Septicaemia, proven

Note

For item codes 1784X and 1788D, pharmaceutical benefits that have the form powder for injection 1 g are equivalent for the purposes of substitution.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

CEFTRIAXONE Powder for injection 1 g, 5

1788D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	13.68	14.83	^a Ceftriaxone Alphapharm [AF]	^a Max Pharma Ceftriaxone [GQ]

ceftriaxone 1 g injection, 1 x 1 g vial

1784X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	5	..	..	*13.66	14.81	^a Ceftriaxone-AFT [AE] ^a Ceftriaxone Sandoz [SZ]	^a Ceftriaxone ICP [PP] ^a Hospira Ceftriaxone [HH]

*Fourth-generation cephalosporins***■ CEFEPIME****Authority required**

Treatment of febrile neutropenia

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

CEFEPIME Powder for injection 1 g (as hydrochloride), 1

8315P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	10	..	..	*60.66	37.70	^a Cefepime-AFT [AE] ^a Cefepime Sandoz [SZ] ^a Omegapharm Pty Ltd [OE]	^a Cefepime Alphapharm [AF] ^a DBL Cefepime [HH]

CEFEPIME Powder for injection 2 g (as hydrochloride), 1

8316Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	10	..	..	*109.36	37.70	^a Cefepime-AFT [AE] ^a Cefepime Sandoz [SZ] ^a Omegapharm Pty Ltd [OE]	^a Cefepime Alphapharm [AF] ^a DBL Cefepime [HH]

SULFONAMIDES AND TRIMETHOPRIM*Trimethoprim and derivatives***■ TRIMETHOPRIM****trimethoprim 300 mg tablet, 7**

2922T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	.. ^B 1.89	8.72 10.61	9.87 9.87	^a Alprim [AF] ^a Triprim [QA]

■ TRIMETHOPRIM**Authority required (STREAMLINED)****4243**

Prophylaxis of urinary tract infection

trimethoprim 300 mg tablet, 7

2666H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	2	.. ^B 3.78	*10.68 *14.46	11.83 11.83	^a Alprim [AF] ^a Triprim [QA]

*Combinations of sulfonamides and trimethoprim, incl. derivatives***■ TRIMETHOPRIM + SULFAMETHOXAZOLE****Caution**

There is an increased risk of severe adverse reactions with this combination in the elderly.

trimethoprim 160 mg + sulfamethoxazole 800 mg tablet, 10

2951H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	.. ^B 3.90	9.58 13.48	10.73 10.73	^a Bactrim DS [RO] ^a Septrin Forte [QA]	^a Resprim Forte [AF]

trimethoprim 160 mg + sulfamethoxazole 800 mg tablet, 10

3390K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	.. ^B 3.90	9.58 13.48	10.73 10.73	^a Bactrim DS [RO] ^a Septrin Forte [QA]	^a Resprim Forte [AF]

trimethoprim 40 mg/5 mL + sulfamethoxazole 200 mg/5 mL oral liquid, 100 mL

3103H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	1	..	9.27	10.42	Bactrim [RO]
			^B 4.25	13.52	10.42	Septin [QA]

trimethoprim 40 mg/5 mL + sulfamethoxazole 200 mg/5 mL oral liquid, 100 mL

3391L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	‡1	..	..	9.27	10.42	Bactrim [RO]
			^B 4.25	13.52	10.42	Septin [QA]

MACROLIDES, LINCOSAMIDES AND STREPTOGRAMINS

Macrolides

▪ **AZITHROMYCIN**

Restricted benefit

Trachoma

Note

No applications for increased maximum quantities and/or repeats will be authorised.

azithromycin 200 mg/5 mL oral liquid: powder for, 15 mL

8201P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	..	..	#23.70	25.20	Zithromax [PF]

azithromycin 500 mg tablet, 2

8336R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	13.25	14.40	^a APO-Azithromycin [TX] ^a Azithromycin Sandoz [SZ] ^a Terry White Chemists Azithromycin [TW] ^a Zitrocin [GN]	^a Azithromycin-GA [UA] ^a Chem mart Azithromycin [CH] ^a Zithromax [PF]

▪ **AZITHROMYCIN**

Restricted benefit

Uncomplicated urethritis due to Chlamydia trachomatis

Restricted benefit

Uncomplicated cervicitis due to Chlamydia trachomatis

Note

No applications for increased maximum quantities and/or repeats will be authorised.

azithromycin 500 mg tablet, 2

8200N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	13.25	14.40	^a APO-Azithromycin [TX] ^a Azithromycin Sandoz [SZ] ^a Terry White Chemists Azithromycin [TW] ^a Zitrocin [GN]	^a Azithromycin-GA [UA] ^a Chem mart Azithromycin [CH] ^a Zithromax [PF]

▪ **CLARITHROMYCIN**

clarithromycin 250 mg tablet, 14

8318T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	10.22	11.37	^a APO-Clarithromycin [TX] ^a Clarac [GN] ^a Clarithro 250 [QA] ^a Clarithromycin Sandoz [SZ] ^a Terry White Chemists Clarithromycin [TW]	^a Chem mart Clarithromycin [CH] ^a Clarihexal [HX] ^a Clarithromycin AN [EA] ^a Kalixocin [AF]
			^B 3.50	13.72	11.37	^a Klacid [GO]	

▪ **CLARITHROMYCIN**

Restricted benefit

Bordetella pertussis

Restricted benefit

Atypical mycobacterial infections

clarithromycin 250 mg/5 mL oral liquid: powder for, 50 mL

9192T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	..	..	#27.92	29.42	Klacid [GO]

ERYTHROMYCIN**erythromycin 250 mg capsule: enteric, 25**

1404X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	11.03	12.18	^a Mayne Pharma Erythromycin [YT]
			^B 2.91	13.94	12.18	^a Eryc [YN]

erythromycin 250 mg capsule: enteric, 25

3325B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	11.03	12.18	^a Mayne Pharma Erythromycin [YT]
			^B 2.91	13.94	12.18	^a Eryc [YN]

ERYTHROMYCIN ETHYLSUCCINATE**erythromycin (as ethylsuccinate) 200 mg/5 mL oral liquid: powder for, 100 mL**

2424N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	1	..	#14.91	16.41	^a E-Mycin 200 [AF]
			^B 2.71	#17.62	16.41	^a E.E.S. 200 [LM]

erythromycin (as ethylsuccinate) 200 mg/5 mL oral liquid: powder for, 100 mL

3334L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	‡1	..	..	#14.91	16.41	^a E-Mycin 200 [AF]
			^B 2.71	#17.62	16.41	^a E.E.S. 200 [LM]

erythromycin (as ethylsuccinate) 400 mg tablet, 25

2750R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	12.40	13.55	^a E-Mycin [AF]
			^B 2.67	15.07	13.55	^a E.E.S. 400 Filmtab [LM]

erythromycin (as ethylsuccinate) 400 mg tablet, 25

3336N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	12.40	13.55	^a E-Mycin [AF]
			^B 2.67	15.07	13.55	^a E.E.S. 400 Filmtab [LM]

erythromycin (as ethylsuccinate) 400 mg/5 mL oral liquid: powder for, 100 mL

2428T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	1	..	#16.42	17.92	^a E-Mycin 400 [AF]
			^B 2.73	#19.15	17.92	^a E.E.S. Granules [LM]

erythromycin (as ethylsuccinate) 400 mg/5 mL oral liquid: powder for, 100 mL

3337P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	‡1	..	..	#16.42	17.92	^a E-Mycin 400 [AF]
			^B 2.73	#19.15	17.92	^a E.E.S. Granules [LM]

ERYTHROMYCIN LACTOBIONATE**erythromycin (as lactobionate) 1 g injection, 1 x 1 g vial**

1397M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	5	..	..	*196.81	37.70	Erythrocin-I.V. [LM]

erythromycin (as lactobionate) 1 g injection, 1 x 1 g vial

5088T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	5	..	..	*196.81	37.70	Erythrocin-I.V. [LM]

ROXITHROMYCIN**roxithromycin 150 mg tablet, 10**

1760P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	8.96	10.11	^a APO-Roxithromycin [TX]	^a Biassig [AV]
						^a Chem mart Roxithromycin [CH]	^a Roxar 150 [QA]
						^a Roximycin [AF]	^a Roxithromycin AN [EA]
						^a Roxithromycin-GA [GN]	^a Roxithromycin GH [GQ]

^a Roxithromycin Sandoz [SZ] ^a Roxithromycin SCP 150 [CR]
^a Terry White Chemists
 Roxithromycin [TW]
^a Rulide [SW]

roxithromycin 150 mg tablet, 10

5260W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	8.96	10.11	^a APO-Roxithromycin [TX] ^a Chem mart Roxithromycin [CH] ^a Roximycin [AF] ^a Roxithromycin-GA [GN] ^a Roxithromycin Sandoz [SZ] ^a Terry White Chemists Roxithromycin [TW]	^a Biaxsig [AV] ^a Roxar 150 [QA] ^a Roxithromycin AN [EA] ^a Roxithromycin GH [GQ] ^a Roxithromycin SCP 150 [CR]
			^B 2.12	11.08	10.11	^a Rulide [SW]	

roxithromycin 300 mg tablet, 5

5261X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	8.96	10.11	^a APO-Roxithromycin [TX] ^a Chem mart Roxithromycin [CH] ^a Roximycin [AF] ^a Roxithromycin-GA [GN] ^a Roxithromycin Sandoz [SZ] ^a Terry White Chemists Roxithromycin [TW]	^a Biaxsig [AV] ^a Roxar 300 [QA] ^a Roxithromycin AN [EA] ^a Roxithromycin GH [GQ] ^a Roxithromycin SCP 300 [CR]
			^B 2.12	11.08	10.11	^a Rulide [SW]	

roxithromycin 300 mg tablet, 5

8016X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	8.96	10.11	^a APO-Roxithromycin [TX] ^a Chem mart Roxithromycin [CH] ^a Roximycin [AF] ^a Roxithromycin-GA [GN] ^a Roxithromycin Sandoz [SZ] ^a Terry White Chemists Roxithromycin [TW]	^a Biaxsig [AV] ^a Roxar 300 [QA] ^a Roxithromycin AN [EA] ^a Roxithromycin GH [GQ] ^a Roxithromycin SCP 300 [CR]
			^B 2.12	11.08	10.11	^a Rulide [SW]	

roxithromycin 50 mg tablet: dispersible, 10

5259T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	13.23	14.38	Rulide D [SW]

roxithromycin 50 mg tablet: dispersible, 10

8129W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	13.23	14.38	Rulide D [SW]

Lincosamides**CLINDAMYCIN****Restricted benefit**

Gram-positive coccal infections where these cannot be safely and effectively treated with a penicillin

clindamycin 150 mg capsule, 24

3138E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP MW	1	..	..	17.96	19.11	^a APO-Clindamycin [TX] ^a Cleocin [FZ] ^a Terry White Chemists Clindamycin [TW]	^a Chem mart Clindamycin [CH] ^a Clindamycin-Link [LM]
			^B 1.71	19.67	19.11	^a Dalacin C [PF]	

clindamycin 150 mg capsule, 24

5057E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	17.96	19.11	^a APO-Clindamycin [TX] ^a Cleocin [FZ] ^a Terry White Chemists Clindamycin [TW]	^a Chem mart Clindamycin [CH] ^a Clindamycin-Link [LM]
			^B 1.71	19.67	19.11	^a Dalacin C [PF]	

■ LINCOMYCIN

lincomycin 600 mg/2 mL injection, 5 x 2 mL vials

2530E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP MW	1	..	..	159.33	37.70	Lincocin [PF]

lincomycin 600 mg/2 mL injection, 5 x 2 mL vials

5144R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	159.33	37.70	Lincocin [PF]

AMINOGLYCOSIDE ANTIBACTERIALS

Other aminoglycosides

■ GENTAMICIN

gentamicin 80 mg/2 mL injection, 10 x 2 mL ampoules

2824P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	20.01	21.16	Pfizer Australia Pty Ltd [PF]

■ TOBRAMYCIN

Restricted benefit

Systemic treatment of Pseudomonas aeruginosa infection in a patient with cystic fibrosis

tobramycin 500 mg/5 mL injection, 10 x 5 mL vials

9480Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	357.71	37.70	Tobra-Day [PL]

■ TOBRAMYCIN

Authority required (STREAMLINED)

3842

Management of a proven Pseudomonas aeruginosa infection in a patient with cystic fibrosis

Note

No applications for increased maximum quantities and/or repeats will be authorised.

Special Pricing Arrangements apply.

tobramycin 300 mg/5 mL inhalation: solution, 56 x 5 mL ampoules

5442K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	2137.70	37.70	Tobi [NV]

■ TOBRAMYCIN

Restricted benefit

Infections where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent

Restricted benefit

Septicaemia, suspected

Restricted benefit

Septicaemia, proven

tobramycin 80 mg/2 mL injection, 5 x 2 mL vials

1356J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	1	..	*65.36	37.70	Hospira Pty Limited [HH]

tobramycin Injection 80 mg (base) in 2 mL (without preservative), 5

8872Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	1	..	*65.36	37.70	Pfizer Australia Pty Ltd [PF]

■ TOBRAMYCIN

Authority required (STREAMLINED)

4456

Proven Pseudomonas aeruginosa infection

Treatment Phase: Initial treatment

Clinical criteria:

Patient must have cystic fibrosis, **AND**

Patient must have been assessed for bronchial hyperresponsiveness as per the TGA-approved Product Information, with a negative test result, **AND**

Patient must be participating in a four week trial of tobramycin inhalation powder and will be assessed for ability to tolerate the dry powder formulation in order to qualify for continued PBS-subsidised therapy. The trial commencement date must be documented in the patient's medical records.

Population criteria:

Patient must be 6 years of age or older.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

tobramycin 28 mg inhalation, 224 capsules

10066T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	2549.70	37.70	TOBI podhaler [NV]

■ TOBRAMYCIN**Authority required (STREAMLINED)****4513**

Proven *Pseudomonas aeruginosa* infection

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have cystic fibrosis, **AND**

Patient must have previously been issued with an authority prescription for tobramycin inhalation capsules, **AND**

Patient must have demonstrated ability to tolerate the dry powder formulation following the initial 4-week treatment period, as agreed by the patient, the patient's family (in the case of paediatric patients) and the treating physician(s).

Population criteria:

Patient must be 6 years of age or older.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

tobramycin 28 mg inhalation, 224 capsules

10074F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	2549.70	37.70	TOBI podhaler [NV]

QUINOLONE ANTIBACTERIALS*Fluoroquinolones***■ CIPROFLOXACIN****Authority required**

Respiratory tract infection proven or suspected to be caused by *Pseudomonas aeruginosa* in severely immunocompromised patients

Authority required

Bacterial gastroenteritis in severely immunocompromised patients

Authority required

Treatment of infections proven to be due to *Pseudomonas aeruginosa* or other gram-negative bacteria resistant to all other oral antimicrobials

Authority required

Treatment of joint and bone infections, epididymo-orchitis, prostatitis or perichondritis of the pinna, suspected or proven to be caused by gram-negative bacteria or gram-positive bacteria resistant to all other appropriate antimicrobials

ciprofloxacin 500 mg tablet, 14

1209P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	17.42	18.57	^a C-Flox 500 [AL] ^a Ciprofloxacin 500 [CR] ^a Ciprofloxacin-BW [GQ] ^a Ciprofloxacin-GA [GN] ^a Ciprol 500 [QA] ^a Loxip 500 [DO]	^a Cifran [RA] ^a Ciprofloxacin AN [EA] ^a Ciprofloxacin-DRLA [RZ] ^a Ciprofloxacin Sandoz [SZ] ^a GenRx Ciprofloxacin [GX]
			^b 1.40	18.82	18.57	^a Ciproxin 500 [BN]	

ciprofloxacin 750 mg tablet, 14

1210Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	22.84	23.99	^a C-Flox 750 [AL] ^a Ciprofloxacin 750 [CR] ^a Ciprofloxacin-BW [GQ]	^a Cifran [RA] ^a Ciprofloxacin AN [EA] ^a Ciprofloxacin-DRLA [RZ]

^a Ciprofloxacin-GA [GN]^a Ciprofloxacin Sandoz [SZ]^a Ciprol 750 [QA]^a GenRx Ciprofloxacin [GX]^a Loxip 750 [DO]

■ CIPROFLOXACIN

Authority requiredRespiratory tract infection proven or suspected to be caused by *Pseudomonas aeruginosa* in severely immunocompromised patients**Authority required**

Bacterial gastroenteritis in severely immunocompromised patients

Authority requiredTreatment of infections proven to be due to *Pseudomonas aeruginosa* or other gram-negative bacteria resistant to all other oral antimicrobials**Authority required**

Treatment of joint and bone infections, epididymo-orchitis, prostatitis or perichondritis of the pinna, suspected or proven to be caused by gram-negative bacteria or gram-positive bacteria resistant to all other appropriate antimicrobials

Authority required

Gonorrhoea

ciprofloxacin 250 mg tablet, 14

1208N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	12.21	13.36	^a C-Flox 250 [AL] ^a Ciprofloxacin Sandoz [SZ] ^a GenRx Ciprofloxacin [GX]	^a Ciprofloxacin-DRLA [RZ] ^a Ciprol 250 [QA]
			^B 1.42	13.63	13.36	^a Ciproxin 250 [BN]	

■ NORFLOXACIN

Authority required

Acute bacterial enterocolitis

Authority required

Complicated urinary tract infection

norfloxacin 400 mg tablet, 14

3010K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	11.38	12.53	^a GenRx Norfloxacin [GX] ^a Norfloxacin-GA [GN] ^a Nufloxib [AF]	^a Norfloxacin AN [EA] ^a Norfloxacin Sandoz [SZ] ^a Roxin [QA]

OTHER ANTIBACTERIALS

Glycopeptide antibacterials

■ VANCOMYCIN

Restricted benefit

Prophylaxis of endocarditis in patients hypersensitive to penicillin

vancomycin 1 g injection, 1 x 1 g vial

2269K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	..	..	10.76	11.91	^a Hospira Pty Limited [HH] ^a Vancomycin Sandoz [SZ]	^a Vancomycin Alphapharm [AF] ^a Vycin IV [GN]

vancomycin 1 g injection, 1 x 1 g vial

5083M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	10.76	11.91	^a Hospira Pty Limited [HH] ^a Vancomycin Sandoz [SZ]	^a Vancomycin Alphapharm [AF] ^a Vycin IV [GN]

vancomycin 500 mg injection, 1 x 500 mg vial

3130R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	..	..	*10.74	11.89	^a Hospira Pty Limited [HH] ^a Vancomycin Alphapharm [AF]	^a Vancocin CP [AS] ^a Vancomycin Sandoz [SZ]

vancomycin 500 mg injection, 1 x 500 mg vial

3323X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	2	..	..	*10.74	11.89	^a Hospira Pty Limited [HH] ^a Vancomycin Alphapharm [AF]	^a Vancocin CP [AS] ^a Vancomycin Sandoz [SZ]

■ VANCOMYCIN

Restricted benefit

Endophthalmitis

Restricted benefit

Use initiated in a hospital for infections where vancomycin is an appropriate antibiotic

vancomycin 1 g injection, 1 x 1 g vial

2270L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	3	..	..	*18.76	19.91	^a Hospira Pty Limited [HH] ^a Vancomycin Sandoz [SZ]	^a Vancomycin Alphapharm [AF] ^a Vycin IV [GN]

vancomycin 500 mg injection, 1 x 500 mg vial

3131T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	5	..	..	*16.71	17.86	^a Hospira Pty Limited [HH] ^a Vancomycin Alphapharm [AF]	^a Vancocin CP [AS] ^a Vancomycin Sandoz [SZ]

Steroid antibacterials

■ FUSIDATE

Restricted benefit

Serious staphylococcal infections

Clinical criteria:

The treatment must be used in combination with another antibiotic, **AND**

The condition must be proven to be due to a staphylococcus.

fusidate sodium 250 mg tablet, 36

2312Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	91.23	37.70	Fucidin [CS]

Imidazole derivatives

■ METRONIDAZOLE

metronidazole 200 mg tablet, 21

1636D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	8.22	9.37	^a Metrogyl 200 [AF]	^a Metronide 200 [AV]
			^b 2.30	10.52	9.37	^a Flagyl [SW]	

metronidazole 200 mg tablet, 21

3339R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	8.22	9.37	^a Metrogyl 200 [AF]	^a Metronide 200 [AV]
			^b 2.30	10.52	9.37	^a Flagyl [SW]	

metronidazole 200 mg/5 mL oral liquid, 100 mL

1630T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	..	..	19.16	20.31	Flagyl S [SW]

metronidazole 200 mg/5 mL oral liquid, 100 mL

3341W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	‡1	..	..	19.16	20.31	Flagyl S [SW]

metronidazole 500 mg suppository, 10

1642K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	..	..	23.50	24.65	Flagyl [SW]

metronidazole 500 mg suppository, 10

5157K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	‡1	..	..	23.50	24.65	Flagyl [SW]

■ METRONIDAZOLE

Restricted benefit

Infection

Clinical criteria:

The condition must be due to anaerobic bacteria.

metronidazole 400 mg tablet, 21

1621H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	10.19	11.34	^a Metrogyl 400 [AF]	^a Metronide 400 [AV]
			^b 2.30	12.49	11.34	^a Flagyl [SW]	

■ METRONIDAZOLE

Restricted benefit

Treatment of anaerobic infections

metronidazole 400 mg tablet, 21

5155H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	10.19	11.34	^a Metrogyl 400 [AF]	^a Metronide 400 [AV]
			^b 2.30	12.49	11.34	^a Flagyl [SW]	

■ METRONIDAZOLE**Restricted benefit**

Acute anaerobic sepsis

Treatment criteria:

Must be treated in a hospital.

Note

Pharmaceutical benefits that have the form metronidazole 500 mg/100 mL (0.5%) injection, 10 x 100 mL bags and pharmaceutical benefits that have the form metronidazole 500 mg/100 mL (0.5%) injection, 5 x 100 mL bags are equivalent for the purposes of substitution.

metronidazole 500 mg/100 mL (0.5%) injection, 10 x 100 mL bags

1832K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	17.94	19.09	^a DBL Metronidazole Intravenous Infusion [HH]	^a Metronidazole Sandoz IV [SZ]

metronidazole 500 mg/100 mL (0.5%) injection, 5 x 100 mL bags

2298Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	2	..	..	*17.94	19.09	^a Metronidazole-Clarix [AE]

■ METRONIDAZOLE**Restricted benefit**

Prophylaxis to prevent infection

Clinical criteria:

Patient must be undergoing large bowel surgery.

Restricted benefit

Acute anaerobic sepsis

Treatment criteria:

Must be treated in a hospital.

Note

Pharmaceutical benefits that have the form metronidazole 500 mg/100 mL (0.5%) injection, 10 x 100 mL bags and pharmaceutical benefits that have the form metronidazole 500 mg/100 mL (0.5%) injection, 5 x 100 mL bags are equivalent for the purposes of substitution.

metronidazole 500 mg/100 mL (0.5%) injection, 10 x 100 mL bags

1821W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	17.94	19.09	^a DBL Metronidazole Intravenous Infusion [HH]	^a Metronidazole Sandoz IV [SZ]

metronidazole 500 mg/100 mL (0.5%) injection, 5 x 100 mL bags

2277W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*17.94	19.09	^a Metronidazole-Clarix [AE]

■ TINIDAZOLE**tinidazole 500 mg tablet, 4**

1465D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	11.13	12.28	^a Simplotan [FZ]
			^b 5.41	16.54	12.28	^a Fasigyn [PF]

Nitrofurantoin derivatives**■ NITROFURANTOIN****Caution**

Nitrofurantoin may cause peripheral neuritis and severe pulmonary reactions.

nitrofurantoin 100 mg capsule, 30

1693D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP MW	1	1	..	30.94	32.09	Macrochantin [PF]

nitrofurantoin 50 mg capsule, 30

1692C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP MW	1	1	..	24.00	25.15	Macrochantin [PF]

Other antibacterials

■ HEXAMINE HIPPURATE

hexamine hippurate 1 g tablet, 100

3124K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	46.02	37.70	Hiprex [IA]

■ ANTIMYCOTICS FOR SYSTEMIC USE

ANTIMYCOTICS FOR SYSTEMIC USE

Triazole derivatives

■ FLUCONAZOLE

Authority required (STREAMLINED)**3615**

Treatment of cryptococcal meningitis

Authority required (STREAMLINED)**3616**

Maintenance therapy in patients with cryptococcal meningitis and immunosuppression

Authority required (STREAMLINED)**3613**

Treatment of oropharyngeal candidiasis in immunosuppressed patients

Authority required (STREAMLINED)**3614**

Treatment of oesophageal candidiasis in immunosuppressed patients

Authority required (STREAMLINED)**3617**

Prophylaxis of oropharyngeal candidiasis in immunosuppressed patients

Authority required (STREAMLINED)**3618**

Treatment of serious and life-threatening candida infections

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

fluconazole 100 mg capsule, 28

1472L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	44.02	37.70	^a Diflucan [PF] ^a Fluconazole Sandoz [SZ]	^a Dizole 100 [AF] ^a Ozole [RA]

fluconazole 100 mg/50 mL injection, 1 x 50 mL vial

1473M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	7	..	..	*22.51	23.66	^a Fluconazole Hexal [HX]	^a Fluconazole Sandoz [SZ]

fluconazole 200 mg capsule, 28

1475P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	76.96	37.70	^a APO-Fluconazole [TX] ^a Dizole 200 [AF] ^a Fluzole 200 [QA]	^a Diflucan [PF] ^a Fluconazole Sandoz [SZ] ^a Ozole [RA]

fluconazole 200 mg/100 mL injection, 1 x 100 mL vial

1474N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	7	..	..	*36.44	37.59	^a Fluconazole Alphapharm [AF] ^a Fluconazole Sandoz [SZ]	^a Fluconazole Hexal [HX]

fluconazole 400 mg/200 mL injection, 1 x 200 mL bag

1757L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	13.43	14.58	Fluconazole Alphapharm [AF]

fluconazole 50 mg capsule, 28

1471K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	26.11	27.26	^a Diflucan [PF] ^a Fluconazole Sandoz [SZ]	^a Dizole 50 [AF] ^a Ozole [RA]

■ FLUCONAZOLE

Authority required

Treatment of cryptococcal meningitis in a patient unable to take a solid dose form of fluconazole

Authority required

Maintenance therapy in a patient with cryptococcal meningitis and immunosuppression unable to take a solid dose form of fluconazole

Authority required

Treatment of oropharyngeal candidiasis in an immunosuppressed patient unable to take a solid dose form of fluconazole

Authority required

Treatment of oesophageal candidiasis in an immunosuppressed patient unable to take a solid dose form of fluconazole

Authority required

Prophylaxis of oropharyngeal candidiasis in an immunosuppressed patient unable to take a solid dose form of fluconazole

Authority required

Treatment of serious and life-threatening candida infections in a patient unable to take a solid dose form of fluconazole

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

fluconazole 50 mg/5 mL oral liquid: powder for, 35 mL

5446P

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	#68.28	37.70	Diflucan [PF]

■ ITRACONAZOLE

Authority required (STREAMLINED)

3607

Systemic aspergillosis

Authority required (STREAMLINED)

3608

Systemic sporotrichosis

Authority required (STREAMLINED)

3609

Systemic histoplasmosis

Authority required (STREAMLINED)

3610

Treatment and maintenance therapy in patients with AIDS who have disseminated pulmonary histoplasmosis infection

Authority required (STREAMLINED)

3612

Treatment and maintenance therapy in patients with AIDS who have chronic pulmonary histoplasmosis infection

Authority required (STREAMLINED)

3613

Treatment of oropharyngeal candidiasis in immunosuppressed patients

Authority required (STREAMLINED)

3614

Treatment of oesophageal candidiasis in immunosuppressed patients

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

itraconazole 100 mg capsule, 60

8196J

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	247.13	37.70	Sporanox [JC]

■ POSACONAZOLE

Authority required

Treatment of invasive aspergillosis in patients intolerant to, or with disease refractory to, alternative therapy

Authority required

Treatment of fusariosis, zygomycosis, coccidioidomycosis, chromoblastomycosis and mycetoma in patients intolerant to, or with disease refractory to, alternative therapy

Authority required

Prophylaxis of invasive fungal infections, including both yeasts and moulds, in a patient who is at high risk of developing these infections, defined as follows:

(1) Neutropenia

Patients with anticipated neutropenia (an absolute neutrophil count of less than 500 cells per cubic millimetre) for at least 10 days, who are receiving chemotherapy for acute myelogenous leukaemia or myelodysplastic syndrome.

Treatment should continue until recovery of the neutrophil count to at least 500 cells per cubic millimetre.

Patients who have had a previous invasive fungal infection should have secondary prophylaxis during subsequent episodes of neutropenia.

(2) Graft versus host disease (GVHD)

Patients with acute GVHD grades II to IV or extensive chronic GVHD, who are receiving intensive immunosuppressive therapy after allogeneic haematopoietic stem cell transplant.

No more than 6 months therapy per episode will be PBS-subsidised

Note

Application for an increased maximum quantity to allow for up to 1 month's treatment and repeats sufficient for up to 6 months' treatment may be authorised.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

posaconazole 40 mg/mL oral liquid, 105 mL

9360P



Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	733.60	37.70	Noxafil [MK]

■ **VORICONAZOLE**

Authority required

Prophylaxis of invasive fungal infections including both yeasts and moulds

Clinical criteria:

Patient must be considered at high risk of developing an invasive fungal infection due to anticipated neutropenia (an absolute neutrophil count less than 500 cells per cubic millimetre) for at least 10 days whilst receiving chemotherapy for acute myeloid leukaemia or myelodysplastic syndrome; OR

Patient must be considered at high risk of developing an invasive fungal infection due to having acute graft versus host disease (GVHD) grade II, III or IV, or, extensive chronic GVHD, whilst receiving intensive immunosuppressive therapy after allogeneic haematopoietic stem cell transplant; OR

Patient must be undergoing allogeneic haematopoietic stem cell transplant using either bone marrow from an unrelated donor or umbilical cord blood (related or unrelated), and, be considered to be at high risk of developing an invasive fungal infection during the neutropenic phase prior to engraftment.

Note

For patients with graft versus host disease, acute myeloid leukaemia or myelodysplastic syndrome, applications for an increased maximum quantity to allow for up to 1 month's treatment and repeats sufficient for up to 6 months' treatment may be authorised.

For patients undergoing allogeneic haematopoietic stem cell transplant, applications for an increased maximum quantity to allow for up to 1 month's treatment and repeats sufficient for up to 2 months' treatment may be authorised.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

voriconazole 200 mg tablet, 56

10198R



Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	2237.86	37.70	Vfend [PF]

voriconazole 40 mg/mL oral liquid: powder for, 70 mL

10168E



Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	#593.97	37.70	Vfend [PF]

voriconazole 50 mg tablet, 56

10173K



Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	591.34	37.70	Vfend [PF]

■ **VORICONAZOLE**

Authority required

Definite or probable invasive aspergillosis

Treatment Phase: Treatment and maintenance therapy

Population criteria:

Patient must be immunocompromised.

Authority required

Serious fungal infections

Treatment Phase: Treatment and maintenance therapy

Clinical criteria:

The condition must be caused by *Scedosporium* species or *Fusarium* species.

Authority required

Serious *Candida* infections

Treatment Phase: Treatment and maintenance therapy

Clinical criteria:

The condition must be caused by species not susceptible to fluconazole; OR

The condition must be resistant to fluconazole; OR

Patient must not tolerate fluconazole.

Authority required

Serious invasive mycosis infections

Treatment Phase: Treatment and maintenance therapy

Clinical criteria:

The treatment must be for invasive mycosis infections other than definite or probable invasive aspergillosis.

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

voriconazole 200 mg tablet, 56

9364W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	2237.86	37.70	Vfend [PF]

voriconazole 50 mg tablet, 56

9363T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	591.34	37.70	Vfend [PF]

▪ **VORICONAZOLE**

Authority required

Definite or probable invasive aspergillosis

Treatment Phase: Treatment and maintenance therapy

Population criteria:

Patient must be immunocompromised.

Authority required

Serious fungal infections

Treatment Phase: Treatment and maintenance therapy

Clinical criteria:

The condition must be caused by *Scedosporium* species or *Fusarium* species.

Authority required

Serious *Candida* infections

Treatment Phase: Treatment and maintenance therapy

Clinical criteria:

The condition must be caused by species not susceptible to fluconazole; OR

The condition must be resistant to fluconazole; OR

Patient must not tolerate fluconazole.

Authority required

Serious invasive mycosis infections

Treatment Phase: Treatment and maintenance therapy

Clinical criteria:

The treatment must be for invasive mycosis infections other than definite or probable invasive aspergillosis.

Note

Application for an increased maximum quantity to allow for up to 1 month's treatment and repeats sufficient for up to 6 months' treatment may be authorised.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

voriconazole 40 mg/mL oral liquid: powder for, 70 mL

9452L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	#593.97	37.70	Vfend [PF]

■ ANTIMYCOBACTERIALS

DRUGS FOR TREATMENT OF TUBERCULOSIS

Hydrazides

■ ISONIAZID

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

isoniazid 100 mg tablet, 100

1554T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	21.83	22.98	Fawns and McAllan Proprietary Limited [FM]

DRUGS FOR TREATMENT OF LEPRA

Drugs for treatment of lepra

■ DAPSONE

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

dapsone 100 mg tablet, 100

1272Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	114.18	37.70	Link Medical Products Pty Ltd [LM]

dapsone 25 mg tablet, 100

8801F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	100.92	37.70	Link Medical Products Pty Ltd [LM]

■ RIFAMPICIN

Authority required

Leprosy in adults

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

rifampicin 150 mg capsule, 100

1982H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	306.14	37.70	Rimycin 150 [AF]

rifampicin 300 mg capsule, 100

1983J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	147.98	37.70	Rimycin 300 [AF]

■ RIFAMPICIN

Restricted benefit

Prophylaxis of meningococcal disease in close contacts and carriers

Restricted benefit

Prophylactic treatment of contacts of patients with Haemophilus influenzae type B

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

rifampicin 100 mg/5 mL oral liquid, 60 mL

8025J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	..	..	30.69	31.84	Rifadin [SW]

rifampicin 150 mg capsule, 10

1981G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	39.12	37.70	Rimycin 150 [AF]

rifampicin 300 mg capsule, 10

1984K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	21.53	22.68	Rimycin 300 [AF]

■ ANTIVIRALS FOR SYSTEMIC USE

DIRECT ACTING ANTIVIRALS

Nucleosides and nucleotides excl. reverse transcriptase inhibitors

■ ACICLOVIR

Authority required (STREAMLINED)

3630

Patients with advanced HIV disease (CD4 cell counts of less than 150 million per litre)

aciclovir 800 mg tablet, 120

8234J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	190.01	37.70	^a Acihexal [SZ]	^a Acyclo-V 800 [AF]

■ ACICLOVIR

Authority required (STREAMLINED)

3633

Episodic treatment or suppressive therapy of moderate to severe recurrent genital herpes. Microbiological confirmation of diagnosis (viral culture, antigen detection or nucleic acid amplification by PCR) is required but need not delay treatment

Note

Aciclovir 200 mg is not PBS-subsidised for chickenpox, herpes zoster or herpes simplex infections other than genital herpes.

aciclovir 200 mg tablet, 90

1007B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	51.44	37.70	^a Aciclovir 200 [CR] ^a Aciclovir Sandoz [HX] ^a Chem mart Aciclovir [CH] ^a Lovir [GN] ^a Terry White Chemists Aciclovir [TW]	^a Aciclovir GH [GQ] ^a Acyclo-V 200 [AF] ^a GenRx Aciclovir [GX] ^a Ozvir [RA]
			^B 1.49	52.93	37.70	^a Zovirax 200 mg [GK]	

■ ACICLOVIR

Authority required (STREAMLINED)

3632

Moderate to severe initial genital herpes. Microbiological confirmation of diagnosis (viral culture, antigen detection or nucleic acid amplification by PCR) is desirable but need not delay treatment

Note

Aciclovir 200 mg is not PBS-subsidised for chickenpox, herpes zoster or herpes simplex infections other than genital herpes.

No applications for increased maximum quantities and/or repeats will be authorised.

For item codes 1003T and 1555W, pharmaceutical benefits that have the form tablet 200 mg are equivalent for the purposes of substitution.

aciclovir 200 mg tablet, 25

1003T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	..	..	*32.42	33.57	^a Aciclovir Sandoz [HX] ^a Acyclo-V 200 [AF]	^a Acihexal [SZ] ^a Lovir [GN]
			^B 2.06	*34.48	33.57	^a Zovirax 200 mg [GK]	

aciclovir 200 mg tablet, 50

1555W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	32.43	33.58	^a GenRx Aciclovir [GX]

■ ACICLOVIR

Authority required (STREAMLINED)**3622**

Treatment of patients with herpes zoster within 72 hours of the onset of the rash

Authority required (STREAMLINED)**3631**

Herpes zoster ophthalmicus

Note

Aciclovir is effective only if commenced within 72 hours of onset of rash.

Aciclovir 800 mg is not PBS-subsidised for herpes simplex or chickenpox.

No applications for repeats will be authorised.

aciclovir 800 mg tablet, 35

1052J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	60.21	37.70	^a Aciclovir 800 [CR] ^a Acyclo-V 800 [AF]	^a Acihexal [SZ] ^a GenRx Aciclovir [GX]
			^b 0.80	61.01	37.70	^a Zovirax 800 mg [GK]	

■ FAMCICLOVIR

Authority required (STREAMLINED)**3624**

Episodic treatment of moderate to severe recurrent genital herpes. Microbiological confirmation of diagnosis (viral culture, antigen detection or nucleic acid amplification by PCR) is required but need not delay treatment

Note

Famciclovir 250 mg is not PBS-subsidised for chickenpox or herpes simplex infections other than genital herpes.

famciclovir 250 mg tablet, 20

2274Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	57.03	37.70	^a APO-Famciclovir [TX] ^a Famciclovir AN [EA] ^a Famciclovir Sandoz [SZ] ^a Favic 250 [QA]	^a Ezovir [AF] ^a Famciclovir-GA [GN] ^a Famvir [NV]

■ FAMCICLOVIR

Authority required (STREAMLINED)**3624**

Episodic treatment of moderate to severe recurrent genital herpes. Microbiological confirmation of diagnosis (viral culture, antigen detection or nucleic acid amplification by PCR) is required but need not delay treatment

Note

Famciclovir 125 mg is not PBS-subsidised for chickenpox, herpes zoster or herpes simplex infections other than genital herpes.

famciclovir 125 mg tablet, 40

8092X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	57.03	37.70	^a APO-Famciclovir [TX] ^a Famciclovir AN [EA] ^a Famvir [NV]	^a Ezovir [AF] ^a Famciclovir-GA [GN] ^a Favic 125 [QA]

■ FAMCICLOVIR

Authority required (STREAMLINED)**3623**

Suppressive therapy of moderate to severe recurrent genital herpes. Microbiological confirmation of diagnosis (viral culture, antigen detection or nucleic acid amplification by PCR) is required but need not delay treatment

Note

Famciclovir 250 mg is not PBS-subsidised for chickenpox or herpes simplex infections other than genital herpes.

famciclovir 250 mg tablet, 56

8217L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	147.51	37.70	^a APO-Famciclovir [TX] ^a Ezovir [AF] ^a Famciclovir-GA [GN] ^a Famciclovir Sandoz [SZ] ^a Famlo [RA] ^a Favic 250 [QA]	^a Auro-Famciclovir 250 [DO] ^a Famciclovir AN [EA] ^a Famciclovir generichealth 250 [GQ] ^a Famciclovir SCP 250 [CR] ^a Famvir [NV]

■ FAMCICLOVIR

Authority required (STREAMLINED)

3622

Treatment of patients with herpes zoster within 72 hours of the onset of the rash

Note

Famciclovir is effective only if commenced within 72 hours of onset of rash.

Famciclovir 250 mg is not PBS-subsidised for chickenpox or herpes simplex infections other than genital herpes.

No applications for repeats will be authorised.

famciclovir 250 mg tablet, 21

8002E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	59.55	37.70	^a APO-Famciclovir [TX] ^a Ezovir [AF] ^a Famciclovir-GA [GN] ^a Famciclovir Sandoz [SZ] ^a Famlo [RA] ^a Favic 250 [QA]	^a Auro-Famciclovir 250 [DO] ^a Famciclovir AN [EA] ^a Famciclovir generichealth 250 [GQ] ^a Famciclovir SCP 250 [CR] ^a Famvir [NV]

■ FAMCICLOVIR

Authority required (STREAMLINED)

3625

Treatment of immunocompromised patients with herpes zoster within 72 hours of the onset of the rash

Note

Famciclovir is effective only if commenced within 72 hours of onset of rash.

Famciclovir 500 mg is not PBS-subsidised for chickenpox.

Famciclovir 500 mg is not PBS-subsidised for herpes zoster, genital herpes or other herpes simplex infections in immunocompetent patients.

No applications for repeats will be authorised.

famciclovir 500 mg tablet, 30

8897G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	82.15	37.70	^a APO-Famciclovir [TX] ^a Famciclovir AN [EA] ^a Famvir [NV] ^a Terry White Chemists Famciclovir [TW]	^a Chem mart Famciclovir [CH] ^a Famciclovir Sandoz [SZ] ^a Favic 500 [QA]

■ FAMCICLOVIR

Authority required (STREAMLINED)

3626

Episodic treatment or suppressive therapy of moderate to severe recurrent genital herpes in immunocompromised patients. Microbiological confirmation of diagnosis (viral culture, antigen detection or nucleic acid amplification by PCR) is required but need not delay treatment

Authority required (STREAMLINED)

3627

Episodic treatment of moderate to severe recurrent oral or labial herpes in a patient with HIV infection and a CD4 cell count of less than 500 million per litre. Microbiological confirmation of diagnosis (viral culture, antigen detection or nucleic acid amplification by PCR) is required but need not delay treatment

Authority required (STREAMLINED)

3628

Suppressive therapy of moderate to severe recurrent oral or labial herpes in a patient with HIV infection and a CD4 cell count of less than 150 million per litre. Microbiological confirmation of diagnosis (viral culture, antigen detection or nucleic acid amplification by PCR) is required but need not delay treatment

Authority required (STREAMLINED)

3629

Suppressive therapy of moderate to severe recurrent oral or labial herpes in a patient with HIV infection and other opportunistic infections or AIDS defining tumours. Microbiological confirmation of diagnosis (viral culture, antigen detection or nucleic acid amplification by PCR) is required but need not delay treatment

Note

Famciclovir 500 mg is not PBS-subsidised for chickenpox.

Famciclovir 500 mg is not PBS-subsidised for herpes zoster, genital herpes or other herpes simplex infections in immunocompetent patients.

famciclovir 500 mg tablet, 56

8896F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	147.51	37.70	^a APO-Famciclovir [TX] ^a Chem mart Famciclovir [CH] ^a Famciclovir AN [EA] ^a Famciclovir generichealth 500 [GQ] ^a Famvir [NV] ^a Terry White Chemists Famciclovir [TW]	^a Auro-Famciclovir 500 [DO] ^a Ezovir [AF] ^a Famciclovir-GA [GN] ^a Famciclovir Sandoz [SZ] ^a Favic 500 [QA]

■ VALACICLOVIR**Authority required (STREAMLINED)****3623**

Suppressive therapy of moderate to severe recurrent genital herpes. Microbiological confirmation of diagnosis (viral culture, antigen detection or nucleic acid amplification by PCR) is required but need not delay treatment

Note

Valaciclovir 500 mg is not PBS-subsidised for chickenpox or herpes simplex infections other than genital herpes.

valaciclovir 500 mg tablet, 30

5480K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	50.35	37.70	^a APO-Valaciclovir [TX] ^a Shilova 500 [DO] ^a Vaclovir [AF] ^a Valaciclovir AN [EA] ^a Valaciclovir generichealth [GQ] ^a Valaciclovir SZ [HX] ^a Valnir [QA] ^a Zelitrex [UA]	^a Chem mart Valaciclovir [CH] ^a Terry White Chemists Valaciclovir [TW] ^a Valaciclovir Actavis [VN] ^a Valaciclovir GA [GN] ^a Valaciclovir RBX [RA] ^a Valacor 500 [CR] ^a Valtrex [AS]

■ VALACICLOVIR**Authority required (STREAMLINED)****3624**

Episodic treatment of moderate to severe recurrent genital herpes. Microbiological confirmation of diagnosis (viral culture, antigen detection or nucleic acid amplification by PCR) is required but need not delay treatment

Note

Valaciclovir 500 mg is not PBS-subsidised for chickenpox or herpes simplex infections other than genital herpes.

valaciclovir 500 mg tablet, 30

8134D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	50.35	37.70	^a APO-Valaciclovir [TX] ^a Shilova 500 [DO] ^a Vaclovir [AF] ^a Valaciclovir AN [EA] ^a Valaciclovir generichealth [GQ] ^a Valaciclovir Sandoz [SZ] ^a Valacor 500 [CR] ^a Valtrex [AS]	^a Chem mart Valaciclovir [CH] ^a Terry White Chemists Valaciclovir [TW] ^a Valaciclovir Actavis [VN] ^a Valaciclovir GA [GN] ^a Valaciclovir RBX [RA] ^a Valaciclovir SZ [HX] ^a Valnir [QA] ^a Zelitrex [UA]

■ VALACICLOVIR**Authority required (STREAMLINED)****3632**

Moderate to severe initial genital herpes. Microbiological confirmation of diagnosis (viral culture, antigen detection or nucleic acid amplification by PCR) is desirable but need not delay treatment

Note

Valaciclovir 500 mg is not PBS-subsidised for chickenpox or herpes simplex infections other than genital herpes.
No applications for increased maximum quantities and/or repeats will be authorised.

valaciclovir 500 mg tablet, 10

8133C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	..	..	*36.72	37.70	^a APO-Valaciclovir [TX] ^a Terry White Chemists Valaciclovir [TW] ^a Valaciclovir Actavis [VN] ^a Valaciclovir GA [GN] ^a Valnir [QA]	^a Chem mart Valaciclovir [CH] ^a Vaclovir [AF] ^a Valaciclovir AN [EA] ^a Valaciclovir Sandoz [SZ] ^a Valtrex [AS]

^a Zelitrex [UA]

■ VALACICLOVIR

Authority required (STREAMLINED)**3622**

Treatment of patients with herpes zoster within 72 hours of the onset of the rash

Authority required (STREAMLINED)**3631**

Herpes zoster ophthalmicus

Note

Valaciclovir is effective only if commenced within 72 hours of onset of rash.

Valaciclovir 500 mg is not PBS-subsidised for chickenpox or herpes simplex infections other than genital herpes.

No applications for repeats will be authorised.

valaciclovir 500 mg tablet, 42

8064K

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	66.96	37.70	^a APO-Valaciclovir [TX] ^a Terry White Chemists Valaciclovir [TW] ^a Valaciclovir Actavis [VN] ^a Valaciclovir GA [GN] ^a Valaciclovir RBX [RA] ^a Valacor 500 [CR] ^a Valtrex [AS]	^a Chem mart Valaciclovir [CH] ^a Vaclovir [AF] ^a Valaciclovir AN [EA] ^a Valaciclovir generichealth [GQ] ^a Valaciclovir Sandoz [SZ] ^a Valnir [QA] ^a Zelitrex [UA]

■ VACCINES

BACTERIAL VACCINES*Pneumococcal vaccines*

■ PNEUMOCOCCAL PURIFIED CAPSULAR POLYSACCHARIDES

Restricted benefit

Splenectomised persons over 2 years of age

Restricted benefit

Persons with Hodgkin's disease

Restricted benefit

Persons at high risk of pneumococcal infections

pneumococcal purified capsular polysaccharides 25 microgram/0.5 mL injection, 1 x 0.5 mL syringe

10210J

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	49.02	37.70	Pneumovax 23 [CS]

pneumococcal purified capsular polysaccharides 25 microgram/0.5 mL injection, 1 x 0.5 mL vial

1903E

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	49.02	37.70	Pneumovax 23 [CS]

Tetanus vaccines

■ DIPHTHERIA TOXOID + TETANUS TOXOID

Note

For immunisation of adults and children aged greater than or equal to 8 years.

diphtheria toxoid 2 Lf/0.5 mL + tetanus toxoid 2 Lf/0.5 mL injection, 10 x 0.5 mL vials

10261C

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	144.59	37.70	MassBiologics tetanus and diphtheria toxoids adsorbed [CS]

diphtheria toxoid 2 international units/0.5 mL + tetanus toxoid 20 international units/0.5 mL injection, 5 x 0.5 mL syringes

8783G

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	75.68	37.70	ADT Booster [CS]

■ ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

■ ANTINEOPLASTIC AGENTS

ALKYLATING AGENTS

Nitrogen mustard analogues

■ CHLORAMBUCIL

chlorambucil 2 mg tablet, 25

1163F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	4	2	..	*154.12	37.70	Leukeran [AS]

■ CYCLOPHOSPHAMIDE

cyclophosphamide 50 mg tablet, 50

10026Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	83.64	37.70	Endoxan [BX]

cyclophosphamide 50 mg tablet, 50

1266P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	31.63	32.78	Cycloblastin [ZX]

■ MELPHALAN

melphalan 2 mg tablet, 25

2547C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	77.11	37.70	Alkeran [AS]

Alkyl sulfonates

■ BUSULFAN

busulfan 2 mg tablet, 100

1128J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	96.18	37.70	Myleran [AS]

Nitrosoureas

■ CARMUSTINE

Restricted benefit

Glioblastoma multiforme, suspected or confirmed, at the time of initial surgery

Note

Carmustine is not PBS-subsidised for use in conjunction with PBS-subsidised temozolomide.

carmustine 7.7 mg implant, 8

8898H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	17539.66	37.70	Gliadel [OA]

Other alkylating agents

■ TEMOZOLOMIDE

temozolomide 100 mg capsule, 5

8380C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	357.50	37.70	^a Astromide [GN] ^a Temizole 100 [QA] ^a Temozolomide Alphapharm [AF]	^a Orion Temozolomide [ON] ^a Temodal [MK] ^a Temozolomide AN [EA]

temozolomide 140 mg capsule, 5

9362R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	474.86	37.70	^a Astromide [GN] ^a Temizole 140 [QA] ^a Temozolomide Alphapharm [AF]	^a Orion Temozolomide [ON] ^a Temodal [MK] ^a Temozolomide AN [EA]

temozolomide 180 mg capsule, 5

2438H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	593.35	37.70	^a Astromide [GN] ^a Temodal [MK]	^a Orion Temozolomide [ON]

temozolomide 20 mg capsule, 5

8379B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	92.20	37.70	^a Astromide [GN] ^a Temizole 20 [QA] ^a Temozolomide Alphapharm [AF]	^a Orion Temozolomide [ON] ^a Temodal [MK] ^a Temozolomide AN [EA]

temozolomide 250 mg capsule, 5

8381D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	828.94	37.70	^a Astromide [GN] ^a Temizole 250 [QA] ^a Temozolomide Alphapharm [AF]	^a Orion Temozolomide [ON] ^a Temodal [MK] ^a Temozolomide AN [EA]

temozolomide 5 mg capsule, 5

8378Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	37.14	37.70	^a Astromide [GN] ^a Temizole 5 [QA] ^a Temozolomide Alphapharm [AF]	^a Orion Temozolomide [ON] ^a Temodal [MK] ^a Temozolomide AN [EA]

▪ **TEMOZOLOMIDE**

Restricted benefit

Glioblastoma multiforme

Treatment criteria:

Patient must be undergoing concomitant radiotherapy.

Note

Temozolomide is not PBS-subsidised for use in conjunction with PBS-subsidised carmustine.

No increase in the maximum number of repeats may be authorised.

temozolomide 100 mg capsule, 5

8821G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	3	2	..	*1044.91	37.70	^a Astromide [GN] ^a Temizole 100 [QA] ^a Temozolomide Alphapharm [AF]	^a Orion Temozolomide [ON] ^a Temodal [MK] ^a Temozolomide AN [EA]

temozolomide 140 mg capsule, 5

9361Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	3	2	..	*1411.06	37.70	^a Astromide [GN] ^a Temizole 140 [QA] ^a Temozolomide Alphapharm [AF]	^a Orion Temozolomide [ON] ^a Temodal [MK] ^a Temozolomide AN [EA]

temozolomide 180 mg capsule, 5

10062N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	3	2	..	*1766.53	37.70	^a Astromide [GN] ^a Temodal [MK]	^a Orion Temozolomide [ON]

temozolomide 20 mg capsule, 5

8820F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	3	2	..	*257.77	37.70	^a Astromide [GN] ^a Temizole 20 [QA] ^a Temozolomide Alphapharm [AF]	^a Orion Temozolomide [ON] ^a Temodal [MK] ^a Temozolomide AN [EA]

temozolomide 5 mg capsule, 5

8819E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	3	2	..	*93.94	37.70	^a Astromide [GN] ^a Temizole 5 [QA] ^a Temozolomide Alphapharm [AF]	^a Orion Temozolomide [ON] ^a Temodal [MK] ^a Temozolomide AN [EA]

ANTIMETABOLITES

Folic acid analogues

■ METHOTREXATE

methotrexate 10 mg tablet, 15

2272N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	20.68	21.83	Methoblastin [PF]

methotrexate 2.5 mg tablet, 30

1622J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	13.46	14.61	^a Hospira Pty Limited [HH]	^a Methoblastin [PF]

methotrexate 5 mg/2 mL injection, 5 x 2 mL vials

2396D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	19.93	21.08	Hospira Pty Limited [HH]

■ METHOTREXATE

Restricted benefit

For patients requiring doses greater than 20 mg per week

methotrexate 10 mg tablet, 50

1623K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	51.58	37.70	Methoblastin [PF]

■ METHOTREXATE

Note

For item codes 2395C and 1818Q, pharmaceutical benefits that have the form injection 50 mg in 2 mL are equivalent for the purposes of substitution.

METHOTREXATE Injection 50 mg in 2 mL, 1

1818Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	5	5	..	*19.71	20.86	^a Methaccord [GN]	^a Methotrexate MYX [YN]

methotrexate 50 mg/2 mL injection, 5 x 2 mL vials

2395C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	19.69	20.84	^a Hospira Pty Limited [HH]

Purine analogues

■ FLUDARABINE

fludarabine phosphate 10 mg tablet, 20

9184J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	937.04	37.70	Fludara [GZ]

■ MERCAPTOPURINE

mercaptopurine 20 mg/mL oral liquid, 100 mL

10214N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	462.37	37.70	Allmercap [LM]

mercaptopurine 50 mg tablet, 25

1598D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	4	2	..	*267.12	37.70	Purinethol [AS]

■ THIIOGUANINE

thioguanine 40 mg tablet, 25

1233X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	243.21	37.70	Lanvis [AS]

Pyrimidine analogues

■ CAPECITABINE

capecitabine 150 mg tablet, 60

8361C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	105.47	37.70	^a Capecitabine Actavis [GN] ^a Capecitabine AN [EA] ^a Capecitabine Sandoz [SZ] ^a Xeloda [RO]	^a Capecitabine Alphapharm [AF] ^a Capecitabine-DRLA [RZ] ^a Xelabine [QA]

capecitabine 500 mg tablet, 120

8362D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	585.31	37.70	^a Capecitabine Actavis [GN] ^a Capecitabine AN [EA] ^a Capecitabine-DRLA [RZ] ^a Capecitabine Sandoz [SZ] ^a Xeloda [RO]	^a Capecitabine Alphapharm [AF] ^a Capecitabine Apotex [TX] ^a Capecitabine GH [GQ] ^a Xelabine [QA]

PLANT ALKALOIDS AND OTHER NATURAL PRODUCTS*Vinca alkaloids and analogues***■ VINORELBINE****Authority required**

Advanced breast cancer

Clinical criteria:

Patient must have failed standard prior therapy, which includes an anthracycline.

Authority required

Locally advanced or metastatic non-small cell lung cancer

vinorelbine 20 mg capsule, 1

9009E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	20	2	..	*1579.56	37.70	Navelbine [FB]

vinorelbine 30 mg capsule, 1

9010F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	16	2	..	*1887.56	37.70	Navelbine [FB]

*Podophyllotoxin derivatives***■ ETOPOSIDE****etoposide 100 mg capsule, 10**

1389D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	391.07	37.70	Vepesid [BQ]

etoposide 50 mg capsule, 20

1396L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	445.28	37.70	Vepesid [BQ]

CYTOTOXIC ANTIBIOTICS AND RELATED SUBSTANCES*Anthracyclines and related substances***■ IDARUBICIN****Restricted benefit**

Acute myelogenous leukaemia

idarubicin hydrochloride 10 mg capsule, 1

2448W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	3	..	..	*494.83	37.70	Zavedos [PF]

idarubicin hydrochloride 5 mg capsule, 1

2446R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	3	..	..	*267.94	37.70	Zavedos [PF]

OTHER ANTINEOPLASTIC AGENTS*Protein kinase inhibitors***■ DABRAFENIB****Authority required**

Unresectable Stage III or Stage IV malignant melanoma

Treatment Phase: Initial treatment

Clinical criteria:The treatment must be the sole PBS-subsidised therapy for this condition, **AND**The condition must be positive for a BRAF V600 mutation, **AND**

The condition must not have been treated previously with PBS subsidised therapy; OR

Patient must have developed intolerance to another BRAF inhibitor of a severity necessitating permanent treatment withdrawal, **AND**

Patient must have a WHO performance status of 2 or less.

Note

A patient who has had progressive disease when treated with another BRAF inhibitor is not eligible to receive PBS-subsidised treatment with this drug.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

dabrafenib 50 mg capsule, 120

2963Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	5888.15	37.70	Tafinlar [GK]

dabrafenib 75 mg capsule, 120

2846T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	8758.87	37.70	Tafinlar [GK]

▪ **DABRAFENIB**

Authority required

Unresectable Stage III or Stage IV malignant melanoma

Treatment Phase: Continuing treatment

Clinical criteria:

The treatment must be the sole PBS-subsidised therapy for this condition, **AND**

Patient must have previously been issued with an authority prescription for this drug, **AND**

Patient must have stable or responding disease.

Note

A patient who has progressive disease when treated with this drug is no longer eligible for PBS-subsidised treatment with this drug.

A patient who has had progressive disease when treated with another BRAF inhibitor is not eligible to receive PBS-subsidised treatment with this drug.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

dabrafenib 50 mg capsule, 120

2954L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	5888.15	37.70	Tafinlar [GK]

dabrafenib 75 mg capsule, 120

10003L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	8758.87	37.70	Tafinlar [GK]

▪ **DASATINIB**

Authority required

Initial treatment, as the sole PBS-subsidised therapy, of a patient in the chronic phase of chronic myeloid leukaemia expressing the Philadelphia chromosome or the transcript, BCR-ABL tyrosine kinase, and who has a primary diagnosis of chronic myeloid leukaemia.

Applications under this restriction will be limited to provide patients with a maximum of 18 months of therapy with dasatinib, imatinib or nilotinib from the date the first application for initial treatment was approved.

Patients should be commenced on a dose of dasatinib of at least 100 mg (base) daily. Continuing therapy is dependent on patients demonstrating a response to dasatinib therapy following the initial 18 months of treatment and at 12 monthly intervals thereafter.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Chronic Myeloid Leukaemia - Chronic Phase, First Line - Supporting Information form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]; and
- (3) a pathology cytogenetic report conducted on peripheral blood or bone marrow supporting the diagnosis of chronic myeloid leukaemia to confirm eligibility for treatment, or a qualitative PCR report documenting the presence of the BCR-ABL transcript in either peripheral blood or bone marrow; and
- (4) a signed patient acknowledgement form

Authority required

Continuing treatment, as the sole PBS-subsidised therapy, of a patient who has received initial PBS-subsidised treatment with dasatinib for the chronic phase of chronic myeloid leukaemia and who has demonstrated either a major cytogenetic response or less than 1% BCR-ABL level in the blood.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) demonstration of continued response to treatment as evidenced by either:

- (a) major cytogenetic response [see Note explaining requirements]. Where this has been supplied within the previous 12 months, only the date of the relevant pathology report need be provided; or
- (b) a peripheral blood level of BCR-ABL of less than 1% on the international scale [see Note explaining requirements]. Where this has been supplied within the previous 12 months, only the date of the relevant pathology report need be provided

Note

Any queries concerning the arrangements to prescribe dasatinib may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Applications for authority to prescribe dasatinib should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of tyrosine kinase inhibitors (TKI) agents for the chronic phase of chronic myeloid leukaemia. Where the term TKI agent appears in the following notes and restrictions it refers to imatinib mesylate, dasatinib or nilotinib.

Patients are eligible for PBS-subsidised treatment with only one TKI agent at any one time and must not be receiving concomitant interferon alfa therapy. Eligible patients may only swap between TKI agents if they have not failed prior PBS-subsidised treatment with that agent.

1. Initial treatment - imatinib mesylate, dasatinib and nilotinib

From 1 April 2012, under the PBS, a patient will be able to be prescribed any of imatinib mesylate, dasatinib or nilotinib within the initial 18 month treatment period, as long as only one agent is used at a time and providing the patient has not failed to respond to any one of these TKIs.

During the initial 18 month treatment period, switching between approved first-line agents may only occur for reasons of intolerance, not failure of response.

2. Continuing treatment with imatinib mesylate - first-line

First continuing applications are to be written and must include a pathology report demonstrating the patient has responded to the initial course of treatment.

Second and subsequent authority applications for continuing therapy with imatinib mesylate may be made on the telephone by contacting Medicare Australia on 1800 700 720 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Patients must maintain a major cytogenetic response or have a peripheral blood BCR-ABL of less than 1% to receive continuing therapy.

3. Continuing treatment with dasatinib or nilotinib - first-line

All continuing applications are to be written and must include a pathology report demonstrating the patient has responded to PBS-subsidised treatment as follows:

(i) within 18 months of the commencement of treatment, at which time patients in whom a major cytogenetic response or peripheral blood BCR-ABL level of less than 1% has been demonstrated may receive authorisation for a further 12 months of treatment; and

(ii) at no greater than 12 month intervals thereafter, to demonstrate that the major cytogenetic response or peripheral blood BCR-ABL level of less than 1% has been sustained.

4. For imatinib mesylate, dasatinib and nilotinib

During continuing therapy beyond the initial 18 month treatment period, switching between approved first-line agents may only occur for reason of intolerance. Where there is failure of response, switching may only occur through application for prescription of second-line agents.

Where a patient has previously received PBS-subsidised treatment with imatinib mesylate, dasatinib or nilotinib no approval will be granted for PBS-subsidised re-treatment in the chronic phase of chronic myeloid leukaemia, where that patient has at any time failed to meet the response criteria whilst on that TKI agent.

5. Authority approval requirements.

Response criteria to initial treatment with imatinib mesylate, dasatinib or nilotinib:

For the purposes of assessing response to PBS-subsidised treatment with imatinib mesylate, dasatinib or nilotinib either cytogenetic analysis indicating the number of Philadelphia positive [t (9;22)] cells in the bone marrow measured by standard karyotyping, or quantitative PCR indicating the relative level of BCR-ABL transcript in the peripheral blood using the international scale, must be submitted. For bone marrow analyses, where the standard karyotyping is not informative for technical reasons, a cytogenetic analysis performed on the bone marrow by the use of fluorescence in situ hybridisation (FISH) with BCR-ABL specific probe must be submitted. The cytogenetic or peripheral blood quantitative PCR analyses must be submitted within 18 months of the commencement of treatment with imatinib mesylate, dasatinib or nilotinib (patients in whom a major cytogenetic response or peripheral blood BCR-ABL level of less than 1% is demonstrable by 18 months are eligible to receive continuing treatment with that agent).

6. Definitions of response.

A major cytogenetic response is defined as less than 35% Philadelphia positive bone marrow cells.

A peripheral blood BCR-ABL level of less than 1% on the international scale (Blood 108: 28-37, 2006) also indicates a response, at least the biological equivalent of a major cytogenetic response.

7. Definitions of loss of response.

Loss of a previously documented major cytogenetic response (demonstrated by the presence of greater than 35% Ph positive cells on bone marrow biopsy), during ongoing tyrosine kinase inhibitor (TKI) therapy.

Loss of a previously demonstrated molecular response (demonstrated by peripheral blood BCR-ABL levels increasing consecutively in value by at least 5 fold to a level of greater than 0.1% confirmed on a subsequent test), during ongoing tyrosine kinase inhibitor therapy.

dasatinib 100 mg tablet, 30

1416M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	5004.14	37.70	Sprycel [BQ]

dasatinib 20 mg tablet, 60

1354G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	3095.79	37.70	Sprycel [BQ]

dasatinib 50 mg tablet, 60

1381Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	5004.14	37.70	Sprycel [BQ]

dasatinib 70 mg tablet, 60

1415L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	6160.53	37.70	Sprycel [BQ]

■ DASATINIB**Authority required**

Initial treatment, as the sole PBS-subsidised therapy, of a patient with chronic myeloid leukaemia in any disease phase who has failed an adequate trial of imatinib or nilotinib as first-line treatment.

Failure of an adequate trial of imatinib or nilotinib is defined as:

(i) Lack of response to initial imatinib or nilotinib therapy, defined as either:

— failure to achieve a haematological response after a minimum of 3 months therapy with imatinib or nilotinib for patients initially treated in chronic phase; or

— failure to achieve any cytogenetic response after a minimum of 6 months therapy with imatinib or nilotinib for patients initially treated in chronic phase as demonstrated on bone marrow biopsy by presence of greater than 95% Philadelphia chromosome positive cells; or

— failure to achieve a major cytogenetic response or a peripheral blood BCR-ABL level of less than 1% after a minimum of 12 months therapy with imatinib or nilotinib; OR

(ii) Loss of a previously documented major cytogenetic response (demonstrated by the presence of greater than 35% Ph positive cells on bone marrow biopsy), during ongoing imatinib or nilotinib therapy; OR

(iii) Loss of a previously demonstrated molecular response (demonstrated by peripheral blood BCR-ABL levels increasing consecutively in value by at least 5 fold to a level of greater than 0.1% confirmed on a subsequent test), during ongoing imatinib or nilotinib therapy; OR

(iv) Development of accelerated phase or blast crisis in a patient previously prescribed imatinib or nilotinib for any phase of chronic myeloid leukaemia.

Accelerated phase is defined by the presence of 1 or more of the following:

(1) Percentage of blasts in the peripheral blood or bone marrow greater than or equal to 15% but less than 30%; or

(2) Percentage of blasts plus promyelocytes in the peripheral blood or bone marrow greater than or equal to 30%, provided that blast count is less than 30%; or

(3) Peripheral basophils greater than or equal to 20%; or

(4) Progressive splenomegaly to a size greater than or equal to 10 cm below the left costal margin to be confirmed on 2 occasions at least 4 weeks apart, or a greater than or equal to 50% increase in size below the left costal margin over 4 weeks; or

(5) Karyotypic evolution (chromosomal abnormalities in addition to a single Philadelphia chromosome); OR

Blast crisis is defined as either:

(1) Percentage of blasts in the peripheral blood or bone marrow greater than or equal to 30%; or

(2) Extramedullary involvement other than spleen and liver; OR

(v) Disease progression (defined as a greater than or equal to 50% increase in peripheral white blood cell count, blast count, basophils or platelets) during first-line imatinib or nilotinib therapy in patients with accelerated phase or blast crisis chronic myeloid leukaemia.

Patients should be commenced on a dose of dasatinib of at least 100 mg (base) daily. Continuing therapy is dependent on patients demonstrating a major cytogenetic response to dasatinib therapy or a peripheral blood BCR-ABL level of less than 1% within 18 months and thereafter at 12 monthly intervals.

Applications for authorisation must be in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Chronic Myeloid Leukaemia - Second and Third Line - Supporting Information Form; and

(c) a signed patient acknowledgement; and

(d) a bone marrow biopsy pathology report demonstrating the patient has active chronic myeloid leukaemia, either manifest as cytogenetic evidence of the Philadelphia chromosome, or RT-PCR level of BCR-ABL transcript greater than 0.1% on the international scale. (The date of the relevant pathology report needs to be provided); and

(e) where there has been a loss of response to imatinib or nilotinib, a copy of the current confirming pathology report(s) from an Approved Pathology Authority or details of the dates of assessment in the case of progressive splenomegaly or extramedullary involvement

Authority required

Continuing treatment, as the sole PBS-subsidised therapy, of a patient who has received initial PBS-subsidised treatment with dasatinib for chronic myeloid leukaemia, and who has demonstrated either a major cytogenetic response, or less than 1% BCR-ABL level in the blood, to dasatinib in the preceding 18 months and thereafter at 12 monthly intervals.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Chronic Myeloid Leukaemia - Second and Third Line - Application Form for continuing treatment; and
- (3) demonstration of continued response to treatment as evidenced by either:
 - (a) major cytogenetic response [see Note explaining definitions of response]. Where this has been supplied within the previous 12 months (or 18 months for the initial supply), only the date of the relevant pathology report needs to be provided; or
 - (b) a peripheral blood level of BCR-ABL of less than 1% on the international scale [see Note explaining definitions of response]. Where this has been supplied within the previous 12 months (or 18 months for the initial supply), only the date of the relevant pathology report needs to be provided

Note

Any queries concerning the arrangements to prescribe dasatinib may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Applications for authority to prescribe dasatinib should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of tyrosine kinase inhibitors (TKI) agents for all phases of chronic myeloid leukaemia. Where the term TKI agent appears in the following notes and restrictions it refers to dasatinib or nilotinib. Imatinib mesylate is not approved for use in second or third line treatment.

Patients are eligible for PBS-subsidised treatment with only one of dasatinib or nilotinib at any one time and must not be receiving concomitant interferon alfa therapy. Eligible patients may only swap between these agents if they have not failed prior PBS-subsidised treatment with that agent.

Nilotinib is not approved for patients in blast crisis.

1. Initial second line treatment

From 1 April 2012, under the PBS, a patient will be able to be prescribed either dasatinib or nilotinib within the initial 18 month treatment period as second-line therapy, as long as only one agent is approved at a time and providing the patient did not fail that drug as first-line therapy.

During the initial 18 month treatment period, switching between approved second-line agents may only occur for reasons of intolerance, not failure of response.

2. Initial third line treatment

Third-line treatment with a TKI can only be approved when imatinib is used for first-line treatment. Patients will only be approved for PBS-subsidised treatment with one third-line agent.

From 1 April 2012, under the PBS, a patient will be able to be prescribed either dasatinib or nilotinib providing the patient did not fail that drug as first or second line therapy and for nilotinib the patient is not in blast crisis.

3. Continuing treatment for second and third line treatment

All continuing applications are to be written and must include a pathology report demonstrating the patient has responded to PBS-subsidised treatment as follows:

(i) within 18 months of the commencement of treatment, at which time patients in whom a major cytogenetic response or peripheral blood BCR-ABL level of less than 1% has been demonstrated may receive authorisation for a further 12 months of treatment; and

(ii) at no greater than 12 month intervals thereafter, to demonstrate that the major cytogenetic response or peripheral blood BCR-ABL level of less than 1% has been sustained.

During second line continuing treatment beyond the initial 18 month treatment period, switching between approved second line TKI agents may only occur for reason of intolerance. Where there is failure of response, switching may only occur through application for prescription of a third line agent.

4. Authority approval requirements.

Response criteria to initial treatment with dasatinib or nilotinib:

For the purposes of assessing response to PBS-subsidised treatment with dasatinib or nilotinib, either cytogenetic analysis indicating the number of Philadelphia positive [t (9;22)] cells in the bone marrow measured by standard karyotyping, or quantitative PCR indicating the relative level of BCR-ABL transcript in the peripheral blood using the international scale, must be submitted. For bone marrow analyses, where the standard karyotyping is not informative for technical reasons, a cytogenetic analysis performed on the bone marrow by the use of fluorescence in situ hybridisation (FISH) with BCR-ABL specific probe must be submitted. The cytogenetic or peripheral blood quantitative PCR analyses must be submitted within 18 months of the commencement of treatment with dasatinib or nilotinib (patients in whom a major cytogenetic response or peripheral blood BCR-ABL level of less than 1% is demonstrable by 18 months are eligible to receive continuing treatment with that agent).

5. Definitions of response.

A major cytogenetic response is defined as less than 35% Philadelphia positive bone marrow cells.

A peripheral blood BCR-ABL level of less than 1% on the international scale (Blood 108: 28-37, 2006) also indicates a response, at least the biological equivalent of a major cytogenetic response.

6. Definitions of loss of response.

Loss of a previously documented major cytogenetic response (demonstrated by the presence of greater than 35% Ph positive cells on bone marrow biopsy), during ongoing tyrosine kinase inhibitor (TKI) therapy.

Loss of a previously demonstrated molecular response (demonstrated by peripheral blood BCR-ABL levels increasing consecutively in value by at least 5 fold to a level of greater than 0.1% confirmed on a subsequent test), during ongoing tyrosine kinase inhibitor therapy.

dasatinib 100 mg tablet, 30

9342Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	5004.14	37.70	Sprycel [BQ]

dasatinib 20 mg tablet, 60

2478K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	3095.79	37.70	Sprycel [BQ]

dasatinib 50 mg tablet, 60

2482P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	5004.14	37.70	Sprycel [BQ]

dasatinib 70 mg tablet, 60

2485T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	6160.53	37.70	Sprycel [BQ]

■ DASATINIB

Authority required

Initial treatment, as monotherapy, of a patient with acute lymphoblastic leukaemia (ALL) bearing the Philadelphia chromosome or expressing the transcript, BCR-ABL, who has failed treatment with chemotherapy AND imatinib and where appropriate, allogeneic haemopoietic stem cell transplantation.

Failure of treatment is defined as either:

- (i) Failure to achieve a complete morphological and cytogenetic remission after a minimum of 2 months treatment with intensive chemotherapy and imatinib;
 - (ii) Morphological or cytogenetic relapse of leukaemia after achieving a complete remission induced by chemotherapy and imatinib;
 - (iii) Morphological or cytogenetic relapse or persistence of leukaemia after allogeneic haemopoietic stem cell transplantation.
- Patients must have active leukaemia, as defined by presence on current pathology assessments of either morphological infiltration of the bone marrow (greater than 5% lymphoblasts) or cerebrospinal fluid or other sites; OR the presence of cells bearing the Philadelphia chromosome on cytogenetic or FISH analysis in the bone marrow of patients in morphological remission.

The first authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Acute Lymphoblastic Leukaemia Dasatinib PBS Authority Application - Supporting Information Form; and
- (c) a signed patient acknowledgement; and
- (d) a pathology report demonstrating that the patient has active acute lymphoblastic leukaemia, either manifest as cytogenetic evidence of the Philadelphia chromosome, or morphological evidence of acute lymphoblastic leukaemia plus qualitative RT-PCR evidence of BCR-ABL transcript. The date of the relevant pathology report(s) need(s) to be provided

Authority required

Initial treatment, as monotherapy, of a patient with acute lymphoblastic leukaemia bearing the Philadelphia chromosome or expressing the transcript, BCR-ABL, who has been treated prior to 1 December 2007 and has failed treatment with chemotherapy and where appropriate, allogeneic haemopoietic stem cell transplantation.

Patients must have active leukaemia, as defined by presence on current pathology assessments of either morphological infiltration of the bone marrow (greater than 5% lymphoblasts) or cerebrospinal fluid or other sites; OR the presence of cells bearing the Philadelphia chromosome on cytogenetic or FISH analysis in the bone marrow of patients in morphological remission.

The first authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Acute Lymphoblastic Leukaemia Dasatinib PBS Authority Application - Supporting Information Form; and
- (c) a signed patient acknowledgement; and
- (d) a pathology report demonstrating that the patient has active acute lymphoblastic leukaemia, either manifest as cytogenetic evidence of the Philadelphia chromosome, or morphological evidence of acute lymphoblastic leukaemia plus qualitative RT-PCR evidence of BCR-ABL transcript. The date of the relevant pathology report(s) need(s) to be provided

Authority required

Continuing treatment, as monotherapy, of a patient with acute lymphoblastic leukaemia bearing the Philadelphia chromosome or expressing the transcript, BCR-ABL, where the patient has previously been issued with an authority prescription for dasatinib and does not have progressive disease.

Authority applications for continuing treatment may be made by telephone on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

Note

Any queries concerning the arrangements to prescribe dasatinib may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Applications for authority to prescribe dasatinib should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Dasatinib will only be subsidised for patients with acute lymphoblastic leukaemia who are not receiving concomitant PBS-subsidised imatinib mesylate and who are not appropriate for an allogeneic haemopoietic stem cell transplant.

No applications for increased repeats will be authorised.

dasatinib 100 mg tablet, 30

9343R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	5004.14	37.70	Sprycel [BQ]

dasatinib 20 mg tablet, 60

9125G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	3095.79	37.70	Sprycel [BQ]

dasatinib 50 mg tablet, 60

9126H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	5004.14	37.70	Sprycel [BQ]

dasatinib 70 mg tablet, 60

9127J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	6160.53	37.70	Sprycel [BQ]

■ ERLOTINIB

Authority required

Stage IIIB (locally advanced) or Stage IV (metastatic) non-small cell lung cancer (NSCLC)

Treatment Phase: Continuing treatment

Clinical criteria:

The treatment must be as monotherapy, **AND**

Patient must have previously been issued with an authority prescription for this drug prior to 1 August 2014, **AND**

Patient must not have progressive disease.

Population criteria:

Patient must have a wild type epidermal growth factor receptor (EGFR) gene; OR

Patient must have an epidermal growth factor receptor (EGFR) gene of unknown type.

erlotinib 100 mg tablet, 30

10019H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1239.13	37.70	Tarceva [RO]

erlotinib 150 mg tablet, 30

10025P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1514.10	37.70	Tarceva [RO]

erlotinib 25 mg tablet, 30

10028T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	355.07	37.70	Tarceva [RO]

■ ERLOTINIB

Authority required

Stage IIIB (locally advanced) or Stage IV (metastatic) non-small cell lung cancer (NSCLC)

Treatment Phase: Initial treatment

Clinical criteria:

The treatment must be as monotherapy, **AND**

The condition must be non-squamous type non-small cell lung cancer (NSCLC) or not otherwise specified type NSCLC, **AND**

Patient must not have received previous PBS-subsidised treatment with another epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor (TKI); OR

Patient must have developed intolerance to another epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor (TKI) of a severity necessitating permanent treatment withdrawal, **AND**
 Patient must have a WHO performance status of 2 or less.

Population criteria:

Patient must have evidence of an activating epidermal growth factor receptor (EGFR) gene mutation known to confer sensitivity to treatment with EGFR tyrosine kinase inhibitors in tumour material.

Authority required

Stage IIIB (locally advanced) or Stage IV (metastatic) non-small cell lung cancer (NSCLC)

Treatment Phase: Continuing treatment

Clinical criteria:

The treatment must be as monotherapy, **AND**

Patient must have previously been issued with an authority prescription for this drug, **AND**

Patient must not have progressive disease.

Population criteria:

Patient must have evidence of an activating epidermal growth factor receptor (EGFR) gene mutation known to confer sensitivity to treatment with EGFR tyrosine kinase inhibitors in tumour material.

erlotinib 100 mg tablet, 30

10020J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1239.13	37.70	Tarceva [RO]

erlotinib 150 mg tablet, 30

10014C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1514.10	37.70	Tarceva [RO]

erlotinib 25 mg tablet, 30

10022L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	355.07	37.70	Tarceva [RO]

■ EVEROLIMUS**Authority required**

Tuberous sclerosis complex (TSC)

Treatment Phase: Initial treatment

Clinical criteria:

The condition must be subependymal giant cell astrocytomas (SEGAs) associated with TSC; OR

The condition must be visceral tumours associated with TSC, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition, **AND**

Patient must not be a candidate for curative surgical resection.

Authority required

Tuberous sclerosis complex (TSC)

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must be subependymal giant cell astrocytomas (SEGAs) associated with TSC; OR

The condition must be visceral tumours associated with TSC, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition, **AND**

Patient must have previously been treated with PBS-subsidised everolimus for this condition, **AND**

Patient must have demonstrated a response to prior treatment.

Note

Special Pricing Arrangements apply.

everolimus 2.5 mg tablet, 30

2818H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1483.50	37.70	Afinitor [NV]

■ EVEROLIMUS**Authority required**

Tuberous sclerosis complex (TSC)

Treatment Phase: Initial treatment

Clinical criteria:

The condition must be subependymal giant cell astrocytomas (SEGAs) associated with TSC; OR

The condition must be visceral tumours associated with TSC, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition, **AND**

Patient must not be a candidate for curative surgical resection.

Authority required

Tuberous sclerosis complex (TSC)

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must be subependymal giant cell astrocytomas (SEGAs) associated with TSC; OR

The condition must be visceral tumours associated with TSC, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition, **AND**

Patient must have previously been treated with PBS-subsidised everolimus for this condition, **AND**

Patient must have demonstrated a response to prior treatment.

Authority required

Metastatic (Stage IV) breast cancer

Clinical criteria:

The condition must be hormone receptor positive, **AND**

The condition must be human epidermal growth factor receptor 2 (HER2) negative, **AND**

The condition must have acquired endocrine resistance as demonstrated by initial response and then recurrence or progression of disease after treatment with letrozole or anastrozole, **AND**

The treatment must be in combination with exemestane.

Population criteria:

Patient must not be pre-menopausal.

Note

Patients who have progressive disease with everolimus are no longer eligible for PBS-subsidised everolimus.

Special Pricing Arrangements apply.

everolimus 10 mg tablet, 30

2985D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	5546.70	37.70	Afinitor [NV]

everolimus 5 mg tablet, 30

2819J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	2846.70	37.70	Afinitor [NV]

▪ **EVEROLIMUS**

Authority required

Stage IV clear cell variant renal cell carcinoma (RCC)

Treatment Phase: Continuing treatment beyond 3 months

Clinical criteria:

Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**

Patient must have stable or responding disease according to the Response Evaluation Criteria In Solid Tumours (RECIST), **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

Patients who have progressive disease with everolimus are no longer eligible for PBS-subsidised everolimus.

Note

Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:

Complete response (CR) is disappearance of all target lesions.

Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.

Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.

Stable disease (SD) is small changes that do not meet above criteria.

Authority required

Metastatic or unresectable, well-differentiated malignant pancreatic neuroendocrine tumour (pNET)

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have previously been issued with an authority prescription for this drug, **AND**

Patient must not have disease progression, **AND**

The treatment must be as monotherapy.

Patients who have progressive disease with this drug are no longer eligible for PBS-subsidised treatment with this drug.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

everolimus 10 mg tablet, 30

10135K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	5546.70	37.70	Afinitor [NV]

everolimus 5 mg tablet, 30

10131F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	2846.70	37.70	Afinitor [NV]

■ EVEROLIMUS**Authority required**

Stage IV clear cell variant renal cell carcinoma (RCC)

Treatment Phase: Initial treatment

Clinical criteria:

Patient must have progressive disease according to the Response Evaluation Criteria In Solid Tumours (RECIST) following first-line treatment with a tyrosine kinase inhibitor, **AND**

Patient must have a WHO performance status of 2 or less, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

Patients who have developed intolerance to a tyrosine kinase inhibitor of a severity necessitating permanent treatment withdrawal are eligible to receive PBS-subsidised everolimus.

Patients who have progressive disease with everolimus are no longer eligible for PBS-subsidised everolimus.

Note

Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:

Complete response (CR) is disappearance of all target lesions.

Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.

Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.

Stable disease (SD) is small changes that do not meet above criteria.

Authority required

Metastatic or unresectable, well-differentiated malignant pancreatic neuroendocrine tumour (pNET)

Treatment Phase: Initial treatment

Clinical criteria:

Patient must be symptomatic (despite somatostatin analogues); OR

Patient must have disease progression, **AND**

The treatment must be as monotherapy.

Disease progression must be documented in the patient's medical records.

Patients who have developed progressive disease on sunitinib are not eligible to receive PBS-subsidised everolimus.

Patients who have developed intolerance to sunitinib of a severity necessitating permanent treatment withdrawal are eligible to receive PBS-subsidised everolimus.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

everolimus 10 mg tablet, 30

10132G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	5546.70	37.70	Afinitor [NV]

everolimus 5 mg tablet, 30

10133H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	2846.70	37.70	Afinitor [NV]

■ GEFITINIB**Authority required**

Stage IIIB (locally advanced) or Stage IV (metastatic) non-small cell lung cancer (NSCLC)

Treatment Phase: Initial treatment

Clinical criteria:

The treatment must be as monotherapy, **AND**

The condition must be non-squamous type non-small cell lung cancer (NSCLC) or not otherwise specified type NSCLC, **AND**

Patient must not have received previous PBS-subsidised treatment with another epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor (TKI); OR

Patient must have developed intolerance to another epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor (TKI) of a severity necessitating permanent treatment withdrawal, **AND**

Patient must have a WHO performance status of 2 or less.

Population criteria:

Patient must have evidence of an activating epidermal growth factor receptor (EGFR) gene mutation known to confer sensitivity to treatment with EGFR tyrosine kinase inhibitors in tumour material.

Authority required

Stage IIIB (locally advanced) or Stage IV (metastatic) non-small cell lung cancer (NSCLC)

Treatment Phase: Continuing treatment

Clinical criteria:

The treatment must be as monotherapy, **AND**

Patient must have previously been issued with an authority prescription for this drug, **AND**

Patient must not have progressive disease.

gefitinib 250 mg tablet, 30

8769M

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	3	..	1514.10	37.70	Iressa [AP]

■ **IMATINIB**

Authority required

Initial treatment, as the sole PBS-subsidised therapy, of a patient in the chronic phase of chronic myeloid leukaemia expressing the Philadelphia chromosome or the transcript, BCR-ABL tyrosine kinase, and who has a primary diagnosis of chronic myeloid leukaemia.

Applications under this restriction will be limited to provide patients with a maximum of 18 months of therapy with dasatinib, imatinib or nilotinib from the date the first application for initial treatment was approved.

Patients should be commenced on a dose of imatinib mesylate of 400 mg (base) daily. Continuing therapy is dependent on patients demonstrating a response to imatinib mesylate therapy following the initial 18 months of treatment and at 12 monthly intervals thereafter.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Chronic Myeloid Leukaemia - Chronic Phase, First Line - Supporting Information form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]; and
- (3) a pathology cytogenetic report conducted on peripheral blood or bone marrow supporting the diagnosis of chronic myeloid leukaemia to confirm eligibility for treatment, or a qualitative PCR report documenting the presence of the BCR-ABL transcript in either peripheral blood or bone marrow; and
- (4) a signed patient acknowledgement form

Authority required

Continuing treatment, as the sole PBS-subsidised therapy, of a patient who has received initial PBS-subsidised treatment with imatinib mesylate for the chronic phase of chronic myeloid leukaemia and who has demonstrated either a major cytogenetic response or less than 1% BCR-ABL level in the blood.

First continuing applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) demonstration of a response to treatment as evidenced by either:
 - (a) major cytogenetic response [see Note explaining requirements]; or
 - (b) a peripheral blood level of BCR-ABL of less than 1% on the international scale [see Note explaining requirements].

Second and subsequent authority applications for continuing therapy with imatinib mesylate may be made on the telephone by contacting Medicare Australia on 1800 700 720 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Patients must maintain a major cytogenetic response or have a peripheral blood BCR-ABL of less than 1% to receive continuing therapy

Note

Any queries concerning the arrangements to prescribe imatinib mesylate may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe imatinib mesylate should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

For the following diseases, written authority is required at initiation and for continuation:

Dermatofibrosarcoma protuberans;

Hypereosinophilic syndrome;

Chronic eosinophilic leukaemia;

Myelodysplastic or myeloproliferative disorder;

Aggressive systemic mastocytosis with eosinophilia.

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of tyrosine kinase inhibitors (TKI) agents for the chronic phase of chronic myeloid leukaemia. Where the term TKI agent appears in the following notes and restrictions it refers to imatinib mesylate, dasatinib or nilotinib.

Patients are eligible for PBS-subsidised treatment with only one TKI agent at any one time and must not be receiving concomitant interferon alfa therapy. Eligible patients may only swap between TKI agents if they have not failed prior PBS-subsidised treatment with that agent.

1. Initial treatment - imatinib mesylate, dasatinib and nilotinib

From 1 April 2012, under the PBS, a patient will be able to be prescribed any of imatinib mesylate, dasatinib or nilotinib within the initial 18 month treatment period, as long as only one agent is used at a time and providing the patient has not failed to respond to any one of these TKIs.

During the initial 18 month treatment period, switching between approved first-line agents may only occur for reasons of intolerance, not failure of response.

2. Continuing treatment with imatinib mesylate - first-line

First continuing applications are to be written and must include a pathology report demonstrating the patient has responded to the initial course of treatment.

Second and subsequent authority applications for continuing therapy with imatinib mesylate may be made on the telephone by contacting Medicare Australia on 1800 700 720 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Patients must maintain a major cytogenetic response or have a peripheral blood BCR-ABL of less than 1% to receive continuing therapy.

3. Continuing treatment with dasatinib or nilotinib - first-line

All continuing applications are to be written and must include a pathology report demonstrating the patient has responded to PBS-subsidised treatment as follows:

(i) within 18 months of the commencement of treatment, at which time patients in whom a major cytogenetic response or peripheral blood BCR-ABL level of less than 1% has been demonstrated may receive authorisation for a further 12 months of treatment; and

(ii) at no greater than 12 month intervals thereafter, to demonstrate that the major cytogenetic response or peripheral blood BCR-ABL level of less than 1% has been sustained.

4. For imatinib mesylate, dasatinib and nilotinib

During continuing therapy beyond the initial 18 month treatment period, switching between approved first-line agents may only occur for reason of intolerance. Where there is failure of response, switching may only occur through application for prescription of second-line agents.

Where a patient has previously received PBS-subsidised treatment with imatinib mesylate, dasatinib or nilotinib no approval will be granted for PBS-subsidised re-treatment in the chronic phase of chronic myeloid leukaemia, where that patient has at any time failed to meet the response criteria whilst on that TKI agent.

5. Authority approval requirements.

Response criteria to initial treatment with imatinib mesylate, dasatinib or nilotinib:

For the purposes of assessing response to PBS-subsidised treatment with imatinib mesylate, dasatinib or nilotinib either cytogenetic analysis indicating the number of Philadelphia positive [t (9;22)] cells in the bone marrow measured by standard karyotyping, or quantitative PCR indicating the relative level of BCR-ABL transcript in the peripheral blood using the international scale, must be submitted. For bone marrow analyses, where the standard karyotyping is not informative for technical reasons, a cytogenetic analysis performed on the bone marrow by the use of fluorescence in situ hybridisation (FISH) with BCR-ABL specific probe must be submitted. The cytogenetic or peripheral blood quantitative PCR analyses must be submitted within 18 months of the commencement of treatment with imatinib mesylate, dasatinib or nilotinib (patients in whom a major cytogenetic response or peripheral blood BCR-ABL level of less than 1% is demonstrable by 18 months are eligible to receive continuing treatment with that agent).

6. Definitions of response.

A major cytogenetic response is defined as less than 35% Philadelphia positive bone marrow cells.

A peripheral blood BCR-ABL level of less than 1% on the international scale (Blood 108: 28-37, 2006) also indicates a response, at least the biological equivalent of a major cytogenetic response.

7. Definitions of loss of response.

Loss of a previously documented major cytogenetic response (demonstrated by the presence of greater than 35% Ph positive cells on bone marrow biopsy), during ongoing tyrosine kinase inhibitor (TKI) therapy.

Loss of a previously demonstrated molecular response (demonstrated by peripheral blood BCR-ABL levels increasing consecutively in value by at least 5 fold to a level of greater than 0.1% confirmed on a subsequent test), during ongoing tyrosine kinase inhibitor therapy.

imatinib 100 mg tablet, 60

9113P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1963.21	37.70	Glivec [NV]

imatinib 400 mg tablet, 30

9114Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	3779.71	37.70	Glivec [NV]

■ IMATINIB

Authority required

Initial PBS-subsidised treatment of a patient with unresectable, locally recurrent or metastatic dermatofibrosarcoma protuberans.

Maximum dose: 800 mg per day.

(1) Where the application for authority to prescribe is being sought on the basis of unresectable tumour, written evidence in support of that claim must be provided; and

(2) Where the application for authority to prescribe is being sought on the basis of locally recurrent disease, the site of the local recurrence must be specified; and

(3) Where the application for authority to prescribe is being sought on the basis of metastatic disease, the site(s) of metastatic disease must be provided.

Applications for authorisation for initial treatment must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Rare Diseases Imatinib PBS Authority Application - Supporting Information Form; and

(c) a signed patient acknowledgement

Authority required

Continuing PBS-subsidised treatment of a patient with unresectable, locally recurrent or metastatic dermatofibrosarcoma protuberans who has previously been issued with an authority prescription for imatinib and who has demonstrated a response, but whose disease remains unresectable.

Maximum dose: 800 mg per day.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Rare Diseases Imatinib PBS Authority Application - Supporting Information Form; and
- (c) a statement that the disease has not progressed on imatinib therapy

Note

Any queries concerning the arrangements to prescribe imatinib mesylate may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe imatinib mesylate should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

For the following diseases, written authority is required at initiation and for continuation:

Dermatofibrosarcoma protuberans;
Hypereosinophilic syndrome;
Chronic eosinophilic leukaemia;
Myelodysplastic or myeloproliferative disorder;

Aggressive systemic mastocytosis with eosinophilia.

No applications for increased repeats will be authorised.

imatinib 100 mg tablet, 60

9172R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	1963.21	37.70	Glivec [NV]

imatinib 400 mg tablet, 30

9173T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	3779.71	37.70	Glivec [NV]

■ IMATINIB

Authority required

Initial PBS-subsidised treatment of a patient with hypereosinophilic syndrome or chronic eosinophilic leukaemia requiring treatment and confirmed to carry the FIP1L1-PDGFR fusion gene.

Maximum dose: 400 mg per day.

Applications for authorisation for initial treatment must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Rare Diseases Imatinib PBS Authority Application - Supporting Information Form; and
- (c) a copy of the pathology report confirming the presence of the FIP1L1-PDGFR fusion gene; and
- (d) a copy of the full blood examination report confirming the presence of hypereosinophilic syndrome or chronic eosinophilic leukaemia; and
- (e) details of organ involvement requiring treatment, including a copy of the radiology, nuclear medicine, respiratory function or anatomical pathology reports as appropriate; and
- (f) a signed patient acknowledgement

Authority required

Continuing PBS-subsidised treatment of a patient with hypereosinophilic syndrome or chronic eosinophilic leukaemia who has previously been issued with an authority prescription for imatinib and who has achieved and maintained a complete haematological response.

Maximum dose: 400 mg per day.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Rare Diseases Imatinib PBS Authority Application - Supporting Information Form; and
- (c) a copy of the full blood examination report which demonstrates a complete haematological response, with a normal eosinophil count; and
- (d) a statement that the disease has not progressed on imatinib therapy

Note

Any queries concerning the arrangements to prescribe imatinib mesylate may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe imatinib mesylate should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

For the following diseases, written authority is required at initiation and for continuation:

Dermatofibrosarcoma protuberans;

Hypereosinophilic syndrome;

Chronic eosinophilic leukaemia;

Myelodysplastic or myeloproliferative disorder;

Aggressive systemic mastocytosis with eosinophilia.

No applications for increased repeats will be authorised.

imatinib 100 mg tablet, 60

9174W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	1963.21	37.70	Glivec [NV]

imatinib 400 mg tablet, 30

9175X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	3779.71	37.70	Glivec [NV]

■ IMATINIB

Authority required

Initial PBS-subsidised treatment of a patient with a myelodysplastic or myeloproliferative disorder where:

(1) there is confirmed evidence of a platelet-derived growth factor receptor (PDGFR) gene re-arrangement either by standard karyotyping, or FISH or PDGFRB fusion gene transcript; and

(2) the patient has previously failed an adequate trial of one or more of the following conventional therapies:

— cytarabine;

— etoposide;

— hydroxyurea.

Maximum dose: 400 mg per day.

Applications for authorisation for initial treatment must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Rare Diseases Imatinib PBS Authority Application - Supporting Information Form; and

(c) a copy of the pathology report confirming the platelet-derived growth factor receptor (PDGFR) gene re-arrangement; and

(d) a copy of the bone marrow biopsy report which demonstrates the presence of a myelodysplastic or myeloproliferative disorder; and

(e) details of the prior therapy trialled and the response; and

(f) a signed patient acknowledgement

Authority required

Continuing PBS-subsidised treatment of a patient with a PDGFRB fusion gene-positive myelodysplastic or myeloproliferative disorder who has previously been issued with an authority prescription for imatinib and who has demonstrated a complete haematological response.

Maximum dose: 400 mg per day.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Rare Diseases Imatinib PBS Authority Application - Supporting Information Form; and

(c) a copy of the full blood examination report which demonstrates a complete haematological response; and

(d) a statement that the disease has not progressed on imatinib therapy

Note

Any queries concerning the arrangements to prescribe imatinib mesylate may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe imatinib mesylate should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

For the following diseases, written authority is required at initiation and for continuation:

Dermatofibrosarcoma protuberans;

Hypereosinophilic syndrome;

Chronic eosinophilic leukaemia;

Myelodysplastic or myeloproliferative disorder;

Aggressive systemic mastocytosis with eosinophilia.

No applications for increased repeats will be authorised.

imatinib 100 mg tablet, 60

9176Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	1963.21	37.70	Glivec [NV]

imatinib 400 mg tablet, 30

9177B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	3779.71	37.70	Glivec [NV]

■ **IMATINIB**

Authority required

Initial PBS-subsidised treatment of a patient with aggressive systemic mastocytosis with eosinophilia where:

- (1) there is confirmed evidence of the FIP1L1-PDGFR fusion gene; and
- (2) the patient has previously failed an adequate trial of one or more of the following conventional therapies:
 - corticosteroids;
 - hydroxyurea.

Maximum dose: 400 mg per day.

Applications for authorisation for initial treatment must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Rare Diseases Imatinib PBS Authority Application - Supporting Information Form; and
- (c) a copy of the pathology report confirming the presence of the FIP1L1-PDGFR fusion gene; and
- (d) a copy of the bone marrow biopsy report and/or other tissue biopsy report confirming the diagnosis of aggressive systemic mastocytosis and a copy of the full blood examination report demonstrating eosinophilia; and
- (e) details of symptomatic organ involvement requiring treatment, including a copy of the radiology, nuclear medicine, respiratory function or anatomical pathology reports as appropriate; and
- (f) details of prior treatment trialled and the response; and
- (g) a signed patient acknowledgement

Authority required

Continuing PBS-subsidised treatment of a patient with aggressive systemic mastocytosis confirmed to carry the FIP1L1-PDGFR fusion gene, who has previously been issued with an authority prescription for imatinib and who has demonstrated a complete haematological response.

Maximum dose: 400 mg per day.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Rare Diseases Imatinib PBS Authority Application - Supporting Information Form; and
- (c) a copy of the full blood examination report which demonstrates a complete haematological response; and
- (d) a statement that the disease has not progressed on imatinib therapy

Note

Any queries concerning the arrangements to prescribe imatinib mesylate may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe imatinib mesylate should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

For the following diseases, written authority is required at initiation and for continuation:

Dermatofibrosarcoma protuberans;
Hypereosinophilic syndrome;
Chronic eosinophilic leukaemia;
Myelodysplastic or myeloproliferative disorder;

Aggressive systemic mastocytosis with eosinophilia.

No applications for increased repeats will be authorised.

imatinib 100 mg tablet, 60

9178C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	1963.21	37.70	Glivec [NV]

imatinib 400 mg tablet, 30

9179D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	3779.71	37.70	Glivec [NV]

■ **IMATINIB****Authority required**

Initial PBS-subsidised treatment, for up to 3 months, of a patient with a metastatic or unresectable malignant gastrointestinal stromal tumour which has been histologically confirmed by the detection of CD117 on immunohistochemical staining. Patients must commence treatment at a dose not exceeding 400 mg per day for at least 3 months. Authority prescriptions for a higher dose will not be approved during this initial 3 month treatment period.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Imatinib Mesylate (Glivec) PBS Authority Application for Use in the Treatment of Metastatic or Unresectable Gastrointestinal Stromal Tumour - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) a copy of a pathology report from an Approved Pathology Authority supporting the diagnosis of a gastrointestinal stromal tumour and confirming the presence of CD117 on immunohistochemical staining; and
 - (ii) a copy of the most recent (within 2 months of the application) computed tomography (CT) scan, magnetic resonance imaging (MRI) or ultrasound assessment of the tumour(s), including whether or not there is evidence of metastatic disease; and
 - (iii) where the application for authority to prescribe is being sought on the basis of an unresectable tumour, written evidence in support of that claim must be provided

Authority required

Continuing PBS-subsidised treatment, at a dose of up to 600 mg per day, of a patient with a metastatic or unresectable malignant gastrointestinal stromal tumour who has previously been issued with an authority prescription for this drug. Applications for continuing treatment may be made by telephone (1800 700 270, hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Patients who have failed to respond or are intolerant to imatinib are no longer eligible to receive PBS-subsidised imatinib

Note

Any queries concerning the arrangements to prescribe imatinib mesylate may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe imatinib mesylate should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

For the following diseases, written authority is required at initiation and for continuation:

Dermatofibrosarcoma protuberans;
Hypereosinophilic syndrome;
Chronic eosinophilic leukaemia;
Myelodysplastic or myeloproliferative disorder;

Aggressive systemic mastocytosis with eosinophilia.

Patients with metastatic/unresectable disease who achieve a response to treatment at an imatinib dose of 400 mg per day should be continued at this dose and assessed for response at regular intervals. Patients who fail to achieve a response to 400 mg per day may have their dose increased to 600 mg per day. Authority applications for doses higher than 600 mg per day will not be approved.

A response to treatment is defined as a decrease from baseline in the sum of the products of the perpendicular diameters of all measurable lesions of 50% or greater. (Response definition based on the Southwest Oncology Group standard criteria, see Demetri et al. N Engl J Med 2002; 347: 472-80.)

No applications for increased repeats will be authorised.

imatinib 100 mg tablet, 60

9111M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	1963.21	37.70	Glivec [NV]

imatinib 400 mg tablet, 30

9112N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	3779.71	37.70	Glivec [NV]

■ **IMATINIB****Authority required**

Gastrointestinal stromal tumour

Treatment Phase: Initial treatment

Clinical criteria:

The treatment must be adjuvant to complete surgical resection of primary gastrointestinal stromal tumour (GIST), **AND** Patient must be at high risk of recurrence following complete surgical resection of primary GIST, **AND**

The condition must be histologically confirmed by the detection of CD117 on immunohistochemical staining, **AND**

The treatment must not exceed a dose of 400 mg per day for a period of 36 months in total (initial plus continuing therapy).

Applications for authorisation of initial treatment must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Imatinib Mesylate (Glivec) PBS Authority Application for Use in Adjuvant Treatment of Gastrointestinal Stromal Tumour - Supporting Information Form which includes the following:
 - (i) a copy of a pathology report from an Approved Pathology Authority supporting the diagnosis of a gastrointestinal stromal tumour and confirming the presence of CD117 on immunohistochemical staining; and
 - (ii) a copy of the pathology report must include the size and mitotic rate of the tumour, and the date of tumour resection must be documented, which must not be more than 3 months prior to the date of this application.

High risk of recurrence is defined as:

Primary GIST greater than 5 cm with a mitotic count of greater than 5/50 high power fields (HPF); or

Primary GIST greater than 10 cm with any mitotic rate; or

Primary GIST with a mitotic count of greater than 10/50 HPF.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Any queries concerning patients who are enrolled on the Imatinib Compassionate Program may be directed to the Department of Human Services on 1800 700 270.

Authority required

Gastrointestinal stromal tumour

Treatment Phase: Continuing treatment

Clinical criteria:

The treatment must be adjuvant to complete surgical resection of primary gastrointestinal stromal tumour (GIST), **AND**

Patient must be at high risk of recurrence following complete surgical resection of primary GIST, **AND**

The treatment must not exceed a dose of 400 mg per day for a period of 36 months in total (initial plus continuing therapy), **AND**

Patient must have previously been issued with an authority prescription for imatinib for adjuvant treatment following complete resection of primary GIST.

Applications for continuing therapy may be made by telephone.

Note

Authority approval for continuing treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

imatinib 100 mg tablet, 60

5443L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1963.21	37.70	Glivec [NV]

imatinib 400 mg tablet, 30

5444M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	3779.71	37.70	Glivec [NV]

■ IMATINIB

Authority required

Treatment of patients in the accelerated phase of chronic myeloid leukaemia expressing the Philadelphia chromosome or the transcript, bcr-abl tyrosine kinase, and who have a primary diagnosis of chronic myeloid leukaemia. Progress to the accelerated phase is defined by the presence of 1 or more of the following:

- (1) Percentage of blasts in the peripheral blood or bone marrow greater than or equal to 15% but less than 30%; or
- (2) Percentage of blasts plus promyelocytes in the peripheral blood or bone marrow greater than or equal to 30%; or
- (3) Peripheral basophils greater than or equal to 20%; or
- (4) Progressive splenomegaly to a size greater than or equal to 10 cm below the left costal margin to be confirmed on 2 occasions at least 4 weeks apart, or a greater than or equal to 50% increase in size below the left costal margin over 4 weeks; or

(5) Karyotypic evolution (chromosomal abnormalities in addition to a single Philadelphia chromosome).

Applications for authorisation must be in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Imatinib Mesylate (Glivec) PBS Authority Application for Use in the Treatment of Chronic Myeloid Leukaemia - Supporting Information form, stating which of the above criteria are satisfied by the patient; and
- (c) a copy of the confirming pathology report from an Approved Pathology Authority in the case of criteria (1), (2), (3) and (5) above, or details of the dates of assessments in the case of progressive splenomegaly

Authority required

Treatment of patients in the blast phase of chronic myeloid leukaemia expressing the Philadelphia chromosome or the transcript, bcr-abl tyrosine kinase, and who have a primary diagnosis of chronic myeloid leukaemia. Progress to myeloid blast crisis is defined as either:

- (1) Percentage of blasts in the peripheral blood or bone marrow greater than or equal to 30%; or
- (2) Extramedullary involvement other than spleen and liver.

Applications for authorisation must be in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Imatinib Mesylate (Glivec) PBS Authority Application for Use in the Treatment of Chronic Myeloid Leukaemia - Supporting Information form, stating which of the above criteria are satisfied by the patient; and
- (c) a copy of the confirming pathology report from an Approved Pathology Authority in the case of criterion (1) above, or details of the date of assessment in the case of extramedullary involvement

Authority required

Continuing treatment of patients with chronic myeloid leukaemia expressing the Philadelphia chromosome or the transcript, bcr-abl tyrosine kinase, where the patient has previously received PBS-subsidised treatment with imatinib mesylate of the accelerated phase of chronic myeloid leukaemia

Authority required

Continuing treatment of patients with chronic myeloid leukaemia expressing the Philadelphia chromosome or the transcript, bcr-abl tyrosine kinase, where the patient has previously received PBS-subsidised treatment with imatinib mesylate of the blast phase of chronic myeloid leukaemia

Note

Any queries concerning the arrangements to prescribe imatinib mesylate may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe imatinib mesylate should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

For the following diseases, written authority is required at initiation and for continuation:

Dermatofibrosarcoma protuberans;
Hypereosinophilic syndrome;
Chronic eosinophilic leukaemia;
Myelodysplastic or myeloproliferative disorder;

Aggressive systemic mastocytosis with eosinophilia.

No applications for increased repeats will be authorised.

imatinib 100 mg tablet, 60

9115R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	1963.21	37.70	Glivec [NV]

imatinib 400 mg tablet, 30

9116T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	3779.71	37.70	Glivec [NV]

■ IMATINIB

Authority required

Initial treatment in combination with chemotherapy as induction or consolidation of a newly diagnosed patient with acute lymphoblastic leukaemia (ALL) bearing the Philadelphia chromosome or expressing the transcript, BCR-ABL.

The first authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Acute Lymphoblastic Leukaemia Imatinib PBS Authority Application - Supporting Information Form; and
- (c) a pathology cytogenetic report conducted on peripheral blood or bone marrow supporting the diagnosis of acute lymphoblastic leukaemia to confirm eligibility for treatment, with either cytogenetic evidence of the Philadelphia chromosome, or a qualitative PCR report documenting the presence of the BCR-ABL transcript in either peripheral blood or bone marrow. (The date of the relevant pathology report needs to be provided); and
- (d) a signed patient acknowledgement

Authority required

Initial treatment of a patient with acute lymphoblastic leukaemia bearing the Philadelphia chromosome or expressing the transcript BCR-ABL who was previously treated with imatinib mesylate under the Imatinib Compassionate Program and who meets all the PBS criteria.

The first authority application must be made in writing and must include:

- a completed authority prescription form; and
- a completed Acute Lymphoblastic Leukaemia Imatinib PBS Authority Application - Supporting Information Form; and
- a pathology cytogenetic report conducted on peripheral blood or bone marrow supporting the diagnosis of acute lymphoblastic leukaemia to confirm eligibility for treatment, with either cytogenetic evidence of the Philadelphia chromosome, or a qualitative PCR report documenting the presence of the BCR-ABL transcript in either peripheral blood or bone marrow. (The date of the relevant pathology report needs to be provided); and
- a signed patient acknowledgement

Authority required

Continuing treatment in combination with chemotherapy as maintenance of first complete remission of patients with acute lymphoblastic leukaemia bearing the Philadelphia chromosome or expressing the transcript, BCR-ABL.

Authority applications for continuing treatment may be made by telephone to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Imatinib mesylate is available with a lifetime maximum of 24 months for continuing treatment with imatinib mesylate therapy for patients with acute lymphoblastic leukaemia reimbursed through the PBS.

Any queries concerning the arrangements to prescribe imatinib mesylate beyond 24 months may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

Note

Any queries concerning the arrangements to prescribe imatinib mesylate may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe imatinib mesylate should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

For the following diseases, written authority is required at initiation and for continuation:

Dermatofibrosarcoma protuberans;
Hypereosinophilic syndrome;
Chronic eosinophilic leukaemia;
Myelodysplastic or myeloproliferative disorder;

Aggressive systemic mastocytosis with eosinophilia.

Allogeneic stem cell transplantation is the preferred therapy for eligible patients achieving a complete remission of Philadelphia positive acute lymphoblastic leukaemia.

No applications for increased repeats will be authorised.

imatinib 100 mg tablet, 60

9123E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	1963.21	37.70	Glivec [NV]

imatinib 400 mg tablet, 30

9124F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	3779.71	37.70	Glivec [NV]

■ LAPATINIB

Authority required

Initial treatment, in combination with capecitabine, of a patient with HER2 positive metastatic breast cancer (equivalent to Stage IIIC or Stage IV) who has received prior therapy with a taxane, for at least 3 cycles, and whose disease has progressed despite treatment with trastuzumab for metastatic disease.

Authority applications for initial treatment must be made in writing and must include:

- a completed authority prescription form;
- a pathology report demonstrating HER2 positivity has been demonstrated by in situ hybridisation (ISH);
- date of last treatment with a taxane and total number of cycles;
- a signed patient acknowledgement;
- dates of treatment with trastuzumab; and
- date of demonstration of progression whilst on treatment with trastuzumab

Authority required

Continuing treatment, in combination with capecitabine, of a patient with HER2 positive metastatic breast cancer who has previously received treatment with PBS-subsidised lapatinib and who does not have progressive disease.

Authority applications must be made in writing and must include:

- a completed authority prescription form; and
- a statement from the prescribing doctor that the disease has not progressed

Note

Any queries concerning the arrangements to prescribe lapatinib may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Lapatinib should not be used in patients with a left ventricular ejection fraction (LVEF) of less than 45% or with symptomatic heart failure. Cardiac function must be tested by a suitable method including, for example, ECHO or MUGA, prior to seeking the initial authority approval and then at 3 monthly intervals during treatment.

Lapatinib is not PBS-subsidised when used in combination with Commonwealth-subsidised trastuzumab.

If disease progression occurs, the prescribing doctor must contact Medicare Australia within one week on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) and lapatinib treatment must be ceased immediately.

Treatment with trastuzumab for metastatic disease is defined as trastuzumab administered alone or in combination with chemotherapy for at least 6 weeks at standard doses.

If treatment with a taxane is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of the accepted toxicities, including severity, can be found on the Medicare Australia website [www.medicareaustralia.gov.au].

No applications for increased maximum quantities and/or repeats will be authorised.

lapatinib 250 mg tablet, 70

9148L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	2	..	*3387.80	37.70	Tykerb [GK]

■ NILOTINIB**Authority required**

Initial treatment, as the sole PBS-subsidised therapy, of a patient in the chronic phase of chronic myeloid leukaemia expressing the Philadelphia chromosome or the transcript, BCR-ABL tyrosine kinase, and who has a primary diagnosis of chronic myeloid leukaemia.

Applications under this restriction will be limited to provide patients with a maximum of 18 months of therapy with dasatinib, imatinib or nilotinib from the date the first application for initial treatment was approved.

Patients should be commenced on a dose of nilotinib of 300 mg twice daily. Continuing therapy is dependent on patients demonstrating a response to nilotinib therapy following the initial 18 months of treatment and at 12 monthly intervals thereafter.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Chronic Myeloid Leukaemia - Chronic Phase, First Line - Supporting Information form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]; and
- (3) a pathology cytogenetic report conducted on peripheral blood or bone marrow supporting the diagnosis of chronic myeloid leukaemia to confirm eligibility for treatment, or a qualitative PCR report documenting the presence of the BCR-ABL transcript in either peripheral blood or bone marrow; and
- (4) a signed patient acknowledgement form

Authority required

Continuing treatment, as the sole PBS-subsidised therapy, of a patient who has received initial PBS-subsidised treatment with nilotinib for the chronic phase of chronic myeloid leukaemia and who has demonstrated either a major cytogenetic response or less than 1% BCR-ABL level in the blood.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) demonstration of continued response to treatment as evidenced by either:
 - (a) major cytogenetic response [see Note explaining requirements]. Where this has been supplied within the previous 12 months, only the date of the relevant pathology report need be provided; or
 - (b) a peripheral blood level of BCR-ABL of less than 1% on the international scale [see Note explaining requirements]. Where this has been supplied within the previous 12 months, only the date of the relevant pathology report need be provided

Note

Any queries concerning the arrangements to prescribe nilotinib may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Applications for authority to prescribe nilotinib should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of tyrosine kinase inhibitors (TKI) agents for the chronic phase of chronic myeloid leukaemia. Where the term TKI agent appears in the following notes and restrictions it refers to imatinib mesylate, dasatinib or nilotinib.

Patients are eligible for PBS-subsidised treatment with only one TKI agent at any one time and must not be receiving concomitant interferon alfa therapy. Eligible patients may only swap between TKI agents if they have not failed prior PBS-subsidised treatment with that agent.

1. Initial treatment - imatinib mesylate, dasatinib and nilotinib

From 1 April 2012, under the PBS, a patient will be able to be prescribed any of imatinib mesylate, dasatinib or nilotinib within the initial 18 month treatment period, as long as only one agent is used at a time and providing the patient has not failed to respond to any one of these TKIs.

During the initial 18 month treatment period, switching between approved first-line agents may only occur for reasons of intolerance, not failure of response.

2. Continuing treatment with imatinib mesylate - first-line

First continuing applications are to be written and must include a pathology report demonstrating the patient has responded to the initial course of treatment.

Second and subsequent authority applications for continuing therapy with imatinib mesylate may be made on the telephone by contacting Medicare Australia on 1800 700 720 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Patients must maintain a major cytogenetic response or have a peripheral blood BCR-ABL of less than 1% to receive continuing therapy.

3. Continuing treatment with dasatinib or nilotinib - first-line

All continuing applications are to be written and must include a pathology report demonstrating the patient has responded to PBS-subsidised treatment as follows:

(i) within 18 months of the commencement of treatment, at which time patients in whom a major cytogenetic response or peripheral blood BCR-ABL level of less than 1% has been demonstrated may receive authorisation for a further 12 months of treatment; and

(ii) at no greater than 12 month intervals thereafter, to demonstrate that the major cytogenetic response or peripheral blood BCR-ABL level of less than 1% has been sustained.

4. For imatinib mesylate, dasatinib and nilotinib

During continuing therapy beyond the initial 18 month treatment period, switching between approved first-line agents may only occur for reason of intolerance. Where there is failure of response, switching may only occur through application for prescription of second-line agents.

Where a patient has previously received PBS-subsidised treatment with imatinib mesylate, dasatinib or nilotinib no approval will be granted for PBS-subsidised re-treatment in the chronic phase of chronic myeloid leukaemia, where that patient has at any time failed to meet the response criteria whilst on that TKI agent.

5. Authority approval requirements.

Response criteria to initial treatment with imatinib mesylate, dasatinib or nilotinib:

For the purposes of assessing response to PBS-subsidised treatment with imatinib mesylate, dasatinib or nilotinib either cytogenetic analysis indicating the number of Philadelphia positive [t (9;22)] cells in the bone marrow measured by standard karyotyping, or quantitative PCR indicating the relative level of BCR-ABL transcript in the peripheral blood using the international scale, must be submitted. For bone marrow analyses, where the standard karyotyping is not informative for technical reasons, a cytogenetic analysis performed on the bone marrow by the use of fluorescence in situ hybridisation (FISH) with BCR-ABL specific probe must be submitted. The cytogenetic or peripheral blood quantitative PCR analyses must be submitted within 18 months of the commencement of treatment with imatinib mesylate, dasatinib or nilotinib (patients in whom a major cytogenetic response or peripheral blood BCR-ABL level of less than 1% is demonstrable by 18 months are eligible to receive continuing treatment with that agent).

6. Definitions of response.

A major cytogenetic response is defined as less than 35% Philadelphia positive bone marrow cells.

A peripheral blood BCR-ABL level of less than 1% on the international scale (Blood 108: 28-37, 2006) also indicates a response, at least the biological equivalent of a major cytogenetic response.

7. Definitions of loss of response.

Loss of a previously documented major cytogenetic response (demonstrated by the presence of greater than 35% Ph positive cells on bone marrow biopsy), during ongoing tyrosine kinase inhibitor (TKI) therapy.

Loss of a previously demonstrated molecular response (demonstrated by peripheral blood BCR-ABL levels increasing consecutively in value by at least 5 fold to a level of greater than 0.1% confirmed on a subsequent test), during ongoing tyrosine kinase inhibitor therapy.

NILOTINIB Capsule 150 mg (as hydrochloride monohydrate), 120

1309X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	4468.21	37.70	Tasigna [NV]

■ NILOTINIB

Authority required

Initial treatment, as the sole PBS-subsidised therapy, of a patient with chronic myeloid leukaemia in chronic or accelerated phase who has failed an adequate trial of imatinib or dasatinib as first-line treatment.

Failure of an adequate trial of imatinib or dasatinib is defined as:

(i) Lack of response to initial imatinib or dasatinib therapy, defined as either:

— failure to achieve a haematological response after a minimum of 3 months therapy with imatinib or dasatinib for patients initially treated in chronic phase; or

— failure to achieve any cytogenetic response after a minimum of 6 months therapy with imatinib or dasatinib for patients initially treated in chronic phase as demonstrated on bone marrow biopsy by presence of greater than 95% Philadelphia chromosome positive cells; or

— failure to achieve a major cytogenetic response or a peripheral blood BCR-ABL level of less than 1% after a minimum of 12 months therapy with imatinib or dasatinib; OR

(ii) Loss of a previously documented major cytogenetic response (demonstrated by the presence of greater than 35% Ph positive cells on bone marrow biopsy), during ongoing imatinib or dasatinib therapy; OR

(iii) Loss of a previously demonstrated molecular response (demonstrated by peripheral blood BCR-ABL levels increasing consecutively in value by at least 5 fold to a level of greater than 0.1% confirmed on a subsequent test), during ongoing imatinib or dasatinib therapy; OR

(iv) Development of accelerated phase in a patient previously prescribed imatinib or dasatinib for the chronic phase of chronic myeloid leukaemia.

Accelerated phase is defined by the presence of 1 or more of the following:

(1) Percentage of blasts in the peripheral blood or bone marrow greater than or equal to 15% but less than 30%; or

(2) Percentage of blasts plus promyelocytes in the peripheral blood or bone marrow greater than or equal to 30%, provided that blast count is less than 30%; or

(3) Peripheral basophils greater than or equal to 20%; or

(4) Progressive splenomegaly to a size greater than or equal to 10 cm below the left costal margin to be confirmed on 2 occasions at least 4 weeks apart, or a greater than or equal to 50% increase in size below the left costal margin over 4 weeks; or

(5) Karyotypic evolution (chromosomal abnormalities in addition to a single Philadelphia chromosome); OR

(v) Disease progression (defined as a greater than or equal to 50% increase in peripheral white blood cell count, blast count, basophils or platelets) during first-line imatinib or dasatinib therapy in patients with accelerated phase chronic myeloid leukaemia, provided that blast crisis has been excluded on bone marrow biopsy.

Patients should be commenced on a dose of nilotinib of 400 mg twice daily. Continuing therapy is dependent on patients demonstrating a major cytogenetic response to nilotinib therapy or a peripheral blood BCR-ABL level of less than 1% within 18 months and thereafter at 12 monthly intervals.

Applications for authorisation must be in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Chronic Myeloid Leukaemia - Second and Third Line - Supporting Information Form; and

(c) a signed patient acknowledgement; and

(d) a bone marrow biopsy pathology report demonstrating the patient has active chronic myeloid leukaemia, either manifest as cytogenetic evidence of the Philadelphia chromosome, or RT-PCR level of BCR-ABL transcript greater than 0.1% on the international scale. (The date of the relevant pathology report needs to be provided); and

(e) where there has been a loss of response to imatinib or dasatinib, a copy of the current confirming pathology report(s) from an Approved Pathology Authority or details of the dates of assessment in the case of progressive splenomegaly or extramedullary involvement

Authority required

Continuing treatment, as the sole PBS-subsidised therapy, of a patient who has received initial PBS-subsidised treatment with nilotinib for chronic myeloid leukaemia, and who has demonstrated either a major cytogenetic response, or less than 1% BCR-ABL level in the blood, to dasatinib in the preceding 18 months and thereafter at 12 monthly intervals.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Chronic Myeloid Leukaemia - Second and Third Line - Application Form for continuing treatment; and

(3) demonstration of continued response to treatment as evidenced by either:

(a) major cytogenetic response [see Note explaining definitions of response]. Where this has been supplied within the previous 12 months (or 18 months for the initial supply), only the date of the relevant pathology report needs to be provided; or

(b) a peripheral blood level of BCR-ABL of less than 1% on the international scale [see Note explaining definitions of response]. Where this has been supplied within the previous 12 months (or 18 months for the initial supply), only the date of the relevant pathology report needs to be provided

Note

Any queries concerning the arrangements to prescribe nilotinib may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Applications for authority to prescribe nilotinib should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of tyrosine kinase inhibitors (TKI) agents for all phases of chronic myeloid leukaemia. Where the term TKI agent appears in the following notes and restrictions it refers to dasatinib or nilotinib. Imatinib mesylate is not approved for use in second or third line treatment.

Patients are eligible for PBS-subsidised treatment with only one of dasatinib or nilotinib at any one time and must not be receiving concomitant interferon alfa therapy. Eligible patients may only swap between these agents if they have not failed prior PBS-subsidised treatment with that agent.

Nilotinib is not approved for patients in blast crisis.

1. Initial second line treatment

From 1 April 2012, under the PBS, a patient will be able to be prescribed either dasatinib or nilotinib within the initial 18 month treatment period as second-line therapy, as long as only one agent is approved at a time and providing the patient did not fail that drug as first-line therapy.

During the initial 18 month treatment period, switching between approved second-line agents may only occur for reasons of intolerance, not failure of response.

2. Initial third line treatment

Third-line treatment with a TKI can only be approved when imatinib is used for first-line treatment. Patients will only be approved for PBS-subsidised treatment with one third-line agent.

From 1 April 2012, under the PBS, a patient will be able to be prescribed either dasatinib or nilotinib providing the patient did not fail that drug as first or second line therapy and for nilotinib the patient is not in blast crisis.

3. Continuing treatment for second and third line treatment

All continuing applications are to be written and must include a pathology report demonstrating the patient has responded to PBS-subsidised treatment as follows:

(i) within 18 months of the commencement of treatment, at which time patients in whom a major cytogenetic response or peripheral blood BCR-ABL level of less than 1% has been demonstrated may receive authorisation for a further 12 months of treatment; and

(ii) at no greater than 12 month intervals thereafter, to demonstrate that the major cytogenetic response or peripheral blood BCR-ABL level of less than 1% has been sustained.

During second line continuing treatment beyond the initial 18 month treatment period, switching between approved second line TKI agents may only occur for reason of intolerance. Where there is failure of response, switching may only occur through application for prescription of a third line agent.

4. Authority approval requirements.

Response criteria to initial treatment with dasatinib or nilotinib:

For the purposes of assessing response to PBS-subsidised treatment with dasatinib or nilotinib, either cytogenetic analysis indicating the number of Philadelphia positive [t (9;22)] cells in the bone marrow measured by standard karyotyping, or quantitative PCR indicating the relative level of BCR-ABL transcript in the peripheral blood using the international scale, must be submitted. For bone marrow analyses, where the standard karyotyping is not informative for technical reasons, a cytogenetic analysis performed on the bone marrow by the use of fluorescence in situ hybridisation (FISH) with BCR-ABL specific probe must be submitted. The cytogenetic or peripheral blood quantitative PCR analyses must be submitted within 18 months of the commencement of treatment with dasatinib or nilotinib (patients in whom a major cytogenetic response or peripheral blood BCR-ABL level of less than 1% is demonstrable by 18 months are eligible to receive continuing treatment with that agent).

5. Definitions of response.

A major cytogenetic response is defined as less than 35% Philadelphia positive bone marrow cells.

A peripheral blood BCR-ABL level of less than 1% on the international scale (Blood 108: 28-37, 2006) also indicates a response, at least the biological equivalent of a major cytogenetic response.

6. Definitions of loss of response.

Loss of a previously documented major cytogenetic response (demonstrated by the presence of greater than 35% Ph positive cells on bone marrow biopsy), during ongoing tyrosine kinase inhibitor (TKI) therapy.

Loss of a previously demonstrated molecular response (demonstrated by peripheral blood BCR-ABL levels increasing consecutively in value by at least 5 fold to a level of greater than 0.1% confirmed on a subsequent test), during ongoing tyrosine kinase inhibitor therapy.

NILOTINIB Capsule 200 mg (as hydrochloride monohydrate), 120

9171Q

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	5872.48	37.70	Tasigna [NV]

■ PAZOPANIB

Authority required

Advanced (unresectable and/or metastatic) soft tissue sarcoma

Treatment Phase: Initial treatment

Clinical criteria:

Patient must have a WHO performance status of 2 or less, **AND**

Patient must have received prior chemotherapy treatment including an anthracycline, **AND**

Patient must not have received prior treatment with an angiogenesis inhibitor, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

Patient must not have any of the following conditions:

adipocytic soft tissue sarcoma;

gastrointestinal stromal tumour (GIST);

rhabdomyosarcoma other than alveolar or pleomorphic;

chondrosarcoma;

osteosarcoma;

Ewings tumour/primitive neuroectodermal tumour;

dermofibromatosis sarcoma protuberans;

inflammatory myofibroblastic sarcoma;

malignant mesothelioma;

mixed mesodermal tumour of the uterus.

The authority application must be made in writing.

Note

No increase in the maximum quantity or number of units may be authorised.
 No increase in the maximum number of repeats may be authorised.
 Special Pricing Arrangements apply.

pazopanib 200 mg tablet, 90

10042M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	3542.16	37.70	Votrient [GK]

pazopanib 400 mg tablet, 60

10041L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	4673.98	37.70	Votrient [GK]

■ PAZOPANIB**Authority required**

Advanced (unresectable and/or metastatic) soft tissue sarcoma

Treatment Phase: Continuing treatment beyond 3 months

Clinical criteria:

Patient must have previously been issued with an authority prescription for pazopanib, **AND**

Patient must have stable or responding disease according to the Response Evaluation Criteria In Solid Tumours (RECIST), **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

Applications for continuing therapy may be made by telephone.

Note

Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:

Complete response (CR) is disappearance of all target lesions.

Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.

Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.

Stable disease (SD) is small changes that do not meet above criteria.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

pazopanib 200 mg tablet, 90

10047T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	3542.16	37.70	Votrient [GK]

pazopanib 400 mg tablet, 60

10043N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	4673.98	37.70	Votrient [GK]

■ PAZOPANIB**Authority required**

Advanced (unresectable and/or metastatic) soft tissue sarcoma

Treatment Phase: Continuing treatment beyond 3 months

Clinical criteria:

Patient must have previously been issued with an authority prescription for pazopanib, **AND**

Patient must have stable or responding disease according to the Response Evaluation Criteria In Solid Tumours (RECIST), **AND**

Patient must require dose adjustment, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

Applications for continuing therapy may be made by telephone.

Note

Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:

Complete response (CR) is disappearance of all target lesions.

Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.

Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.

Stable disease (SD) is small changes that do not meet above criteria.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

pazopanib 200 mg tablet, 30

10054E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1256.59	37.70	Votrient [GK]

pazopanib 400 mg tablet, 30

10052C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	2410.34	37.70	Votrient [GK]

■ PAZOPANIB**Authority required**

Stage IV clear cell variant renal cell carcinoma (RCC)

Treatment Phase: Continuing treatment beyond 3 months

Clinical criteria:

Patient must have previously been issued with an authority prescription for pazopanib, **AND**

Patient must have stable or responding disease according to the Response Evaluation Criteria In Solid Tumours (RECIST), **AND**

Patient must require dose adjustment, **AND**

The treatment must be the sole PBS-subsidised tyrosine kinase inhibitor therapy for this condition.

Note

Patients who have progressive disease with pazopanib are no longer eligible for PBS-subsidised pazopanib.

Patients who have progressive disease on sunitinib are not eligible to receive PBS-subsidised pazopanib.

Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:

Complete response (CR) is disappearance of all target lesions.

Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.

Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.

Stable disease (SD) is small changes that do not meet above criteria.

Special Pricing Arrangements apply.

pazopanib 200 mg tablet, 30

2232L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1256.59	37.70	Votrient [GK]

pazopanib 400 mg tablet, 30

2201W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	2410.34	37.70	Votrient [GK]

■ PAZOPANIB**Authority required**

Stage IV clear cell variant renal cell carcinoma (RCC)

Treatment Phase: Initial treatment

Clinical criteria:

Patient must meet the Memorial Sloan Kettering Cancer Centre (MSKCC) low to intermediate risk group criteria, **AND**

Patient must have a WHO performance status of 2 or less, **AND**

The treatment must be the sole PBS-subsidised tyrosine kinase inhibitor therapy for this condition.

Patients who have progressive disease on sunitinib are not eligible to receive PBS-subsidised pazopanib.

Note

Patients who have developed intolerance to sunitinib of a severity necessitating permanent treatment withdrawal are eligible to receive PBS-subsidised pazopanib.

Patients who have progressive disease with pazopanib are no longer eligible for PBS-subsidised pazopanib.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

pazopanib 200 mg tablet, 90

2029T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	3542.16	37.70	Votrient [GK]

pazopanib 400 mg tablet, 60

2030W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	4673.98	37.70	Votrient [GK]

■ PAZOPANIB**Authority required**

Stage IV clear cell variant renal cell carcinoma (RCC)
Treatment Phase: Continuing treatment beyond 3 months

Clinical criteria:

Patient must have previously been issued with an authority prescription for pazopanib, **AND**
Patient must have stable or responding disease according to the Response Evaluation Criteria In Solid Tumours (RECIST), **AND**

The treatment must be the sole PBS-subsidised tyrosine kinase inhibitor therapy for this condition.

Note

Patients who have progressive disease on sunitinib are not eligible to receive PBS-subsidised pazopanib.

Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:

Complete response (CR) is disappearance of all target lesions.

Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.

Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.

Stable disease (SD) is small changes that do not meet above criteria.

Authority required

Stage IV clear cell variant renal cell carcinoma (RCC)

Treatment Phase: Initial treatment

Clinical criteria:

Patient must have been receiving treatment with pazopanib prior to 1 October 2012, **AND**

The treatment must be the sole PBS-subsidised tyrosine kinase inhibitor therapy for this condition.

Note

Patients who have progressive disease with pazopanib are no longer eligible for PBS-subsidised pazopanib.

Special Pricing Arrangements apply.

pazopanib 200 mg tablet, 90

2034C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	3542.16	37.70	Votrient [GK]

pazopanib 400 mg tablet, 60

2035D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	4673.98	37.70	Votrient [GK]

▪ SORAFENIB**Authority required**

Stage IV clear cell variant renal cell carcinoma (RCC)

Treatment Phase: Initial treatment

Clinical criteria:

Patient must have progressive disease according to the Response Evaluation Criteria In Solid Tumours (RECIST) following first-line treatment with a tyrosine kinase inhibitor, **AND**

Patient must have a WHO performance status of 2 or less, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

Patients who have developed intolerance to a tyrosine kinase inhibitor of a severity necessitating permanent treatment withdrawal are eligible to receive PBS-subsidised treatment with this drug.

A patient who has progressive disease when treated with this drug is no longer eligible for PBS-subsidised treatment with this drug.

Note

Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:

Complete response (CR) is disappearance of all target lesions.

Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.

Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.

Stable disease (SD) is small changes that do not meet above criteria.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

sorafenib 200 mg tablet, 60

10226F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	2	..	*6457.42	37.70	Nexavar [BN]

▪ SORAFENIB**Authority required**

Stage IV clear cell variant renal cell carcinoma (RCC)

Treatment Phase: Continuing treatment beyond 3 months

Clinical criteria:

Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**
 Patient must have stable or responding disease according to the Response Evaluation Criteria In Solid Tumours (RECIST), **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

A patient who has progressive disease when treated with this drug is no longer eligible for PBS-subsidised treatment with this drug.

Note

Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:

Complete response (CR) is disappearance of all target lesions.

Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.

Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.

Stable disease (SD) is small changes that do not meet above criteria.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

sorafenib 200 mg tablet, 60

10242C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*6457.42	37.70	Nexavar [BN]

■ SORAFENIB**Authority required (STREAMLINED)****4230**

Advanced Barcelona Clinic Liver Cancer Stage C hepatocellular carcinoma

Treatment Phase: Initial

Clinical criteria:

The treatment must be the sole PBS-subsidised therapy for this condition, **AND**

Patient must have a WHO performance status of 2 or less, **AND**

Patient must have Child Pugh class A.

Authority required (STREAMLINED)**4234**

Advanced Barcelona Clinic Liver Cancer Stage C hepatocellular carcinoma

Treatment Phase: Continuing

Clinical criteria:

The treatment must be the sole PBS-subsidised therapy for this condition, **AND**

Patient must have previously been treated with PBS-subsidised sorafenib, **AND**

Patient must not have progressive disease.

Note

Sorafenib is not PBS-subsidised for adjunctive treatment after resection, ablation or chemoembolization.

Sorafenib is not PBS-subsidised for maintenance therapy after disease progression.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

sorafenib 200 mg tablet, 60

9380Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	2	..	*6457.42	37.70	Nexavar [BN]

■ SUNITINIB**Authority required**

Metastatic or unresectable, well-differentiated malignant pancreatic neuroendocrine tumour (pNET)

Treatment Phase: Initial treatment

Clinical criteria:

Patient must be symptomatic (despite somatostatin analogues); OR

Patient must have disease progression, **AND**

The treatment must be as monotherapy.

Disease progression must be documented in the patient's medical records.

Patients who have developed progressive disease on everolimus are not eligible to receive PBS-subsidised sunitinib for this condition.

Patients who have developed intolerance to everolimus of a severity necessitating permanent treatment withdrawal are eligible to receive PBS-subsidised sunitinib.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.
Special Pricing Arrangements apply.

sunitinib 12.5 mg capsule, 28

10004M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	1834.54	37.70	Sutent [PF]

sunitinib 25 mg capsule, 28

2959R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	3522.10	37.70	Sutent [PF]

sunitinib 50 mg capsule, 28

2837H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	6897.78	37.70	Sutent [PF]

■ SUNITINIB**Authority required**

Metastatic or unresectable, well-differentiated malignant pancreatic neuroendocrine tumour (pNET)

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have previously been issued with an authority prescription for this drug, **AND**

Patient must not have disease progression, **AND**

The treatment must be as monotherapy.

Patients who have progressive disease with this drug are no longer eligible for PBS-subsidised treatment with this drug.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

sunitinib 12.5 mg capsule, 28

10009T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1834.54	37.70	Sutent [PF]

sunitinib 25 mg capsule, 28

2842N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	3522.10	37.70	Sutent [PF]

sunitinib 50 mg capsule, 28

10010W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	6897.78	37.70	Sutent [PF]

■ SUNITINIB**Authority required**

Stage IV clear cell variant renal cell carcinoma (RCC)

Treatment Phase: Continuing treatment beyond 3 months

Clinical criteria:

Patient must have previously been issued with an authority prescription for sunitinib, **AND**

Patient must have stable or responding disease according to the Response Evaluation Criteria In Solid Tumours (RECIST), **AND**

The treatment must be the sole PBS-subsidised tyrosine kinase inhibitor therapy for this condition.

Note

Patients who have progressive disease with sunitinib are no longer eligible for PBS-subsidised sunitinib.

Patients who have developed progressive disease on pazopanib are not eligible to receive PBS-subsidised sunitinib.

Response Evaluation Criteria In Solid Tumours (RECIST) is defined as follows:

Complete response (CR) is disappearance of all target lesions.

Partial response (PR) is a 30% decrease in the sum of the longest diameter of target lesions.

Progressive disease (PD) is a 20% increase in the sum of the longest diameter of target lesions.

Stable disease (SD) is small changes that do not meet above criteria.

Special Pricing Arrangements apply.

sunitinib 12.5 mg capsule, 28

9420T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1834.54	37.70	Sutent [PF]

sunitinib 25 mg capsule, 28

9421W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	3522.10	37.70	Sutent [PF]

sunitinib 50 mg capsule, 28

9422X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	6897.78	37.70	Sutent [PF]

▪ **SUNITINIB**

Authority required

Initial PBS-subsidised treatment as monotherapy of a patient with WHO performance status of 2 or less with a metastatic or unresectable malignant gastrointestinal stromal tumour after failure of imatinib mesylate treatment due to resistance or intolerance.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Sunitinib Malate (Sutent) PBS Authority Application for Use in the Treatment of Gastrointestinal Stromal Tumour - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]; and
- (3) a signed patient acknowledgement.

Patients who have failed to respond or are intolerant to imatinib are no longer eligible to receive PBS-subsidised imatinib

Authority required

Continuing PBS-subsidised treatment as monotherapy of a patient with WHO performance status of 2 or less with a metastatic or unresectable malignant gastrointestinal stromal tumour who has previously been issued with an authority prescription for sunitinib and who does not have progressive disease.

Applications for continuing treatment may be made by telephone (1800 700 270, hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Patients who have failed to respond or who are intolerant to imatinib are no longer eligible to receive PBS-subsidised imatinib.

Patients who have progressive disease on sunitinib are no longer eligible for PBS-subsidised sunitinib

Note

Any queries concerning the arrangements to prescribe sunitinib malate may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Any queries concerning patients who are enrolled on the Sunitinib Compassionate Program may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authority to prescribe sunitinib malate should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

Sunitinib malate is not PBS-subsidised for the treatment of patients with resectable malignant gastrointestinal stromal tumours.

No applications for increased maximum quantities and/or repeats will be authorised.

Special Pricing Arrangements apply.

sunitinib 12.5 mg capsule, 28

9488J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	1834.54	37.70	Sutent [PF]

sunitinib 25 mg capsule, 28

9489K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	3522.10	37.70	Sutent [PF]

sunitinib 50 mg capsule, 28

9490L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	6897.78	37.70	Sutent [PF]

▪ **SUNITINIB**

Authority required

Stage IV clear cell variant renal cell carcinoma (RCC)

Treatment Phase: Initial treatment

Clinical criteria:

Patient must meet the Memorial Sloan Kettering Cancer Centre (MSKCC) low to intermediate risk group criteria, **AND**

Patient must have a WHO performance status of 2 or less, **AND**

The treatment must be the sole PBS-subsidised tyrosine kinase inhibitor therapy for this condition.

Patients who have developed progressive disease on pazopanib are not eligible to receive PBS-subsidised sunitinib.

Note

Patients who have developed intolerance to pazopanib of a severity necessitating permanent treatment withdrawal are eligible to receive PBS-subsidised sunitinib.

Patients who have progressive disease with sunitinib are no longer eligible for PBS-subsidised sunitinib.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

sunitinib 12.5 mg capsule, 28

9417P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	1834.54	37.70	Sutent [PF]

sunitinib 25 mg capsule, 28

9418Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	3522.10	37.70	Sutent [PF]

sunitinib 50 mg capsule, 28

9419R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	6897.78	37.70	Sutent [PF]

Other antineoplastic agents

■ **HYDROXYUREA**

hydroxyurea 500 mg capsule, 100

3093T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	76.80	37.70	Hydrea [BQ]

■ **ENDOCRINE THERAPY**

HORMONES AND RELATED AGENTS

Progestogens

■ **MEDROXYPROGESTERONE**

Restricted benefit

Hormone-dependent advanced breast cancer

medroxyprogesterone acetate 500 mg tablet, 30

2728N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	144.38	37.70	Provera [PF]

■ **MEDROXYPROGESTERONE**

Restricted benefit

Hormone-dependent breast cancer

Restricted benefit

Endometrial cancer

medroxyprogesterone acetate 100 mg tablet, 100

2725K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	103.15	37.70	Provera [PF]

medroxyprogesterone acetate 200 mg tablet, 60

2316X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	116.42	37.70	Provera [PF]

medroxyprogesterone acetate 250 mg tablet, 60

2727M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	144.38	37.70	Provera [PF]

■ **MEGESTROL**

megestrol acetate 160 mg tablet, 30

2734X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	83.73	37.70	Megace [QA]

Gonadotropin releasing hormone analogues■ **GOSERELIN****Restricted benefit**

Carcinoma of the prostate

Clinical criteria:

The condition must be locally advanced (stage C); OR

The condition must be metastatic (stage D).

goserelin 10.8 mg implant, 1

8093Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	1109.10	37.70	Zoladex 10.8 Implant [AP]

■ **GOSERELIN****Restricted benefit**

Carcinoma of the prostate

Clinical criteria:

The condition must be locally advanced (stage C); OR

The condition must be metastatic (stage D).

Restricted benefit

Breast cancer

Clinical criteria:

The condition must be locally advanced (stage III); OR

The condition must be metastatic (stage IV), **AND**

The condition must be hormone receptor positive.

Restricted benefit

Endometriosis

Clinical criteria:The condition must be visually proven, **AND**

The treatment must be for the short-term (up to 6 months).

Note

Only 1 course of not more than 6 months' therapy will be authorised.

Restricted benefit

Breast cancer

Clinical criteria:The condition must be hormone receptor positive, **AND**

The treatment must be an alternative to adjuvant chemotherapy.

goserelin 3.6 mg implant, 1

1454M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	333.34	37.70	Zoladex Implant [AP]

■ **GOSERELIN (&) BICALUTAMIDE****Restricted benefit**

Carcinoma of the prostate

Clinical criteria:The condition must be metastatic (stage D), **AND**

Patient must require a combination of an antiandrogen and a GnRH (LH-RH) agonist.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

goserelin 10.8 mg implant [1 implant] (&) bicalutamide 50 mg tablet [28 tablets], 1 pack

9065D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	1248.63	37.70	ZolaCos CP 10.8/50(28) [AP]

goserelin 10.8 mg implant [1 implant] (&) bicalutamide 50 mg tablet [84 tablets], 1 pack

9066E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	1527.71	37.70	ZolaCos CP 10.8/50(84) [AP]

goserelin 3.6 mg implant [1 implant] (&) bicalutamide 50 mg tablet [28 tablets], 1 pack

9064C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	477.71	37.70	ZolaCos CP 3.6/50 [AP]

■ LEUPRORELIN

Authority required (STREAMLINED)**4871**

Central precocious puberty

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have previously been issued with an authority prescription for this drug for this condition.

Treatment criteria:

Must be treated by a medical practitioner in consultation with a paediatric endocrinologist; OR

Must be treated by a medical practitioner in consultation with an endocrinologist specialising in paediatrics.

leuprorelin acetate 30 mg injection: modified release [1 syringe] (&) inert substance diluent [1 syringe], 1 pack

10255R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	1	..	1451.67	37.70	Lucrin Depot Paediatric 30 mg PDS [VE]

■ LEUPRORELIN

Authority required

Central precocious puberty

Treatment Phase: Initial treatment

Population criteria:

Patient must be under 8 years of age (girls) or 9 years of age (boys); OR

Patient must have received treatment with a gonadotropin releasing hormone analogue (GnRHa) for this condition prior to 1 May 2015.

Treatment criteria:

Must be treated by a paediatric endocrinologist; OR

Must be treated by an endocrinologist specialising in paediatrics.

leuprorelin acetate 30 mg injection: modified release [1 syringe] (&) inert substance diluent [1 syringe], 1 pack

10256T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	1	..	1451.67	37.70	Lucrin Depot Paediatric 30 mg PDS [VE]

■ LEUPRORELIN

Authority required (STREAMLINED)**3229**

Locally advanced (equivalent to stage C) or metastatic (equivalent to stage D) carcinoma of the prostate

leuprorelin acetate 22.5 mg injection: modified release [1 syringe] (&) inert substance diluent [1 syringe], 1 pack

8708H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	1109.10	37.70	Eligard 3 month [TL]

leuprorelin acetate 22.5 mg injection: modified release [1 x 22.5 mg syringe] (&) inert substance diluent [1 x 2 mL syringe], 1 pack

8876E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	1109.10	37.70	Lucrin Depot 3 Month PDS [VE]

leuprorelin acetate 30 mg injection: modified release [1 syringe] (&) inert substance diluent [1 syringe], 1 pack

8709J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	1451.67	37.70	Eligard 4 month [TL]

leuprorelin acetate 30 mg injection: modified release [1 x 30 mg syringe] (&) inert substance diluent [1 x 2 mL syringe], 1 pack

8877F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	1451.67	37.70	Lucrin Depot 4 Month PDS [VE]

leuprorelin acetate 45 mg injection: modified release [1 syringe] (&) inert substance diluent [1 syringe], 1 pack

8859G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	2124.32	37.70	Eligard 6 month [TL]

leuprorelin acetate 7.5 mg injection: modified release [1 syringe] (&) inert substance diluent [1 syringe], 1 pack

8707G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	420.54	37.70	Eligard 1 month [TL]

leuporelin acetate 7.5 mg injection: modified release [1 x 7.5 mg syringe] (&) inert substance diluent [1 x 2 mL syringe], 1 pack

8875D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	420.54	37.70	Lucrin Depot 7.5mg PDS [VE]

▪ TRIPTORELIN

Authority required (STREAMLINED)

3229

Locally advanced (equivalent to stage C) or metastatic (equivalent to stage D) carcinoma of the prostate

triptorelin 11.25 mg injection [1 x 11.25 mg vial] (&) inert substance diluent [1 x 2 mL ampoule], 1 pack

9379P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	1109.10	37.70	Diphereline [IS]

triptorelin 22.5 mg injection [1 x 22.5 mg vial] (&) inert substance diluent [1 x 2 mL ampoule], 1 pack

5297T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	2124.32	37.70	Diphereline [IS]

triptorelin 3.75 mg injection [1 x 3.75 mg vial] (&) inert substance diluent [1 x 2 mL ampoule], 1 pack

9378N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	420.54	37.70	Diphereline [IS]

HORMONE ANTAGONISTS AND RELATED AGENTS

Anti-estrogens

▪ TAMOXIFEN

Restricted benefit

Treatment of hormone-dependent breast cancer

Note

This drug is not PBS-subsidised for primary prevention of breast cancer.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

tamoxifen 10 mg tablet, 60

2109B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	21.78	22.93	Genox 10 [AF]

▪ TAMOXIFEN

Restricted benefit

Treatment of hormone-dependent breast cancer

Note

This drug is not PBS-subsidised for primary prevention of breast cancer.

For item codes 2110C and 1880Y, pharmaceutical benefits that have the form tablet 20 mg (base) are equivalent for the purposes of substitution.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

tamoxifen 20 mg tablet, 30

1880Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	^B 1.88	[*] 34.68	33.95	^a Nolvadex-D [AP]

tamoxifen 20 mg tablet, 60

2110C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	32.80	33.95	^a Genox 20 [AF] ^a Tamosin [QA] ^a Tamoxifen Sandoz [SZ]	^a GenRx Tamoxifen [GX] ^a Tamoxen 20 mg [GN]

■ TOREMIFENE

toremifene 60 mg tablet, 30

8216K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	74.08	37.70	Fareston [MK]

Anti-androgens

■ BICALUTAMIDE

Authority required (STREAMLINED)**3674**

Metastatic (equivalent to stage D) prostatic carcinoma in combination with GnRH (LH-RH) analogue therapy


Note

No applications for increased maximum quantities and/or repeats will be authorised.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

bicalutamide 50 mg tablet, 28

8094B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	103.54	37.70	^a APO-Bicalutamide [TX] ^a Bicalutamide AN [EA] ^a Calutex [QA] ^a Cosudex [AP]	^a Bicalox [ER] ^a Bicalutamide-GA [GN] ^a Cosamide [AF]

■ CYPROTERONE

Authority required (STREAMLINED)**1014**

Advanced carcinoma of the prostate

Authority required (STREAMLINED)**1404**

To reduce drive in sexual deviations in males

cyproterone acetate 100 mg tablet, 50

8019C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	85.11	37.70	^a Cyprocur 100 [QA] ^a Cyproterone AN [EA] ^a GenRx Cyproterone Acetate [GX]	^a Cyprostat-100 [SY] ^a Cyproterone Sandoz [HX] ^a Procur 100 [GN]
			^B 0.80	85.91	37.70	^a Androcur-100 [BN]	

cyproterone acetate 50 mg tablet, 50

1270W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*107.36	37.70	^a Cyprocur 50 [QA] ^a Cyprostat [SY] ^a Cyproterone Sandoz [HX] ^a GenRx Cyproterone Acetate [GX]	^a Cyprone [AF] ^a Cyproterone AN [EA] ^a Cyrotone [ER] ^a Procur [GN]
			^B 1.88	*109.24	37.70	^a Androcur [BN]	

■ ENZALUTAMIDE

Authority required

Castration resistant metastatic carcinoma of the prostate

Clinical criteria:The treatment must not be used in combination with chemotherapy, **AND**

Patient must have failed treatment with docetaxel due to resistance or intolerance; OR

Patient must be unsuitable for docetaxel treatment on the basis of predicted intolerance to docetaxel, **AND**Patient must have a WHO performance status of 2 or less, **AND**Patient must not receive PBS-subsidised treatment with this drug if progressive disease develops while on this drug, **AND**

Patient must not have received prior treatment with abiraterone; OR

Patient must have developed intolerance to abiraterone of a severity necessitating permanent treatment withdrawal.

Note

Special Pricing Arrangements apply.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

enzalutamide 40 mg capsule, 112

10174L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	3700.00	37.70	Xtandi [LL]

▪ **FLUTAMIDE**

Authority required (STREAMLINED)

3674

Metastatic (equivalent to stage D) prostatic carcinoma in combination with GnRH (LH-RH) analogue therapy

Note

No applications for increased maximum quantities and/or repeats will be authorised.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

flutamide 250 mg tablet, 100

1417N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	181.97	37.70	Flutamin [AF]

▪ **NILUTAMIDE**

Authority required (STREAMLINED)

3675

Locally advanced (equivalent to stage C) or metastatic (equivalent to stage D) prostatic carcinoma, in combination with GnRH (LH-RH) analogue therapy

Authority required (STREAMLINED)

3300

Locally advanced (equivalent to stage C) or metastatic (equivalent to stage D) prostatic carcinoma, in conjunction with surgical orchidectomy

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

nilutamide 150 mg tablet, 30

8131Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	236.90	37.70	Anandron [SW]

Aromatase inhibitors

▪ **ANASTROZOLE**

Restricted benefit

Breast cancer

Clinical criteria:

The condition must be hormone receptor positive.

Population criteria:

Patient must not be pre-menopausal.

Note

This drug is not PBS-subsidised for primary prevention of breast cancer.

This drug is not PBS-subsidised for adjuvant hormonal treatment of early breast cancer where the total duration of this drug (or any other aromatase inhibitor) treatment extends beyond 5 years.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

anastrozole 1 mg tablet, 30

8179L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	85.59	37.70	^a Anastro [QA] ^a Anastrozole-DRLA [RZ] ^a Anastrozole-GA [GN] ^a Anastrozole RBX [RA] ^a Anzole [UA] ^a Arianna [AF] ^a Azastrole [ER]	^a Anastrozole AN [EA] ^a Anastrozole FBM [FO] ^a Anastrozole GH [GQ] ^a Anastrozole Sandoz [SZ] ^a APO-Anastrozole [TX] ^a Arimidex [AP] ^a Chem mart Anastrozole [CH]

^a Pharmacor Anastrozole 1 [CR] ^a Pharmacy Choice Anastrozole [RI]
^a Terry White Chemists Anastrozole [TW]

■ EXEMESTANE

Restricted benefit

Metastatic (Stage IV) breast cancer

Clinical criteria:

The condition must be hormone receptor positive, **AND**

The condition must be human epidermal growth factor receptor 2 (HER2) negative, **AND**

Patient must be receiving PBS-subsidised everolimus concomitantly for this condition.

Population criteria:

Patient must not be pre-menopausal.

exemestane 25 mg tablet, 30

10103R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	106.86	37.70	^a APO-Exemestane [TX] ^a Exaccord [RA] ^a Exemestane-GA [GN] ^a Exemestane Pfizer [FZ]	^a Aromasin [PF] ^a Exemestane AN [EA] ^a Exemestane GH [GQ] ^a Exemestane Sandoz [SZ]

■ EXEMESTANE

Restricted benefit

Advanced breast cancer

Clinical criteria:

The condition must be hormone receptor positive, **AND**

The condition must have progressed following treatment with tamoxifen.

Population criteria:

Patient must not be pre-menopausal.

Restricted benefit

Early breast cancer

Clinical criteria:

The condition must be hormone receptor positive, **AND**

The condition must have previously been treated with tamoxifen for a minimum of 2 years.

Population criteria:

Patient must not be pre-menopausal.

Note


This drug is not PBS-subsidised for primary prevention of breast cancer.

This drug is not PBS-subsidised for adjuvant hormonal treatment of early breast cancer extended beyond 5 years, i.e. a patient who has received 2 years of tamoxifen therapy may only receive 3 years of PBS-subsidised treatment with exemestane.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

exemestane 25 mg tablet, 30

8506Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	106.86	37.70	^a APO-Exemestane [TX] ^a Exaccord [RA] ^a Exemestane-GA [GN] ^a Exemestane Pfizer [FZ]	^a Aromasin [PF] ^a Exemestane AN [EA] ^a Exemestane GH [GQ] ^a Exemestane Sandoz [SZ]

■ LETROZOLE

Restricted benefit

Breast cancer

Clinical criteria:

The condition must be hormone receptor positive.

Population criteria:

Patient must not be pre-menopausal.

Restricted benefit

Early breast cancer

Clinical criteria:

The condition must be hormone receptor positive, **AND**

The treatment must be for extended adjuvant treatment of the condition commencing within 6 months of ceasing treatment with tamoxifen.

Population criteria:

Patient must not be pre-menopausal.

Note

This drug is not PBS-subsidised for primary prevention of breast cancer.

This drug is not PBS-subsidised for adjuvant hormonal treatment of early breast cancer where the total duration of this drug (or any other aromatase inhibitor) treatment extends beyond 5 years.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

letrozole 2.5 mg tablet, 30

8245Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	80.43	37.70	^a APO-Letrozole [TX] ^a Femara 2.5 mg [NV] ^a Fera [QA] ^a Letrozole Actavis [VN] ^a Letrozole-DRLA [RZ] ^a Letrozole-GA [GN] ^a Letrozole RBX [RA] ^a Lezole [UA] ^a Pharmacy Choice Letrozole [RI]	^a Chem mart Letrozole [CH] ^a Femolet [AF] ^a Gynotril [ER] ^a Letrozole AN [EA] ^a Letrozole FBM [FO] ^a Letrozole generichealth [GQ] ^a Letrozole Sandoz [SZ] ^a Pharmacor Letrozole 2.5 [CR] ^a Terry White Chemists Letrozole [TW]

Other hormone antagonists and related agents
ABIRATERONE
Authority required

Castration resistant metastatic carcinoma of the prostate

Clinical criteria:

 The treatment must be in combination with prednisone or prednisolone, **AND**

 The treatment must not be used in combination with chemotherapy, **AND**

Patient must have failed treatment with docetaxel due to resistance or intolerance; OR

 Patient must be unsuitable for docetaxel treatment on the basis of predicted intolerance to docetaxel, **AND**

 Patient must have a WHO performance status of 2 or less, **AND**

 Patient must not receive PBS-subsidised abiraterone if progressive disease develops while on abiraterone, **AND**

Patient must not have received prior treatment with enzalutamide; OR

Patient must have developed intolerance to enzalutamide of a severity necessitating permanent treatment withdrawal.

Note

Special Pricing Arrangements apply.

abiraterone acetate 250 mg tablet, 120

2698B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	3600.24	37.70	Zytiga [JC]

DEGARELIX
Authority required (STREAMLINED)
3229

Locally advanced (equivalent to stage C) or metastatic (equivalent to stage D) carcinoma of the prostate

degarelix 80 mg injection [1 x 80 mg vial] (&) inert substance diluent [1 syringe], 1 pack

2784M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	420.54	37.70	Firmagon 80mg [FP]

DEGARELIX
Authority required (STREAMLINED)
3229

Locally advanced (equivalent to stage C) or metastatic (equivalent to stage D) carcinoma of the prostate

Note

No applications for increased maximum quantities and/or repeats will be authorised for the 120 mg powder for injection.

degarelix 120 mg injection [2 x 120 mg vials] (&) inert substance diluent [2 syringes], 1 pack

2785N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	439.06	37.70	Firmagon 120mg [FP]

■ IMMUNOSTIMULANTS

IMMUNOSTIMULANTS

Interferons

■ INTERFERON ALFA-2A

Caution

Treatment with interferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required

Myeloproliferative disease with excessive thrombocytosis

interferon alfa-2a 4.5 million international units/0.5 mL injection, 1 x 0.5 mL syringe

8551C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	5	4	..	*265.06	37.70	Roferon-A [RO]

interferon alfa-2a 6 million international units/0.5 mL injection, 1 x 0.5 mL syringe

8552D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	5	4	..	*345.06	37.70	Roferon-A [RO]

interferon alfa-2a 9 million international units/0.5 mL injection, 1 x 0.5 mL syringe

8553E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	5	4	..	*506.46	37.70	Roferon-A [RO]

■ INTERFERON ALFA-2A

Caution

Treatment with interferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required

Low grade non-Hodgkin's lymphoma with clinical features suggestive of a poor prognosis, in combination with anthracycline-based chemotherapy

interferon alfa-2a 3 million international units/0.5 mL injection, 1 x 0.5 mL syringe

8181N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	15	5	..	*506.56	37.70	Roferon-A [RO]

interferon alfa-2a 4.5 million international units/0.5 mL injection, 1 x 0.5 mL syringe

8182P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	5	5	..	*265.06	37.70	Roferon-A [RO]

interferon alfa-2a 6 million international units/0.5 mL injection, 1 x 0.5 mL syringe

8183Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	5	5	..	*345.06	37.70	Roferon-A [RO]

interferon alfa-2a 9 million international units/0.5 mL injection, 1 x 0.5 mL syringe

8184R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	5	5	..	*506.46	37.70	Roferon-A [RO]

■ INTERFERON ALFA-2A

Caution

Treatment with interferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required

Hairy cell leukaemia

Authority required

Myeloproliferative disease with excessive thrombocytosis

interferon alfa-2a 3 million international units/0.5 mL injection, 1 x 0.5 mL syringe

8180M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	15	4	..	*506.56	37.70	Roferon-A [RO]

■ INTERFERON ALFA-2B

Caution

Treatment with interferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required

Hairy cell leukaemia

interferon alfa-2b 18 million international units/1.2 mL injection, 1 x 1.2 mL cartridge

8572E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	3	4	..	*606.37	37.70	Intron A Redipen [MK]

▪ **INTERFERON ALFA-2B**

Caution

Treatment with interferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required

Maintenance treatment of multiple myeloma once remission has been achieved with chemotherapy

Authority required

Low grade non-Hodgkin's lymphoma with clinical features suggestive of a poor prognosis, in combination with anthracycline-based chemotherapy

interferon alfa-2b 18 million international units/1.2 mL injection, 1 x 1.2 mL cartridge

8348J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	3	5	..	*606.37	37.70	Intron A Redipen [MK]

interferon alfa-2b 30 million international units/1.2 mL injection, 1 x 1.2 mL cartridge

8476D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	3	5	..	*1006.09	37.70	Intron A Redipen [MK]

▪ **INTERFERON BETA-1A**

Authority required (STREAMLINED)

4881

Multiple sclerosis

Treatment Phase: Initial treatment

Clinical criteria:

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis, with written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**

Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years, **AND**

Patient must be ambulatory (without assistance or support).

Where applicable, the date of the magnetic resonance imaging scan must be recorded in the patient's medical records.

Authority required (STREAMLINED)

4887

Multiple sclerosis

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis, **AND**

Patient must have previously been issued with an authority prescription for this drug, **AND**

Patient must not show continuing progression of disability while on treatment with this drug, **AND**

Patient must have demonstrated compliance with, and an ability to tolerate this therapy.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

INTERFERON BETA-1a Injection 44 micrograms (12,000,000 i.u.) in 0.5 mL single dose autoinjector, 12

8968B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1057.11	37.70	Rebif 44 [SG]

interferon beta-1a 30 microgram (6 million international units) injection [4 x 30 microgram vials] (&) inert substance diluent [4 x 1.1 mL syringes], 1 pack

8289G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1057.11	37.70	Avonex [BD]

interferon beta-1a 30 microgram/0.5 mL (6 million international units) injection, 4 x 0.5 mL syringes

8805K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1057.11	37.70	Avonex [BD]

interferon beta-1a 44 microgram/0.5 mL (12 million international units) injection, 12 x 0.5 mL syringes

8403G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1057.11	37.70	Rebif 44 [SG]

interferon beta-1a 44 microgram/0.5 mL (12 million international units) injection, 4 x 1.5 mL cartridges

9332E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1057.11	37.70	Rebif 44 [SG]

■ INTERFERON BETA-1B**Authority required (STREAMLINED)****4881**

Multiple sclerosis

Treatment Phase: Initial treatment

Clinical criteria:

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis, with written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**

Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years, **AND**

Patient must be ambulatory (without assistance or support).

Where applicable, the date of the magnetic resonance imaging scan must be recorded in the patient's medical records.

Authority required (STREAMLINED)**4887**

Multiple sclerosis

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis, **AND**

Patient must have previously been issued with an authority prescription for this drug, **AND**

Patient must not show continuing progression of disability while on treatment with this drug, **AND**

Patient must have demonstrated compliance with, and an ability to tolerate this therapy.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

interferon beta-1b 8 million international units (250 microgram) injection [15 x 250 microgram vials] (&) inert substance diluent [15 x 1.2 mL syringes], 1 pack

8101J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1001.15	37.70	Betaferon [BN]

■ PEGINTERFERON BETA-1A**Authority required (STREAMLINED)****4881**

Multiple sclerosis

Treatment Phase: Initial treatment

Clinical criteria:

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis, with written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**

Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years, **AND**

Patient must be ambulatory (without assistance or support).

Where applicable, the date of the magnetic resonance imaging scan must be recorded in the patient's medical records.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

peginterferon beta-1a 125 microgram/0.5 mL injection, 2 x 0.5 mL injection devices

10212L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	4	..	1057.11	37.70	Plegridy [BD]

peginterferon beta-1a 63 microgram/0.5 mL injection [0.5 mL injection device] (&) peginterferon beta-1a 94 microgram/0.5 mL injection [0.5 mL injection device], 1 pack

10218T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	..	..	1057.11	37.70	Plegridy [BD]

▪ PEGINTERFERON BETA-1A**Authority required (STREAMLINED)****4887**

Multiple sclerosis

Treatment Phase: Continuing treatment

Clinical criteria:The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis, **AND**Patient must have previously been issued with an authority prescription for this drug, **AND**Patient must not show continuing progression of disability while on treatment with this drug, **AND**

Patient must have demonstrated compliance with, and an ability to tolerate this therapy.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

peginterferon beta-1a 125 microgram/0.5 mL injection, 2 x 0.5 mL injection devices

10220X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1057.11	37.70	Plegridy [BD]

*Other immunostimulants***▪ BACILLUS CALMETTE AND GUERIN-CONNAUGHT STRAIN****Restricted benefit**

Treatment of carcinoma in situ of the urinary bladder

Bacillus Calmette and Guerin-Connaught strain 660 million colony forming units injection [1 x 81 mg vial] (&) inert substance diluent [1 x 3 mL vial], 1 pack

1140B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	3	1	..	*460.21	37.70	ImmuCyst [SW]

▪ BACILLUS CALMETTE AND GUERIN-TICE STRAIN**Restricted benefit**

Primary and relapsing superficial urothelial carcinoma of the bladder

Bacillus Calmette and Guerin-Tice strain 500 million colony forming units injection, 3 x 500 million colony forming units vials

1131M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	556.73	37.70	OncoTICE [MK]

▪ GLATIRAMER ACETATE**Authority required (STREAMLINED)****4881**

Multiple sclerosis

Treatment Phase: Initial treatment

Clinical criteria:

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis, with written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years, **AND**

Patient must be ambulatory (without assistance or support).

Where applicable, the date of the magnetic resonance imaging scan must be recorded in the patient's medical records.

Authority required (STREAMLINED)**4887**

Multiple sclerosis

Treatment Phase: Continuing treatment

Clinical criteria:The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis, **AND**Patient must have previously been issued with an authority prescription for this drug, **AND**Patient must not show continuing progression of disability while on treatment with this drug, **AND**

Patient must have demonstrated compliance with, and an ability to tolerate this therapy.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

glatiramer acetate 20 mg/mL injection, 28 x 1 mL syringes

8726G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1092.99	37.70	Copaxone [TB]

■ IMMUNOSUPPRESSANTS

IMMUNOSUPPRESSANTS

Selective immunosuppressants

■ ABATACEPT

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment.

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have demonstrated an adequate response to treatment with this drug, **AND**

Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

- a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,
- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and
- once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or
- (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
- (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply.

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

abatacept 125 mg/mL injection, 4 x 1 mL syringes

1221G

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	1754.25	37.70	Orencia [BQ]

■ ABATACEPT
Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Clinical criteria:

Patient must have severe active rheumatoid arthritis, **AND**

Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**

Patient must not have failed previous PBS-subsidised treatment with this drug for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDs which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

If methotrexate is contraindicated according to the TGA-approved Product Information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialed, their doses and duration of treatment, and all relevant contraindications and/or intolerances.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

- (1) completed authority prescription forms; and
- (2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and
- (3) a signed patient acknowledgement.

Initial treatment with an I.V. loading dose: Two completed authority prescriptions must be submitted with the initial application. One prescription must be for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription must be written for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats.

Initial treatment with no loading dose: One completed authority prescription must be submitted with the initial application. The prescription must be written with a maximum quantity of 4 and up to 3 repeats.

Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted no later than 1 month from the date of completion of this initial course of treatment.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) a total active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note

The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:

(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose; (b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;

(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alpha antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alpha antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

- a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,

- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and

- once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alpha antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than

24 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD.

However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months).

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

The authority application must be made in writing and must include:

(a) completed authority prescription forms; and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment, within the timeframes specified below.

Initial treatment with an I.V. loading dose: Two completed authority prescriptions must be submitted with the initial application. One prescription must be for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription must be written for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats.

Initial treatment with no loading dose: One completed authority prescription must be submitted with the initial application. The prescription must be written with a maximum quantity of 4 and up to 3 repeats.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to a treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

A patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

- a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,
- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and
- once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or
- (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
- (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New

baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

the Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply.

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR
Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

abatacept 125 mg/mL injection, 4 x 1 mL syringes

1220F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1754.25	37.70	Orencia [BQ]

■ EVEROLIMUS**Caution**

Careful monitoring of patients is mandatory.

Authority required

Maintenance therapy, following initiation and stabilisation of treatment with everolimus and where therapy remains under the supervision and direction of the transplant unit reviewing that patient, of patients with renal transplants. The name of the specialised transplant unit reviewing treatment and the date of the latest review at the specialised transplant unit must be included in the authority application

Authority required

Maintenance therapy, following initiation and stabilisation of treatment with everolimus and where therapy remains under the supervision and direction of the transplant unit reviewing that patient, of patients with cardiac transplants. The name of the specialised transplant unit reviewing treatment and the date of the latest review at the specialised transplant unit must be included in the authority application

everolimus 1 mg tablet, 60

9352F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	3	..	*2069.10	37.70	Certican [NV]

everolimus 250 microgram tablet, 60

8840G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	283.13	37.70	Certican [NV]

everolimus 500 microgram tablet, 60

8841H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	544.17	37.70	Certican [NV]

everolimus 750 microgram tablet, 60

8842J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	3	..	*1578.96	37.70	Certican [NV]

■ FINGOLIMOD**Authority required**

Initial treatment, as monotherapy, of clinically definite relapsing-remitting multiple sclerosis in an ambulatory (without assistance or support) patient who has experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years. The diagnosis must be confirmed by magnetic resonance imaging of the brain and/or spinal cord and the date of the scan included in the authority application, unless the authority application is accompanied by written certification provided by a radiologist that an MRI scan is contraindicated because of the risk of physical (not psychological) injury to the patient. The authority will be limited to the maximum quantity and number of repeats indicated in the schedule

Authority required

Continuing treatment, as monotherapy, of clinically definite relapsing-remitting multiple sclerosis in a patient previously issued with an authority prescription for this drug who does not show continuing progression of disability while on treatment with this drug and who has demonstrated compliance with, and an ability to tolerate, this therapy. Authorities will be limited to the maximum quantity and number of repeats indicated in the schedule

Note

Special Pricing Arrangements apply.

fingolimod 500 microgram capsule, 28

5262Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	2313.32	37.70	Gilenya [NV]

▪ LEFLUNOMIDE**Caution**

Leflunomide is a category X drug and must not be given to pregnant women. Pregnancy should be avoided for two years after cessation of therapy, unless special wash-out procedures are carried out.

Authority required (STREAMLINED)**2682**

Treatment of severe active psoriatic arthritis where other disease modifying anti-rheumatic drugs (including methotrexate) are ineffective and/or inappropriate. Treatment must be initiated by a physician

leflunomide 10 mg tablet, 30

5449T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	48.94	37.70	^a Arabloc [AV] ^a Leflunomide Sandoz [SZ]	^a Arava [SW]

leflunomide 20 mg tablet, 30

5450W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	69.85	37.70	^a Arabloc [AV] ^a Leflunomide Sandoz [SZ]	^a Arava [SW]

▪ LEFLUNOMIDE**Caution**

Leflunomide is a category X drug and must not be given to pregnant women. Pregnancy should be avoided for two years after cessation of therapy, unless special wash-out procedures are carried out.

Authority required (STREAMLINED)**2644**

Treatment of severe active rheumatoid arthritis where other disease modifying anti-rheumatic drugs (including methotrexate) are ineffective and/or inappropriate. Treatment must be initiated by a physician

leflunomide 10 mg tablet, 30

8374R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	48.94	37.70	^a APO-Leflunomide [TX] ^a Arava [SW] ^a Leflunomide-GA [GN] ^a Leflunomide Sandoz [SZ]	^a Arabloc [AV] ^a Leflunomide AN [EA] ^a Leflunomide GH [GQ] ^a Lunava 10 [ZP]

leflunomide 20 mg tablet, 30

8375T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	69.85	37.70	^a APO-Leflunomide [TX] ^a Arava [SW] ^a Leflunomide-GA [GN] ^a Leflunomide Sandoz [SZ]	^a Arabloc [AV] ^a Leflunomide AN [EA] ^a Leflunomide GH [GQ] ^a Lunava 20 [ZP]

▪ MYCOPHENOLATE**Caution**

Careful monitoring of patients is mandatory.

mycophenolate 180 mg tablet: enteric, 120 tablets

2150E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	135.45	37.70	Myfortic [NV]

mycophenolate 360 mg tablet: enteric, 120 tablets

2193K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	258.73	37.70	Myfortic [NV]

mycophenolate mofetil 1 g/5 mL oral liquid: powder for, 165 mL

8651H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	#290.29	37.70	CellCept [RO]

mycophenolate mofetil 500 mg tablet, 50

8650G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	3	5	..	*317.23	37.70	^a APO-Mycophenolate [TX] ^a Ceptolate [AF] ^a Pharmacor Mycophenolate 500 [CR]	^a CellCept [RO] ^a Mycophenolate Sandoz [SZ]

■ MYCOPHENOLATE

Caution

Careful monitoring of patients is mandatory.

Note

For item codes 8649F and 1836P, pharmaceutical benefits that have the form capsule 250 mg are equivalent for the purposes of substitution.

mycophenolate Capsule 250 mg, 50

1836P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	6	5	..	*317.26	37.70	^a Ceptolate [AF]

mycophenolate mofetil 250 mg capsule, 100

8649F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	3	5	..	*317.26	37.70	^a APO-Mycophenolate [TX] ^a Mycophenolate Sandoz [SZ]	^a CellCept [RO] ^a Pharmacor Mycophenolate 250 [CR]

■ SIROLIMUS

Caution

Careful monitoring of patients is mandatory.

sirolimus 1 mg tablet, 100

8724E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	815.59	37.70	Rapamune [PF]

sirolimus 1 mg/mL oral liquid, 60 mL

8725F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	3	..	530.08	37.70	Rapamune [PF]

sirolimus 2 mg tablet, 100

8833X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1584.03	37.70	Rapamune [PF]

sirolimus 500 microgram tablet, 100

8984W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	413.63	37.70	Rapamune [PF]

■ TERIFLUNOMIDE

Caution

Teriflunomide is a category X drug and must not be given to pregnant women or women of childbearing potential who are not currently using reliable contraception.

Pregnancy should be avoided for two years after cessation of therapy, unless special wash-out procedures are carried out.

Authority required

Multiple sclerosis

Treatment Phase: Initial treatment

Clinical criteria:

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by accompanying written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**

The treatment must be as monotherapy, **AND**

Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years; OR

Patient must have been receiving treatment with this drug prior to 1 December 2013, **AND**

Patient must be ambulatory (without assistance or support).

Where applicable, the date of the magnetic resonance imaging scan must be provided with the authority application.

Authority required

Multiple sclerosis

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by accompanying written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**

The treatment must be as monotherapy, **AND**

Patient must have previously been issued with an authority prescription for this drug, **AND**

Patient must not show continuing progression of disability while on treatment with this drug.

Where applicable, the date of the magnetic resonance imaging scan must be provided with the authority application.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

teriflunomide 14 mg tablet, 28

2898M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1847.26	37.70	Aubagio [GZ]

Tumor necrosis factor alpha (TNF-) inhibitors

▪ **ADALIMUMAB**

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**

Patient must have demonstrated an adequate response to treatment with adalimumab, **AND**

Patient must have received adalimumab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) an active joint count of fewer than 10 active (swollen and tender) joints; or

(b) a reduction in the active (swollen and tender) joint count by at least 50% from baseline; or

(c) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

All applications for continuing treatment with adalimumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with adalimumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH A HISTORY OF JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient over 18 years who has a history of juvenile idiopathic arthritis with onset prior to the age of 18 years. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.

From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:

(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and

(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 5 year break in PBS-subsidised bDMARD therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 24 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 24 months may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 24 months must commence a new treatment cycle. The length of the break in therapy is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

A patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count and ESR/CRP) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.

(4) Re-commencement of treatment after a 24 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 24 months, must requalify for treatment under the Initial 1 treatment restriction.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment – balance of supply

Clinical criteria:

Patient must have received insufficient adalimumab therapy under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

5284D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.70	37.70	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

5283C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.70	37.70	Humira [VE]

■ ADALIMUMAB

Authority required

Initial 1

Initial treatment of complex refractory FISTULISING CROHN DISEASE.

Initial PBS-subsidised treatment with adalimumab by a gastroenterologist or a consultant physician as specified in the NOTE below, of a patient with complex refractory fistulising Crohn disease who:

(a) has confirmed Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or a consultant physician as specified in the NOTE below; and

(b) has an externally draining enterocutaneous or rectovaginal fistula; and

(c) has signed a patient acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

Authority applications must be made in writing and must include:

(a) two completed authority prescription forms; and

(b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) a completed current Fistula Assessment Form including the date of assessment of the patient's condition; and

(ii) a signed patient acknowledgement.

The most recent fistula assessment must be no more than 1 month old at the time of application.

A maximum of 16 weeks treatment will be authorised under this criterion.

Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats. Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment with adalimumab may be

requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

An assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of therapy so that there is adequate time for a response to be demonstrated.

This assessment must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised adalimumab treatment

Authority required

Initial 2

Change or re-commencement of treatment of complex refractory FISTULISING CROHN DISEASE.

Initial PBS-subsidised treatment with adalimumab of complex refractory fistulising Crohn disease by a gastroenterologist or a consultant physician as specified in the NOTE below, of a patient with complex refractory fistulising Crohn disease who:

- (a) has a documented history of complex refractory fistulising Crohn disease; and
- (b) in this treatment cycle, has received prior PBS-subsidised treatment with adalimumab or infliximab for a draining enterocutaneous or rectovaginal fistula; and
- (c) has not failed PBS-subsidised therapy with adalimumab for this condition more than once in the current treatment cycle.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of TNF-alfa antagonist therapy within the time frames specified in the relevant restriction.

Where the most recent course of PBS-subsidised TNF-alfa antagonist treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of TNF-alfa antagonist treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of TNF-alfa antagonist.

Authority applications must be made in writing and must include:

- (a) two completed authority prescription forms; and
- (b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) a completed current Fistula Assessment Form including the date of assessment of the patient's condition; and details of prior TNF-alfa antagonist treatment including details of date and duration of treatment.

The most recent fistula assessment must be no more than 1 month old at the time of application.

A maximum of 16 weeks treatment will be authorised under this criterion.

Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats. Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment with adalimumab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

An assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of therapy so that there is adequate time for a response to be demonstrated.

This assessment must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised adalimumab treatment

Note

Any queries concerning the arrangements to prescribe adalimumab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe adalimumab should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

TREATMENT OF COMPLEX REFRACTORY FISTULISING CROHN DISEASE

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab and infliximab for patients with complex refractory fistulising Crohn disease. Where the term 'tumour necrosis factor (TNF) alfa antagonist' appears in the following NOTES and restrictions, it refers to adalimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any 1 time.

From 1 April 2011, under the PBS, all patients will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.

A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 April 2011 is considered to be in their first cycle as of 1 April 2011.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised TNF-alfa antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alfa antagonist under the new treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised TNF-alfa antagonist therapy after 1 April 2011.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised TNF-alfa antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
- (ii) a patient has received prior PBS-subsidised (initial or continuing) TNF-alfa antagonist therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iii) a patient wishes to re-commence treatment with a specific TNF-alfa antagonist following a break in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab and 14 weeks of therapy for infliximab.

From 1 April 2011, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab, and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Adalimumab only: Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific TNF-alfa antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing TNF-alfa antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF-alfa antagonist supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised TNF-alfa antagonist is approved, a patient may swap if eligible to the alternate TNF-alfa antagonist within the same treatment cycle.

A patient may trial the alternate TNF-alfa antagonist at any time, regardless of whether they are receiving therapy (initial or continuing) with a TNF-alfa antagonist at the time of the application. However, they cannot swap to a particular TNF-alfa antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to the alternate TNF-alfa antagonist should be accompanied by the approved authority prescription or remaining repeats for the TNF-alfa antagonist the patient is ceasing.

(3) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated based on the baseline measurements submitted with the first authority application for a TNF-alfa antagonist. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and Medicare Australia will assess response according to these revised baseline measurements.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF-alfa antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity.

(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab or infliximab.

A patient who commenced treatment with adalimumab for complex refractory fistulising Crohn disease prior to 4 November

2010 or infliximab prior to 1 March 2010 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction.

A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab or infliximab will be authorised under this criterion.

Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab or infliximab will be assessed under the continuing treatment restriction.

'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

No applications for increased maximum quantities and/or repeats will be authorised.

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

8965W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	1774.70	37.70	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

8963R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	1774.70	37.70	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 6 x 0.8 mL cartridges

8962Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	5036.70	37.70	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 6 x 0.8 mL syringes

8961P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	5036.70	37.70	Humira [VE]

■ ADALIMUMAB

Authority required

Initial 3 (grandfather)

Initial PBS-subsidised treatment of complex refractory FISTULISING CROHN DISEASE in a patient who has previously received non-PBS-subsidised therapy with adalimumab.

Initial PBS-subsidised supply for continuing treatment with adalimumab by a gastroenterologist, a consultant physician as specified in the NOTE below, or other consultant physician in consultation with a gastroenterologist of a patient who satisfies the following criteria:

- (a) has a documented history of complex refractory fistulising Crohn disease and was receiving treatment with adalimumab prior to 4 November 2010; and
- (b) had a draining enterocutaneous or rectovaginal fistula(e) prior to commencing treatment with adalimumab; and
- (c) has signed a patient acknowledgement indicating that they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and
- (d) is receiving treatment with adalimumab at the time of application; and
- (e) has demonstrated or sustained an adequate response to treatment with adalimumab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to adalimumab treatment is defined as:

- (a) a decrease from baseline in the number of open draining fistulae of greater than or equal to 50%; and/or
- (b) a marked reduction in drainage of all fistula(e) from baseline, together with less pain and induration as reported by the patient.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) a completed current and baseline Fistula Assessment form including the date of assessment of the patient's condition; and
 - (ii) a signed patient acknowledgement.

The current fistula assessment must be no more than 1 month old at the time of application.

The baseline fistula assessment must be from immediately prior to commencing treatment with adalimumab.

An assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criteria.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with adalimumab.

A maximum of 24 weeks treatment will be approved under this criterion.

Where fewer than 5 repeats are requested at the time of application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Patients may qualify for PBS-subsidised treatment under this restriction once only

Authority required

Continuing treatment of complex refractory FISTULISING CROHN DISEASE.

Continuing PBS-subsidised treatment with adalimumab by a gastroenterologist, a consultant physician as specified in the NOTE below or other consultant physician in consultation with a gastroenterologist, of a patient who:

(a) has a documented history of complex refractory fistulising Crohn disease; and

(b) has demonstrated or sustained an adequate response to treatment with adalimumab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response is defined as:

(a) a decrease from baseline in the number of open draining fistulae of greater than or equal to 50%; and/or

(b) a marked reduction in drainage of all fistula(e) from baseline, together with less pain and induration as reported by the patient.

Authority applications must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes a completed Fistula Assessment form including the date of the assessment of the patient's condition.

The fistula assessment must be no more than 1 month old at the time of application.

If the application is the first application for continuing treatment with adalimumab, an assessment of the patient's response must be made following a minimum of 12 weeks after the first dose so that there is adequate time for a response to be demonstrated.

An assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criteria.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with adalimumab.

Patients are eligible to receive continuing adalimumab treatment in courses of up to 24 weeks providing they continue to sustain the response.

A maximum of 24 weeks treatment will be authorised under this criterion.

Where fewer than 5 repeats are requested at the time of application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

Note

Any queries concerning the arrangements to prescribe adalimumab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe adalimumab should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF COMPLEX REFRACTORY FISTULISING CROHN DISEASE

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab and infliximab for patients with complex refractory fistulising Crohn disease. Where the term 'tumour necrosis factor (TNF) alfa antagonist' appears in the following NOTES and restrictions, it refers to adalimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any 1 time.

From 1 April 2011, under the PBS, all patients will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.

A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 April 2011 is considered to be in their first cycle as of 1 April 2011.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised TNF-alfa antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alfa antagonist under the new treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised TNF-alfa antagonist therapy after 1 April 2011.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised TNF-alfa antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
- (ii) a patient has received prior PBS-subsidised (initial or continuing) TNF-alfa antagonist therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iii) a patient wishes to re-commence treatment with a specific TNF-alfa antagonist following a break in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab and 14 weeks of therapy for infliximab.

From 1 April 2011, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab, and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Adalimumab only: Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific TNF-alfa antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing TNF-alfa antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF-alfa antagonist supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised TNF-alfa antagonist is approved, a patient may swap if eligible to the alternate TNF-alfa antagonist within the same treatment cycle.

A patient may trial the alternate TNF-alfa antagonist at any time, regardless of whether they are receiving therapy (initial or continuing) with a TNF-alfa antagonist at the time of the application. However, they cannot swap to a particular TNF-alfa antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to the alternate TNF-alfa antagonist should be accompanied by the approved authority prescription or remaining repeats for the TNF-alfa antagonist the patient is ceasing.

(3) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated based on the baseline measurements submitted with the first authority application for a TNF-alfa antagonist. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and Medicare Australia will assess response according to these revised baseline measurements.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF-alfa antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity.

(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab or infliximab.

A patient who commenced treatment with adalimumab for complex refractory fistulising Crohn disease prior to 4 November 2010 or infliximab prior to 1 March 2010 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction.

A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab or infliximab will be authorised under this criterion.

Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab or infliximab will be assessed under the continuing treatment restriction.

'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

No applications for increased maximum quantities and/or repeats will be authorised.

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

8966X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.70	37.70	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

8964T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.70	37.70	Humira [VE]

■ ADALIMUMAB

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have demonstrated an adequate response to treatment with this drug, **AND**

Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Applications for treatment with this drug where the dosing frequency exceeds 40 mg per fortnight will not be approved.

Special Pricing Arrangements apply

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF- α antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

- a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,
- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and
- once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF- α antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or
- (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
- (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate,

where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

the Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply.

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

9100Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.70	37.70	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

8741C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.70	37.70	Humira [VE]

■ ADALIMUMAB

Authority required

Continuing treatment (Whole body)

Continuing PBS-subsidised treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over:

- (a) who have a documented history of severe chronic plaque psoriasis; and
- (b) whose most recent course of PBS-subsidised biological treatment for this condition in this Treatment Cycle was with adalimumab; and
- (c) who have demonstrated an adequate response to their most recent course of treatment with adalimumab.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-biological treatment baseline value for this Treatment Cycle.

This assessment must be provided to Medicare Australia no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with adalimumab, the assessment of response must be after a minimum of 12 weeks of treatment with an initial course.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet along with the date of the assessment of the patient's condition.

The most recent PASI assessment must be no more than 1 month old at the time of application.

Approval will be based on the PASI assessment of response to the most recent course of treatment with adalimumab.

A maximum of 24 weeks of treatment with adalimumab will be authorised under this restriction.

Where fewer than 5 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for continuing authority applications, or for treatment that would otherwise extend the treatment period beyond 24 weeks.

A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised adalimumab treatment.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle

Authority required

Continuing treatment (Face, hand, foot)

Continuing PBS-subsidised treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over:

- (a) who have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot; and
- (b) whose most recent course of PBS-subsidised biological treatment for this condition in this Treatment Cycle was with adalimumab; and
- (c) who have demonstrated an adequate response to treatment with adalimumab.

An adequate response to adalimumab treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

- (i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or
- (ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

This assessment must be provided to Medicare Australia no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with adalimumab, the assessment of response must be after a minimum of 12 weeks of treatment with an initial course.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet and face, hand, foot area diagrams along with the date of the assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)].

The most recent PASI assessment must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with adalimumab will be authorised under this restriction.

Where fewer than 5 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for continuing authority applications, or for treatment that would otherwise extend the treatment period beyond 24 weeks.

A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised adalimumab treatment.

The PASI assessment for continuing treatment must be performed on the same affected area assessed at baseline.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle

Note

Any queries concerning the arrangements to prescribe adalimumab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe adalimumab should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab and ustekinumab, for adult patients with severe chronic plaque psoriasis. Therefore, where the term 'biological agents' appears in the following NOTES and restrictions, it only refers to adalimumab, etanercept, infliximab and ustekinumab.

From 1 March 2010, all patients will be able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial adalimumab, etanercept, infliximab or ustekinumab without having to meet the initial treatment criteria, that is they will not need to experience a disease flare when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

A patient who received PBS-subsidised biological agent treatment for chronic plaque psoriasis prior to 1 March 2010 is considered to be in their first Cycle as of 1 March 2010.

Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.

Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment. A patient who, prior to 1 March 2010, was authorised to receive PBS-subsidised initial treatment for chronic plaque psoriasis with the same agent twice, is exempt from this condition in respect of applications approved prior to 1 March 2010.

Patients must be assessed for response to each course of continuing treatment according to the criteria included in the relevant continuing treatment restriction.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.

Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe chronic plaque psoriasis after 1 March 2010.

There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made in the following situations:

- (i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
- (ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
- (iii) patients who wish to re-commence treatment following a break in PBS-subsidised therapy with that agent (Initial 2).

All applications for initial treatment will be limited to provide for a maximum of 16 weeks of treatment in the case of

adalimumab and etanercept, 22 weeks of treatment in the case of infliximab and 28 weeks of treatment in the case of ustekinumab.

(2) Assessment of response to initial treatment.

When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to Medicare Australia within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.

(3) Application for continuing treatment.

Following the completion of an initial treatment course of a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.

For second and subsequent courses of PBS-subsidised treatment with adalimumab, etanercept, infliximab or ustekinumab it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Where a response assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to sustain a response to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

(4) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.

Patients who commenced treatment with adalimumab prior to 1 June 2009 or ustekinumab prior to 1 March 2010 access these interchangeability arrangements in the same way as patients who have not.

To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the approved authority prescription or remaining repeats for the agent being ceased.

(5) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatment applications.

(6) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

No applications for increased maximum quantities and/or repeats will be authorised.

Special Pricing Arrangements apply.

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

9428F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.70	37.70	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

9427E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.70	37.70	Humira [VE]

▪ **ADALIMUMAB**

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**

Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months; OR

Patient must have received no PBS-subsidised bDMARD treatment for at least 5 years if they failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) in their last treatment cycle, **AND**

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDs which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

If methotrexate is contraindicated according to the TGA-approved Product Information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance and dose for each DMARD must be provided in the authority application.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; **AND** either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle. A patient may re-trial adalimumab after a minimum of 5 years have elapsed between the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle and the date of the first application under a new treatment cycle.

Note

The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:

- (a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
- (b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive

DMARD trial;

(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (change or recommencement of treatment after break of less than 24 months)

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**

Patient must have received prior PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in this treatment cycle, **AND**

Patient must not have failed PBS-subsidised therapy with adalimumab for this condition in the current treatment cycle, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has received PBS-subsidised treatment with adalimumab in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised adalimumab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised adalimumab treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised adalimumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

If a patient fails to respond to PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) an active joint count of fewer than 10 active (swollen and tender) joints; or

(b) a reduction in the active (swollen and tender) joint count by at least 50% from baseline; or

(c) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH A HISTORY OF JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient over 18 years who has a history of juvenile idiopathic arthritis with onset prior to the age of 18 years. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.

From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:

(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and

(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 5 year break in PBS-subsidised bDMARD therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 24 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 24 months may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 24 months must commence a new treatment cycle. The length of the break in therapy is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

A patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count and ESR/CRP) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.

(4) Re-commencement of treatment after a 24 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 24 months, must requalify for treatment under the Initial 1 treatment restriction.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply

Clinical criteria:

Patient must have received insufficient adalimumab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient adalimumab therapy under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

5282B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1774.70	37.70	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

5281Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1774.70	37.70	Humira [VE]

▪ **ADALIMUMAB**

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of active ankylosing spondylitis, **AND**

Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**

Patient must have demonstrated an adequate response to treatment with this drug.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

An adequate response is defined as an improvement from baseline of at least 2 of the BASDAI and 1 of the following:

(a) an ESR measurement no greater than 25 mm per hour; or

(b) a CRP measurement no greater than 10 mg per L; or

(c) an ESR or CRP measurement reduced by at least 20% from baseline.

Where only 1 acute phase reactant measurement is supplied in the first application for PBS-subsidised treatment, that same marker must be measured and supplied in all subsequent continuing treatment applications.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

All measurements provided must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment following an initial treatment course it must be made following a minimum of 12 weeks of treatment with this drug. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab and infliximab for adult patients with active ankylosing spondylitis.

Where the term 'bDMARD' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 5 bDMARDs at any 1 time.

From 1 March 2007, under the PBS, all patients will be able to commence a treatment cycle where they may trial PBS-subsidised bDMARDs without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.

A patient who received PBS-subsidised bDMARD treatment prior to 1 March 2007 is considered to be in their first cycle as of 1 March 2007.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once. A patient who, prior to 1 March 2007, was authorised to receive PBS-subsidised initial treatment for ankylosing spondylitis with the same agent twice, is exempt from this condition in respect of applications approved prior to 1 March 2007.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
- (ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 2).

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the

approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.

For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment – balance of supply

Clinical criteria:

Patient must have a documented history of active ankylosing spondylitis, **AND**

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

9104E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.70	37.70	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

9078T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.70	37.70	Humira [VE]

■ ADALIMUMAB

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Clinical criteria:

Patient must have severe active rheumatoid arthritis, **AND**

Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**

Patient must not have failed previous PBS-subsidised treatment with this drug for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a

dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDs which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

If methotrexate is contraindicated according to the TGA-approved Product Information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialed, their doses and duration of treatment, and all relevant contraindications and/or intolerances.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and
- (3) a signed patient acknowledgement.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

- (a) a total active joint count of at least 20 active (swollen and tender) joints; or
- (b) at least 4 active joints from the following list of major joints:
 - (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - (ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note

The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:

(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;

(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months)

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

Application for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Applications for treatment with this drug where the dosing frequency exceeds 40 mg per fortnight will not be approved.

Special Pricing Arrangements apply

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept). Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

- a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,
- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and
- once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or
- (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
- (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required. The first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD.

However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply.

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

9099X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1774.70	37.70	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

8737W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1774.70	37.70	Humira [VE]

■ ADALIMUMAB**Authority required**

Severe psoriatic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:Patient must have a documented history of severe active psoriatic arthritis, **AND**Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**Patient must demonstrate, at the time of application, an adequate response to treatment with this drug, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab or infliximab.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Note

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab and infliximab for adult patients with severe active psoriatic arthritis.

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.

Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab and infliximab only.

Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restriction for each agent.

Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].

The duration of the break in therapy will be measured from the date the last approval for PBS-subsidised treatment was granted in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.

Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.

Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle. There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe active psoriatic arthritis.

(1) Initial treatment.

Applications for initial treatment should be made where:

- (i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and
- (ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and
- (iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 2).

All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept and golimumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), and 22 weeks of therapy for infliximab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.

Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

Grandfather patients - certolizumab pegol only.

For patients who commenced treatment with certolizumab pegol for psoriatic arthritis prior to 1 April 2015, applications for initial PBS-subsidised treatment as continuing therapy may be made under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with any biological agent prior to PBS listing of that agent.

Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment for all agents. Approval will be based on the criteria included in the relevant restriction.

(2) Continuing treatment.

Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

(3) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.

Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.

Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:

- (i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
- (ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
- (iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.

To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the approved authority prescription or remaining repeats for the biological agent the patient is ceasing.

(4) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.

(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment with respect to both the indices of disease severity. Patients must have received treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment - balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

9102C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.70	37.70	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

9034L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.70	37.70	Humira [VE]

▪ ADALIMUMAB

Authority required

Initial 1 (new patients)

Initial treatment of Crohn disease in a patient assessed by CDAI.

Initial PBS-subsidised treatment with adalimumab by a gastroenterologist or a consultant physician as specified in the NOTE below, of a patient with severe refractory Crohn disease who satisfies the following criteria:

(a) has confirmed Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or a consultant physician as specified in the NOTE below; and

(b) has signed a patient acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and

(c) has failed to achieve an adequate response to prior systemic therapy including:

(i) a tapered course of steroids, starting at a dose of at least 40 mg prednisolone (or equivalent), over a 6 week period; and

(ii) immunosuppressive therapy including:
— azathioprine at a dose of at least 2 mg per kg daily for 3 or more months; or
— 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months; or
— methotrexate at a dose of at least 15 mg weekly for 3 or more months.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of the accepted toxicities including severity can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criterion indicates failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

(a) have a severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 300 as assessed.

All tests and assessments should be performed preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

The most recent CDAI assessment must be no more than 1 month old at the time of application.

Applications for authorisation must be made in writing and must include:

(a) two completed authority prescription forms; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the completed current Crohn Disease Activity Index (CDAI) calculation sheet including the date of assessment of the patient's condition; and

(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and

(iii) the signed patient acknowledgement.

A maximum of 16 weeks treatment will be authorised under this criterion.

Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats. Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment with adalimumab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

A CDAI assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks therapy so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised adalimumab treatment

Authority required

Initial 2

Change or re-commencement of treatment of Crohn disease in a patient assessed by CDAI.

Initial PBS-subsidised treatment with adalimumab by a gastroenterologist or a consultant physician as specified in the NOTE below of a patient who:

(a) has a documented history of severe refractory Crohn disease; and

(b) in this treatment cycle, has received prior PBS-subsidised treatment with infliximab or adalimumab for this condition; and

(c) has not failed PBS-subsidised therapy with adalimumab for this condition more than once in the current treatment cycle.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of TNF-alfa antagonist therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised TNF-alfa antagonist treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of TNF-alfa antagonist treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of TNF-alfa antagonist.

Authority applications must be made in writing and must include:

(a) two completed authority prescription forms; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the completed current Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition; and

(ii) details of prior TNF alfa antagonist treatment including details of date and duration of treatment.

Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats. Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment with adalimumab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday

to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

A CDAI assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks therapy so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised adalimumab treatment

Authority required

Initial 1

Initial treatment of Crohn disease in a patient with short gut syndrome or an ostomy patient.

Initial PBS-subsidised treatment with adalimumab by a gastroenterologist, or consultant physician as specified in the NOTE below of a patient who satisfies the following criteria:

- (a) has confirmed Crohn disease defined by standard clinical, endoscopic and/or imaging features, including histological evidence with the diagnosis confirmed by a gastroenterologist or consultant physician as specified in the NOTE below; and
- (b) has diagnostic imaging or surgical evidence of short gut syndrome or has an ileostomy or colostomy; and
- (c) has evidence of intestinal inflammation; and
- (d) has signed a patient acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and
- (e) has failed to achieve an adequate response to prior systemic drug therapy including:
 - (i) a tapered course of steroids, starting at a dose of at least 40 mg prednisolone (or equivalent), over a 6 week period; and
 - (ii) immunosuppressive therapy including:
 - azathioprine at a dose of at least 2 mg per kg daily for 3 or more months; or
 - 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months; or
 - methotrexate at a dose of at least 15 mg weekly for 3 or more months.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of the accepted toxicities including severity can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

- (a) have evidence of intestinal inflammation, including:
 - (i) blood: higher than normal platelet count, or, an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour, or, a C-reactive protein (CRP) level greater than 15 mg per L; AND/OR
 - (ii) faeces: higher than normal lactoferrin or calprotectin level; AND/OR
 - (iii) diagnostic imaging: demonstration of increased uptake of intravenous contrast with thickening of the bowel wall or mesenteric lymphadenopathy or fat streaking in the mesentery;
 AND/OR
- (b) be assessed clinically as being in a high faecal output state;
- AND/OR
- (c) be assessed clinically as requiring surgery or total parenteral nutrition (TPN) as the next therapeutic option, in the absence of adalimumab.

All tests and assessments should be performed preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

Any one of the baseline criteria may be used to determine response to an initial course of treatment and eligibility for continued therapy, according to the criteria included in the continuing treatment restriction. However, the same criterion must be used for any subsequent determination of response to treatment, for the purpose of eligibility for continuing PBS-subsidised therapy.

Applications for authorisation must be made in writing and must include:

- (a) two completed authority prescription forms; and
- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and
 - (ii) reports and dates of the pathology or diagnostic imaging test(s) nominated as the response criterion, if relevant; and
 - (iii) date of the most recent clinical assessment; and
 - (iv) the signed patient acknowledgement.

All assessments, pathology tests and diagnostic imaging studies must be made within 1 month of the date of application. A maximum of 16 weeks treatment will be authorised under this criterion.

Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats. Where fewer than 2 repeats are requested at the time of the application,

authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment with adalimumab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks therapy so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised adalimumab treatment

Authority required

Initial 2

Change or re-commencement of treatment of Crohn disease in a patient with short gut syndrome, an ostomy patient or a patient with extensive small intestine disease.

Initial PBS-subsidised treatment with adalimumab by a gastroenterologist or a consultant physician as specified in the NOTE below of a patient who:

- (a) has a documented history of severe refractory Crohn disease; and
- (b) in this treatment cycle, has received prior PBS-subsidised treatment with infliximab or adalimumab for this condition; and
- (c) has not failed PBS-subsidised therapy with adalimumab for this condition more than once in the current treatment cycle.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of TNF-alfa antagonist therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised TNF-alfa antagonist treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of TNF-alfa antagonist treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of TNF-alfa antagonist.

Authority applications must be made in writing and must include:

- (a) two completed authority prescription forms; and
- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) reports and dates of the pathology or diagnostic imaging test(s) nominated as the response criteria, if relevant; and
 - (ii) details of prior TNF alfa antagonist treatment including details of date and duration of treatment.

A maximum of 16 weeks of treatment will be approved under this criterion.

Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats. Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment with adalimumab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of therapy so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised adalimumab treatment

Authority required

Initial 1

Initial treatment of Crohn disease in a patient with extensive small intestine disease.

Initial PBS-subsidised treatment with adalimumab by a gastroenterologist or a consultant physician as specified in the NOTE below, of a patient with severe refractory Crohn disease who satisfies the following criteria:

- (a) has confirmed Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or consultant physician as specified in the NOTE below; and
- (b) has extensive small intestinal disease with radiological evidence of intestinal inflammation affecting more than 50 cm of the small intestine; and
- (c) has signed a patient acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and
- (d) has failed to achieve an adequate response to prior systemic therapy including:
 - (i) a tapered course of steroids, starting at a dose of at least 40 mg prednisolone (or equivalent), over a 6 week period; and

(ii) immunosuppressive therapy including:

- azathioprine at a dose of at least 2 mg per kg daily for 3 or more months; or
- 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months; or
- methotrexate at a dose of at least 15 mg weekly for 3 or more months.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of the accepted toxicities including severity can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

(a) have severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 220;

AND/OR

(b) have evidence of active intestinal inflammation, including:

- (i) blood: higher than normal platelet count, or, an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour, or, a C-reactive protein (CRP) level greater than 15 mg per L; AND/OR
- (ii) faeces: higher than normal lactoferrin or calprotectin level; AND/OR
- (iii) diagnostic imaging: demonstration of increased uptake of intravenous contrast with thickening of the bowel wall or mesenteric lymphadenopathy or fat streaking in the mesentery;

AND/OR

(c) be assessed clinically as being in a high faecal output state;

AND/OR

(d) be assessed clinically as requiring surgery or total parenteral nutrition (TPN) as the next therapeutic option, in the absence of adalimumab.

All tests and assessments should be performed preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

Any one of the baseline criteria may be used to determine response to an initial course of treatment and eligibility for continued therapy, according to the criteria included in the continuing treatment restriction. However, the same criterion must be used for any subsequent determination of response to treatment, for the purpose of eligibility for continuing PBS-subsidised therapy.

Applications for authorisation must be made in writing and must include:

- (a) two completed authority prescription forms; and
- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and
 - (ii) (1) reports and dates of the pathology or diagnostic imaging test(s) nominated as the response criterion, if relevant; or (2) the completed current Crohn Disease Activity Index (CDAI) calculation sheet including the dates of assessment of the patient's condition, if relevant; and
 - (iii) date of the most recent clinical assessment; and
 - (iv) the signed patient acknowledgement.

All assessments, pathology tests and diagnostic imaging studies must be made within 1 month of the date of application.

A maximum of 16 weeks treatment of adalimumab will be authorised under this criterion.

Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats. Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment with adalimumab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of therapy after the first dose so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised adalimumab treatment

Note

Any queries concerning the arrangements to prescribe adalimumab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe adalimumab should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE REFRACTORY CROHN DISEASE

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab and infliximab for adult patients with severe refractory Crohn disease. Where the term 'tumour necrosis factor (TNF) alfa antagonist' appears in the following NOTES and restrictions, it refers to adalimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any 1 time.

From 1 August 2008, under the PBS, all patients will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.

A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 August 2008 is considered to be in their first cycle as of 1 August 2008.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised TNF-alfa antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alfa antagonist under the new treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised TNF-alfa antagonist therapy after 1 August 2008.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised TNF-alfa antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
- (ii) a patient has received prior PBS-subsidised (initial or continuing) TNF-alfa antagonist therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iii) a patient wishes to re-commence treatment with a specific TNF-alfa antagonist following a break in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab and 14 weeks of therapy for infliximab.

From 1 August 2008, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab, and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Adalimumab only: Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific TNF-alfa antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing TNF-alfa antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF-alfa antagonist supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised TNF-alfa antagonist is approved, a patient may swap if eligible to the alternate TNF-alfa antagonist within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Crohn Disease Activity Index (CDAI) Score, evidence of intestinal inflammation), or the prior corticosteroid therapy and immunosuppressive therapy.

A patient may trial the alternate TNF-alfa antagonist at any time, regardless of whether they are receiving therapy (initial or continuing) with a TNF-alfa antagonist at the time of the application. However, they cannot swap to a particular TNF-alfa antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to the alternate TNF-alfa antagonist should be accompanied by the approved authority prescription or remaining repeats for the TNF-alfa antagonist the patient is ceasing.

(3) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated based on the baseline measurements of the CDAI or evidence of intestinal inflammation submitted with the first authority application for a TNF-alfa antagonist. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and Medicare Australia will assess response according to these revised baseline measurements.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF-alfa antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with a corticosteroid and at least 1 immunosuppressive agent, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the CDAI score or the indices of intestinal inflammation are measured.

(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab or infliximab.

A patient who commenced treatment with adalimumab for severe refractory Crohn disease prior to 9 November 2007 or infliximab prior to 7 March 2007 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction.

A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab or infliximab will be authorised under this criterion.

Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab or infliximab will be assessed under the continuing treatment restriction.

'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

No applications for increased maximum quantities and/or repeats will be authorised.

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

9190Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	1774.70	37.70	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

9188N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	1774.70	37.70	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 6 x 0.8 mL cartridges

9187M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	5036.70	37.70	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 6 x 0.8 mL syringes

9186L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	5036.70	37.70	Humira [VE]

■ ADALIMUMAB

Authority required

Initial 3 (grandfather)

Initial PBS-subsidised treatment of Crohn disease in a patient assessed by CDAI who has previously received non-PBS-subsidised therapy with adalimumab.

Initial PBS-subsidised supply for continuing treatment with adalimumab by a gastroenterologist, a consultant physician as specified in the NOTE below, or other consultant physician in consultation with a gastroenterologist of a patient who:

(a) has a documented history of severe refractory Crohn disease and was receiving treatment with adalimumab prior to 9 November 2007; and

(b) had a Crohn Disease Activity Index (CDAI) Score of greater than or equal to 300 prior to commencing treatment with adalimumab. Where a baseline CDAI assessment is not available, please call Medicare Australia on 1800 700 270 to discuss; and

(c) has signed a patient acknowledgement indicating that they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and

(d) has demonstrated or sustained an adequate response to treatment with adalimumab. For advice please contact Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to adalimumab treatment is defined as a reduction in Crohn Disease Activity Index (CDAI) Score to no greater than 150.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the completed current and baseline Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition; and

(ii) the signed patient acknowledgement.

The current CDAI assessment must be no more than 1 month old at the time of application. The baseline CDAI assessment must be from immediately prior to commencing treatment with adalimumab.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with adalimumab.

A maximum of 24 weeks treatment will be approved under this criterion.

Where fewer than 5 repeats are requested at the time of application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Patients may qualify for PBS-subsidised treatment under this restriction once only

Authority required

Continuing treatment of Crohn disease in a patient assessed by CDAI.

Continuing PBS-subsidised treatment with adalimumab by a gastroenterologist, a consultant physician as specified in the NOTE below or other consultant physician in consultation with a gastroenterologist, of a patient who:

(a) has a documented history of severe refractory Crohn disease; and

(b) has demonstrated or sustained an adequate response to treatment with adalimumab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to adalimumab treatment is defined as a reduction in Crohn Disease Activity Index (CDAI) Score to a level no greater than 150.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the completed Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition.

The CDAI assessment must be no more than 1 month old at the time of application.

If the application is the first application for continuing treatment with adalimumab, a CDAI assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of therapy so that there is adequate time for a response to be demonstrated.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with adalimumab.

Patients are eligible to receive continuing adalimumab treatment in courses of up to 24 weeks providing they continue to sustain the response.

A maximum of 24 weeks treatment will be authorised under this criterion.

Where fewer than 5 repeats are requested at the time of application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

Authority required

Continuing treatment of Crohn disease in a patient with short gut syndrome or an ostomy patient.

Continuing PBS-subsidised treatment with adalimumab by a gastroenterologist, a consultant physician as specified in the NOTE below or other consultant physician in consultation with a gastroenterologist, of a patient who:

(a) has a documented history of severe refractory Crohn disease with intestinal inflammation and with short gut syndrome or with an ileostomy or colostomy; and

(b) has demonstrated or sustained an adequate response to treatment with adalimumab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to adalimumab treatment is defined as:

(a) improvement of intestinal inflammation as demonstrated by:

(i) blood: normalisation of the platelet count, or an erythrocyte sedimentation rate (ESR) level no greater than 25 mm per hour, or a C-reactive protein (CRP) level no greater than 15 mg per L; AND/OR

(ii) faeces: normalisation of lactoferrin or calprotectin level; AND/OR

(iii) evidence of mucosal healing, as demonstrated by diagnostic imaging findings, compared to the baseline assessment; or

(b) reversal of high faecal output state; or

(c) avoidance of the need for surgery or total parenteral nutrition (TPN).

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the reports and dates of the pathology or diagnostic imaging test(s) used to assess response to therapy or the date of clinical assessment.

The patient's assessment must be no more than 1 month old at the time of application.

If the application is the first application for continuing treatment with adalimumab, an assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of therapy after the first dose so that there is adequate time for a response to be demonstrated.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with adalimumab.

Patients are eligible to receive continuing adalimumab treatment in courses of up to 24 weeks providing they continue to sustain the response.

A maximum of 24 weeks of treatment will be authorised under this criterion.

Where fewer than 5 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

Authority required

Continuing treatment of Crohn disease in a patient with extensive small intestine disease.

Continuing PBS-subsidised treatment with adalimumab by a gastroenterologist, or consultant physician as specified in the NOTE below or other consultant physician in consultation with a gastroenterologist, of a patient who:

(a) has a documented history of severe refractory Crohn disease with extensive intestinal inflammation affecting more than 50 cm of the small intestine; and

(b) has demonstrated or sustained an adequate response to treatment with adalimumab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to adalimumab treatment is defined as:

(a) a reduction in Crohn Disease Activity Index (CDAI) Score to no greater than 150; or

(b) improvement of intestinal inflammation as demonstrated by:

(i) blood: normalisation of the platelet count, or an erythrocyte sedimentation rate (ESR) level no greater than 25 mm per hour, or a C-reactive protein (CRP) level no greater than 15 mg per L; AND/OR

(ii) faeces: normalisation of lactoferrin or calprotectin level; AND/OR

(iii) evidence of mucosal healing, as demonstrated by diagnostic imaging findings, compared to the baseline assessment; or

(c) reversal of high faecal output state; or

(d) avoidance of the need for surgery or total parenteral nutrition (TPN).

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the completed Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition; or

(ii) the reports and dates of the pathology test or diagnostic imaging test(s) used to assess response to therapy; or

(iii) the date of clinical assessment.

All assessments must be no more than 1 month old at the time of application.

If the application is the first application for continuing treatment with adalimumab, an assessment of the patient's response must be made following a minimum of 12 weeks of therapy so that there is adequate time for a response to be demonstrated.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with adalimumab.

Patients are eligible to receive continuing adalimumab treatment in courses of up to 24 weeks providing they continue to sustain the response.

A maximum of 24 weeks treatment will be authorised under this criterion.

Where fewer than 5 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

Authority required

Initial 3

Initial PBS-subsidised treatment of Crohn disease in a patient with short gut syndrome, an ostomy patient, or a patient with extensive small intestine disease, who has previously received non-PBS-subsidised therapy with adalimumab.

Initial PBS-subsidised supply for continuing treatment with adalimumab by a gastroenterologist, a consultant physician as specified in the NOTE below, or other consultant physician in consultation with a gastroenterologist, of a patient who:

(a) has a documented history of severe refractory Crohn disease and was receiving treatment with adalimumab prior to 9 November 2007; and

- (b) (1) has a history of extensive small intestinal disease with radiological evidence of intestinal inflammation affecting more than 50 cm of the small intestine; or
- (2) has diagnostic imaging or surgical evidence of short gut syndrome or has an ileostomy or colostomy with a documented history of intestinal inflammation; and
- (c) has signed a patient acknowledgement indicating that they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and
- (d) has demonstrated or sustained an adequate response to treatment with adalimumab according to the criteria included in the relevant continuation restriction. For advice please contact Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

The same criteria used to determine an inadequate response to prior treatment at baseline must be used to determine response to treatment and eligibility for continuing therapy, according to the criteria included in the continuing treatment restriction.

An adequate response to adalimumab treatment is defined as:

- (a) a reduction in Crohn Disease Activity Index (CDAI) Score to no greater than 150; or
- (b) improvement of intestinal inflammation as demonstrated by:
 - (i) blood: normalisation of the platelet count, or an erythrocyte sedimentation rate (ESR) level no greater than 25 mm per hour, or a C-reactive protein (CRP) level no greater than 15 mg per L; AND/OR
 - (ii) faeces: normalisation of lactoferrin or calprotectin level; AND/OR
 - (iii) evidence of mucosal healing, as demonstrated by diagnostic imaging findings, compared to the baseline assessment; or
- (c) reversal of high faecal output state; or
- (d) avoidance of the need for surgery or total parenteral nutrition (TPN).

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) (1) the completed current and baseline Crohn Disease Activity Index (CDAI) Score calculation sheet, where relevant, including the date of the assessment of the patient's condition; or
 - (2) the reports and dates of the current and baseline pathology or diagnostic imaging test(s) in order to assess response to therapy; or
 - (3) the date of clinical assessment(s); and
- (ii) the signed patient acknowledgement.

The patient's assessment must be no more than 1 month old at the time of application. The baseline CDAI assessments must be from immediately prior to commencing treatment with adalimumab. Where a baseline assessment is not available, please call Medicare Australia on 1800 700 270 to discuss.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with adalimumab.

Patients are eligible to receive continuing adalimumab treatment in courses of up to 24 weeks providing they continue to sustain the response.

Patients who fail to demonstrate or sustain a response to treatment with adalimumab for Crohn disease as specified in the criteria for continuing treatment with adalimumab, will not be eligible to recommence PBS-subsidised treatment with this drug within 12 months of the date on which treatment was ceased.

A maximum of 24 weeks treatment will be authorised under this criterion.

Where fewer than 5 repeats are requested at the time of this application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Patients may qualify for PBS-subsidised treatment under this restriction once only

Note

Any queries concerning the arrangements to prescribe adalimumab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe adalimumab should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE REFRACTORY CROHN DISEASE

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab and infliximab for adult patients with severe refractory Crohn disease. Where the term 'tumour necrosis factor (TNF) alfa antagonist' appears in the following NOTES and restrictions, it refers to adalimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any 1 time.

From 1 August 2008, under the PBS, all patients will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.

A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 August 2008 is considered to be in their first cycle as of 1 August 2008.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised TNF-alfa antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alfa antagonist under the new treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised TNF-alfa antagonist therapy after 1 August 2008.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised TNF-alfa antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient has received prior PBS-subsidised (initial or continuing) TNF-alfa antagonist therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iii) a patient wishes to re-commence treatment with a specific TNF-alfa antagonist following a break in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab and 14 weeks of therapy for infliximab.

From 1 August 2008, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab, and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Adalimumab only: Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific TNF-alfa antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing TNF-alfa antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF-alfa antagonist supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised TNF-alfa antagonist is approved, a patient may swap if eligible to the alternate TNF-alfa antagonist within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Crohn Disease Activity Index (CDAI) Score, evidence of intestinal inflammation), or the prior corticosteroid therapy and immunosuppressive therapy.

A patient may trial the alternate TNF-alfa antagonist at any time, regardless of whether they are receiving therapy (initial or continuing) with a TNF-alfa antagonist at the time of the application. However, they cannot swap to a particular TNF-alfa antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to the alternate TNF-alfa antagonist should be accompanied by the approved authority prescription or remaining repeats for the TNF-alfa antagonist the patient is ceasing.

(3) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated based on the baseline measurements of the CDAI or evidence of intestinal inflammation submitted with the first authority application for a TNF-alfa antagonist. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and Medicare Australia will assess response according to these revised baseline measurements.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF- α antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with a corticosteroid and at least 1 immunosuppressive agent, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the CDAI score or the indices of intestinal inflammation are measured.

(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab or infliximab.

A patient who commenced treatment with adalimumab for severe refractory Crohn disease prior to 9 November 2007 or infliximab prior to 7 March 2007 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction.

A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab or infliximab will be authorised under this criterion.

Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab or infliximab will be assessed under the continuing treatment restriction.

'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

No applications for increased maximum quantities and/or repeats will be authorised.

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

9191R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.70	37.70	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

9189P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.70	37.70	Humira [VE]

■ ADALIMUMAB

Authority required

Initial treatment [Initial 1, Whole body (New patients — No prior biological agent)]

Initial treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over who:

- (a) have severe chronic plaque psoriasis where lesions have been present for at least 6 months from the time of initial diagnosis; and
- (b) have not received any prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle; and
- (c) have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (whole body); and
- (d) have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments:
 - (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or
 - (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or
 - (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or
 - (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks.

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity to necessitate permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of acceptable toxicities including severity, associated with phototherapy, methotrexate, cyclosporin and acitretin, can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criterion indicates failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

- (a) A current Psoriasis Area and Severity Index (PASI) score of greater than 15, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.
- (b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]; and
 - (ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and
 - (iii) the signed patient and prescriber acknowledgements.

A maximum of 16 weeks of treatment with adalimumab will be authorised under this restriction.

Where fewer than 4 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period beyond 16 weeks.

A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised adalimumab treatment

Authority required

Initial or re-Treatment [Initial 2, Whole body (Received prior biological agent under PBS)]

Treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over who:

- (a) have a documented history of severe chronic plaque psoriasis; and
- (b) have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle; and
- (c) have not failed PBS-subsidised therapy with adalimumab for the treatment of this condition in the current Treatment Cycle.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]; and
 - (ii) details of prior biological treatment, including dosage, date and duration of treatment.

Applications for patients who have demonstrated a response to PBS-subsidised adalimumab treatment within this Treatment Cycle and who wish to re-commence adalimumab treatment within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised adalimumab treatment has been submitted to Medicare Australia within 1 month of cessation of treatment.

A maximum of 16 weeks of treatment with adalimumab will be authorised under this restriction.

Where fewer than 4 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period beyond 16 weeks.

A PASI assessment of the patient's response to this course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised adalimumab treatment.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle

Authority required

Initial treatment [Initial 1, Face, hand, foot (New patients — No prior biological agent)]

Initial treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over who:

- (a) have severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis; and
- (b) have not received any prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle; and
- (c) have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (face, hand, foot); and
- (d) have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments:
 - (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or
 - (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or
 - (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or
 - (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks.

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity to necessitate permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of acceptable toxicities including severity, associated with phototherapy, methotrexate, cyclosporin and acitretin, can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criterion indicates failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

(a) Chronic plaque psoriasis classified as severe due to a plaque or plaques on the face, palm of a hand or sole of a foot where:

(i) at least 2 of the 3 Psoriasis Area and Severity Index (PASI) symptom subscores for erythema, thickness and scaling are rated as severe or very severe, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment; or

(ii) the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]]; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

A maximum of 16 weeks of treatment with adalimumab will be authorised under this restriction.

Where fewer than 4 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period beyond 16 weeks.

A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised adalimumab treatment.

The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline

Authority required

Initial or re-Treatment [Initial 2, Face, hand, foot (Received prior biological agent under PBS)]

Treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over who:

(a) have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot; and

(b) have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle; and

(c) have not failed PBS-subsidised therapy with adalimumab for the treatment of this condition in the current Treatment Cycle.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]]; and

(ii) details of prior biological treatment, including dosage, date and duration of treatment.

Applications for patients who have demonstrated a response to PBS-subsidised adalimumab treatment within this Treatment Cycle and who wish to re-commence adalimumab treatment within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised adalimumab treatment has been submitted to Medicare Australia within 1 month of cessation of treatment.

A maximum of 16 weeks of treatment with adalimumab will be authorised under this restriction.

Where fewer than 4 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be

granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period beyond 16 weeks.

A PASI assessment of the patient's response to this course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised adalimumab treatment.

The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle

Note

Any queries concerning the arrangements to prescribe adalimumab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe adalimumab should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab and ustekinumab, for adult patients with severe chronic plaque psoriasis.

Therefore, where the term 'biological agents' appears in the following NOTES and restrictions, it only refers to adalimumab, etanercept, infliximab and ustekinumab.

From 1 March 2010, all patients will be able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial adalimumab, etanercept, infliximab or ustekinumab without having to meet the initial treatment criteria, that is they will not need to experience a disease flare when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

A patient who received PBS-subsidised biological agent treatment for chronic plaque psoriasis prior to 1 March 2010 is considered to be in their first Cycle as of 1 March 2010.

Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.

Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment. A patient who, prior to 1 March 2010, was authorised to receive PBS-subsidised initial treatment for chronic plaque psoriasis with the same agent twice, is exempt from this condition in respect of applications approved prior to 1 March 2010.

Patients must be assessed for response to each course of continuing treatment according to the criteria included in the relevant continuing treatment restriction.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.

Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe chronic plaque psoriasis after 1 March 2010.

There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made in the following situations:

- (i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
- (ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
- (iii) patients who wish to re-commence treatment following a break in PBS-subsidised therapy with that agent (Initial 2).

All applications for initial treatment will be limited to provide for a maximum of 16 weeks of treatment in the case of adalimumab and etanercept, 22 weeks of treatment in the case of infliximab and 28 weeks of treatment in the case of ustekinumab.

(2) Assessment of response to initial treatment.

When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to Medicare Australia within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.

(3) Application for continuing treatment.

Following the completion of an initial treatment course of a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.

For second and subsequent courses of PBS-subsidised treatment with adalimumab, etanercept, infliximab or ustekinumab it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Where a response assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to sustain a response to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

(4) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.

Patients who commenced treatment with adalimumab prior to 1 June 2009 or ustekinumab prior to 1 March 2010 access these interchangeability arrangements in the same way as patients who have not.

To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the approved authority prescription or remaining repeats for the agent being ceased.

(5) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatment applications.

(6) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

No applications for increased maximum quantities and/or repeats will be authorised.

Special Pricing Arrangements apply.

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

9426D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	4	..	1774.70	37.70	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

9425C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	4	..	1774.70	37.70	Humira [VE]

■ ADALIMUMAB**Authority required**

Active ankylosing spondylitis

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

The condition must be radiographically (plain X-ray) confirmed Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis, **AND**

Patient must not have received any PBS-subsidised treatment with either adalimumab, certolizumab pegol, etanercept, golimumab or infliximab in this treatment cycle, **AND**

Patient must have at least 2 of the following: (i) low back pain and stiffness for 3 or more months that is relieved by exercise but not by rest; or (ii) limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by a score

of at least 1 on each of the lumbar flexion and lumbar side flexion measurements of the Bath Ankylosing Spondylitis Metrology Index (BASMI); or (iii) limitation of chest expansion relative to normal values for age and gender, **AND** Patient must have failed to achieve an adequate response following treatment with at least 2 non-steroidal anti-inflammatory drugs (NSAIDs), whilst completing an appropriate exercise program, for a total period of 3 months.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

The application must include details of the NSAIDs trialled, their doses and duration of treatment.

If the NSAID dose is less than the maximum recommended dose in the relevant TGA-approved Product Information, the application must include the reason a higher dose cannot be used.

If treatment with NSAIDs is contraindicated according to the relevant TGA-approved Product Information, the application must provide details of the contraindication.

If intolerance to NSAID treatment develops during the relevant period of use which is of a severity to necessitate permanent treatment withdrawal, the application must provide details of the nature and severity of this intolerance.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of the initial application:

(a) a Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 4 on a 0-10 scale; **AND**

(b) an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 10 mg per L.

The BASDAI must be determined at the completion of the 3 month NSAID and exercise trial, but prior to ceasing NSAID treatment. The BASDAI must be no more than 1 month old at the time of initial application.

Both ESR and CRP measures should be provided with the initial treatment application and both must be no more than 1 month old. If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reason this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form which must include the following:

(i) a copy of the radiological report confirming Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis; and

(ii) a completed BASDAI Assessment Form; and

(iii) a completed Exercise Program Self Certification Form included in the supporting information form; and

(iv) a signed patient acknowledgment.

The assessment of the patient's response to the initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted no later than 4 weeks from the cessation of that treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

A maximum of 16 weeks of treatment with this drug will be approved under this criterion.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) was approved in this cycle and the date of the first application under a new cycle.

Note

Details of the toxicities, including severity, which will be accepted for the purposes of administering this restriction can be found on the Department of Human Services website at www.humanservices.gov.au

For details on the appropriate minimum exercise program that will be accepted for the purposes of administering this restriction, please refer to the Department of Human Services website at www.humanservices.gov.au

Authority required

Ankylosing spondylitis

Treatment Phase: Initial 2 (change or recommencement for all patients)

Clinical criteria:

Patient must have a documented history of active ankylosing spondylitis, **AND**

Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition in this treatment cycle, **AND**

Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle, **AND**

Patient must be eligible to receive further bDMARD therapy.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

Where the most recent course of PBS-subsidised bDMARD treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised bDMARD therapy or, under this restriction, for patients who have received previous PBS-subsidised bDMARD therapy) the patient must have been assessed for response to that course following a minimum of 12 weeks of treatment. These assessments must be provided to the Department of Human Services no later than 4 weeks from the date the course was ceased. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, patients must have been assessed for response, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

The authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

A maximum of 16 weeks of treatment with this drug will be approved under this criterion.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab and infliximab for adult patients with active ankylosing spondylitis.

Where the term 'bDMARD' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 5 bDMARDs at any 1 time.

From 1 March 2007, under the PBS, all patients will be able to commence a treatment cycle where they may trial PBS-subsidised bDMARDs without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.

A patient who received PBS-subsidised bDMARD treatment prior to 1 March 2007 is considered to be in their first cycle as of 1 March 2007.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once. A patient who, prior to 1 March 2007, was authorised to receive PBS-subsidised initial treatment for ankylosing spondylitis with the same agent twice, is exempt from this condition in respect of applications approved prior to 1 March 2007.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
- (ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 2).

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD

within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.

However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.

For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Authority required

Ankylosing spondylitis

Treatment Phase: Initial treatment – Initial 1 (new patients) or Initial 2 (change or recommencement for all patients) – balance of supply

Clinical criteria:

Patient must have active, or a documented history of active, ankylosing spondylitis, **AND**

Patient must have received insufficient therapy with this drug under the Initial 1 (new patients) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement for all patients) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

9103D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1774.70	37.70	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

9077R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1774.70	37.70	Humira [VE]

▪ ADALIMUMAB

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

Patient must have severe active psoriatic arthritis, **AND**

Patient must have received no prior PBS-subsidised treatment with a biological agent for this condition; OR

Patient must have received no PBS-subsidised treatment with a biological agent for at least 5 years if they have previously received PBS-subsidised treatment with a biological agent for this condition, **AND**

Patient must have failed to achieve an adequate response to methotrexate at a dose of at least 20 mg weekly for a minimum period of 3 months, **AND**

Patient must have failed to achieve an adequate response to sulfasalazine at a dose of at least 2 g per day for a minimum period of 3 months; OR

Patient must have failed to achieve an adequate response to leflunomide at a dose of up to 20 mg daily for a minimum period of 3 months, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab or infliximab.

Where treatment with methotrexate, sulfasalazine or leflunomide is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

Where intolerance to treatment with methotrexate, sulfasalazine or leflunomide developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following initiation criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; and

either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

Note

Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 3 months treatment with methotrexate and 3 months treatment with sulfasalazine or leflunomide can be found on the Department of Human Services website (www.humanservices.gov.au)

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 2 (change or recommencement of treatment)

Clinical criteria:

Patient must have a documented history of severe active psoriatic arthritis, **AND**

Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**

Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents within this Treatment Cycle, **AND**

Patient must not have failed, or ceased to respond to, PBS-subsidised treatment with this drug during the current Treatment Cycle, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab or infliximab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has previously received PBS-subsidised treatment with this drug within this Treatment Cycle and who wishes to recommence therapy with this drug within this same Cycle, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug.

Where the most recent course of PBS-subsidised treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised biological therapy or, under this restriction, for patients who have received previous PBS-subsidised biological therapy), the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must have been submitted no later than 4 weeks from the date that course was ceased. Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment was not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note

The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab and infliximab for adult patients with severe active psoriatic arthritis.

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.

Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab and infliximab only.

Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restriction for each agent.

Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].

The duration of the break in therapy will be measured from the date the last approval for PBS-subsidised treatment was granted in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.

Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.

Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle. There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe active psoriatic arthritis.

(1) Initial treatment.

Applications for initial treatment should be made where:

- (i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and
- (ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and
- (iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 2).

All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept and golimumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), and 22 weeks of therapy for infliximab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.

Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

Grandfather patients - certolizumab pegol only.

For patients who commenced treatment with certolizumab pegol for psoriatic arthritis prior to 1 April 2015, applications for initial PBS-subsidised treatment as continuing therapy may be made under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with any biological agent prior to PBS listing of that agent.

Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment for all agents. Approval will be based on the criteria included in the relevant restriction.

(2) Continuing treatment.

Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

(3) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.

Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.

Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:

- (i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
- (ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
- (iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.

To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the approved authority prescription or remaining repeats for the biological agent the patient is ceasing.

(4) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.

(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment with respect to both the indices of disease severity. Patients must have received treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2 (change or recommencement of treatment) - balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

9101B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1774.70	37.70	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

9033K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1774.70	37.70	Humira [VE]

■ CERTOLIZUMAB PEGOL**Authority required**

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Clinical criteria:

Patient must have severe active rheumatoid arthritis, **AND**

Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**

Patient must not have not failed previous PBS-subsidised treatment with this drug for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times., **AND**

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDs which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**

Patient must not receive more than 18 to 20 weeks of treatment, depending on the dosage regimen, under this restriction..

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

If methotrexate is contraindicated according to the TGA-approved product information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance including severity to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances including severity.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance including severity and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and
- (3) a signed patient acknowledgement.

Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

- (a) a total active joint count of at least 20 active (swollen and tender) joints; or
- (b) at least 4 active joints from the following list of major joints:
 - (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - (ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note

The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:

- (a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
- (b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;

- (c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Special Pricing Arrangements apply.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months).

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**

Patient must not receive more than 18 to 20 weeks of treatment, depending on the dosage regimen, under this restriction..

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

Application for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply.

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 18 to 20 weeks treatment, depending on the dosage regimen; OR

Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 18 to 20 weeks treatment, depending on the dosage regimen,

AND

The treatment must provide no more than the balance of up to 18 to 20 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 18-20 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 18-20 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have demonstrated an adequate response to treatment with this drug, **AND**

Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

- a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,

- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and

- once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for

treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of

rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

the Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply.

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

certolizumab pegol 200 mg/mL injection, 2 x 1 mL syringes

3425G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1708.98	37.70	Cimzia [UC]

■ CERTOLIZUMAB PEGOL

Authority required

Active ankylosing spondylitis

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

The condition must be radiographically (plain X-ray) confirmed Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis, **AND**

Patient must not have received any PBS-subsidised treatment with either adalimumab, certolizumab pegol, etanercept, golimumab or infliximab in this treatment cycle, **AND**

Patient must have at least 2 of the following: (i) low back pain and stiffness for 3 or more months that is relieved by exercise but not by rest; or (ii) limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by a score of at least 1 on each of the lumbar flexion and lumbar side flexion measurements of the Bath Ankylosing Spondylitis Metrology Index (BASMI); or (iii) limitation of chest expansion relative to normal values for age and gender, **AND**

Patient must have failed to achieve an adequate response following treatment with at least 2 non-steroidal anti-inflammatory drugs (NSAIDs), whilst completing an appropriate exercise program, for a total period of 3 months.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

The application must include details of the NSAIDs trialed, their doses and duration of treatment.

If the NSAID dose is less than the maximum recommended dose in the relevant TGA-approved Product Information, the application must include the reason a higher dose cannot be used.

If treatment with NSAIDs is contraindicated according to the relevant TGA-approved Product Information, the application must provide details of the contraindication.

If intolerance to NSAID treatment develops during the relevant period of use which is of a severity to necessitate permanent treatment withdrawal, the application must provide details of the nature and severity of this intolerance.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of the initial application:

- (a) a Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 4 on a 0-10 scale; AND
- (b) an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 10 mg per L.

The BASDAI must be determined at the completion of the 3 month NSAID and exercise trial, but prior to ceasing NSAID treatment. The BASDAI must be no more than 1 month old at the time of initial application.

Both ESR and CRP measures should be provided with the initial treatment application and both must be no more than 1 month old. If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reason this criterion cannot be satisfied.

The authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form which must include the following:
 - (i) a copy of the radiological report confirming Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis; and
 - (ii) a completed BASDAI Assessment Form; and
 - (iii) a completed Exercise Program Self Certification Form included in the supporting information form; and
 - (iv) a signed patient acknowledgment.

The assessment of the patient's response to the initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted no later than 4 weeks from the cessation of that treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

A maximum of 18 to 20 weeks of treatment with this drug will be approved under this criterion.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) was approved in this cycle and the date of the first application under a new cycle.

Note

Details of the toxicities, including severity, which will be accepted for the purposes of administering this restriction can be found on the Department of Human Services website at www.humanservices.gov.au

For details on the appropriate minimum exercise program that will be accepted for the purposes of administering this restriction, please refer to the Department of Human Services website at www.humanservices.gov.au

Authority required

Ankylosing spondylitis

Treatment Phase: Initial 2 (change or recommencement for all patients)

Clinical criteria:

Patient must have a documented history of active ankylosing spondylitis, **AND**

Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition in this treatment cycle, **AND**

Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle, **AND**

Patient must be eligible to receive further bDMARD therapy.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

Where the most recent course of PBS-subsidised bDMARD treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised bDMARD therapy or, under this restriction, for patients who have received previous PBS-subsidised bDMARD therapy) the patient must have been assessed for response to that course following a minimum of 12 weeks of treatment. These assessments must be provided to the Department of Human Services no later than 4 weeks from the date the course was ceased. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, patients must have been assessed for response, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

The authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

A maximum of 18 to 20 weeks of treatment with this drug will be approved under this criterion.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Authority required

Ankylosing spondylitis

Treatment Phase: Initial treatment – Initial 1 (new patients) or Initial 2 (change or recommencement for all patients) – balance of supply

Clinical criteria:

Patient must have active, or a documented history of active, ankylosing spondylitis, **AND**

Patient must have received insufficient therapy with this drug under the Initial 1 (new patients) restriction to complete 18 to 20 weeks treatment; OR

Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement for all patients) restriction to complete 18 to 20 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 18 to 20 weeks treatment available under the above restrictions.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

Note

Authority approval for sufficient therapy to complete a maximum of 18 to 20 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 18 to 20 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of active ankylosing spondylitis, **AND**

Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**

Patient must have demonstrated an adequate response to treatment with this drug.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

An adequate response is defined as an improvement from baseline of at least 2 of the BASDAI and 1 of the following:

(a) an ESR measurement no greater than 25 mm per hour; or

(b) a CRP measurement no greater than 10 mg per L; or

(c) an ESR or CRP measurement reduced by at least 20% from baseline.

Where only 1 acute phase reactant measurement is supplied in the first application for PBS-subsidised treatment, that same marker must be measured and supplied in all subsequent continuing treatment applications.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

All measurements provided must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment following an initial treatment course it must be made following a minimum of 12 weeks of treatment with this drug. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab and infliximab for adult patients with active ankylosing spondylitis. Where the term 'bDMARD' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 5 bDMARDs at any 1 time.

From 1 March 2007, under the PBS, all patients will be able to commence a treatment cycle where they may trial PBS-subsidised bDMARDs without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.

A patient who received PBS-subsidised bDMARD treatment prior to 1 March 2007 is considered to be in their first cycle as of 1 March 2007.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once. A patient who, prior to 1 March 2007, was authorised to receive PBS-subsidised initial treatment for ankylosing spondylitis with the same agent twice, is exempt from this condition in respect of applications approved prior to 1 March 2007.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
- (ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 2).

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.

However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.

For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.
To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response.
(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment – balance of supply

Clinical criteria:

Patient must have a documented history of active ankylosing spondylitis, **AND**

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

certolizumab pegol 200 mg/mL injection, 2 x 1 mL syringes

10137M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1708.98	37.70	Cimzia [UC]

▪ **CERTOLIZUMAB PEGOL**

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

Patient must have severe active psoriatic arthritis, **AND**

Patient must have received no prior PBS-subsidised treatment with a biological agent for this condition; OR

Patient must have received no PBS-subsidised treatment with a biological agent for at least 5 years if they have previously received PBS-subsidised treatment with a biological agent for this condition, **AND**

Patient must have failed to achieve an adequate response to methotrexate at a dose of at least 20 mg weekly for a minimum period of 3 months, **AND**

Patient must have failed to achieve an adequate response to sulfasalazine at a dose of at least 2 g per day for a minimum period of 3 months; OR

Patient must have failed to achieve an adequate response to leflunomide at a dose of up to 20 mg daily for a minimum period of 3 months, **AND**

Patient must not receive more than 18 to 20 weeks of treatment, depending on the dosage regimen, under this restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab or infliximab.

Where treatment with methotrexate, sulfasalazine or leflunomide is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

Where intolerance to treatment with methotrexate, sulfasalazine or leflunomide developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following initiation criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; and

either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

Note

Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 3 months treatment with methotrexate and 3 months treatment with sulfasalazine or leflunomide can be found on the Department of Human Services website (www.humanservices.gov.au)

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 2 (change or recommencement of treatment)

Clinical criteria:

Patient must have a documented history of severe active psoriatic arthritis, **AND**

Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**

Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents within this Treatment Cycle, **AND**

Patient must not have failed, or ceased to respond to, PBS-subsidised treatment with this drug during the current Treatment Cycle, **AND**

Patient must not receive more than 18 to 20 weeks of treatment, depending on the dosage regimen, under this restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab or infliximab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has previously received PBS-subsidised treatment with this drug within this Treatment Cycle and who wishes to recommence therapy with this drug within this same Cycle, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug.

Where the most recent course of PBS-subsidised treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised biological therapy or, under this restriction, for patients who have received previous PBS-subsidised biological therapy), the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must have been submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment was not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2 (change or recommencement of treatment) - balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 18 to 20 weeks treatment; OR

Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment) restriction to complete 18 to 20 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 18 to 20 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 18 to 20 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 18 to 20 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment - Initial 3 (initial PBS-subsidised supply for continuing treatment in a patient commenced on non-PBS-subsidised therapy)

Clinical criteria:

Patient must have a documented history of severe active psoriatic arthritis, **AND**

Patient must have been receiving treatment with certolizumab pegol for this condition prior to 1 April 2015, **AND**

Patient must be receiving treatment with certolizumab pegol at the time of application, **AND**

Patient must have demonstrated a response to treatment as specified in the criteria for continuing PBS-subsidised treatment with certolizumab pegol, **AND**

Patient must not receive more than 24 weeks of treatment under this restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

A patient may qualify for PBS-subsidised treatment under this restriction once only.

Note

The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment - Initial 3 (initial PBS-subsidised supply for continuing treatment in a patient commenced on non-PBS-subsidised therapy) - balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Initial 3 (initial PBS-subsidised supply for continuing treatment in a patient commenced on non-PBS-subsidised therapy) restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Authority required

Severe psoriatic arthritis
Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active psoriatic arthritis, **AND**

Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**

Patient must demonstrate, at the time of application, an adequate response to treatment with this drug, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab or infliximab.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Note

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab and infliximab for adult patients with severe active psoriatic arthritis.

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.

Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab and infliximab only.

Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restriction for each agent.

Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].

The duration of the break in therapy will be measured from the date the last approval for PBS-subsidised treatment was granted in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.

Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.

Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe active psoriatic arthritis.

(1) Initial treatment.

Applications for initial treatment should be made where:

(i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and

(ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and

(iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 2).

All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept and golimumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), and 22 weeks of therapy for infliximab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.

Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

Grandfather patients - certolizumab pegol only.

For patients who commenced treatment with certolizumab pegol for psoriatic arthritis prior to 1 April 2015, applications for initial PBS-subsidised treatment as continuing therapy may be made under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with any biological agent prior to PBS listing of that agent.

Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment for all agents. Approval will be based on the criteria included in the relevant restriction.

(2) Continuing treatment.

Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

(3) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.

Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.

Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:

(i) they have not received PBS-subsidised treatment with that particular biological agent previously; or

(ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and

(iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.

To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the approved authority prescription or remaining repeats for the biological agent the patient is ceasing.

(4) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.

(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment with respect to both the indices of disease severity. Patients must have received treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment - balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

certolizumab pegol 200 mg/mL injection, 2 x 1 mL syringes

10238W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1708.98	37.70	Cimzia [UC]

■ ETANERCEPT**Authority required**

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**

Patient must have demonstrated an adequate response to treatment with etanercept, **AND**

Patient must have received etanercept as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) an active joint count of fewer than 10 active (swollen and tender) joints; or

(b) a reduction in the active (swollen and tender) joint count by at least 50% from baseline; or

(c) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

All applications for continuing treatment with etanercept must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with etanercept, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH A HISTORY OF JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient over 18 years who has a history of juvenile idiopathic arthritis with onset prior to the age of 18 years. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.

From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:

(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and

(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 5 year break in PBS-subsidised bDMARD therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 24 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 24 months may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 24 months must commence a new treatment cycle. The length of the break in therapy is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24

weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. A patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count and ESR/CRP) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.

(4) Re-commencement of treatment after a 24 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 24 months, must requalify for treatment under the Initial 1 treatment restriction.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment – balance of supply

Clinical criteria:

Patient must have received insufficient etanercept therapy under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

3450N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.71	37.70	Enbrel [PF]

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

3449M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.71	37.70	Enbrel [PF]

etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

3448L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*1774.70	37.70	Enbrel [PF]

▪ ETANERCEPT

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have demonstrated an adequate response to treatment with this drug, **AND**

Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,

a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please

contact the Department of Human Services on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised

TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

9460X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.71	37.70	Enbrel [PF]

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

9090K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.71	37.70	Enbrel [PF]

etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

8638P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*1774.70	37.70	Enbrel [PF]

▪ ETANERCEPT

Authority required

Continuing treatment (Whole body)

Continuing PBS-subsidised treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over:

- (a) who have a documented history of severe chronic plaque psoriasis; and
- (b) whose most recent course of PBS-subsidised biological treatment for this condition in this Treatment Cycle was with etanercept; and
- (c) who have demonstrated an adequate response to their most recent course of treatment with etanercept.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-biological treatment baseline value for this Treatment Cycle.

This assessment must be provided to Medicare Australia no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with etanercept, the assessment of response must be after a minimum of 12 weeks of treatment with an initial course.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet along with the date of the assessment of the patient's condition.

The most recent PASI assessment must be no more than 1 month old at the time of application.

Approval will be based on the PASI assessment of response to the most recent course of treatment with etanercept.

A maximum of 24 weeks of treatment with etanercept will be authorised under this restriction.

Where fewer than 5 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for continuing authority applications, or for treatment that would otherwise extend the treatment period beyond 24 weeks.

A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment must be submitted to Medicare Australia no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised etanercept treatment.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle

Authority required

Continuing treatment (Face, hand, foot)

Continuing PBS-subsidised treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over:

- (a) who have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot; and
- (b) whose most recent course of PBS-subsidised biological treatment for this condition in this Treatment Cycle was with etanercept; and
- (c) who have demonstrated an adequate response to treatment with etanercept.

An adequate response to etanercept treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

- (i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or
- (ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

This assessment must be provided to Medicare Australia no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with etanercept, the assessment of response must be after a minimum of 12 weeks of treatment with an initial course.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet and face, hand, foot area diagrams along with the date of the assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]

The most recent PASI assessment must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with etanercept will be authorised under this restriction.

Where fewer than 5 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for continuing authority applications, or for treatment that would otherwise extend the treatment period beyond 24 weeks.

A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment must be submitted to Medicare Australia no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised etanercept treatment.

The PASI assessment for continuing treatment must be performed on the same affected area assessed at baseline.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle

Note

Any queries concerning the arrangements to prescribe etanercept may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe etanercept should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab and ustekinumab, for adult patients with severe chronic plaque psoriasis. Therefore, where the term 'biological agents' appears in the following NOTES and restrictions, it only refers to adalimumab, etanercept, infliximab and ustekinumab.

From 1 March 2010, all patients will be able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial adalimumab, etanercept, infliximab or ustekinumab without having to meet the initial treatment criteria, that is they will not need to experience a disease flare when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

A patient who received PBS-subsidised biological agent treatment for chronic plaque psoriasis prior to 1 March 2010 is considered to be in their first Cycle as of 1 March 2010.

Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.

Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment. A patient who, prior to 1 March 2010, was authorised to receive PBS-subsidised initial treatment for chronic plaque psoriasis with the same agent twice, is exempt from this condition in respect of applications approved prior to 1 March 2010.

Patients must be assessed for response to each course of continuing treatment according to the criteria included in the relevant continuing treatment restriction.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.

Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe chronic plaque psoriasis after 1 March 2010.

There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made in the following situations:

- (i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
- (ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
- (iii) patients who wish to re-commence treatment following a break in PBS-subsidised therapy with that agent (Initial 2).

All applications for initial treatment will be limited to provide for a maximum of 16 weeks of treatment in the case of adalimumab and etanercept, 22 weeks of treatment in the case of infliximab and 28 weeks of treatment in the case of ustekinumab.

(2) Assessment of response to initial treatment.

When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to Medicare Australia within 1 month of the completion of this initial

treatment course. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.

(3) Application for continuing treatment.

Following the completion of an initial treatment course of a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.

For second and subsequent courses of PBS-subsidised treatment with adalimumab, etanercept, infliximab or ustekinumab it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Where a response assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to sustain a response to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

(4) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.

Patients who commenced treatment with adalimumab prior to 1 June 2009 or ustekinumab prior to 1 March 2010 access these interchangeability arrangements in the same way as patients who have not.

To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the approved authority prescription or remaining repeats for the agent being ceased.

(5) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatment applications.

(6) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

No applications for increased maximum quantities and/or repeats will be authorised.

Special Pricing Arrangements apply.

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

9462B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.71	37.70	Enbrel [PF]

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

9431J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.71	37.70	Enbrel [PF]

etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

9429G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*1774.70	37.70	Enbrel [PF]

■ ETANERCEPT

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**

Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months; OR

Patient must have received no PBS-subsidised bDMARD treatment for at least 5 years if they failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) in their last treatment cycle, **AND**

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDs which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

If methotrexate is contraindicated according to the TGA-approved Product Information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialed, their doses and duration of treatment, and all relevant contraindications and/or intolerances.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance and dose for each DMARD must be provided in the authority application.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle. A patient may re-trial etanercept after a minimum of 5 years have elapsed between the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle and the date of the first application under a new treatment cycle.

Note

The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:

(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose; (b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;

(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (change or recommencement of treatment after break of less than 24 months)

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**

Patient must have received prior PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in this treatment cycle, **AND**

Patient must not have failed PBS-subsidised therapy with etanercept for this condition in the current treatment cycle, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

The authority application must be made in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has received PBS-subsidised treatment with etanercept in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised etanercept treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised etanercept treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised etanercept treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept.

If a patient fails to respond to PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

- (a) an active joint count of fewer than 10 active (swollen and tender) joints; or
- (b) a reduction in the active (swollen and tender) joint count by at least 50% from baseline; or
- (c) a reduction in the number of the following active joints, from at least 4, by at least 50%:
 - (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - (ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH A HISTORY OF JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient over 18 years who has a history of juvenile idiopathic arthritis with onset prior to the age of 18 years. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.

From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:

- (i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
- (ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 5 year break in PBS-subsidised bDMARD therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 24 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 24 months may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 24 months must commence a new treatment cycle. The length of the break in therapy is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
- (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
- (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

A patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count and ESR/CRP) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.

(4) Re-commencement of treatment after a 24 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 24 months, must requalify for treatment under the Initial 1 treatment restriction.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply

Clinical criteria:

Patient must have received insufficient etanercept therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR
 Patient must have received insufficient etanercept therapy under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**
 The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

3447K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1774.71	37.70	Enbrel [PF]

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

3446J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1774.71	37.70	Enbrel [PF]

etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

3445H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	3	..	*1774.70	37.70	Enbrel [PF]

■ ETANERCEPT**Authority required**

Ankylosing spondylitis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of active ankylosing spondylitis, **AND**

Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**

Patient must have demonstrated an adequate response to treatment with this drug.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

An adequate response is defined as an improvement from baseline of at least 2 of the BASDAI and 1 of the following:

- (a) an ESR measurement no greater than 25 mm per hour; or
- (b) a CRP measurement no greater than 10 mg per L; or
- (c) an ESR or CRP measurement reduced by at least 20% from baseline.

Where only 1 acute phase reactant measurement is supplied in the first application for PBS-subsidised treatment, that same marker must be measured and supplied in all subsequent continuing treatment applications.

The authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

All measurements provided must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment following an initial treatment course it must be made following a minimum of 12 weeks of treatment with this drug. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab and infliximab for adult patients with active ankylosing spondylitis.

Where the term 'bDMARD' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 5 bDMARDs at any 1 time.

From 1 March 2007, under the PBS, all patients will be able to commence a treatment cycle where they may trial PBS-subsidised bDMARDs without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.

A patient who received PBS-subsidised bDMARD treatment prior to 1 March 2007 is considered to be in their first cycle as of 1 March 2007.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once. A patient who, prior to 1 March 2007, was authorised to receive PBS-subsidised initial treatment for ankylosing spondylitis with the same agent twice, is exempt from this condition in respect of applications approved prior to 1 March 2007.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
- (ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 2).

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the

approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.

For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment – balance of supply

Clinical criteria:

Patient must have a documented history of active ankylosing spondylitis, **AND**

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

9456Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.71	37.70	Enbrel [PF]

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

9086F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.71	37.70	Enbrel [PF]

etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

8779C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*1774.70	37.70	Enbrel [PF]

■ ETANERCEPT

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Clinical criteria:

Patient must have severe active rheumatoid arthritis, **AND**

Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**

Patient must not have failed previous PBS-subsidised treatment with this drug for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDs which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

If methotrexate is contraindicated according to the TGA-approved product information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance including severity to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances including severity.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance including severity and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and
- (3) a signed patient acknowledgement.

Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; **AND** either

- (a) a total active joint count of at least 20 active (swollen and tender) joints; or
 - (b) at least 4 active joints from the following list of major joints:
 - (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - (ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).
- The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note

The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:

(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
(b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;

(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Special Pricing Arrangements apply.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months)

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

The authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to a treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

A patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

- (a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or
- (b) a reduction in the number of the following active joints, from at least 4, by at least 50%:
 - (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - (ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,

a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services

no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply.

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

9459W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1774.71	37.70	Enbrel [PF]

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

9089J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1774.71	37.70	Enbrel [PF]

etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

8637N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	3	..	*1774.70	37.70	Enbrel [PF]

▪ **ETANERCEPT**

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active psoriatic arthritis, **AND**

Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**

Patient must demonstrate, at the time of application, an adequate response to treatment with this drug, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab or infliximab.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Note

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab and infliximab for adult patients with severe active psoriatic arthritis.

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.

Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab and infliximab only.

Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restriction for each agent.

Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].

The duration of the break in therapy will be measured from the date the last approval for PBS-subsidised treatment was granted in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.

Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.

Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle. There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe active psoriatic arthritis.

(1) Initial treatment.

Applications for initial treatment should be made where:

- (i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and
- (ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and
- (iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 2).

All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept and golimumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), and 22 weeks of therapy for infliximab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.

Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

Grandfather patients - certolizumab pegol only.

For patients who commenced treatment with certolizumab pegol for psoriatic arthritis prior to 1 April 2015, applications for initial PBS-subsidised treatment as continuing therapy may be made under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with any biological agent prior to PBS listing of that agent.

Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment for all agents. Approval will be based on the criteria included in the relevant restriction.

(2) Continuing treatment.

Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

(3) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.

Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or

continuing) with a biological agent at the time of the application or not.

Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:

- (i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
- (ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
- (iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.

To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the approved authority prescription or remaining repeats for the biological agent the patient is ceasing.

(4) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.

(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment with respect to both the indices of disease severity. Patients must have received treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment - balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

9458T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.71	37.70	Enbrel [PF]

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

9088H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1774.71	37.70	Enbrel [PF]

etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

9036N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*1774.70	37.70	Enbrel [PF]

■ ETANERCEPT

Authority required

Initial treatment [Initial 1, Whole body (New patients — No prior biological agent)]

Initial treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over who:

- (a) have severe chronic plaque psoriasis where lesions have been present for at least 6 months from the time of initial diagnosis; and
- (b) have not received any prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle; and
- (c) have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (whole body); and
- (d) have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments:
 - (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or
 - (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or
 - (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or
 - (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks.

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity to necessitate permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of acceptable toxicities including severity, associated with phototherapy, methotrexate, cyclosporin and acitretin, can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criterion indicates failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

- (a) A current Psoriasis Area and Severity Index (PASI) score of greater than 15, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.
- (b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.
- (c) The most recent PASI assessment must be no more than 1 month old at the time of application.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]]; and
 - (ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and
 - (iii) the signed patient and prescriber acknowledgements.

A maximum of 16 weeks of treatment with etanercept will be authorised under this restriction.

Where fewer than 3 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period beyond 16 weeks.

A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised etanercept treatment

Authority required

Initial or re-Treatment [Initial 2, Whole body (Received prior biological agent under PBS)]

Treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over who:

- (a) have a documented history of severe chronic plaque psoriasis; and
- (b) have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle; and
- (c) have not failed PBS-subsidised therapy with etanercept for the treatment of this condition in the current Treatment Cycle.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]]; and
 - (ii) details of prior biological treatment, including dosage, date and duration of treatment.

Applications for patients who have demonstrated a response to PBS-subsidised etanercept treatment within this Treatment Cycle and who wish to re-commence etanercept treatment within the same Cycle following a break in therapy, will only be

approved where evidence of the patient's response to their most recent course of PBS-subsidised etanercept treatment has been submitted to Medicare Australia within 1 month of cessation of treatment.

A maximum of 16 weeks of treatment with etanercept will be authorised under this restriction.

Where fewer than 3 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period beyond 16 weeks.

A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised etanercept treatment.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle

Authority required

Initial treatment [Initial 1, Face, hand, foot (New patients — No prior biological agent)]

Initial treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over who:

- (a) have severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis; and
- (b) have not received any prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle; and

(c) have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (face, hand, foot); and

(d) have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments:

- (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or
- (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or
- (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or
- (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks.

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity to necessitate permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of acceptable toxicities including severity, associated with phototherapy, methotrexate, cyclosporin and acitretin, can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criterion indicates failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

(a) Chronic plaque psoriasis classified as severe due to a plaque or plaques on the face, palm of a hand or sole of a foot where:

- (i) at least 2 of the 3 Psoriasis Area and Severity Index (PASI) symptom subscores for erythema, thickness and scaling are rated as severe or very severe, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment; or
- (ii) the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]; and
 - (ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and
 - (iii) the signed patient and prescriber acknowledgements.

A maximum of 16 weeks of treatment with etanercept will be authorised under this restriction.

Where fewer than 3 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800

700 700 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period beyond 16 weeks.

A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 700 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised etanercept treatment.

The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline

Authority required

Initial or re-Treatment [Initial 2, Face, hand, foot (Received prior biological agent under PBS)]

Treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over who:

- (a) have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot; and
- (b) have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle; and
- (c) have not failed PBS-subsidised therapy with etanercept for the treatment of this condition in the current Treatment Cycle.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]; and
 - (ii) details of prior biological treatment, including dosage, date and duration of treatment.

Applications for patients who have demonstrated a response to PBS-subsidised etanercept treatment within this Treatment Cycle and who wish to re-commence etanercept treatment within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised etanercept treatment has been submitted to Medicare Australia within 1 month of cessation of treatment.

A maximum of 16 weeks of treatment with etanercept will be authorised under this restriction.

Where fewer than 3 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 700 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period beyond 16 weeks.

A PASI assessment of the patient's response to this course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 700 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised etanercept treatment.

The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle

Note

Any queries concerning the arrangements to prescribe etanercept may be directed to Medicare Australia on 1800 700 700 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe etanercept should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab and ustekinumab, for adult patients with severe chronic plaque psoriasis.

Therefore, where the term 'biological agents' appears in the following NOTES and restrictions, it only refers to adalimumab, etanercept, infliximab and ustekinumab.

From 1 March 2010, all patients will be able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial adalimumab, etanercept, infliximab or ustekinumab without having to meet the initial treatment criteria, that is they will not need to experience a disease flare when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

A patient who received PBS-subsidised biological agent treatment for chronic plaque psoriasis prior to 1 March 2010 is considered to be in their first Cycle as of 1 March 2010.

Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.

Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment. A patient who, prior to 1 March 2010, was authorised to receive PBS-subsidised initial treatment for chronic plaque psoriasis with the same agent twice, is exempt from this condition in respect of applications approved prior to 1 March 2010.

Patients must be assessed for response to each course of continuing treatment according to the criteria included in the relevant continuing treatment restriction.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.

Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe chronic plaque psoriasis after 1 March 2010.

There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made in the following situations:

- (i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
- (ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
- (iii) patients who wish to re-commence treatment following a break in PBS-subsidised therapy with that agent (Initial 2).

All applications for initial treatment will be limited to provide for a maximum of 16 weeks of treatment in the case of adalimumab and etanercept, 22 weeks of treatment in the case of infliximab and 28 weeks of treatment in the case of ustekinumab.

(2) Assessment of response to initial treatment.

When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to Medicare Australia within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.

(3) Application for continuing treatment.

Following the completion of an initial treatment course of a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.

For second and subsequent courses of PBS-subsidised treatment with adalimumab, etanercept, infliximab or ustekinumab it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Where a response assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to sustain a response to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

(4) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.

Patients who commenced treatment with adalimumab prior to 1 June 2009 or ustekinumab prior to 1 March 2010 access these interchangeability arrangements in the same way as patients who have not.

To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the approved authority prescription or remaining repeats for the agent being ceased.

(5) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatment applications.

(6) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

No applications for increased maximum quantities and/or repeats will be authorised.

Special Pricing Arrangements apply.

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

9461Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1774.71	37.70	Enbrel [PF]

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

9091L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1774.71	37.70	Enbrel [PF]

etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

9037P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	3	..	*1774.70	37.70	Enbrel [PF]

■ ETANERCEPT

Authority required

Active ankylosing spondylitis

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

The condition must be radiographically (plain X-ray) confirmed Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis, **AND**

Patient must not have received any PBS-subsidised treatment with either adalimumab, certolizumab pegol, etanercept, golimumab or infliximab in this treatment cycle, **AND**

Patient must have at least 2 of the following: (i) low back pain and stiffness for 3 or more months that is relieved by exercise but not by rest; or (ii) limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by a score of at least 1 on each of the lumbar flexion and lumbar side flexion measurements of the Bath Ankylosing Spondylitis Metrology Index (BASMI); or (iii) limitation of chest expansion relative to normal values for age and gender, **AND**

Patient must have failed to achieve an adequate response following treatment with at least 2 non-steroidal anti-inflammatory drugs (NSAIDs), whilst completing an appropriate exercise program, for a total period of 3 months.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

The application must include details of the NSAIDs trialled, their doses and duration of treatment.

If the NSAID dose is less than the maximum recommended dose in the relevant TGA-approved Product Information, the application must include the reason a higher dose cannot be used.

If treatment with NSAIDs is contraindicated according to the relevant TGA-approved Product Information, the application must provide details of the contraindication.

If intolerance to NSAID treatment develops during the relevant period of use which is of a severity to necessitate permanent treatment withdrawal, the application must provide details of the nature and severity of this intolerance.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of the initial application:

(a) a Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 4 on a 0-10 scale; **AND**

(b) an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 10 mg per L.

The BASDAI must be determined at the completion of the 3 month NSAID and exercise trial, but prior to ceasing NSAID treatment. The BASDAI must be no more than 1 month old at the time of initial application.

Both ESR and CRP measures should be provided with the initial treatment application and both must be no more than 1 month old. If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reason this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form which must include the following:

- (i) a copy of the radiological report confirming Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis; and
- (ii) a completed BASDAI Assessment Form; and
- (iii) a completed Exercise Program Self Certification Form included in the supporting information form; and
- (iv) a signed patient acknowledgment.

The assessment of the patient's response to the initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted no later than 4 weeks from the cessation of that treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

A maximum of 16 weeks of treatment with this drug will be approved under this criterion.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) was approved in this cycle and the date of the first application under a new cycle.

Note

Details of the toxicities, including severity, which will be accepted for the purposes of administering this restriction can be found on the Department of Human Services website at www.humanservices.gov.au

For details on the appropriate minimum exercise program that will be accepted for the purposes of administering this restriction, please refer to the Department of Human Services website at www.humanservices.gov.au

Authority required

Ankylosing spondylitis

Treatment Phase: Initial 2 (change or recommencement for all patients)

Clinical criteria:

Patient must have a documented history of active ankylosing spondylitis, **AND**

Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition in this treatment cycle, **AND**

Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle, **AND**

Patient must be eligible to receive further bDMARD therapy.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

Where the most recent course of PBS-subsidised bDMARD treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised bDMARD therapy or, under this restriction, for patients who have received previous PBS-subsidised bDMARD therapy) the patient must have been assessed for response to that course following a minimum of 12 weeks of treatment. These assessments must be provided to the Department of Human Services no later than 4 weeks from the date the course was ceased. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, patients must have been assessed for response, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

The authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

A maximum of 16 weeks of treatment with this drug will be approved under this criterion.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab and infliximab for adult patients with active ankylosing spondylitis.

Where the term 'bDMARD' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 5 bDMARDs at any 1 time.

From 1 March 2007, under the PBS, all patients will be able to commence a treatment cycle where they may trial PBS-subsidised bDMARDs without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with

a bDMARD while they continue to show a response to therapy.

A patient who received PBS-subsidised bDMARD treatment prior to 1 March 2007 is considered to be in their first cycle as of 1 March 2007.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once. A patient who, prior to 1 March 2007, was authorised to receive PBS-subsidised initial treatment for ankylosing spondylitis with the same agent twice, is exempt from this condition in respect of applications approved prior to 1 March 2007.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 2).

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.

However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.

For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Authority required

Ankylosing spondylitis

Treatment Phase: Initial treatment – Initial 1 (new patients) or Initial 2 (change or recommencement for all patients) – balance of supply

Clinical criteria:

Patient must have active, or a documented history of active, ankylosing spondylitis, **AND**

Patient must have received insufficient therapy with this drug under the Initial 1 (new patients) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement for all patients) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

9455P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1774.71	37.70	Enbrel [PF]

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

9085E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1774.71	37.70	Enbrel [PF]

etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

8778B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	3	..	*1774.70	37.70	Enbrel [PF]

▪ **ETANERCEPT**

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

Patient must have severe active psoriatic arthritis, **AND**

Patient must have received no prior PBS-subsidised treatment with a biological agent for this condition; OR

Patient must have received no PBS-subsidised treatment with a biological agent for at least 5 years if they have previously received PBS-subsidised treatment with a biological agent for this condition, **AND**

Patient must have failed to achieve an adequate response to methotrexate at a dose of at least 20 mg weekly for a minimum period of 3 months, **AND**

Patient must have failed to achieve an adequate response to sulfasalazine at a dose of at least 2 g per day for a minimum period of 3 months; OR

Patient must have failed to achieve an adequate response to leflunomide at a dose of up to 20 mg daily for a minimum period of 3 months, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab or infliximab.

Where treatment with methotrexate, sulfasalazine or leflunomide is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

Where intolerance to treatment with methotrexate, sulfasalazine or leflunomide developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following initiation criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; and

either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

Note

Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 3 months treatment with methotrexate and 3 months treatment with sulfasalazine or leflunomide can be found on the Department of Human Services website (www.humanservices.gov.au)

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 2 (change or recommencement of treatment)

Clinical criteria:

Patient must have a documented history of severe active psoriatic arthritis, **AND**

Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**

Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents within this Treatment Cycle, **AND**

Patient must not have failed, or ceased to respond to, PBS-subsidised treatment with this drug during the current Treatment Cycle, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab or infliximab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has previously received PBS-subsidised treatment with this drug within this Treatment Cycle and who wishes to recommence therapy with this drug within this same Cycle, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug.

Where the most recent course of PBS-subsidised treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised biological therapy or, under this restriction, for patients who have received previous PBS-subsidised biological therapy), the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must have been submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment was not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note

The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab and infliximab for adult patients with severe active psoriatic arthritis.

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.

Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab and infliximab only.

Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restriction for each agent.

Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].

The duration of the break in therapy will be measured from the date the last approval for PBS-subsidised treatment was granted in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.

Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.

Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe active psoriatic arthritis.

(1) Initial treatment.

Applications for initial treatment should be made where:

(i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and

(ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and

(iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 2).

All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept and golimumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), and 22 weeks of therapy for infliximab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.

Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

Grandfather patients - certolizumab pegol only.

For patients who commenced treatment with certolizumab pegol for psoriatic arthritis prior to 1 April 2015, applications for initial PBS-subsidised treatment as continuing therapy may be made under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with any biological agent prior to PBS listing of that agent.

Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment for all agents. Approval will be based on the criteria included in the relevant restriction.

(2) Continuing treatment.

Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

(3) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.

Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.

Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:

- (i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
- (ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
- (iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.

To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the approved authority prescription or remaining repeats for the biological agent the patient is ceasing.

(4) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.

(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment with respect to both the indices of disease severity. Patients must have received treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2 (change or recommencement of treatment) - balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

9457R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1774.71	37.70	Enbrel [PF]

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

9087G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1774.71	37.70	Enbrel [PF]

etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

9035M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	3	..	*1774.70	37.70	Enbrel [PF]

▪ **ETANERCEPT**

Authority required

TREATMENT OF PATIENTS UNDER 18 YEARS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing of etanercept under the Pharmaceutical Benefits Scheme (PBS) for patients under 18 years with severe chronic plaque psoriasis.

Applications for treatment of this condition will be limited to provide patients with a maximum of 24 weeks of therapy per course of treatment. A maximum of 16 weeks treatment with etanercept will be authorised for the primary application. The balance, a further 8 weeks treatment, will be authorised if the submitted Psoriasis Area and Severity Index (PASI) assessment demonstrates an adequate response to treatment. Where fewer than 3 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone.

Once a patient has failed to respond to treatment 2 times, they must have, at a minimum, a 12 month break. The length of a treatment break is measured from the date the most recent treatment was stopped to the date of the first application for initial treatment.

There are separate restrictions for treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made for patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy.

(2) Applications for approval for re-treatment.

Applications for re-treatment with etanercept should be made in the following situations:

(i) a patient who has received prior PBS-subsidised etanercept and experiences a disease flare, and wishes to start a second or subsequent treatment course with etanercept following a break of less than 12 months in PBS-subsidised therapy; or

(ii) a patient who has received and failed to respond to prior PBS-subsidised etanercept and wishes to start a second or subsequent treatment course following a break of less than 12 months in PBS-subsidised therapy.

For psoriasis affecting the whole body:

Patients are eligible for re-treatment due to disease flare if there is a 50% or greater change in the patients PASI score or the patient has a current PASI score of greater than 15, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

For psoriasis affecting the face, hand or foot:

Patients are eligible for re-treatment due to disease flare if:

(i) all subscores are rated moderate to severe or 2 of the three subscores are rated severe to very severe; OR

(ii) the skin area affected is a 50% or greater change or the area affected is 30% or more of the face, palm of a hand or sole of a foot, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

(3) Applications for approval for completion of a course

Applications for a further 8 weeks of treatment to allow for completion of 24 weeks of therapy should be submitted with a PASI assessment.

The PASI assessment must be conducted after at least 12 weeks of treatment.

This assessment must be submitted to Department of Human Services (the Department) within 1 month of the completion of 12 weeks of treatment. Where a response assessment is not undertaken and submitted to the Department within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department on 1800 700 270 to discuss.

(4) Baseline measurements to determine response.

The Department will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for etanercept. However, prescribers may provide new baseline measurements any time that an initial or re-treatment authority is submitted and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of gaining approval for the remainder of 24 weeks treatment.

(5) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment course with etanercept following a break in PBS-subsidised etanercept therapy of at least 12 months, must requalify for treatment under the initial treatment restriction. The most recent PASI assessment must be no more than 1 month old at the time of application.

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment (whole body)

Clinical criteria:

The treatment must be as systemic monotherapy; OR

The treatment must be in combination with methotrexate, **AND**

Patient must have lesions present for at least 6 months from the time of initial diagnosis, **AND**

Patient must not have received any prior PBS-subsidised treatment with etanercept for this condition; OR

Patient must not have received any PBS-subsidised treatment with etanercept for this condition for at least 12 months, **AND**

Patient must have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 2 of the following 3 treatments: (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or (ii) methotrexate at a dose of at least 10 mg or 10 mg per square metre weekly (whichever is lowest) for at least 6 weeks; and/or (iii) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks, **AND**

Patient must not receive more than 16 weeks of treatment with etanercept under this restriction.

Population criteria:

Patient must be under 18 years of age and a parent or authorised guardian must have signed a patient acknowledgement.

Treatment criteria:

Must be treated by a dermatologist.

Where treatment with any of the above-mentioned drugs was contraindicated according to the relevant TGA-approved Product Information, or where phototherapy was contraindicated, details must be provided at the time of application.

Where intolerance to phototherapy, methotrexate and/or acitretin developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following criterion indicates failure to achieve an adequate response to prior treatment and must be demonstrated in a patient at the time of the application:

- (a) A current Psoriasis Area and Severity Index (PASI) score of greater than 15, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.
- (b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.
- (c) The most recent PASI assessment must be no more than 1 month old at the time of application.

The authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis in Patients Less Than 18 Years PBS Authority Application - Supporting Information Form which includes the following:
 - (i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition and
 - (ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and
 - (iii) the parent or authorised guardian signed patient and prescriber acknowledgements.

Where a patient has had a 12 month treatment break, the length of the break is measured from the date the most recent treatment was stopped to the date of the application to re-commence treatment.

Authority required

TREATMENT OF PATIENTS UNDER 18 YEARS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing of etanercept under the Pharmaceutical Benefits Scheme (PBS) for patients under 18 years with severe chronic plaque psoriasis.

Applications for treatment of this condition will be limited to provide patients with a maximum of 24 weeks of therapy per course of treatment. A maximum of 16 weeks treatment with etanercept will be authorised for the primary application. The balance, a further 8 weeks treatment, will be authorised if the submitted Psoriasis Area and Severity Index (PASI) assessment demonstrates an adequate response to treatment. Where fewer than 3 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone.

Once a patient has failed to respond to treatment 2 times, they must have, at a minimum, a 12 month break. The length of a treatment break is measured from the date the most recent treatment was stopped to the date of the first application for initial treatment.

There are separate restrictions for treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made for patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy.

(2) Applications for approval for re-treatment.

Applications for re-treatment with etanercept should be made in the following situations:

- (i) a patient who has received prior PBS-subsidised etanercept and experiences a disease flare, and wishes to start a second or subsequent treatment course with etanercept following a break of less than 12 months in PBS-subsidised therapy; or
- (ii) a patient who has received and failed to respond to prior PBS-subsidised etanercept and wishes to start a second or subsequent treatment course following a break of less than 12 months in PBS-subsidised therapy.

For psoriasis affecting the whole body:

Patients are eligible for re-treatment due to disease flare if there is a 50% or greater change in the patients PASI score or the patient has a current PASI score of greater than 15, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

For psoriasis affecting the face, hand or foot:

Patients are eligible for re-treatment due to disease flare if:

- (i) all subscores are rated moderate to severe or 2 of the three subscores are rated severe to very severe; OR
- (ii) the skin area affected is a 50% or greater change or the area affected is 30% or more of the face, palm of a hand or sole of a foot, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

(3) Applications for approval for completion of a course

Applications for a further 8 weeks of treatment to allow for completion of 24 weeks of therapy should be submitted with a PASI assessment.

The PASI assessment must be conducted after at least 12 weeks of treatment.

This assessment must be submitted to Department of Human Services (the Department) within 1 month of the completion of 12 weeks of treatment. Where a response assessment is not undertaken and submitted to the Department within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department on 1800 700 270 to discuss.

(4) Baseline measurements to determine response.

The Department will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for etanercept. However, prescribers may provide new baseline measurements any time that an initial or re-treatment authority is submitted and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of gaining approval for the remainder of 24 weeks treatment.

(5) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment course with etanercept following a break in PBS-subsidised etanercept therapy of at least 12 months, must requalify for treatment under the initial treatment restriction. The most recent PASI assessment must be no more than 1 month old at the time of application.

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment or Re-treatment (Whole body) - balance of first supply

Clinical criteria:

The treatment must be as systemic monotherapy; OR

The treatment must be in combination with methotrexate, **AND**

Patient must have received insufficient therapy under the Initial treatment (whole body) restriction for severe chronic plaque psoriasis to complete 16 weeks treatment; OR

Patient must have received insufficient therapy under the Re-treatment (whole body) restriction for severe chronic plaque psoriasis to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a dermatologist.

Authority required

TREATMENT OF PATIENTS UNDER 18 YEARS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing of etanercept under the Pharmaceutical Benefits Scheme (PBS) for patients under 18 years with severe chronic plaque psoriasis.

Applications for treatment of this condition will be limited to provide patients with a maximum of 24 weeks of therapy per course of treatment. A maximum of 16 weeks treatment with etanercept will be authorised for the primary application. The balance, a further 8 weeks treatment, will be authorised if the submitted Psoriasis Area and Severity Index (PASI) assessment demonstrates an adequate response to treatment. Where fewer than 3 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone.

Once a patient has failed to respond to treatment 2 times, they must have, at a minimum, a 12 month break. The length of a treatment break is measured from the date the most recent treatment was stopped to the date of the first application for initial treatment.

There are separate restrictions for treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made for patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy.

(2) Applications for approval for re-treatment.

Applications for re-treatment with etanercept should be made in the following situations:

- (i) a patient who has received prior PBS-subsidised etanercept and experiences a disease flare, and wishes to start a second or subsequent treatment course with etanercept following a break of less than 12 months in PBS-subsidised therapy; or
- (ii) a patient who has received and failed to respond to prior PBS-subsidised etanercept and wishes to start a second or subsequent treatment course following a break of less than 12 months in PBS-subsidised therapy.

For psoriasis affecting the whole body:

Patients are eligible for re-treatment due to disease flare if there is a 50% or greater change in the patients PASI score or the patient has a current PASI score of greater than 15, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

For psoriasis affecting the face, hand or foot:

Patients are eligible for re-treatment due to disease flare if:

- (i) all subscores are rated moderate to severe or 2 of the three subscores are rated severe to very severe; OR
- (ii) the skin area affected is a 50% or greater change or the area affected is 30% or more of the face, palm of a hand or sole of a foot, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

(3) Applications for approval for completion of a course

Applications for a further 8 weeks of treatment to allow for completion of 24 weeks of therapy should be submitted with a PASI assessment.

The PASI assessment must be conducted after at least 12 weeks of treatment.

This assessment must be submitted to Department of Human Services (the Department) within 1 month of the completion of 12 weeks of treatment. Where a response assessment is not undertaken and submitted to the Department within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department on 1800 700 270 to discuss.

(4) Baseline measurements to determine response.

The Department will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for etanercept. However, prescribers may provide new baseline measurements any time that an initial or re-treatment authority is submitted and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of gaining approval for the remainder of 24 weeks treatment.

(5) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment course with etanercept following a break in PBS-subsidised etanercept therapy of at least 12 months, must requalify for treatment under the initial treatment restriction. The most recent PASI assessment must be no more than 1 month old at the time of application.

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment or Re-treatment (Whole body) - completion of course

Clinical criteria:

The treatment must be as systemic monotherapy; OR

The treatment must be in combination with methotrexate, **AND**

Patient must have received 16 weeks treatment under the Initial treatment (whole body) restriction for severe chronic plaque psoriasis; OR

Patient must have received 16 weeks treatment under the Re-treatment (whole body) restriction for severe chronic plaque psoriasis, **AND**

Patient must have demonstrated an adequate response to treatment, **AND**

Patient must not receive more than 8 weeks of treatment with etanercept under this restriction.

Treatment criteria:

Must be treated by a dermatologist.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, when compared with the pre-etanercept treatment baseline value.

The authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) the completed current Psoriasis Area and Severity Index (PASI) calculation sheet including the date of assessment of the patient's condition.

The same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of gaining approval for the remainder of 24 weeks treatment.

A PASI assessment of the patient's response to the initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for a further 8 weeks of treatment, must be submitted no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept.

Authority required

TREATMENT OF PATIENTS UNDER 18 YEARS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing of etanercept under the Pharmaceutical Benefits Scheme (PBS) for patients under 18 years with severe chronic plaque psoriasis.

Applications for treatment of this condition will be limited to provide patients with a maximum of 24 weeks of therapy per course of treatment. A maximum of 16 weeks treatment with etanercept will be authorised for the primary application. The balance, a further 8 weeks treatment, will be authorised if the submitted Psoriasis Area and Severity Index (PASI) assessment demonstrates an adequate response to treatment. Where fewer than 3 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone.

Once a patient has failed to respond to treatment 2 times, they must have, at a minimum, a 12 month break. The length of a treatment break is measured from the date the most recent treatment was stopped to the date of the first application for initial treatment.

There are separate restrictions for treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made for patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy.

(2) Applications for approval for re-treatment.

Applications for re-treatment with etanercept should be made in the following situations:

(i) a patient who has received prior PBS-subsidised etanercept and experiences a disease flare, and wishes to start a second or subsequent treatment course with etanercept following a break of less than 12 months in PBS-subsidised therapy; or

(ii) a patient who has received and failed to respond to prior PBS-subsidised etanercept and wishes to start a second or subsequent treatment course following a break of less than 12 months in PBS-subsidised therapy.

For psoriasis affecting the whole body:

Patients are eligible for re-treatment due to disease flare if there is a 50% or greater change in the patients PASI score or the patient has a current PASI score of greater than 15, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

For psoriasis affecting the face, hand or foot:

Patients are eligible for re-treatment due to disease flare if:

(i) all subscores are rated moderate to severe or 2 of the three subscores are rated severe to very severe; OR

(ii) the skin area affected is a 50% or greater change or the area affected is 30% or more of the face, palm of a hand or sole of a foot, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

(3) Applications for approval for completion of a course

Applications for a further 8 weeks of treatment to allow for completion of 24 weeks of therapy should be submitted with a PASI assessment.

The PASI assessment must be conducted after at least 12 weeks of treatment.

This assessment must be submitted to Department of Human Services (the Department) within 1 month of the completion of 12 weeks of treatment. Where a response assessment is not undertaken and submitted to the Department within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department on 1800 700 270 to discuss.

(4) Baseline measurements to determine response.

The Department will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for etanercept. However, prescribers may provide new baseline measurements any time that an initial or re-treatment authority is submitted and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of gaining approval for the remainder of 24 weeks treatment.

(5) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment course with etanercept following a break in PBS-subsidised etanercept therapy of at least 12 months, must requalify for treatment under the initial treatment restriction. The most recent PASI assessment must be no more than 1 month old at the time of application.

Severe chronic plaque psoriasis

Treatment Phase: Re-treatment (Whole body)

Clinical criteria:

The treatment must be as systemic monotherapy; OR

The treatment must be in combination with methotrexate, **AND**

Patient must have a documented history of severe chronic plaque psoriasis of the whole body, **AND**

Patient must have received prior PBS-subsidised treatment with etanercept for this condition in the past 12 months, **AND**

Patient must have demonstrated a response to etanercept and experienced a disease flare; OR

Patient must not have failed more than once to achieve an adequate response with etanercept, **AND**

Patient must not receive more than 16 weeks of treatment with etanercept under this restriction.

Population criteria:

Patient must be under 18 years of age.

Treatment criteria:

Must be treated by a dermatologist.

A patient is eligible for re-treatment due to disease flare if there is a 50% or greater change in the patients PASI score or the patient has a current PASI score of greater than 15, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis in Patients Less Than 18 Years PBS Authority Application - Supporting Information which includes the following:

- (i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition; and
- (ii) details of prior etanercept treatment, including date ceased.

Where a patient has had a treatment break the length of the break is measured from the date the most recent treatment was stopped to the date of the application for further treatment.

Authority required

TREATMENT OF PATIENTS UNDER 18 YEARS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing of etanercept under the Pharmaceutical Benefits Scheme (PBS) for patients under 18 years with severe chronic plaque psoriasis.

Applications for treatment of this condition will be limited to provide patients with a maximum of 24 weeks of therapy per course of treatment. A maximum of 16 weeks treatment with etanercept will be authorised for the primary application. The balance, a further 8 weeks treatment, will be authorised if the submitted Psoriasis Area and Severity Index (PASI) assessment demonstrates an adequate response to treatment. Where fewer than 3 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone.

Once a patient has failed to respond to treatment 2 times, they must have, at a minimum, a 12 month break. The length of a treatment break is measured from the date the most recent treatment was stopped to the date of the first application for initial treatment.

There are separate restrictions for treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made for patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy.

(2) Applications for approval for re-treatment.

Applications for re-treatment with etanercept should be made in the following situations:

- (i) a patient who has received prior PBS-subsidised etanercept and experiences a disease flare, and wishes to start a second or subsequent treatment course with etanercept following a break of less than 12 months in PBS-subsidised therapy; or
- (ii) a patient who has received and failed to respond to prior PBS-subsidised etanercept and wishes to start a second or subsequent treatment course following a break of less than 12 months in PBS-subsidised therapy.

For psoriasis affecting the whole body:

Patients are eligible for re-treatment due to disease flare if there is a 50% or greater change in the patients PASI score or the patient has a current PASI score of greater than 15, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

For psoriasis affecting the face, hand or foot:

Patients are eligible for re-treatment due to disease flare if:

- (i) all subscores are rated moderate to severe or 2 of the three subscores are rated severe to very severe; OR
- (ii) the skin area affected is a 50% or greater change or the area affected is 30% or more of the face, palm of a hand or sole of a foot, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

(3) Applications for approval for completion of a course

Applications for a further 8 weeks of treatment to allow for completion of 24 weeks of therapy should be submitted with a PASI assessment.

The PASI assessment must be conducted after at least 12 weeks of treatment.

This assessment must be submitted to Department of Human Services (the Department) within 1 month of the completion of 12 weeks of treatment. Where a response assessment is not undertaken and submitted to the Department within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department on 1800 700 270 to discuss.

(4) Baseline measurements to determine response.

The Department will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for etanercept. However, prescribers may provide new baseline measurements any time that an initial or re-treatment authority is submitted and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of gaining approval for the remainder of 24 weeks treatment.

(5) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment course with etanercept following a break in PBS-subsidised etanercept therapy of at least 12 months, must requalify for treatment under the initial treatment restriction. The most recent PASI assessment must be no more than 1 month old at the time of application.

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment (Face, hand, foot)

Clinical criteria:

The treatment must be as systemic monotherapy; OR

The treatment must be in combination with methotrexate, **AND**

Patient must have the plaque or plaques of the face, or palm of hand or sole of foot present for at least 6 months from the time of initial diagnosis, **AND**

Patient must not have received any prior PBS-subsidised treatment with etanercept for this condition; OR

Patient must not have received any PBS-subsidised treatment with etanercept for this condition for at least 12 months, **AND** Patient must have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 2 of the following 3 treatments: (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or (ii) methotrexate at a dose of at least 10 mg or 10 mg per square metre weekly (whichever is lowest) for at least 6 weeks; and/or (iii) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks, **AND** Patient must not receive more than 16 weeks of treatment with etanercept under this restriction.

Population criteria:

Patient must be under 18 years of age and a parent or authorised guardian must have signed a patient acknowledgement.

Treatment criteria:

Must be treated by a dermatologist.

Where treatment with any of the above-mentioned drugs was contraindicated according to the relevant TGA-approved Product Information, or where phototherapy was contraindicated, details must be provided at the time of application.

Where intolerance to phototherapy, methotrexate and/or acitretin developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following criterion indicates failure to achieve an adequate response to prior treatment and must be demonstrated in a patient at the time of the application:

(a) Chronic plaque psoriasis classified as severe due to a plaque or plaques on the face, palm of a hand or sole of a foot where:

(i) at least 2 of the 3 Psoriasis Area and Severity Index (PASI) symptom subscores for erythema, thickness and scaling are rated as severe or very severe, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment; or

(ii) the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment;

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis in Patients Less Than 18 Years PBS Authority Application - Supporting Information Form which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets, and face, hand, foot area diagrams including the dates of assessment of the patient's condition

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the parent or authorised guardian signed patient and prescriber acknowledgements.

Where a patient has had a 12 month treatment break, the length of the break is measured from the date the most recent treatment was stopped to the date of the application to re-commence treatment.

Note

Details of acceptable toxicities including severity, associated with phototherapy, methotrexate and acitretin, can be found on the Department of Human Services website at www.humanservices.gov.au

Authority required

TREATMENT OF PATIENTS UNDER 18 YEARS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing of etanercept under the Pharmaceutical Benefits Scheme (PBS) for patients under 18 years with severe chronic plaque psoriasis.

Applications for treatment of this condition will be limited to provide patients with a maximum of 24 weeks of therapy per course of treatment. A maximum of 16 weeks treatment with etanercept will be authorised for the primary application. The balance, a further 8 weeks treatment, will be authorised if the submitted Psoriasis Area and Severity Index (PASI) assessment demonstrates an adequate response to treatment. Where fewer than 3 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone.

Once a patient has failed to respond to treatment 2 times, they must have, at a minimum, a 12 month break. The length of a treatment break is measured from the date the most recent treatment was stopped to the date of the first application for initial treatment.

There are separate restrictions for treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made for patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy.

(2) Applications for approval for re-treatment.

Applications for re-treatment with etanercept should be made in the following situations:

(i) a patient who has received prior PBS-subsidised etanercept and experiences a disease flare, and wishes to start a second or subsequent treatment course with etanercept following a break of less than 12 months in PBS-subsidised therapy; or

(ii) a patient who has received and failed to respond to prior PBS-subsidised etanercept and wishes to start a second or subsequent treatment course following a break of less than 12 months in PBS-subsidised therapy.

For psoriasis affecting the whole body:

Patients are eligible for re-treatment due to disease flare if there is a 50% or greater change in the patients PASI score or the patient has a current PASI score of greater than 15, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

For psoriasis affecting the face, hand or foot:

Patients are eligible for re-treatment due to disease flare if:

- (i) all subscores are rated moderate to severe or 2 of the three subscores are rated severe to very severe; OR
- (ii) the skin area affected is a 50% or greater change or the area affected is 30% or more of the face, palm of a hand or sole of a foot, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

(3) Applications for approval for completion of a course

Applications for a further 8 weeks of treatment to allow for completion of 24 weeks of therapy should be submitted with a PASI assessment.

The PASI assessment must be conducted after at least 12 weeks of treatment.

This assessment must be submitted to Department of Human Services (the Department) within 1 month of the completion of 12 weeks of treatment. Where a response assessment is not undertaken and submitted to the Department within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department on 1800 700 270 to discuss.

(4) Baseline measurements to determine response.

The Department will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for etanercept. However, prescribers may provide new baseline measurements any time that an initial or re-treatment authority is submitted and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of gaining approval for the remainder of 24 weeks treatment.

(5) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment course with etanercept following a break in PBS-subsidised etanercept therapy of at least 12 months, must requalify for treatment under the initial treatment restriction. The most recent PASI assessment must be no more than 1 month old at the time of application.

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment of Re-treatment (Face, hand, foot) - balance of first supply

Clinical criteria:

The treatment must be as systemic monotherapy; OR

The treatment must be in combination with methotrexate, **AND**

Patient must have received insufficient therapy under the Initial treatment (Face, hand, foot) restriction for severe chronic plaque psoriasis to complete 16 weeks treatment; OR

Patient must have received insufficient therapy under the Re-treatment (Face, hand, foot) restriction for severe chronic plaque psoriasis to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a dermatologist.

Note

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

TREATMENT OF PATIENTS UNDER 18 YEARS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing of etanercept under the Pharmaceutical Benefits Scheme (PBS) for patients under 18 years with severe chronic plaque psoriasis.

Applications for treatment of this condition will be limited to provide patients with a maximum of 24 weeks of therapy per course of treatment. A maximum of 16 weeks treatment with etanercept will be authorised for the primary application. The balance, a further 8 weeks treatment, will be authorised if the submitted Psoriasis Area and Severity Index (PASI) assessment demonstrates an adequate response to treatment. Where fewer than 3 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone.

Once a patient has failed to respond to treatment 2 times, they must have, at a minimum, a 12 month break. The length of a treatment break is measured from the date the most recent treatment was stopped to the date of the first application for initial treatment.

There are separate restrictions for treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made for patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy.

(2) Applications for approval for re-treatment.

Applications for re-treatment with etanercept should be made in the following situations:

(i) a patient who has received prior PBS-subsidised etanercept and experiences a disease flare, and wishes to start a second or subsequent treatment course with etanercept following a break of less than 12 months in PBS-subsidised therapy; or

(ii) a patient who has received and failed to respond to prior PBS-subsidised etanercept and wishes to start a second or subsequent treatment course following a break of less than 12 months in PBS-subsidised therapy.

For psoriasis affecting the whole body:

Patients are eligible for re-treatment due to disease flare if there is a 50% or greater change in the patients PASI score or the patient has a current PASI score of greater than 15, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

For psoriasis affecting the face, hand or foot:

Patients are eligible for re-treatment due to disease flare if:

(i) all subscores are rated moderate to severe or 2 of the three subscores are rated severe to very severe; OR

(ii) the skin area affected is a 50% or greater change or the area affected is 30% or more of the face, palm of a hand or sole of a foot, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

(3) Applications for approval for completion of a course

Applications for a further 8 weeks of treatment to allow for completion of 24 weeks of therapy should be submitted with a PASI assessment.

The PASI assessment must be conducted after at least 12 weeks of treatment.

This assessment must be submitted to Department of Human Services (the Department) within 1 month of the completion of 12 weeks of treatment. Where a response assessment is not undertaken and submitted to the Department within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department on 1800 700 270 to discuss.

(4) Baseline measurements to determine response.

The Department will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for etanercept. However, prescribers may provide new baseline measurements any time that an initial or re-treatment authority is submitted and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of gaining approval for the remainder of 24 weeks treatment.

(5) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment course with etanercept following a break in PBS-subsidised etanercept therapy of at least 12 months, must requalify for treatment under the initial treatment restriction. The most recent PASI assessment must be no more than 1 month old at the time of application.

Severe chronic plaque psoriasis

Treatment Phase: Initial treatment or Re-treatment (Face, hand, foot) - completion of course

Clinical criteria:

The treatment must be as systemic monotherapy; OR

The treatment must be in combination with methotrexate, **AND**

Patient must have received 16 weeks treatment under the Initial treatment (Face, hand, foot) restriction for severe chronic plaque psoriasis; OR

Patient must have received 16 weeks treatment under the Re-treatment (Face, hand, foot) restriction for severe chronic plaque psoriasis, **AND**

Patient must have demonstrated an adequate response to treatment, **AND**

Patient must not receive more than 8 weeks of treatment with etanercept under this restriction.

Treatment criteria:

Must be treated by a dermatologist.

An adequate response to treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

(i) a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or

(ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) the completed current Psoriasis Area and Severity Index (PASI) calculation sheet including the date of assessment of the patient's condition.

The same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of gaining approval for the remainder of 24 weeks treatment.

A PASI assessment of the patient's response to the initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for a further 8 weeks of treatment, must be submitted no later than 1 month from the date of completion

of this initial course of treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept.

Note

It is recommended that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their initial 16 week treatment course to ensure continuity of treatment for those patients who meet the eligibility criterion for a further 8 weeks of PBS-subsidised etanercept treatment.

In circumstances where it is not possible to submit a response assessment after 12 weeks of treatment, please call the Department of Human Services on 1800 700 270 to discuss.

The Department of Human Services will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for etanercept.

Authority required

TREATMENT OF PATIENTS UNDER 18 YEARS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing of etanercept under the Pharmaceutical Benefits Scheme (PBS) for patients under 18 years with severe chronic plaque psoriasis.

Applications for treatment of this condition will be limited to provide patients with a maximum of 24 weeks of therapy per course of treatment. A maximum of 16 weeks treatment with etanercept will be authorised for the primary application. The balance, a further 8 weeks treatment, will be authorised if the submitted Psoriasis Area and Severity Index (PASI) assessment demonstrates an adequate response to treatment. Where fewer than 3 repeats are requested at the time of the authority application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone.

Once a patient has failed to respond to treatment 2 times, they must have, at a minimum, a 12 month break. The length of a treatment break is measured from the date the most recent treatment was stopped to the date of the first application for initial treatment.

There are separate restrictions for treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made for patients who have received no prior PBS-subsidised biological treatment and wish to commence such therapy.

(2) Applications for approval for re-treatment.

Applications for re-treatment with etanercept should be made in the following situations:

(i) a patient who has received prior PBS-subsidised etanercept and experiences a disease flare, and wishes to start a second or subsequent treatment course with etanercept following a break of less than 12 months in PBS-subsidised therapy; or

(ii) a patient who has received and failed to respond to prior PBS-subsidised etanercept and wishes to start a second or subsequent treatment course following a break of less than 12 months in PBS-subsidised therapy.

For psoriasis affecting the whole body:

Patients are eligible for re-treatment due to disease flare if there is a 50% or greater change in the patients PASI score or the patient has a current PASI score of greater than 15, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

For psoriasis affecting the face, hand or foot:

Patients are eligible for re-treatment due to disease flare if:

(i) all subscores are rated moderate to severe or 2 of the three subscores are rated severe to very severe; OR

(ii) the skin area affected is a 50% or greater change or the area affected is 30% or more of the face, palm of a hand or sole of a foot, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

(3) Applications for approval for completion of a course

Applications for a further 8 weeks of treatment to allow for completion of 24 weeks of therapy should be submitted with a PASI assessment.

The PASI assessment must be conducted after at least 12 weeks of treatment.

This assessment must be submitted to Department of Human Services (the Department) within 1 month of the completion of 12 weeks of treatment. Where a response assessment is not undertaken and submitted to the Department within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call the Department on 1800 700 270 to discuss.

(4) Baseline measurements to determine response.

The Department will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for etanercept. However, prescribers may provide new baseline measurements any time that an initial or re-treatment authority is submitted and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of gaining approval for the remainder of 24 weeks treatment.

(5) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment course with etanercept following a break in PBS-subsidised etanercept therapy of at least 12 months, must requalify for treatment under the initial treatment restriction. The most recent PASI assessment must be no more than 1 month old at the time of application.

Severe chronic plaque psoriasis

Treatment Phase: Re-treatment (Face, hand, foot)

Clinical criteria:

The treatment must be as systemic monotherapy; OR

The treatment must be in combination with methotrexate, **AND**

Patient must have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, **AND**

Patient must have received prior PBS-subsidised treatment with etanercept for this condition in the past 12 months, **AND**

Patient must have demonstrated a response to etanercept and experienced a disease flare; OR

Patient must not have failed more than once to achieve an adequate response with etanercept, **AND**

Patient must not receive more than 16 weeks of treatment with etanercept under this restriction.

Population criteria:

Patient must be under 18 years of age.

Treatment criteria:

Must be treated by a dermatologist.

A patient is eligible for re-treatment due to disease flare if:

(i) all subscores are rated moderate to severe or 2 of the 3 subscores are rated severe to very severe; or

(ii) the skin area affected is a 50% or greater change or the area affected is 30% or more of the face, palm of a hand or sole of a foot, compared to the most recent response assessment following cessation of the most recent 24 weeks of PBS-subsidised etanercept.

The authority application must be made in writing and must include :

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis in Patients Less Than 18 Years PBS Authority Application - Supporting Information which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition; and

(ii) details of prior etanercept treatment, including date ceased.

Where a patient has had a treatment break the length of the break is measured from the date the most recent treatment was stopped to the date of the application for further treatment.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

1964J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1774.71	37.70	Enbrel [PF]

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

1963H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1774.71	37.70	Enbrel [PF]

etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

1954W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	3	..	*1774.70	37.70	Enbrel [PF]

▪ **GOLIMUMAB**

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have demonstrated an adequate response to treatment with this drug, **AND**

Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) a completed authority prescription form and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

All applications for continuing treatment with golimumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with golimumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with golimumab.

If a patient fails to demonstrate a response to treatment with golimumab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note

Special Pricing Arrangements apply.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

- a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,

- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and

- once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs

for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who

has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further

details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the

month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing

DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe

3428K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1777.63	37.70	Simponi [JC]

golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe

3429L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1777.63	37.70	Simponi [JC]

■ GOLIMUMAB

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of active ankylosing spondylitis, **AND**

Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**

Patient must have demonstrated an adequate response to treatment with this drug.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

An adequate response is defined as an improvement from baseline of at least 2 of the BASDAI and 1 of the following:

- (a) an ESR measurement no greater than 25 mm per hour; or
- (b) a CRP measurement no greater than 10 mg per L; or
- (c) an ESR or CRP measurement reduced by at least 20% from baseline.

Where only 1 acute phase reactant measurement is supplied in the first application for PBS-subsidised treatment, that same marker must be measured and supplied in all subsequent continuing treatment applications.

The authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

All measurements provided must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment following an initial treatment course it must be made following a minimum of 12 weeks of treatment with this drug. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab and infliximab for adult patients with active ankylosing spondylitis.

Where the term 'bDMARD' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 5 bDMARDs at any 1 time.

From 1 March 2007, under the PBS, all patients will be able to commence a treatment cycle where they may trial PBS-subsidised bDMARDs without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.

A patient who received PBS-subsidised bDMARD treatment prior to 1 March 2007 is considered to be in their first cycle as of 1 March 2007.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once. A patient who, prior to 1 March 2007, was authorised to receive PBS-subsidised initial treatment for ankylosing spondylitis with the same agent twice, is exempt from this condition in respect of applications approved prior to 1 March 2007.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

- (ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 2).

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.

However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.

For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment – balance of supply

Clinical criteria:

Patient must have a documented history of active ankylosing spondylitis, **AND**

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe

3436W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1777.63	37.70	Simponi [JC]

golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe

3437X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1777.63	37.70	Simponi [JC]

■ GOLIMUMAB

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Clinical criteria:

Patient must have severe active rheumatoid arthritis, **AND**

Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**

Patient must not have failed previous PBS-subsidised treatment with this drug for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDs which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

If methotrexate is contraindicated according to the TGA-approved Product Information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialed, their doses and duration of treatment, and all relevant contraindications and/or intolerances.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and
- (3) a signed patient acknowledgement.

Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility

for continuing treatment, must be submitted no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

- (a) a total active joint count of at least 20 active (swollen and tender) joints; or
- (b) at least 4 active joints from the following list of major joints:
 - (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - (ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note

The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:

- (a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
- (b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;

- (c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months)

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

The authority application must be made in writing and must include:

- (a) a completed authority prescription form and
- (b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

Application for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note

Special Pricing Arrangements apply.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alpha antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alpha antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

- a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,

- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and

- once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alpha antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a

minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply.

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe

3426H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1777.63	37.70	Simponi [JC]

golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe

3427J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1777.63	37.70	Simponi [JC]

▪ **GOLIMUMAB**

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active psoriatic arthritis, **AND**

Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**

Patient must demonstrate, at the time of application, an adequate response to treatment with this drug, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab or infliximab.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Note

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab and infliximab for adult patients with severe active psoriatic arthritis.

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.

Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab and infliximab only.

Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restriction for each agent.

Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].

The duration of the break in therapy will be measured from the date the last approval for PBS-subsidised treatment was granted in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.

Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.

Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle. There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe active psoriatic arthritis.

(1) Initial treatment.

Applications for initial treatment should be made where:

- (i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and
- (ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and
- (iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 2).

All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept and golimumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), and 22 weeks of therapy for infliximab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.

Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

Grandfather patients - certolizumab pegol only.

For patients who commenced treatment with certolizumab pegol for psoriatic arthritis prior to 1 April 2015, applications for

initial PBS-subsidised treatment as continuing therapy may be made under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with any biological agent prior to PBS listing of that agent.

Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment for all agents. Approval will be based on the criteria included in the relevant restriction.

(2) Continuing treatment.

Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

(3) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.

Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.

Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:

- (i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
- (ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
- (iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.

To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the approved authority prescription or remaining repeats for the biological agent the patient is ceasing.

(4) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.

(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment with respect to both the indices of disease severity. Patients must have received treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment - balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe

3432P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1777.63	37.70	Simponi [JC]

golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe

3433Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1777.63	37.70	Simponi [JC]

■ GOLIMUMAB**Authority required**

Active ankylosing spondylitis

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

The condition must be radiographically (plain X-ray) confirmed Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis, **AND**

Patient must not have received any PBS-subsidised treatment with either adalimumab, certolizumab pegol, etanercept, golimumab or infliximab in this treatment cycle, **AND**

Patient must have at least 2 of the following: (i) low back pain and stiffness for 3 or more months that is relieved by exercise but not by rest; or (ii) limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by a score of at least 1 on each of the lumbar flexion and lumbar side flexion measurements of the Bath Ankylosing Spondylitis Metrology Index (BASMI); or (iii) limitation of chest expansion relative to normal values for age and gender, **AND**

Patient must have failed to achieve an adequate response following treatment with at least 2 non-steroidal anti-inflammatory drugs (NSAIDs), whilst completing an appropriate exercise program, for a total period of 3 months.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

The application must include details of the NSAIDs trialled, their doses and duration of treatment.

If the NSAID dose is less than the maximum recommended dose in the relevant TGA-approved Product Information, the application must include the reason a higher dose cannot be used.

If treatment with NSAIDs is contraindicated according to the relevant TGA-approved Product Information, the application must provide details of the contraindication.

If intolerance to NSAID treatment develops during the relevant period of use which is of a severity to necessitate permanent treatment withdrawal, the application must provide details of the nature and severity of this intolerance.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of the initial application:

(a) a Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 4 on a 0-10 scale; **AND**

(b) an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 10 mg per L.

The BASDAI must be determined at the completion of the 3 month NSAID and exercise trial, but prior to ceasing NSAID treatment. The BASDAI must be no more than 1 month old at the time of initial application.

Both ESR and CRP measures should be provided with the initial treatment application and both must be no more than 1 month old. If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reason this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form which must include the following:

(i) a copy of the radiological report confirming Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis; and

(ii) a completed BASDAI Assessment Form; and

(iii) a completed Exercise Program Self Certification Form included in the supporting information form; and

(iv) a signed patient acknowledgment.

The assessment of the patient's response to the initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted no later than 4 weeks from the cessation of that treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

A maximum of 16 weeks of treatment with this drug will be approved under this criterion.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) was approved in this cycle and the date of the first application under a new cycle.

Note

Details of the toxicities, including severity, which will be accepted for the purposes of administering this restriction can be found on the Department of Human Services website at www.humanservices.gov.au

For details on the appropriate minimum exercise program that will be accepted for the purposes of administering this restriction, please refer to the Department of Human Services website at www.humanservices.gov.au

Authority required

Ankylosing spondylitis

Treatment Phase: Initial 2 (change or recommencement for all patients)

Clinical criteria:

Patient must have a documented history of active ankylosing spondylitis, **AND**

Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition in this treatment cycle, **AND**

Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle, **AND**

Patient must be eligible to receive further bDMARD therapy.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

Where the most recent course of PBS-subsidised bDMARD treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised bDMARD therapy or, under this restriction, for patients who have received previous PBS-subsidised bDMARD therapy) the patient must have been assessed for response to that course following a minimum of 12 weeks of treatment. These assessments must be provided to the Department of Human Services no later than 4 weeks from the date the course was ceased. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, patients must have been assessed for response, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

A maximum of 16 weeks of treatment with this drug will be approved under this criterion.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab and infliximab for adult patients with active ankylosing spondylitis.

Where the term 'bDMARD' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 5 bDMARDs at any 1 time.

From 1 March 2007, under the PBS, all patients will be able to commence a treatment cycle where they may trial PBS-subsidised bDMARDs without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.

A patient who received PBS-subsidised bDMARD treatment prior to 1 March 2007 is considered to be in their first cycle as of 1 March 2007.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once. A patient who, prior to 1 March 2007, was authorised to receive PBS-subsidised initial treatment for ankylosing spondylitis with the same agent twice, is exempt from this condition in respect of applications approved prior to 1 March 2007.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
- (ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 2).

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.

However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.

For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Authority required

Ankylosing spondylitis

Treatment Phase: Initial treatment – Initial 1 (new patients) or Initial 2 (change or recommencement for all patients) – balance of supply

Clinical criteria:

Patient must have active, or a documented history of active, ankylosing spondylitis, **AND**

Patient must have received insufficient therapy with this drug under the Initial 1 (new patients) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement for all patients) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe

3434R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1777.63	37.70	Simponi [JC]

golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe

3435T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1777.63	37.70	Simponi [JC]

■ GOLIMUMAB

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

Patient must have severe active psoriatic arthritis, **AND**

Patient must have received no prior PBS-subsidised treatment with a biological agent for this condition; OR

Patient must have received no PBS-subsidised treatment with a biological agent for at least 5 years if they have previously received PBS-subsidised treatment with a biological agent for this condition, **AND**

Patient must have failed to achieve an adequate response to methotrexate at a dose of at least 20 mg weekly for a minimum period of 3 months, **AND**

Patient must have failed to achieve an adequate response to sulfasalazine at a dose of at least 2 g per day for a minimum period of 3 months; OR

Patient must have failed to achieve an adequate response to leflunomide at a dose of up to 20 mg daily for a minimum period of 3 months, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab or infliximab.

Where treatment with methotrexate, sulfasalazine or leflunomide is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

Where intolerance to treatment with methotrexate, sulfasalazine or leflunomide developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following initiation criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; and

either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

Note

Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 3 months treatment with methotrexate and 3 months treatment with sulfasalazine or leflunomide can be found on the Department of Human Services website (www.humanservices.gov.au)

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 2 (change or recommencement of treatment)

Clinical criteria:

Patient must have a documented history of severe active psoriatic arthritis, **AND**

Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**

Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents within this Treatment Cycle, **AND**

Patient must not have failed, or ceased to respond to, PBS-subsidised treatment with this drug during the current Treatment Cycle, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab or infliximab.

The authority application must be made in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has previously received PBS-subsidised treatment with this drug within this Treatment Cycle and who wishes to recommence therapy with this drug within this same Cycle, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug.

Where the most recent course of PBS-subsidised treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised biological therapy or, under this restriction, for patients who have received previous PBS-subsidised biological therapy), the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must have been submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment was not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

- (a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or
- (b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:
 - (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - (ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note

The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab and infliximab for adult patients with severe active psoriatic arthritis.

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.

Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab and infliximab only.

Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restriction for each agent.

Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].

The duration of the break in therapy will be measured from the date the last approval for PBS-subsidised treatment was granted in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.

Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.

Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe active psoriatic arthritis.

(1) Initial treatment.

Applications for initial treatment should be made where:

- (i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and
- (ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and
- (iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 2).

All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept and golimumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), and 22 weeks of therapy for infliximab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.

Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

Grandfather patients - certolizumab pegol only.

For patients who commenced treatment with certolizumab pegol for psoriatic arthritis prior to 1 April 2015, applications for initial PBS-subsidised treatment as continuing therapy may be made under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with any biological agent prior to PBS listing of that agent.

Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment for all agents. Approval will be based on the criteria included in the relevant restriction.

(2) Continuing treatment.

Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

(3) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.

Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.

Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:

- (i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
- (ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
- (iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.

To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is

important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the approved authority prescription or remaining repeats for the biological agent the patient is ceasing.

(4) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.

(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment with respect to both the indices of disease severity. Patients must have received treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2 (change or recommencement of treatment) - balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe

3430M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1777.63	37.70	Simponi [JC]

golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe

3431N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	1777.63	37.70	Simponi [JC]

Interleukin inhibitors

■ USTEKINUMAB

Authority required

Continuing treatment (Whole body)

Continuing PBS-subsidised treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over:

(a) who have a documented history of severe chronic plaque psoriasis; and

(b) whose most recent course of PBS-subsidised biological treatment for this condition in this Treatment Cycle was with ustekinumab; and

(c) who have demonstrated an adequate response to their most recent course of treatment with ustekinumab.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-biological treatment baseline value for this Treatment Cycle.

This assessment must be provided to Medicare Australia no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with ustekinumab, the assessment of response must be after a minimum of 12 weeks of treatment with an initial course.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet along with the date of the assessment of the patient's condition.

The most recent PASI assessment must be no more than 1 month old at the time of application.

Approval will be based on the PASI assessment of response to the most recent course of treatment with ustekinumab.

A maximum of 24 weeks of treatment with ustekinumab will be authorised under this restriction.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single injection. Up to a maximum of 1 repeat will be authorised.

Where fewer than 1 repeat is requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for continuing authority applications, or for treatment that would otherwise extend the treatment period beyond 24 weeks.

A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with ustekinumab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised ustekinumab treatment.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Authority required

Continuing treatment (Face, hand, foot)

Continuing PBS-subsidised treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over:

- (a) who have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot; and
- (b) whose most recent course of PBS-subsidised biological treatment for this condition in this Treatment Cycle was with ustekinumab; and
- (c) who have demonstrated an adequate response to treatment with ustekinumab.

An adequate response to ustekinumab treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

- (i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or
- (ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

This assessment must be provided to Medicare Australia no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with ustekinumab, the assessment of response must be after a minimum of 12 weeks of treatment with an initial course.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet and face, hand, foot area diagrams along with the date of the assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)].

The most recent PASI assessment must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with ustekinumab will be authorised under this restriction.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single injection. Up to a maximum of 1 repeat will be authorised.

Where fewer than 1 repeat is requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for continuing authority applications, or for treatment that would otherwise extend the treatment period beyond 24 weeks.

A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to

have failed to respond to treatment with ustekinumab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised ustekinumab treatment.

The PASI assessment for continuing treatment must be performed on the same affected area assessed at baseline.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle

Note

Any queries concerning the arrangements to prescribe ustekinumab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe ustekinumab should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab and ustekinumab, for adult patients with severe chronic plaque psoriasis.

Therefore, where the term 'biological agents' appears in the following NOTES and restrictions, it only refers to adalimumab, etanercept, infliximab and ustekinumab.

From 1 March 2010, all patients will be able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial adalimumab, etanercept, infliximab or ustekinumab without having to meet the initial treatment criteria, that is they will not need to experience a disease flare when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

A patient who received PBS-subsidised biological agent treatment for chronic plaque psoriasis prior to 1 March 2010 is considered to be in their first Cycle as of 1 March 2010.

Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.

Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment. A patient who, prior to 1 March 2010, was authorised to receive PBS-subsidised initial treatment for chronic plaque psoriasis with the same agent twice, is exempt from this condition in respect of applications approved prior to 1 March 2010.

Patients must be assessed for response to each course of continuing treatment according to the criteria included in the relevant continuing treatment restriction.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.

Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe chronic plaque psoriasis after 1 March 2010.

There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made in the following situations:

- (i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
- (ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
- (iii) patients who wish to re-commence treatment following a break in PBS-subsidised therapy with that agent (Initial 2).

All applications for initial treatment will be limited to provide for a maximum of 16 weeks of treatment in the case of adalimumab and etanercept, 22 weeks of treatment in the case of infliximab and 28 weeks of treatment in the case of ustekinumab.

(2) Assessment of response to initial treatment.

When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to Medicare Australia within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.

(3) Application for continuing treatment.

Following the completion of an initial treatment course of a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.

For second and subsequent courses of PBS-subsidised treatment with adalimumab, etanercept, infliximab or ustekinumab it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Where a response assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to sustain a response to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

(4) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.

Patients who commenced treatment with adalimumab prior to 1 June 2009 or ustekinumab prior to 1 March 2010 access these interchangeability arrangements in the same way as patients who have not.

To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the approved authority prescription or remaining repeats for the agent being ceased.

(5) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatment applications.

(6) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

No applications for increased repeats will be authorised.

Special Pricing Arrangements apply.

ustekinumab 45 mg/0.5 mL injection, 1 x 0.5 mL vial

9305R

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	1	..	4601.76	37.70	Stelara [JC]

■ USTEKINUMAB

Authority required

Initial treatment [Initial 1, Whole body (New patients — No prior biological agent)]

Initial treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over who:

- (a) have severe chronic plaque psoriasis where lesions have been present for at least 6 months from the time of initial diagnosis; and
- (b) have not received any prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle; and
- (c) have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (whole body); and
- (d) have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments:
 - (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or
 - (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or
 - (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or
 - (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks.

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity to necessitate permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of acceptable

toxicities including severity, associated with phototherapy, methotrexate, cyclosporin and acitretin, can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criterion indicates failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

- (a) A current Psoriasis Area and Severity Index (PASI) score of greater than 15, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.
- (b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.
- (c) The most recent PASI assessment must be no more than 1 month old at the time of application.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] and
 - (ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and
 - (iii) the signed patient and prescriber acknowledgements.

A maximum of 28 weeks of treatment with ustekinumab will be authorised under this restriction.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single injection. Up to a maximum of 2 repeats will be authorised.

Where fewer than 2 repeats are requested at the time of the initial application, authority approvals for sufficient repeats to complete a maximum of 28 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period beyond 28 weeks.

A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with ustekinumab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised ustekinumab treatment

Authority required

Initial or re-Treatment [Initial 2, Whole body (Received prior biological agent under PBS)]

Treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over who:

- (a) have a documented history of severe chronic plaque psoriasis; and
- (b) have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle; and
- (c) have not failed PBS-subsidised therapy with ustekinumab for the treatment of this condition in the current Treatment Cycle.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] and
 - (ii) details of prior biological treatment, including dosage, date and duration of treatment.

Applications for patients who have demonstrated a response to PBS-subsidised ustekinumab treatment within this Treatment Cycle and who wish to re-commence ustekinumab treatment within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised ustekinumab treatment has been submitted to Medicare Australia within 1 month of cessation of treatment.

A maximum of 28 weeks of treatment with ustekinumab will be authorised under this restriction.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single injection. Up to a maximum of 2 repeats will be authorised.

Where fewer than 2 repeats are requested at the time of the initial application, authority approvals for sufficient repeats to complete a maximum of 28 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period beyond 28 weeks.

A PASI assessment of the patient's response to this course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with ustekinumab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised ustekinumab treatment.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle

Authority required

Initial treatment [Initial 1, Face, hand, foot (New patients — No prior biological agent)]

Initial treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over who:

- (a) have severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis; and
- (b) have not received any prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle; and

(c) have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (face, hand, foot); and

(d) have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments:

- (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or
- (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or
- (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or
- (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks.

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity to necessitate permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of acceptable toxicities including severity, associated with phototherapy, methotrexate, cyclosporin and acitretin, can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criterion indicates failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

(a) Chronic plaque psoriasis classified as severe due to a plaque or plaques on the face, palm of a hand or sole of a foot where:

(i) at least 2 of the 3 Psoriasis Area and Severity Index (PASI) symptom subscores for erythema, thickness and scaling are rated as severe or very severe, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment; or

(ii) the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]]; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

A maximum of 28 weeks of treatment with ustekinumab will be authorised under this restriction.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single injection. Up to a maximum of 2 repeats will be authorised.

Where fewer than 2 repeats are requested at the time of the initial application, authority approvals for sufficient repeats to complete a maximum of 28 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period beyond 28 weeks.

A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with ustekinumab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised ustekinumab treatment.

The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline

Authority required

Initial or re-Treatment [Initial 2, Face, hand, foot (Received prior biological agent under PBS)]

Treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over who:

- (a) have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot; and
- (b) have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle; and
- (c) have not failed PBS-subsidised therapy with ustekinumab for the treatment of this condition in the current Treatment Cycle.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] and
 - (ii) details of prior biological treatment, including dosage, date and duration of treatment.

Applications for patients who have demonstrated a response to PBS-subsidised ustekinumab treatment within this Treatment Cycle and who wish to re-commence ustekinumab treatment within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised ustekinumab treatment has been submitted to Medicare Australia within 1 month of cessation of treatment.

A maximum of 28 weeks of treatment with ustekinumab will be authorised under this restriction.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single injection. Up to a maximum of 2 repeats will be authorised.

Where fewer than 2 repeats are requested at the time of the initial application, authority approvals for sufficient repeats to complete a maximum of 28 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period beyond 28 weeks.

A PASI assessment of the patient's response to this course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with ustekinumab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised ustekinumab treatment.

The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle

Note

Any queries concerning the arrangements to prescribe ustekinumab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe ustekinumab should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab and ustekinumab, for adult patients with severe chronic plaque psoriasis. Therefore, where the term 'biological agents' appears in the following NOTES and restrictions, it only refers to adalimumab, etanercept, infliximab and ustekinumab.

From 1 March 2010, all patients will be able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial adalimumab, etanercept, infliximab or ustekinumab without having to meet the initial treatment criteria, that is they will not need to experience a disease flare when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

A patient who received PBS-subsidised biological agent treatment for chronic plaque psoriasis prior to 1 March 2010 is considered to be in their first Cycle as of 1 March 2010.

Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.

Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological

agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment. A patient who, prior to 1 March 2010, was authorised to receive PBS-subsidised initial treatment for chronic plaque psoriasis with the same agent twice, is exempt from this condition in respect of applications approved prior to 1 March 2010.

Patients must be assessed for response to each course of continuing treatment according to the criteria included in the relevant continuing treatment restriction.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.

Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe chronic plaque psoriasis after 1 March 2010.

There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made in the following situations:

- (i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
- (ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
- (iii) patients who wish to re-commence treatment following a break in PBS-subsidised therapy with that agent (Initial 2).

All applications for initial treatment will be limited to provide for a maximum of 16 weeks of treatment in the case of adalimumab and etanercept, 22 weeks of treatment in the case of infliximab and 28 weeks of treatment in the case of ustekinumab.

(2) Assessment of response to initial treatment.

When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to Medicare Australia within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.

(3) Application for continuing treatment.

Following the completion of an initial treatment course of a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.

For second and subsequent courses of PBS-subsidised treatment with adalimumab, etanercept, infliximab or ustekinumab it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Where a response assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to sustain a response to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

(4) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.

Patients who commenced treatment with adalimumab prior to 1 June 2009 or ustekinumab prior to 1 March 2010 access these interchangeability arrangements in the same way as patients who have not.

To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the approved authority prescription or remaining repeats for the agent being ceased.

(5) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatment applications.

(6) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction

and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

No applications for increased repeats will be authorised.

Special Pricing Arrangements apply.

ustekinumab 45 mg/0.5 mL injection, 1 x 0.5 mL vial

9304Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	4601.76	37.70	Stelara [JC]

Calcineurin inhibitors

■ CYCLOSPORIN

Caution

Careful monitoring of patients is mandatory.

cyclosporin 10 mg capsule, 60

8657P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	3	..	*94.76	37.70	Neoral 10 [NV]

cyclosporin 100 mg capsule, 30

8660T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	3	..	*374.78	37.70	^a Cyclosporin Sandoz [SZ]	^a Neoral 100 [NV]

cyclosporin 100 mg/mL oral liquid, 50 mL

8661W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	3	..	*713.00	37.70	Neoral [NV]

cyclosporin 25 mg capsule, 30

8658Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	3	..	*97.58	37.70	^a Cyclosporin Sandoz [SZ]	^a Neoral 25 [NV]

cyclosporin 50 mg capsule, 30

8659R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	3	..	*195.72	37.70	^a Cyclosporin Sandoz [SZ]	^a Neoral 50 [NV]

■ TACROLIMUS

Caution

Careful monitoring of patients is mandatory.

tacrolimus 1 mg capsule, 100

8647D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	3	..	340.63	37.70	^a Pharmacor Tacrolimus 1 [CR] ^a Tacrolimus Sandoz [SZ]	^a Prograf [LL]

tacrolimus 1 mg capsule: modified release, 60 capsules

5300Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	214.27	37.70	Prograf XL [LL]

tacrolimus 5 mg capsule, 50

8648E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	3	..	827.61	37.70	^a Pharmacor Tacrolimus 5 [CR] ^a Tacrolimus Sandoz [SZ]	^a Prograf [LL]

tacrolimus 5 mg capsule: modified release, 30 capsules

5451X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	499.53	37.70	Prograf XL [LL]

tacrolimus 500 microgram capsule, 100

8646C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	3	..	180.49	37.70	^a Pharmacor Tacrolimus 0.5 [CR] ^a Tacrolimus Sandoz [SZ]	^a Prograf [LL]

tacrolimus 500 microgram capsule: modified release, 30 capsules

5299X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	58.88	37.70	Prograf XL [LL]

Other immunosuppressants

■ AZATHIOPRINE

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

azathioprine 25 mg tablet, 100

2688L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	26.22	27.37	^a APO-Azathioprine [TX] ^a Azathioprine Sandoz [SZ]	^a Azathioprine GH [GQ] ^a Imuran [AS]

azathioprine 50 mg tablet, 100

2687K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	39.88	37.70	^a APO-Azathioprine [TX] ^a Azapin [QA] ^a Azathioprine GH [GQ] ^a GenRx Azathioprine [GX] ^a Imuran [AS]	^a Azamun [GN] ^a Azathioprine AN [EA] ^a Azathioprine Sandoz [SZ] ^a Imazan [ER] ^a Thioprine 50 [AF]

■ METHOTREXATE

methotrexate 10 mg tablet, 15

2272N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	20.68	21.83	Methoblastin [PF]

methotrexate 2.5 mg tablet, 30

1622J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	13.46	14.61	^a Hospira Pty Limited [HH]	^a Methoblastin [PF]

■ METHOTREXATE

Restricted benefit

For patients requiring doses greater than 20 mg per week

methotrexate 10 mg tablet, 50

1623K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	51.58	37.70	Methoblastin [PF]

■ MUSCULO-SKELETAL SYSTEM

■ ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS

ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS, NON-STERIODS

Acetic acid derivatives and related substances

■ DICLOFENAC

diclofenac sodium 100 mg suppository, 20

1302M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP MW	2	3	..	*25.26	26.41	Voltaren 100 [NV]

diclofenac sodium 100 mg suppository, 20

5079H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	2	..	..	*25.26	26.41	Voltaren 100 [NV]

■ DICLOFENAC

Restricted benefit

Chronic arthropathies (including osteoarthritis) with an inflammatory component

Restricted benefit

Bone pain due to malignant disease

diclofenac sodium 25 mg tablet: enteric, 50 tablets

1299J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	3	..	*10.62	11.77	^a APO-Diclofenac [TX] ^a Clonac 25 [QA] ^a Diclofenac-GA [GN]	^a Chem mart Diclofenac [CH] ^a Diclofenac AN [EA] ^a Diclofenac Sandoz [SZ]

^a Fenac 25 [AF]^a Terry White Chemists
Diclofenac [TW]^B1.44 *12.06 11.77 ^a Voltaren 25 [NV]**diclofenac sodium 25 mg tablet: enteric, 50 tablets**

5076E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	2	..	..	*10.62	11.77	^a APO-Diclofenac [TX] ^a Clonac 25 [QA] ^a Diclofenac-GA [GN] ^a Fenac 25 [AF]	^a Chem mart Diclofenac [CH] ^a Diclofenac AN [EA] ^a Diclofenac Sandoz [SZ] ^a Terry White Chemists Diclofenac [TW]
			^B 1.44	*12.06	11.77	^a Voltaren 25 [NV]	

diclofenac sodium 50 mg tablet: enteric, 50 tablets

1300K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	9.44	10.59	^a APO-Diclofenac [TX] ^a Clonac 50 [QA] ^a Diclofenac-GA [GN] ^a Fenac [AF]	^a Chem mart Diclofenac [CH] ^a Diclofenac AN [EA] ^a Diclofenac Sandoz [SZ] ^a Terry White Chemists Diclofenac [TW]
			^B 1.43	10.87	10.59	^a Voltaren 50 [NV]	

diclofenac sodium 50 mg tablet: enteric, 50 tablets

5077F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	9.44	10.59	^a APO-Diclofenac [TX] ^a Clonac 50 [QA] ^a Diclofenac-GA [GN] ^a Fenac [AF]	^a Chem mart Diclofenac [CH] ^a Diclofenac AN [EA] ^a Diclofenac Sandoz [SZ] ^a Terry White Chemists Diclofenac [TW]
			^B 1.43	10.87	10.59	^a Voltaren 50 [NV]	

■ INDOMETHACIN**indomethacin 100 mg suppository, 20**

2757D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*22.84	23.99	Indocid [AS]

indomethacin 100 mg suppository, 20

5128X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	2	..	..	*22.84	23.99	Indocid [AS]

■ INDOMETHACIN**Restricted benefit**

Chronic arthropathies (including osteoarthritis) with an inflammatory component

Restricted benefit

Bone pain due to malignant disease

indomethacin 25 mg capsule, 50

2454E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*13.20	14.35	^a Arthrexin [AF]
			^B 4.64	*17.84	14.35	^a Indocid [AS]

indomethacin 25 mg capsule, 50

5126T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	2	..	..	*13.20	14.35	^a Arthrexin [AF]
			^B 4.64	*17.84	14.35	^a Indocid [AS]

Oxicams**■ MELOXICAM****Restricted benefit**

Symptomatic treatment of osteoarthritis

Restricted benefit

Symptomatic treatment of rheumatoid arthritis

Note

The use of meloxicam for the treatment of the following conditions is not subsidised through the PBS:

- (a) acute pain;
(b) soft tissue injury;

(c) arthrosis without an inflammatory component.

Pharmaceutical benefits that have the form meloxicam tablet 7.5 mg and pharmaceutical benefits that have the form meloxicam capsule 7.5 mg are equivalent for the purposes of substitution.

meloxicam 7.5 mg capsule, 30

8887R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	11.27	12.42	^a APO-Meloxicam [TX] ^a Melox 7.5 [GN] ^a Terry White Chemists Meloxicam [TW]	^a Chem mart Meloxicam [CH] ^a Movalis 7.5 [QA]
			^b 2.09	13.36	12.42	^a Mobic [BY]	

meloxicam 7.5 mg tablet, 30

8561N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	11.27	12.42	^a APO-Meloxicam [TX] ^a GenRx Meloxicam [GX] ^a Meloxibell [GQ] ^a Meloxicam-GA [GN] ^a Meloxicam Sandoz [SZ] ^a Moxicam 7.5 [AF] ^a Terry White Chemists Meloxicam 7.5 mg [TW]	^a Chem mart Meloxicam 7.5 mg [CH] ^a Meloxiauro 7.5 [DO] ^a Meloxicam AN [EA] ^a Meloxicam Ranbaxy [RA] ^a Movalis 7.5 [QA] ^a Pharmacor Meloxicam 7.5 [CR]
			^b 2.09	13.36	12.42	^a Mobic [BY]	

■ MELOXICAM

Restricted benefit

Symptomatic treatment of osteoarthritis

Restricted benefit

Symptomatic treatment of rheumatoid arthritis

Note

The use of meloxicam for the treatment of the following conditions is not subsidised through the PBS:

- (a) acute pain;
- (b) soft tissue injury;

(c) arthrosis without an inflammatory component.

Pharmaceutical benefits that have the form meloxicam tablet 15 mg and pharmaceutical benefits that have the form meloxicam capsule 15 mg are equivalent for the purposes of substitution.

meloxicam 15 mg capsule, 30

8888T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	13.35	14.50	^a APO-Meloxicam [TX] ^a Melox 15 [GN] ^a Terry White Chemists Meloxicam [TW]	^a Chem mart Meloxicam [CH] ^a Movalis 15 [QA]
			^b 2.08	15.43	14.50	^a Mobic [BY]	

meloxicam 15 mg tablet, 30

8562P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	13.35	14.50	^a APO-Meloxicam [TX] ^a GenRx Meloxicam [GX] ^a Meloxibell [GQ] ^a Meloxicam-GA [GN] ^a Meloxicam Sandoz [SZ] ^a Moxicam 15 [AF] ^a Terry White Chemists Meloxicam 15 mg [TW]	^a Chem mart Meloxicam 15 mg [CH] ^a Meloxiauro 15 [DO] ^a Meloxicam AN [EA] ^a Meloxicam Ranbaxy [RA] ^a Movalis 15 [QA] ^a Pharmacor Meloxicam 15 [CR]
			^b 2.08	15.43	14.50	^a Mobic [BY]	

■ PIROXICAM

Restricted benefit

Chronic arthropathies (including osteoarthritis) with an inflammatory component

piroxicam 10 mg capsule, 50

1897W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	12.54	13.69	^a Chem mart Piroxicam [CH]	^a GenRx Piroxicam [GX]

						^a Mobilis 10 [AF]	^a Terry White Chemists Piroxicam [TW]
			^B 3.08	15.62	13.69	^a Feldene [PF]	
piroxicam 10 mg capsule, 50							
5203W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	12.54	13.69	^a Chem mart Piroxicam [CH] ^a Mobilis 10 [AF]	^a GenRx Piroxicam [GX] ^a Terry White Chemists Piroxicam [TW]
			^B 3.08	15.62	13.69	^a Feldene [PF]	

piroxicam 10 mg tablet: dispersible, 50

1895R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
NP	1	3	..	12.54	13.69	Mobilis D-10 [AF]	

piroxicam 10 mg tablet: dispersible, 50

5201R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
DP	1	..	..	12.54	13.69	Mobilis D-10 [AF]	

piroxicam 20 mg capsule, 25

1898X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	12.26	13.41	^a Chem mart Piroxicam [CH] ^a Mobilis 20 [AF]	^a GenRx Piroxicam [GX] ^a Terry White Chemists Piroxicam [TW]
			^B 2.86	15.12	13.41	^a Feldene [PF]	

piroxicam 20 mg capsule, 25

5204X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	12.26	13.41	^a Chem mart Piroxicam [CH] ^a Mobilis 20 [AF]	^a GenRx Piroxicam [GX] ^a Terry White Chemists Piroxicam [TW]
			^B 2.86	15.12	13.41	^a Feldene [PF]	

piroxicam 20 mg tablet: dispersible, 25

1896T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
NP	1	3	..	12.26	13.41	^a Mobilis D-20 [AF]	
			^B 3.86	16.12	13.41	^a Feldene-D [PF]	

piroxicam 20 mg tablet: dispersible, 25

5202T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
DP	1	..	..	12.26	13.41	^a Mobilis D-20 [AF]	
			^B 3.86	16.12	13.41	^a Feldene-D [PF]	

*Propionic acid derivatives***■ IBUPROFEN****ibuprofen 400 mg tablet, 30**

3192B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
NP MW	1	..	..	9.53	10.68	Brufen [GO]	

ibuprofen 400 mg tablet, 30

5124Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
DP	1	..	..	9.53	10.68	Brufen [GO]	

■ IBUPROFEN**Restricted benefit**

Chronic arthropathies (including osteoarthritis) with an inflammatory component

Restricted benefit

Bone pain due to malignant disease

ibuprofen 400 mg tablet, 30

3190X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
NP	3	3	..	*15.07	16.22	Brufen [GO]	

ibuprofen 400 mg tablet, 30

5123P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
DP	3	..	..	*15.07	16.22	Brufen [GO]	

■ KETOPROFEN

ketoprofen 100 mg suppository, 20

1588N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*25.64	26.79	Orudis [SW]

ketoprofen 100 mg suppository, 20

5139L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	2	..	..	*25.64	26.79	Orudis [SW]

■ KETOPROFEN

Restricted benefit

Chronic arthropathies (including osteoarthritis) with an inflammatory component

ketoprofen 200 mg capsule: modified release, 28 capsules

1590Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	3	..	19.44	20.59	^a Oruvail SR [AV]
			^B 2.21	21.65	20.59	^a Orudis SR 200 [SW]

ketoprofen 200 mg capsule: modified release, 28 capsules

5136H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	19.44	20.59	^a Oruvail SR [AV]
			^B 2.21	21.65	20.59	^a Orudis SR 200 [SW]

■ NAPROXEN

Restricted benefit

Chronic arthropathies (including osteoarthritis) with an inflammatory component

Restricted benefit

Bone pain due to malignant disease

naproxen 1 g tablet: modified release, 28

1615B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	3	..	14.30	15.45	^a Proxen SR 1000 [MD]
			^B 1.29	15.59	15.45	^a Naprosyn SR1000 [RO]

naproxen 1 g tablet: modified release, 28

5179N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	14.30	15.45	^a Proxen SR 1000 [MD]
			^B 1.29	15.59	15.45	^a Naprosyn SR1000 [RO]

naproxen 250 mg tablet, 50

1674D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*13.68	14.83	^a Inza 250 [AF]
			^B 2.24	*15.92	14.83	^a Naprosyn [RO]

naproxen 250 mg tablet, 50

5176K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	2	..	..	*13.68	14.83	^a Inza 250 [AF]
			^B 2.24	*15.92	14.83	^a Naprosyn [RO]

naproxen 500 mg tablet, 50

1659H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	3	..	12.94	14.09	^a Inza 500 [AF]
			^B 1.28	14.22	14.09	^a Naprosyn [RO]

naproxen 500 mg tablet, 50

5177L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	12.94	14.09	^a Inza 500 [AF]
			^B 1.28	14.22	14.09	^a Naprosyn [RO]

naproxen 750 mg tablet: modified release, 28 tablets

1614Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	3	..	12.42	13.57	^a Proxen SR 750 [MD]
			^B 1.22	13.64	13.57	^a Naprosyn SR750 [RO]

naproxen 750 mg tablet: modified release, 28 tablets

5178M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	12.42	13.57	^a Proxen SR 750 [MD]

^B1.22 13.64 13.57 ^a Naprosyn SR750 [RO]

■ NAPROXEN

Authority required (STREAMLINED)

4159

Chronic arthropathies (including osteoarthritis)

Clinical criteria:

The condition must have an inflammatory component, **AND**

Patient must be unable to take a solid dose form of a non-steroidal anti-inflammatory agent.

Authority required (STREAMLINED)

4124

Bone pain

Clinical criteria:

The condition must be due to malignant disease, **AND**

Patient must be unable to take a solid dose form of a non-steroidal anti-inflammatory agent.

naproxen 125 mg/5 mL oral liquid, 474 mL

1658G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	3	..	127.96	37.70	Phebra Naproxen Suspension [PL]

■ NAPROXEN

Restricted benefit

Chronic arthropathies (including osteoarthritis) with an inflammatory component

Restricted benefit

Bone pain due to malignant disease

Note

Naproxen sodium 550 mg is approximately equivalent to 500 mg of naproxen acid.

naproxen sodium 550 mg tablet, 50

1795L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	3	..	13.11	14.26	^a Crysanal [MD]
			^B 2.17	15.28	14.26	^a Anaprox 550 [RO]

naproxen sodium 550 mg tablet, 50

5186Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	13.11	14.26	^a Crysanal [MD]
			^B 2.17	15.28	14.26	^a Anaprox 550 [RO]

Fenamates

■ MEFENAMIC ACID

Restricted benefit

Dysmenorrhoea

Restricted benefit

Menorrhagia

mefenamic acid 250 mg capsule, 50

1824B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	18.50	19.65	Ponstan [PF]

Coxibs

■ CELECOXIB

Restricted benefit

Osteoarthritis

Clinical criteria:

The treatment must be for symptomatic treatment.

Restricted benefit

Rheumatoid arthritis

Clinical criteria:

The treatment must be for symptomatic treatment.

Note

The use of this drug for the treatment of the following conditions is not subsidised through the PBS:

(a) acute pain;

(b) soft tissue injury;

(c) arthrosis without an inflammatory component.

celecoxib 100 mg capsule, 60

8439E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	28.51	29.66	^a APO-Celecoxib [TX]	^a Blooms the Chemist Celecoxib [IB]
						^a Celaxib [AF]	^a Celebrex [PF]
						^a Celecoxib Actavis [GN]	^a Celecoxib AN [EA]
						^a Celecoxib GH [GQ]	^a Celecoxib RBX [RA]
						^a Celecoxib Sandoz [SZ]	^a Celexi [QA]
						^a Chem mart Celecoxib [CH]	^a Kudeq [FZ]
						^a Terry White Chemists Celecoxib [TW]	

celecoxib 200 mg capsule, 30

8440F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	28.51	29.66	^a APO-Celecoxib [TX]	^a Blooms the Chemist Celecoxib [IB]
						^a Celaxib [AF]	^a Celebrex [PF]
						^a Celecoxib Actavis [GN]	^a Celecoxib AN [EA]
						^a Celecoxib GH [GQ]	^a Celecoxib RBX [RA]
						^a Celecoxib Sandoz [SZ]	^a Celexi [QA]
						^a Chem mart Celecoxib [CH]	^a Kudeq [FZ]
						^a Terry White Chemists Celecoxib [TW]	

SPECIFIC ANTIRHEUMATIC AGENTS*Quinolines***■ HYDROXYCHLOROQUINE****Note**

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

hydroxychloroquine sulfate 200 mg tablet, 100

1512N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	30.24	31.39	^a APO- Hydroxychloroquine [TX]	^a Chem mart Hydroxychloroquine [CH]
						^a Hydroxychloroquine Actavis [GN]	^a Hydroxychloroquine RBX [RA]
						^a Plaquenil [SW]	^a Terry White Chemists Hydroxychloroquine [TW]

*Gold preparations***■ AURANOFIN****Caution**

Regular blood and urine checks are essential.

AURANOFIN Capsule 3 mg, 60

2022K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	779.33	37.70	Ridaura [GH]

■ AURANOFIN**Caution**

Regular blood and urine checks are essential.

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

auranofin 3 mg tablet, 60

1095P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	63.89	37.70	Ridaura [GH]

■ AUROTHIOMALATE SODIUM**Caution**

Regular blood and urine checks are essential.

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

aurothiomalate sodium 10 mg/0.5 mL injection, 10 x 0.5 mL ampoules

2016D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	83.64	37.70	Myocrisin [SW]

aurothiomalate sodium 20 mg/0.5 mL injection, 10 x 0.5 mL ampoules

2017E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	125.03	37.70	Myocrisin [SW]

aurothiomalate sodium 50 mg/0.5 mL injection, 10 x 0.5 mL ampoules

2018F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	152.81	37.70	Myocrisin [SW]

*Penicillamine and similar agents***■ PENICILLAMINE****Caution**

Regular blood and urine checks are essential.

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

penicillamine 125 mg tablet, 100

2721F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	31.97	33.12	D-Penamine [AL]

penicillamine 250 mg tablet, 100

2838J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	53.63	37.70	D-Penamine [AL]

■ MUSCLE RELAXANTS**MUSCLE RELAXANTS, CENTRALLY ACTING AGENTS***Other centrally acting agents***■ BACLOFEN****baclofen 10 mg tablet, 100**

2729P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	19.59	20.74	^a Chem mart Baclofen [CH] ^a GenRx Baclofen [GX] ^a Stelax 10 [QA]	^a Clofen 10 [AF] ^a Lioresal 10 [NV] ^a Terry White Chemists Baclofen [TW]

baclofen 25 mg tablet, 100

2730Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	34.81	35.96	^a Chem mart Baclofen [CH] ^a GenRx Baclofen [GX] ^a Stelax 25 [QA]	^a Clofen 25 [AF] ^a Lioresal 25 [NV] ^a Terry White Chemists Baclofen [TW]

MUSCLE RELAXANTS, DIRECTLY ACTING AGENTS*Dantrolene and derivatives***■ DANTROLENE****Restricted benefit**

Treatment of chronic spasticity

dantrolene sodium 25 mg capsule, 100

1779P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	81.53	37.70	Dantrium [PF]

dantrolene sodium 50 mg capsule, 100

1780Q

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	2	..	82.15	37.70	Dantrium [PF]

■ **ANTIGOUT PREPARATIONS****ANTIGOUT PREPARATIONS***Preparations inhibiting uric acid production*■ **ALLOPURINOL****Note**

The dose should be adjusted in accordance with renal function.

allopurinol 300 mg tablet, 60

2604C

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	2	..	9.43	10.58	^a Allopurinol Sandoz [SZ] ^a APO-Allopurinol [TX] ^a GenRx Allopurinol [GX] ^a Terry White Chemists Allopurinol [TW]	^a Allosig [FM] ^a Chem mart Allopurinol [CH] ^a Progout 300 [AF]
		^B 4.00	13.43	10.58	^a Zyloprim [QA]	

■ **ALLOPURINOL****Note**

The dose should be adjusted in accordance with renal function.

For item codes 2600W and 1557Y, pharmaceutical benefits that have the form tablet 100 mg are equivalent for the purposes of substitution.

allopurinol 100 mg tablet, 100

1557Y

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
2	2	..	*11.32	12.47	^a Progout 100 [AF]

allopurinol 100 mg tablet, 200

2600W

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	2	..	11.31	12.46	^a Allopurinol Sandoz [SZ] ^a APO-Allopurinol [TX] ^a GenRx Allopurinol [GX]	^a Allosig [FM] ^a Chem mart Allopurinol [CH] ^a Terry White Chemists Allopurinol [TW]
		^B 3.99	15.30	12.46	^a Zyloprim [QA]	

Preparations increasing uric acid excretion■ **PROBENECID****probenecid 500 mg tablet, 100**

1940D

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	76.03	37.70	Pro-Cid [PL]

Preparations with no effect on uric acid metabolism■ **COLCHICINE****colchicine 500 microgram tablet, 30**

3410L

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	11.34	12.49	^a Lengout [LN] ^a Colgout [AS]
		^B 3.33	14.67	12.49	

■ **DRUGS FOR TREATMENT OF BONE DISEASES****DRUGS AFFECTING BONE STRUCTURE AND MINERALIZATION***Bisphosphonates*■ **ALENDRONATE****Restricted benefit**

Corticosteroid-induced osteoporosis

Clinical criteria:Patient must currently be on long-term (at least 3 months), high-dose (at least 7.5 mg per day prednisolone or equivalent) corticosteroid therapy, **AND**Patient must have a Bone Mineral Density (BMD) T-score of -1.5 or less, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition. The duration and dose of corticosteroid therapy together with the date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Restricted benefit

Osteoporosis

Clinical criteria:

Patient must have a Bone Mineral Density (BMD) T-score of -2.5 or less, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

Population criteria:

Patient must be aged 70 years or older.

The date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Note

Anti-resorptive agents in osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride, strontium ranelate and zoledronic acid.

Restricted benefit

Established osteoporosis

Clinical criteria:

Patient must have fracture due to minimal trauma, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

Note

Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride, strontium ranelate and zoledronic acid.

alendronate 70 mg tablet, 4

8511Y

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	14.01	15.16	^a Alendrobell 70mg [GQ] ^a Alendronate-GA [GN] ^a Alendro Once Weekly [QA] ^a Chem mart Alendronate 70mg [CH] ^a Fonat [AL] ^a Terry White Chemists Alendronate 70mg [TW]	^a Alendronate AN [EA] ^a Alendronate Sandoz [SZ] ^a APO-Alendronate [TX] ^a Densate 70 [DO] ^a Ossmax 70mg [RA]

■ CLODRONATE**Restricted benefit**

Hypercalcaemia of malignancy

Clinical criteria:

Patient must have a malignancy refractory to anti-neoplastic therapy.

Restricted benefit

Multiple myeloma

Restricted benefit

Bone metastases

Clinical criteria:

The condition must be due to breast cancer.

Note**Continuing Therapy Only:**

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

clodronate sodium 400 mg capsule, 100

8132B

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	2	..	334.42	37.70	Bonefos [BN]

clodronate sodium 800 mg tablet, 60

8265B

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	2	..	391.78	37.70	Bonefos 800 mg [BN]

■ IBANDRONIC ACID

Restricted benefit

Bone metastases

Clinical criteria:

The condition must be due to breast cancer.

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

ibandronic acid 50 mg tablet, 28

9357L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	342.68	37.70	Bondronat [RO]

■ PAMIDRONATE DISODIUM

Restricted benefit

Symptomatic Paget disease of bone

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

pamidronate disodium 15 mg/5 mL injection, 1 x 5 mL vial

8461H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	..	..	*87.96	37.70	Pamisol [HH]

pamidronate disodium 60 mg/10 mL injection, 1 x 10 mL vial

8463K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	87.95	37.70	Pamisol [HH]

■ PAMIDRONATE DISODIUM

Restricted benefit

Symptomatic Paget disease of bone

Note

Pharmaceutical benefits that have the form disodium pamidronate powder for I.V. infusion 30 mg (after reconstitution) and pharmaceutical benefits that have the form disodium pamidronate concentrated injection 30 mg are equivalent for the purposes of substitution.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

pamidronate disodium 30 mg injection [2 x 30 mg vials] (&) inert substance diluent [2 x 10 mL ampoules], 1 pack

8209C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	87.96	37.70	^a Aredia 30 mg [NV]

pamidronate disodium 30 mg/10 mL injection, 1 x 10 mL vial

8462J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*87.96	37.70	^a Pamisol [HH]

■ RISEDRONATE

Restricted benefit

Symptomatic Paget disease of bone

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

risedronate sodium 30 mg tablet, 28

8482K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	235.41	37.70	Actonel [UA]

■ RISEDRONATE**Restricted benefit**

Corticosteroid-induced osteoporosis

Clinical criteria:Patient must currently be on long-term (at least 3 months), high-dose (at least 7.5 mg per day prednisolone or equivalent) corticosteroid therapy, **AND**Patient must have a Bone Mineral Density (BMD) T-score of -1.5 or less, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The duration and dose of corticosteroid therapy together with the date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Restricted benefit

Osteoporosis

Clinical criteria:Patient must have a Bone Mineral Density (BMD) T-score of -2.5 or less, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

Population criteria:

Patient must be aged 70 years or older.

The date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Note

Anti-resorptive agents in osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride, strontium ranelate and zoledronic acid.

Restricted benefit

Established osteoporosis

Clinical criteria:Patient must have fracture due to minimal trauma, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

Note

Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride, strontium ranelate and zoledronic acid.

RISEDRONATE SODIUM Tablet 35 mg (enteric coated), 4

8972F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	42.11	37.70	Actonel EC [UA]

risedronate sodium 150 mg tablet, 1

9391G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	44.69	37.70	^a Acris Once-a-Month [AF] ^a APO-Risedronate [TX] ^a Terry White Chemists Risedronate [TW]	^a Actonel Once-a-Month [UA] ^a Chem mart Risedronate [CH]

risedronate sodium 35 mg tablet, 4

8621R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	42.11	37.70	^a Acris Once-a-Week [AF] ^a Risedronate AN [EA] ^a Risedronate Sandoz [SZ]	^a APO-Risedronate [TX] ^a Risedronate-GA [GN] ^a Risedro once a week [QA]

risedronate sodium 5 mg tablet, 28

8481J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	42.11	37.70	Actonel [UA]

■ TILUDRONATE**Restricted benefit**

Symptomatic Paget disease of bone

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

tiludronate 200 mg tablet, 56

8267D

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	2	..	304.96	37.70	Skelid [SW]

■ ZOLEDRONIC ACID**Authority required (STREAMLINED)****4876**

Symptomatic Paget disease of bone

Only 1 treatment each year per patient will be PBS-subsidised

zoledronic acid 5 mg/100 mL injection, 1 x 100 mL vial

9350D

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	589.51	37.70	Aclasta [NV]

■ ZOLEDRONIC ACID**Authority required (STREAMLINED)****4100**

Corticosteroid-induced osteoporosis

Clinical criteria:

Patient must currently be on long-term (at least 3 months), high-dose (at least 7.5 mg per day prednisolone or equivalent) corticosteroid therapy, **AND**

Patient must have a Bone Mineral Density (BMD) T-score of -1.5 or less, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition, **AND**

Patient must not receive more than one PBS-subsidised treatment per year.

The duration and dose of corticosteroid therapy together with the date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)**4149**

Osteoporosis

Clinical criteria:

Patient must have a Bone Mineral Density (BMD) T-score of -3.0 or less, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition, **AND**

Patient must not receive more than one PBS-subsidised treatment per year.

Population criteria:

Patient must be aged 70 years or older.

The date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)**4157**

Established osteoporosis

Clinical criteria:

Patient must have fracture due to minimal trauma, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition, **AND**

Patient must not receive more than one PBS-subsidised treatment per year.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

Note

Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride, strontium ranelate and zoledronic acid.

zoledronic acid 5 mg/100 mL injection, 1 x 100 mL vial

9288W

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	589.51	37.70	Aclasta [NV]

Bisphosphonates, combinations**■ ALENDRONATE + COLECALCIFEROL****Authority required (STREAMLINED)****4122**

Corticosteroid-induced osteoporosis

Clinical criteria:

Patient must currently be on long-term (at least 3 months), high-dose (at least 7.5 mg per day prednisolone or equivalent) corticosteroid therapy, **AND**

Patient must have a Bone Mineral Density (BMD) T-score of -1.5 or less, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The duration and dose of corticosteroid therapy together with the date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)

4133

Osteoporosis

Clinical criteria:

Patient must have a Bone Mineral Density (BMD) T-score of -2.5 or less, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

Population criteria:

Patient must be aged 70 years or older.

The date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)

4123

Established osteoporosis

Clinical criteria:

Patient must have fracture due to minimal trauma, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

Note

Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride, strontium ranelate and zoledronic acid.

alendronate 70 mg + colecalciferol 140 microgram tablet, 4

9183H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	45.51	37.70	^a Alendronate D3 70 mg/140 microgram [UA]	^a Alendronate plus D3-DRLA [RZ]
						^a APO-Alendronate Plus D3 70 mg/140 mcg [TX]	^a Dronalen Plus [GN]
						^a FonatPLUS [AF]	
			^b 2.49	48.00	37.70	^a Fosamax Plus 70 mg/140 mcg [MK]	

▪ **ALENDRONATE + COLECALCIFEROL**

Authority required (STREAMLINED)

4070

Corticosteroid-induced osteoporosis

Clinical criteria:

Patient must currently be on long-term (at least 3 months), high-dose (at least 7.5 mg per day prednisolone or equivalent) corticosteroid therapy, **AND**

Patient must have a Bone Mineral Density (BMD) T-score of -1.5 or less, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The duration and dose of corticosteroid therapy together with the date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)

4110

Osteoporosis

Clinical criteria:

Patient must have a Bone Mineral Density (BMD) T-score of -2.5 or less, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

Population criteria:

Patient must be aged 70 years or older.

The date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)

4087

Established osteoporosis

Clinical criteria:

Patient must have fracture due to minimal trauma, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

Note

Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride, strontium ranelate and zoledronic acid.

Fosamax Plus provides a supplemental intake of vitamin D. The amount of colecalciferol present in Fosamax Plus is not sufficient to use as the sole treatment for correction of vitamin D deficiency.

alendronate 70 mg + colecalciferol 70 microgram tablet, 4

9012H

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	45.51	37.70	^a Alendronate D3 70 mg/70 microgram [UA] ^a APO-Alendronate Plus D3 70 mg/70 mcg [TX] ^a Fosamax Plus [MK]	^a Alendronate plus D3-DRLA [RZ] ^a FonatPLUS [AF]

■ ALENDRONATE + COLECALCIFEROL (&) CALCIUM CARBONATE**Authority required (STREAMLINED)****4122**

Corticosteroid-induced osteoporosis

Clinical criteria:

Patient must currently be on long-term (at least 3 months), high-dose (at least 7.5 mg per day prednisolone or equivalent) corticosteroid therapy, **AND**

Patient must have a Bone Mineral Density (BMD) T-score of -1.5 or less, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The duration and dose of corticosteroid therapy together with the date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)**4133**

Osteoporosis

Clinical criteria:

Patient must have a Bone Mineral Density (BMD) T-score of -2.5 or less, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

Population criteria:

Patient must be aged 70 years or older.

The date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)**4123**

Established osteoporosis

Clinical criteria:

Patient must have fracture due to minimal trauma, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

Note

Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride, strontium ranelate and zoledronic acid.

alendronate 70 mg + colecalciferol 140 microgram tablet [4] (&) calcium (as carbonate) 500 mg tablet [48], 1 pack

9351E

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
±1	5	..	45.51	37.70	^a Alendronate Plus D3 and Calcium Sandoz [SZ] ^a Dronalen Plus D-Cal [FR] ^a ReddyMax Plus D-Cal [RZ]	^a Alendronate Plus D3 Calcium Actavis [UA] ^a Fosamax Plus D-Cal [MK]

■ RISEDRONATE (&) CALCIUM CARBONATE

Authority required (STREAMLINED)

4122

Corticosteroid-induced osteoporosis

Clinical criteria:

Patient must currently be on long-term (at least 3 months), high-dose (at least 7.5 mg per day prednisolone or equivalent) corticosteroid therapy, **AND**

Patient must have a Bone Mineral Density (BMD) T-score of -1.5 or less, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The duration and dose of corticosteroid therapy together with the date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)

4133

Osteoporosis

Clinical criteria:

Patient must have a Bone Mineral Density (BMD) T-score of -2.5 or less, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

Population criteria:

Patient must be aged 70 years or older.

The date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)

4123

Established osteoporosis

Clinical criteria:

Patient must have fracture due to minimal trauma, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

Note

Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride, strontium ranelate and zoledronic acid.

RISEDRONATE SODIUM and CALCIUM CARBONATE Pack containing 4 enteric coated tablets risedronate sodium 35 mg and 24 tablets calcium carbonate 1.25 g (equivalent to 500 mg calcium), 1

8973G

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
±1	5	..	45.73	37.70	Actonel EC Combi [UA]

risedronate sodium 35 mg tablet [4] (&) calcium (as carbonate) 500 mg tablet [24], 28

8899J

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
±1	5	..	45.73	37.70	Acris Combi [AF]

■ RISEDRONATE (&) CALCIUM CARBONATE + COLECALCIFEROL

Authority required (STREAMLINED)

4122

Corticosteroid-induced osteoporosis

Clinical criteria:

Patient must currently be on long-term (at least 3 months), high-dose (at least 7.5 mg per day prednisolone or equivalent) corticosteroid therapy, **AND**

Patient must have a Bone Mineral Density (BMD) T-score of -1.5 or less, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The duration and dose of corticosteroid therapy together with the date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)

4133

Osteoporosis

Clinical criteria:

Patient must have a Bone Mineral Density (BMD) T-score of -2.5 or less, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

Population criteria:

Patient must be aged 70 years or older.

The date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)**4123**

Established osteoporosis

Clinical criteria:Patient must have fracture due to minimal trauma, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

Note

Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride, strontium ranelate and zoledronic acid.

RISEDRONATE SODIUM and CALCIUM CARBONATE with COLECALCIFEROL Pack containing 4 enteric coated tablets risedronate sodium 35 mg and 24 sachets containing granules of calcium carbonate 2.5 g (equivalent to 1 g calcium) with colecalciferol 22 micrograms, 1

8974H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	45.73	37.70	Actonel EC Combi D [UA]

Other drugs affecting bone structure and mineralization**■ CALCITRIOL****Authority required (STREAMLINED)****1165**

Hypocalcaemia due to renal disease

Authority required (STREAMLINED)**1166**

Hypoparathyroidism

Authority required (STREAMLINED)**1167**

Hypophosphataemic rickets

Authority required (STREAMLINED)**1467**

Vitamin D-resistant rickets

Authority required (STREAMLINED)**2636**

Treatment for established osteoporosis in patients with fracture due to minimal trauma. The fracture must have been demonstrated radiologically and the year of plain x-ray or CT-scan or MRI scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body

calcitriol 0.25 microgram capsule, 100

2502Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	30.62	31.77	^a Calciprox [ER] ^a Calcitriol-GA [UA] ^a GenRx Calcitriol [GX] ^a Rocaltrol [RO]	^a Calcitriol AN [EA] ^a Calcitriol Sandoz [SZ] ^a Kosteo [QA] ^a Sical [AF]

■ DENOSUMAB**Authority required (STREAMLINED)****4504**

Giant cell tumour of bone

Clinical criteria:

Patient must be one in whom surgical resection is not feasible; OR

Patient must be one in whom surgical resection is possible but surgery would result in significant morbidity.

Population criteria:

Patient must be an adult; OR

Patient must be a skeletally mature adolescent.

Note

Denosumab is not PBS-subsidised for use in patients who have undergone curative surgical resection.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

denosumab 120 mg/1.7 mL injection, 1 x 1.7 mL vial

10061M

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	532.31	37.70	Xgeva [AN]

■ **DENOSUMAB****Authority required (STREAMLINED)****4158**

Bone metastases

Clinical criteria:

The condition must be due to breast cancer.

Authority required (STREAMLINED)**4150**

Bone metastases

Clinical criteria:

The condition must be due to castration-resistant prostate cancer.

Note**Continuing Therapy Only:**

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

denosumab 120 mg/1.7 mL injection, 1 x 1.7 mL vial

5110Y

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	532.31	37.70	Xgeva [AN]

■ **DENOSUMAB****Authority required (STREAMLINED)****4314**

Osteoporosis

Clinical criteria:Patient must have a Bone Mineral Density (BMD) T-score of -2.5 or less, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

Population criteria:

Patient must be aged 70 years or older.

The date, site (femoral neck or lumbar spine) and score of the qualifying BMD measurement must be documented in the patient's medical records when treatment is initiated.

Authority required (STREAMLINED)**4347**

Established osteoporosis

Clinical criteria:Patient must have fracture due to minimal trauma, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

Note

Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride, strontium ranelate and zoledronic acid.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

denosumab 60 mg/mL injection, 1 x 1 mL syringe

5457F

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	296.00	37.70	Prolia [AN]

■ **RALOXIFENE****Authority required (STREAMLINED)****4071**

Established post-menopausal osteoporosis

Clinical criteria:Patient must have fracture due to minimal trauma, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition. The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated. A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

Note

Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride, strontium ranelate and zoledronic acid.

raloxifene hydrochloride 60 mg tablet, 28

8363E

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	50.55	37.70	^a APO-Raloxifene [TX] ^a Evifyne [EL] ^a Raloxifene AN [EA]	^a Chem mart Raloxifene [CH] ^a Evista [LY] ^a Terry White Chemists Raloxifene [TW]

■ STRONTIUM**Authority required**

Severe established osteoporosis

Clinical criteria:

Patient must have fracture due to minimal trauma, **AND**

Patient must not receive concomitant treatment with any other PBS-subsidised anti-resorptive agent for this condition, **AND**

Patient must be at high risk of fracture, **AND**

Patient must be unable to use other medications for the treatment of osteoporosis due to contraindications or intolerance.

The fracture must have been demonstrated radiologically and the year of plain x-ray or computed tomography (CT) scan or magnetic resonance imaging (MRI) scan must be documented in the patient's medical records when treatment is initiated.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

Note

Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride, strontium ranelate and zoledronic acid.

strontium ranelate 2 g granules, 28 x 2 g sachets

3036T

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	52.00	37.70	Protos 2 g [SE]

■ TERIPARATIDE**Authority required**

Severe established osteoporosis

Treatment Phase: Initial treatment

Clinical criteria:

Patient must be at very high risk of fracture, **AND**

Patient must have a bone mineral density (BMD) T-score of -3.0 or less, **AND**

Patient must have had 2 or more fractures due to minimal trauma, **AND**

Patient must have experienced at least 1 symptomatic new fracture after at least 12 months continuous therapy with an anti-resorptive agent at adequate doses, **AND**

The treatment must be the sole PBS-subsidised agent, **AND**

The treatment must not exceed a lifetime maximum of 18 months therapy.

Treatment criteria:

Must be treated by a specialist; OR

Must be treated by a consultant physician.

A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or, a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

If treatment with anti-resorptive therapy is contraindicated according to the relevant TGA-approved Product Information, details of the contraindication must be documented in the patient's medical record at the time treatment with teriparatide is initiated.

If an intolerance of a severity necessitating permanent treatment withdrawal develops during the relevant period of use of one anti-resorptive agent, alternate anti-resorptive agents must be trialled so that the patient achieves the minimum requirement of 12 months continuous therapy. Details must be documented in the patient's medical record at the time treatment with teriparatide is initiated.

Anti-resorptive therapies for osteoporosis and their adequate doses which will be accepted for the purposes of administering this restriction are alendronate sodium 10 mg per day or 70 mg once weekly, risedronate sodium 5 mg per day or 35 mg once weekly or 150 mg once monthly, raloxifene hydrochloride 60 mg per day (women only), denosumab 60 mg once every 6 months, strontium ranelate 2 g per day and zoledronic acid 5 mg per annum.

Details of prior anti-resorptive therapy, fracture history including the date(s), site(s), the symptoms associated with the fracture(s) which developed after at least 12 months continuous anti-resorptive therapy and the score of the qualifying BMD measurement must be provided at the time of application.

Note

Details of accepted toxicities including severity can be found on the Department of Human Services website at www.humanservices.gov.au.

Authority required

Severe established osteoporosis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have previously been issued with an authority prescription for this drug, **AND**

The treatment must not exceed a lifetime maximum of 18 months therapy.

Note

Up to a maximum of 18 pens will be reimbursed through the PBS.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

teriparatide 20 microgram/dose injection, 1 x 2.4 mL cartridge

9411H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	438.71	37.70	Forteo [LY]

■ NERVOUS SYSTEM

■ ANALGESICS

OPIOIDS

Natural opium alkaloids

■ CODEINE

codeine phosphate 30 mg tablet, 20

1214X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	17.21	18.36	Fawns and McAllan Proprietary Limited [FM]

■ CODEINE

Note

Prescribing of drugs of addiction by dentists is not permitted in some States/Territories.

codeine phosphate 30 mg tablet, 20

5063L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	17.21	18.36	Fawns and McAllan Proprietary Limited [FM]

■ HYDROMORPHONE

Caution

The risk of drug dependence is high.

hydromorphone hydrochloride 10 mg/mL injection, 5 x 1 mL ampoules

8421F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	29.31	30.46	Dilaudid-HP [MF]

hydromorphone hydrochloride 2 mg/mL injection, 5 x 1 mL ampoules

8420E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	23.18	24.33	Dilaudid [MF]

hydromorphone hydrochloride 50 mg/5 mL injection, 5 x 5 mL ampoules

8422G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	52.34	37.70	Dilaudid-HP [MF]

hydromorphone hydrochloride 500 mg/50 mL injection, 1 x 50 mL vial

8423H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	75.75	37.70	Dilaudid-HP [MF]

■ HYDROMORPHONE

Caution

The risk of drug dependence is high.

Restricted benefit

Severe disabling pain

Clinical criteria:

The condition must be unresponsive to non-narcotic analgesics.

Note

Prescribing of drugs of addiction by dentists is not permitted in some States/Territories.

hydromorphone hydrochloride 1 mg/mL oral liquid, 473 mL

5132D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	64.04	37.70	Dilaudid [MF]

hydromorphone hydrochloride 2 mg tablet, 20

5115F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	17.45	18.60	Dilaudid [MF]

hydromorphone hydrochloride 4 mg tablet, 20

5116G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	20.19	21.34	Dilaudid [MF]

hydromorphone hydrochloride 8 mg tablet, 20

5117H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	30.37	31.52	Dilaudid [MF]

■ HYDROMORPHONE

Caution

The risk of drug dependence is high.

Restricted benefit

Severe disabling pain

Clinical criteria:

The condition must be unresponsive to non-narcotic analgesics.

Note

Authorities for increased maximum quantities and/or repeats will be granted only for:

- (i) severe disabling pain associated with proven malignant neoplasia; or
- (ii) chronic severe disabling pain not responding to non-narcotic analgesics where the total duration of narcotic analgesic treatment is less than 12 months; or
- (iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-narcotic analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing narcotic analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or

- (iv) subsequent application for treatment of chronic severe disabling pain not responding to non-narcotic analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

hydromorphone hydrochloride 1 mg/mL oral liquid, 473 mL

8424J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	64.04	37.70	Dilaudid [MF]

hydromorphone hydrochloride 2 mg tablet, 20

8541M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	17.45	18.60	Dilaudid [MF]

hydromorphone hydrochloride 4 mg tablet, 20

8542N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	20.19	21.34	Dilaudid [MF]

hydromorphone hydrochloride 8 mg tablet, 20

8543P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	30.37	31.52	Dilaudid [MF]

■ HYDROMORPHONE

Caution

The risk of drug dependence is high.

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

The condition must be unresponsive to non-narcotic analgesics.

Note

Authorities for increased maximum quantities and/or repeats will be granted only for:

- (i) chronic severe disabling pain associated with proven malignant neoplasia; or
- (ii) chronic severe disabling pain not responding to non-narcotic analgesics where the total duration of narcotic analgesic treatment is less than 12 months; or
- (iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-narcotic analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing narcotic analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or

- (iv) subsequent application for treatment of chronic severe disabling pain not responding to non-narcotic analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

hydromorphone hydrochloride 16 mg tablet: modified release, 14 tablets

9407D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	53.16	37.70	Jurnista [JC]

hydromorphone hydrochloride 32 mg tablet: modified release, 14 tablets

9408E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	89.04	37.70	Jurnista [JC]

hydromorphone hydrochloride 4 mg tablet: modified release, 14 tablets

9299K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	31.29	32.44	Jurnista [JC]

hydromorphone hydrochloride 64 mg tablet: modified release, 14 tablets

9409F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	149.72	37.70	Jurnista [JC]

hydromorphone hydrochloride 8 mg tablet: modified release, 14 tablets

9406C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	36.75	37.70	Jurnista [JC]

▪ **MORPHINE**

Caution

The risk of drug dependence is high.

morphine sulfate 10 mg/mL injection, 5 x 1 mL ampoules

1644M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP MW	1	..	..	16.76	17.91	Hospira Pty Limited [HH]

morphine sulfate 15 mg/mL injection, 5 x 1 mL ampoules

1645N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP MW	1	..	..	17.30	18.45	Hospira Pty Limited [HH]

morphine sulfate 30 mg/mL injection, 5 x 1 mL ampoules

1647Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	19.43	20.58	Hospira Pty Limited [HH]

morphine tartrate 120 mg/1.5 mL injection, 5 x 1.5 mL ampoules

1607N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	39.62	37.70	Hospira Pty Limited [HH]

▪ **MORPHINE**

Caution

The risk of drug dependence is high.

Note

Prescribing of drugs of addiction by dentists is not permitted in some States/Territories.

morphine sulfate 10 mg/mL injection, 5 x 1 mL ampoules

5168B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	16.76	17.91	Hospira Pty Limited [HH]

morphine sulfate 15 mg/mL injection, 5 x 1 mL ampoules

5169C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	17.30	18.45	Hospira Pty Limited [HH]

morphine sulfate 30 mg/mL injection, 5 x 1 mL ampoules

5170D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	19.43	20.58	Hospira Pty Limited [HH]

■ MORPHINE**Caution**

The risk of drug dependence is high.

Authority required

Chronic severe disabling pain

Clinical criteria:

The condition must be due to cancer, **AND**

The condition must be unresponsive to non-narcotic analgesics.

morphine sulfate 200 mg granules: modified release, 28 sachets

8454Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	164.09	37.70	MS Contin Suspension 200 mg [MF]

morphine sulfate 200 mg tablet: modified release, 28 tablets

8453X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	122.20	37.70	MS Contin [MF]

■ MORPHINE**Caution**

The risk of drug dependence is high.

Restricted benefit

Severe disabling pain

Clinical criteria:

The condition must be due to cancer, **AND**

The condition must be unresponsive to non-narcotic analgesics.

morphine sulfate 10 mg tablet, 20

8669G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	14.66	15.81	Sevredol [MF]

morphine sulfate 20 mg tablet, 20

8670H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	15.60	16.75	Sevredol [MF]

■ MORPHINE**Caution**

The risk of drug dependence is high.

Restricted benefit

Severe disabling pain

Clinical criteria:

The condition must be unresponsive to non-narcotic analgesics.

Note

Authorities for increased maximum quantities and/or repeats will be granted only for:

- (i) severe disabling pain associated with proven malignant neoplasia; or
- (ii) chronic severe disabling pain not responding to non-narcotic analgesics where the total duration of narcotic analgesic treatment is less than 12 months; or
- (iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-narcotic analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing narcotic analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or

(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-narcotic analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

morphine hydrochloride 10 mg/mL oral liquid, 200 mL

2124T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	27.20	28.35	Ordine 10 [MF]

morphine hydrochloride 2 mg/mL oral liquid, 200 mL

2122Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	20.67	21.82	Ordine 2 [MF]

morphine hydrochloride 5 mg/mL oral liquid, 200 mL

2123R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	23.07	24.22	Ordine 5 [MF]

morphine sulfate 30 mg tablet, 20

1646P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	14.37	15.52	Anamorph [FM]

■ MORPHINE

Caution

The risk of drug dependence is high.

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

The condition must be unresponsive to non-narcotic analgesics.

Note

Authorities for increased maximum quantities and/or repeats will be granted only for:

- (i) chronic severe disabling pain associated with proven malignant neoplasia; or
- (ii) chronic severe disabling pain not responding to non-narcotic analgesics where the total duration of narcotic analgesic treatment is less than 12 months; or
- (iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-narcotic analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing narcotic analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or

(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-narcotic analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

morphine Capsule 10 mg (containing sustained release pellets), 28

8349K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	20.37	21.52	Kapanol [YN]

morphine Capsule 100 mg (containing sustained release pellets), 28

2841M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	70.81	37.70	Kapanol [YN]

morphine Capsule 20 mg (containing sustained release pellets), 28

2839K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	25.35	26.50	Kapanol [YN]

morphine Capsule 50 mg (containing sustained release pellets), 28

2840L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	43.65	37.70	Kapanol [YN]

morphine Sachet containing controlled release granules for oral suspension, 30 mg per sachet, 28

8146R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	62.41	37.70	MS Contin Suspension 30 mg [MF]

morphine Sachet containing controlled release granules for oral suspension, 60 mg per sachet, 28

8305D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	70.21	37.70	MS Contin Suspension 60 mg [MF]

morphine sulfate 10 mg tablet: modified release, 28 tablets

1653B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	20.38	21.53	^a Momex SR 10 [QA] ^a MS Contin [MF]	^a MORPHINE MR APOTEX [TX]

morphine sulfate 100 mg granules: modified release, 28 sachets

8306E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
NP	1	..	..	86.71	37.70	MS Contin Suspension 100 mg [MF]	

morphine sulfate 100 mg tablet: modified release, 28 tablets

1656E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	72.85	37.70	^a APOTEX-MORPHINE MR [TX] ^a MS Contin [MF]	^a Momex SR 100 [QA]

morphine sulfate 120 mg capsule: modified release, 14 capsules

8494C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
NP	1	..	..	54.81	37.70	MS Mono [MF]	

morphine sulfate 15 mg tablet: modified release, 28 tablets

8489T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
NP	1	..	..	24.57	25.72	MS Contin [MF]	

morphine sulfate 20 mg granules: modified release, 28 sachets

8490W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
NP	1	..	..	60.63	37.70	MS Contin Suspension 20 mg [MF]	

morphine sulfate 30 mg capsule: modified release, 14 capsules

8491X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
NP	1	..	..	24.56	25.71	MS Mono [MF]	

morphine sulfate 30 mg tablet: modified release, 28 tablets

1654C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	36.23	37.38	^a Momex SR 30 [QA] ^a MS Contin [MF]	^a MORPHINE MR APOTEX [TX]

morphine sulfate 5 mg tablet: modified release, 28 tablets

8035X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
NP	1	..	..	17.95	19.10	MS Contin [MF]	

morphine sulfate 60 mg capsule: modified release, 14 capsules

8492Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
NP	1	..	..	36.21	37.36	MS Mono [MF]	

morphine sulfate 60 mg tablet: modified release, 28 tablets

1655D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	54.82	37.70	^a Momex SR 60 [QA] ^a MS Contin [MF]	^a MORPHINE MR APOTEX [TX]

morphine sulfate 90 mg capsule: modified release, 14 capsules

8493B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
NP	1	..	..	41.76	37.70	MS Mono [MF]	

■ MORPHINE**Caution**

The risk of drug dependence is high.

Restricted benefit

Severe disabling pain

Clinical criteria:

The condition must be unresponsive to non-narcotic analgesics.

Note

Prescribing of drugs of addiction by dentists is not permitted in some States/Territories.

morphine hydrochloride 10 mg/mL oral liquid, 200 mL

5239R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	27.20	28.35	Ordine 10 [MF]

morphine hydrochloride 2 mg/mL oral liquid, 200 mL

5237P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	20.67	21.82	Ordine 2 [MF]

morphine hydrochloride 5 mg/mL oral liquid, 200 mL

5238Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	23.07	24.22	Ordine 5 [MF]

morphine sulfate 30 mg tablet, 20

5163R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	14.37	15.52	Anamorph [FM]

■ OXYCODONE**Caution**

The risk of drug dependence is high.

Restricted benefit

Severe disabling pain

Clinical criteria:

The condition must be unresponsive to non-narcotic analgesics.

Note

Authorities for increased maximum quantities and/or repeats will be granted only for:

- (i) severe disabling pain associated with proven malignant neoplasia; or
- (ii) chronic severe disabling pain not responding to non-narcotic analgesics where the total duration of narcotic analgesic treatment is less than 12 months; or
- (iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-narcotic analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing narcotic analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or

- (iv) subsequent application for treatment of chronic severe disabling pain not responding to non-narcotic analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

oxycodone 30 mg suppository, 12

2481N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	44.00	37.70	Proladone [PL]

oxycodone hydrochloride 10 mg capsule, 20

8501K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	14.76	15.91	OxyNorm [MF]

oxycodone hydrochloride 20 mg capsule, 20

8502L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	18.72	19.87	OxyNorm [MF]

oxycodone hydrochloride 5 mg capsule, 20

8464L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	12.14	13.29	OxyNorm [MF]

oxycodone hydrochloride 5 mg tablet, 20

2622B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	12.14	13.29	Endone [QA]

oxycodone hydrochloride 5 mg/5 mL oral liquid, 250 mL

8644Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	21.07	22.22	OxyNorm Liquid 5mg/5mL [MF]

■ OXYCODONE**Caution**

The risk of drug dependence is high.

Restricted benefit

Severe disabling pain

Clinical criteria:

The condition must be unresponsive to non-narcotic analgesics.

Note

Prescribing of drugs of addiction by dentists is not permitted in some States/Territories.

oxycodone 30 mg suppository, 12

5194J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	44.00	37.70	Proladone [PL]

oxycodone hydrochloride 10 mg capsule, 20

5197M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	14.76	15.91	OxyNorm [MF]

oxycodone hydrochloride 5 mg capsule, 20

5191F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	12.14	13.29	OxyNorm [MF]

oxycodone hydrochloride 5 mg tablet, 20

5195K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	12.14	13.29	Endone [QA]

oxycodone hydrochloride 5 mg/5 mL oral liquid, 250 mL

5190E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	21.07	22.22	OxyNorm Liquid 5mg/5mL [MF]

■ OXYCODONE**Caution**

The risk of drug dependence is high.

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

The condition must be unresponsive to non-narcotic analgesics.

Note

Authorities for increased maximum quantities and/or repeats will be granted only for:

- (i) chronic severe disabling pain associated with proven malignant neoplasia; or
- (ii) chronic severe disabling pain not responding to non-narcotic analgesics where the total duration of narcotic analgesic treatment is less than 12 months; or
- (iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-narcotic analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing narcotic analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or

- (iv) subsequent application for treatment of chronic severe disabling pain not responding to non-narcotic analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

OxyContin modified release tablets are intended to be crush-deterrent and to reduce the rapid release of oxycodone upon accidental or intentional misuse.

oxycodone hydrochloride 10 mg tablet: modified release, 28 tablets

8385H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	24.57	25.72	^a Oxycodone Sandoz [SZ]	^a OxyContin [MF]

oxycodone hydrochloride 15 mg tablet: modified release, 28 tablets

9399Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	31.60	32.75	OxyContin [MF]

oxycodone hydrochloride 20 mg tablet: modified release, 28 tablets

8386J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	36.22	37.37	^a Oxycodone Sandoz [SZ]	^a OxyContin [MF]

oxycodone hydrochloride 30 mg tablet: modified release, 28 tablets

9400R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	46.79	37.70	OxyContin [MF]

oxycodone hydrochloride 40 mg tablet: modified release, 28 tablets

8387K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	54.81	37.70	^a Oxycodone Sandoz [SZ]	^a OxyContin [MF]

oxycodone hydrochloride 80 mg tablet: modified release, 28 tablets

8388L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	83.05	37.70	^a Oxycodone Sandoz [SZ]	^a OxyContin [MF]

■ OXYCODONE + NALOXONE**Caution**

The risk of drug dependence is high.

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

The condition must be unresponsive to non-narcotic analgesics.

Note

Authorities for increased maximum quantities and/or repeats will be granted only for:

- (i) chronic severe disabling pain associated with proven malignant neoplasia; or
- (ii) chronic severe disabling pain not responding to non-narcotic analgesics where the total duration of narcotic analgesic treatment is less than 12 months; or
- (iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-narcotic analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing narcotic analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or

- (iv) subsequent application for treatment of chronic severe disabling pain not responding to non-narcotic analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

oxycodone hydrochloride 10 mg + naloxone hydrochloride 5 mg tablet: modified release, 28 tablets

8934F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	31.01	32.16	Targin 10/5mg [MF]

oxycodone hydrochloride 20 mg + naloxone hydrochloride 10 mg tablet: modified release, 28 tablets

8935G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	47.19	37.70	Targin 20/10mg [MF]

oxycodone hydrochloride 40 mg + naloxone hydrochloride 20 mg tablet: modified release, 28 tablets

8936H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	73.62	37.70	Targin 40/20mg [MF]

oxycodone hydrochloride 5 mg + naloxone hydrochloride 2.5 mg tablet: modified release, 28 tablets

8000C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	29.71	30.86	Targin 5/2.5mg [MF]

■ PARACETAMOL + CODEINE**CODEINE PHOSPHATE with PARACETAMOL Tablet 30 mg-500 mg, 20**

3316M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	7.68	8.83	^a APO- Paracetamol/Codeine 500/30 [TX]	^a Codalgin Forte [FM]
						^a Codapane Forte [AL]	^a Comfarol Forte [SZ]
						^a Paracetamol/Codeine GH 500/30 [GQ]	^a Prodeine Forte [AV]
			^B 2.40	10.08	8.83	^a Panadeine Forte [SW]	

■ PARACETAMOL + CODEINE**Note**

Authorities for increased maximum quantities and/or repeats will not be granted except as detailed under the 'Authority required' listing of codeine phosphate with paracetamol.

CODEINE PHOSPHATE with PARACETAMOL Tablet 30 mg-500 mg, 20

1215Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	7.68	8.83	^a APO- Paracetamol/Codeine 500/30 [TX]	^a Codalgin Forte [FM]
						^a Codapane Forte [AL]	^a Comfarol Forte [SZ]
						^a Paracetamol/Codeine GH 500/30 [GQ]	^a Prodeine Forte [AV]
			^b 2.40	10.08	8.83	^a Panadeine Forte [SW]	

■ PARACETAMOL + CODEINE

Authority required

Severe disabling pain

Clinical criteria:

The condition must be unresponsive to non-narcotic analgesics.

Note

Each authority approval will be limited to no more than 240 tablets per month for no more than 6 months.

CODEINE PHOSPHATE with PARACETAMOL Tablet 30 mg-500 mg, 20

8785J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	3	..	..	*9.52	10.67	^a APO- Paracetamol/Codeine 500/30 [TX]	^a Codalgin Forte [FM]
						^a Codapane Forte [AL]	^a Comfarol Forte [SZ]
						^a Paracetamol/Codeine GH 500/30 [GQ]	^a Prodeine Forte [AV]
			^b 7.20	*16.72	10.67	^a Panadeine Forte [SW]	

Phenylpiperidine derivatives

■ FENTANYL

Caution

The risk of drug dependence is high.

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

The condition must be unresponsive to non-narcotic analgesics.

Note

Authorities for increased maximum quantities and/or repeats will be granted only for:

- (i) chronic severe disabling pain associated with proven malignant neoplasia; or
- (ii) chronic severe disabling pain not responding to non-narcotic analgesics where the total duration of narcotic analgesic treatment is less than 12 months; or
- (iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-narcotic analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing narcotic analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or

(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-narcotic analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

Fentanyl transdermal patches are not recommended in opioid naive patients with non-cancer pain because of a high incidence of adverse events in these patients. Patients with cancer pain may be initiated on the lowest strength patch (12 micrograms per hour).

Pharmaceutical benefits that have the form fentanyl 12 microgram/hour patch are equivalent for the purposes of substitution. Pharmaceutical benefits that have the form fentanyl 25 microgram/hour patch are equivalent for the purposes of substitution. Pharmaceutical benefits that have the form fentanyl 50 microgram/hour patch are equivalent for the purposes of substitution. Pharmaceutical benefits that have the form fentanyl 75 microgram/hour patch are equivalent for the purposes of substitution. Pharmaceutical benefits that have the form fentanyl 100 microgram/hour patch are equivalent for the purposes of substitution.

fentanyl 100 microgram/hour patch, 5

5280X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	69.30	37.70	^a Denpax [AF]

fentanyl 100 microgram/hour patch, 5

5441J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	69.30	37.70	^a Dutran 100 [GN]	^a Fenpatch 100 [ZP]

fentanyl 100 microgram/hour patch, 5

8894D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	69.30	37.70	^a Durogesic 100 [JC]	^a Fentanyl Sandoz [SZ]

fentanyl 12 microgram/hour patch, 5

5265D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	25.21	26.36	^a Denpax [AF]	

fentanyl 12 microgram/hour patch, 5

5437E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	25.21	26.36	^a Dutran 12 [GN]	^a Fenpatch 12 [ZP]

fentanyl 12 microgram/hour patch, 5

8878G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	25.21	26.36	^a Durogesic 12 [JC]	^a Fentanyl Sandoz [SZ]

fentanyl 25 microgram/hour patch, 5

5277R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	29.49	30.64	^a Denpax [AF]	

fentanyl 25 microgram/hour patch, 5

5438F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	29.49	30.64	^a Dutran 25 [GN]	^a Fenpatch 25 [ZP]

fentanyl 25 microgram/hour patch, 5

8891Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	29.49	30.64	^a Durogesic 25 [JC]	^a Fentanyl Sandoz [SZ]

fentanyl 50 microgram/hour patch, 5

5278T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	45.96	37.70	^a Denpax [AF]	

fentanyl 50 microgram/hour patch, 5

5439G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	45.96	37.70	^a Dutran 50 [GN]	^a Fenpatch 50 [ZP]

fentanyl 50 microgram/hour patch, 5

8892B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	45.96	37.70	^a Durogesic 50 [JC]	^a Fentanyl Sandoz [SZ]

fentanyl 75 microgram/hour patch, 5

5279W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	57.81	37.70	^a Denpax [AF]	

fentanyl 75 microgram/hour patch, 5

5440H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	57.81	37.70	^a Dutran 75 [GN]	^a Fenpatch 75 [ZP]

fentanyl 75 microgram/hour patch, 5

8893C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	57.81	37.70	^a Durogesic 75 [JC]	^a Fentanyl Sandoz [SZ]

*Diphenylpropylamine derivatives***■ METHADONE****Caution**

The risk of drug dependence is high.

Restricted benefit

Severe disabling pain

Clinical criteria:

The condition must be unresponsive to non-narcotic analgesics.

Note

Authorities for increased maximum quantities and/or repeats will be granted only for:

- (i) severe disabling pain associated with proven malignant neoplasia; or
- (ii) chronic severe disabling pain not responding to non-narcotic analgesics where the total duration of narcotic analgesic

treatment is less than 12 months; or

(iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-narcotic analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing narcotic analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or

(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-narcotic analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

methadone hydrochloride 10 mg tablet, 20

1609Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	15.57	16.72	Physeptone [QA]

methadone hydrochloride 10 mg/mL injection, 5 x 1 mL ampoules

1606M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	49.65	37.70	Physeptone [QA]

Oripavine derivatives

▪ **BUPRENORPHINE**

Caution

The risk of drug dependence is high.

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

The condition must be unresponsive to non-narcotic analgesics.

Note

Authorities for increased maximum quantities and/or repeats will be granted only for:

- (i) chronic severe disabling pain associated with proven malignant neoplasia; or
- (ii) chronic severe disabling pain not responding to non-narcotic analgesics where the total duration of narcotic analgesic treatment is less than 12 months; or
- (iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-narcotic analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing narcotic analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or

(iv) subsequent application for treatment of chronic severe disabling pain not responding to non-narcotic analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

buprenorphine 10 microgram/hour patch, 2

8866P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	41.11	37.70	Norspan [MF]

buprenorphine 20 microgram/hour patch, 2

8867Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	56.42	37.70	Norspan [MF]

buprenorphine 5 microgram/hour patch, 2

8865N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	27.04	28.19	Norspan [MF]

Other opioids

▪ **TAPENTADOL**

Caution

The risk of drug dependence is high.

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

The condition must be unresponsive to non-narcotic analgesics.

Note

Authorities for increased maximum quantities and/or repeats will be granted only for:

- (i) chronic severe disabling pain associated with proven malignant neoplasia; or
- (ii) chronic severe disabling pain not responding to non-narcotic analgesics where the total duration of narcotic analgesic treatment is less than 12 months; or
- (iii) first application for treatment beyond 12 months of chronic severe disabling pain not responding to non-narcotic analgesics where the patient's pain management has been reviewed through consultation by the patient with another medical practitioner, and the clinical need for continuing narcotic analgesic treatment has been confirmed. The date of the consultation must be no more than 3 months prior to the application for a PBS authority. The full name of the medical practitioner consulted and the date of consultation are to be provided at the time of application; or

- (iv) subsequent application for treatment of chronic severe disabling pain not responding to non-narcotic analgesics where a PBS authority prescription for treatment beyond 12 months has previously been issued for this patient.

tapentadol 100 mg tablet: modified release, 28

10094G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	31.65	32.80	Palexia SR [CS]

tapentadol 150 mg tablet: modified release, 28

10100N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	40.35	37.70	Palexia SR [CS]

tapentadol 200 mg tablet: modified release, 28

10091D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	47.49	37.70	Palexia SR [CS]

tapentadol 250 mg tablet: modified release, 28

10092E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	53.15	37.70	Palexia SR [CS]

tapentadol 50 mg tablet: modified release, 28

10096J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	22.60	23.75	Palexia SR [CS]

■ TRAMADOL**Restricted benefit**

For pain where aspirin and/or paracetamol alone are inappropriate or have failed

tramadol hydrochloride 100 mg/mL oral liquid, 10 mL

5150C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	±1	..	..	14.05	15.20	Tramal [CS]

■ TRAMADOL**Restricted benefit**

Short-term treatment of acute pain

tramadol hydrochloride 100 mg/2 mL injection, 5 x 2 mL ampoules

5231H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	11.92	13.07	^a Tramadol ACT [GN] ^a Tramal 100 [CS]	^a Tramadol Sandoz [SZ]

■ TRAMADOL**Restricted benefit**

For pain where aspirin and/or paracetamol alone are inappropriate or have failed

Note

Authorities for increased maximum quantities and/or repeats will be granted only for severe disabling pain not responding to non-narcotic analgesics.

tramadol hydrochloride 100 mg tablet: modified release, 20 tablets

8523N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	9.89	11.04	^a APO-Tramadol SR [TX] ^a GA Tramadol SR 100mg [GN] ^a Terry White Chemists Tramadol SR [TW] ^a Tramadol Sandoz SR [SZ]	^a Chem mart Tramadol SR [CH] ^a Lodam SR 100 [ZP] ^a Tramadol AN SR [EA] ^a Tramadol SR generichealth [GQ]

				^a Tramedo SR 100 [AF]	^a Zydol SR 100 [QA]
		^B 3.83	13.72	11.04	^a Tramal SR 100 [CS]

tramadol hydrochloride 100 mg/mL oral liquid, 10 mL

8843K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	..	..	14.05	15.20	Tramal [CS]

tramadol hydrochloride 150 mg tablet: modified release, 20 tablets

8524P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	10.97	12.12	^a APO-Tramadol SR [TX] ^a GA Tramadol SR 150mg [GN] ^a Terry White Chemists Tramadol SR [TW] ^a Tramadol Sandoz SR [SZ] ^a Tramedo SR 150 [AF] ^a Tramal SR 150 [CS]	^a Chem mart Tramadol SR [CH] ^a Lodam SR 150 [ZP] ^a Tramadol AN SR [EA] ^a Tramadol SR generichealth [GQ] ^a Zydol SR 150 [QA]
			^B 4.58	15.55	12.12		

tramadol hydrochloride 200 mg tablet: modified release, 20 tablets

8525Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	11.88	13.03	^a APO-Tramadol SR [TX] ^a GA Tramadol SR 200mg [GN] ^a Tramadol AN SR [EA] ^a Tramadol SR generichealth [GQ] ^a Zydol SR 200 [QA] ^a Tramal SR 200 [CS]	^a Chem mart Tramadol SR [CH] ^a Terry White Chemists Tramadol SR [TW] ^a Tramadol Sandoz SR [SZ] ^a Tramedo SR 200 [AF]
			^B 5.20	17.08	13.03		

tramadol hydrochloride 50 mg tablet: modified release, 20 tablets

2527B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	10.38	11.53	Tramal SR 50 [CS]

■ TRAMADOL**Restricted benefit**

For acute pain where aspirin and/or paracetamol alone are inappropriate or have failed

Restricted benefit

For dosage titration in chronic pain where aspirin and/or paracetamol alone are inappropriate or have failed

tramadol hydrochloride 50 mg capsule, 20

5232J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	7.91	9.06	^a APO-Tramadol [TX] ^a GA Tramadol 50mg [GN] ^a Tramadol Actavis [UA] ^a Tramadol Sandoz [SZ] ^a Tramedo [AF] ^a Tramal [CS]	^a Chem mart Tramadol [CH] ^a Terry White Chemists Tramadol [TW] ^a Tramadol AN [EA] ^a Tramadol SCP [CR] ^a Zydol [QA]
			^B 2.05	9.96	9.06		

■ TRAMADOL**Restricted benefit**

For acute pain where aspirin and/or paracetamol alone are inappropriate or have failed

Note

No applications for increased maximum quantities and/or repeats will be authorised.

tramadol hydrochloride 50 mg capsule, 20

8455B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	7.91	9.06	^a APO-Tramadol [TX] ^a GA Tramadol 50mg [GN] ^a Tramadol Actavis [UA] ^a Tramadol Sandoz [SZ] ^a Tramedo [AF] ^a Tramal [CS]	^a Chem mart Tramadol [CH] ^a Terry White Chemists Tramadol [TW] ^a Tramadol AN [EA] ^a Tramadol SCP [CR] ^a Zydol [QA]
			^B 2.05	9.96	9.06		

■ TRAMADOL**Restricted benefit**

Short-term treatment of acute pain

Note

No applications for increased maximum quantities and/or repeats will be authorised.

tramadol hydrochloride 100 mg/2 mL injection, 5 x 2 mL ampoules

8582Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	11.92	13.07	^a Tramadol ACT [GN] ^a Tramal 100 [CS]	^a Tramadol Sandoz [SZ]

■ TRAMADOL

Restricted benefit

For dosage titration in chronic pain where aspirin and/or paracetamol alone are inappropriate or have failed

Note

No applications for increased maximum quantities and/or repeats will be authorised.

tramadol hydrochloride 50 mg capsule, 20

8611F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	7.91	9.06	^a APO-Tramadol [TX] ^a GA Tramadol 50mg [GN] ^a Tramadol Actavis [UA] ^a Tramadol Sandoz [SZ] ^a Tramedo [AF]	^a Chem mart Tramadol [CH] ^a Terry White Chemists Tramadol [TW] ^a Tramadol AN [EA] ^a Tramadol SCP [CR] ^a Zydol [QA]
			^b 2.05	9.96	9.06	^a Tramal [CS]	

OTHER ANALGESICS AND ANTIPYRETICS

Salicylic acid and derivatives

■ ASPIRIN

aspirin 300 mg tablet: effervescent, 96

1010E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	8.51	9.66	Solprin [RC]

aspirin 300 mg tablet: effervescent, 96

5018D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	8.51	9.66	Solprin [RC]

Anilides

■ PARACETAMOL

paracetamol 120 mg/5 mL oral liquid, 100 mL

1747Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	2	..	9.72	10.87	Panamax [SW]

paracetamol 120 mg/5 mL oral liquid, 100 mL

3348F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	±1	..	..	9.72	10.87	Panamax [SW]

paracetamol 240 mg/5 mL oral liquid, 200 mL

1770E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	2	..	11.02	12.17	Panamax 240 Elixir [SW]

paracetamol 240 mg/5 mL oral liquid, 200 mL

3349G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	±1	..	..	11.02	12.17	Panamax 240 Elixir [SW]

paracetamol 500 mg tablet, 100

1746X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	8.66	9.81	^a APO-Paracetamol [TX] ^a Generic Health Pty Ltd [GQ] ^a Paracetamol (Sandoz) [SZ] ^a Parapane [AF]	^a Febridol [GN] ^a Panamax [SW] ^a Paralgin [FM]

paracetamol 500 mg tablet, 100

5196L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	8.66	9.81	^a APO-Paracetamol [TX] ^a Generic Health Pty Ltd [GQ] ^a Paracetamol (Sandoz) [SZ]	^a Febridol [GN] ^a Panamax [SW] ^a Paralgin [FM]

^a Parapane [AF]

■ PARACETAMOL

Restricted benefit

Persistent pain

Clinical criteria:

The condition must be associated with osteoarthritis.

paracetamol 665 mg tablet: modified release, 96 tablets

8814X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*15.34	16.49	^a Osteomol 665 Paracetamol [CR]
			^B 1.64	*16.98	16.49	^a Panadol Osteo [GC]

■ PARACETAMOL

Restricted benefit

Chronic arthropathies

paracetamol 500 mg tablet, 100

5224Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	3	..	..	*12.46	13.61	^a APO-Paracetamol [TX] ^a Generic Health Pty Ltd [GQ] ^a Paracetamol (Sandoz) [SZ] ^a Parapane [AF]	^a Febridol [GN] ^a Panamax [SW] ^a Paralgin [FM]

paracetamol 500 mg tablet, 100

8784H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	3	4	..	*12.46	13.61	^a APO-Paracetamol [TX] ^a Generic Health Pty Ltd [GQ] ^a Paracetamol (Sandoz) [SZ] ^a Parapane [AF]	^a Febridol [GN] ^a Panamax [SW] ^a Paralgin [FM]

Other analgesics and antipyretics

■ PREGABALIN

Authority required (STREAMLINED)

4172

Neuropathic pain

Clinical criteria:

The condition must be refractory to treatment with other drugs.

Note**Continuing Therapy Only:**

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

pregabalin 150 mg capsule, 56

2355Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	70.63	37.70	Lyrica [PF]

pregabalin 25 mg capsule, 56

2348N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	26.44	27.59	Lyrica [PF]

pregabalin 300 mg capsule, 56

2363J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	102.05	37.70	Lyrica [PF]

pregabalin 75 mg capsule, 56

2335X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	49.11	37.70	Lyrica [PF]

ANTIMIGRAINE PREPARATIONS*Selective serotonin (5HT₁) agonists*

■ ELETRIPTAN

Caution

Selective serotonin (5HT₁) agonists are contraindicated in patients with known or suspected coronary artery disease. The drug should not be used within 24 hours of ergotamine or dihydroergotamine use.

Authority required (STREAMLINED)

4573

Migraine attack

Clinical criteria:

The condition must have usually failed to respond to analgesics in the past.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

eletriptan 40 mg tablet, 4

5290K

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	25.10	26.25	Relpax [PF]

eletriptan 80 mg tablet, 4

5291L

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	25.10	26.25	Relpax [PF]

▪ **NARATRIPTAN**

Caution

Selective serotonin (5HT₁) agonists are contraindicated in patients with known or suspected coronary artery disease. The drug should not be used within 24 hours of ergotamine or dihydroergotamine use.

Authority required

Migraine attack

Clinical criteria:

The condition must have usually failed to respond to analgesics in the past.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

naratriptan 2.5 mg tablet, 2

8298R

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
2	5	\$2.78	*29.02	27.39	Naramig [AS]

▪ **NARATRIPTAN**

Caution

Naratriptan is contraindicated in patients with known or suspected coronary artery disease. The drug should not be used within 24 hours of ergotamine or dihydroergotamine use.

Authority required

Migraine attack in a patient where attacks in the past have usually failed to respond to analgesics, and where adverse events have occurred with other suitable PBS-listed drugs

Authority required

Migraine attack in a patient where attacks in the past have usually failed to respond to analgesics, and where drug interactions have occurred with other suitable PBS-listed drugs

Authority required

Migraine attack in a patient where attacks in the past have usually failed to respond to analgesics, and where drug interactions are expected to occur with other suitable PBS-listed drugs

Authority required

Migraine attack in a patient where attacks in the past have usually failed to respond to analgesics, and where transfer to another suitable PBS-listed drug would cause patient confusion resulting in problems with compliance

Authority required

Migraine attack in a patient where attacks in the past have usually failed to respond to analgesics, and where transfer to another suitable PBS-listed drug is likely to result in adverse clinical consequences

Note

No applications for increased maximum quantities and/or repeats will be authorised.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

naratriptan 2.5 mg tablet, 2

9734H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*29.02	30.17	Naramig [AS]

■ RIZATRIPTAN

Caution

Selective serotonin (5HT₁) agonists are contraindicated in patients with known or suspected coronary artery disease. The drug should not be used within 24 hours of ergotamine or dihydroergotamine use.

Authority required (STREAMLINED)

4573

Migraine attack

Clinical criteria:

The condition must have usually failed to respond to analgesics in the past.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

rizatriptan 10 mg wafer, 2

9313E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*25.46	26.61	Maxalt [MK]

■ SUMATRIPTAN

Caution

Selective serotonin (5HT₁) agonists are contraindicated in patients with known or suspected coronary artery disease. The drug should not be used within 24 hours of ergotamine or dihydroergotamine use.

Authority required (STREAMLINED)

4558

Migraine attack

Clinical criteria:

The condition must have usually failed to respond to analgesics in the past.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Pharmaceutical benefits that have the form sumatriptan tablet 50 mg (as succinate) and pharmaceutical benefits that have the form sumatriptan tablet (fast disintegrating) 50 mg (as succinate) are equivalent for the purposes of substitution.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

SUMATRIPTAN Tablet (fast disintegrating) 50 mg (as succinate), 2

8885P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	^B 2.04	*16.76	15.87	^a Imigran FDT [AS]

SUMATRIPTAN Tablet 50 mg (as succinate), 2

8144P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*14.72	15.87	^a APO-Sumatriptan [TX] ^a Iptam [AL] ^a Sumatab [AF] ^a Sumatriptan Sandoz [SZ]	^a Chem mart Sumatriptan [CH] ^a Sumagran Aspen 50 [AS] ^a Sumatran [QA] ^a Terry White Chemists Sumatriptan [TW]
			^B 2.04	*16.76	15.87	^a Imigran [LN]	

sumatriptan 20 mg/actuation nasal spray, 2 actuations

8341B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	19.59	20.74	Imigran [AS]

sumatriptan 50 mg tablet, 4

1849H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.72	15.87	^a APO-Sumatriptan [TX] ^a Iptam [AL] ^a Sumatran [QA] ^a Sumatriptan-GA [GN] ^a Sumatriptan RBX [RA] ^a Terry White Chemists Sumatriptan [TW]	^a Chem mart Sumatriptan [CH] ^a Pharmacor Sumatriptan 50 [CR] ^a Sumatriptan AN [EA] ^a Sumatriptan generichealth [GQ] ^a Sumatriptan Sandoz [SZ]

■ ZOLMITRIPTAN**Caution**

Selective serotonin (5HT₁) agonists are contraindicated in patients with known or suspected coronary artery disease. The drug should not be used within 24 hours of ergotamine or dihydroergotamine use.

Authority required (STREAMLINED)**4573**

Migraine attack

Clinical criteria:

The condition must have usually failed to respond to analgesics in the past.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

zolmitriptan 2.5 mg tablet, 2

8266C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*26.18	27.33	^a APO-Zolmitriptan [TX]	^a Zoltrip [QA]
			^B 2.76	*28.94	27.33	^a Zomig [AP]	

*Other antimigraine preparations***■ CYPROHEPTADINE****Restricted benefit**

Prevention of migraine

Note

Cyproheptadine hydrochloride is not PBS-subsidised for use in hay fever or atopy.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

cyproheptadine hydrochloride 4 mg tablet, 100

1798P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	14.53	15.68	Periactin [AS]

■ PIZOTIFEN**Note****Continuing Therapy Only:**

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

pizotifen 500 microgram tablet, 100

3074T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	22.09	23.24	Sandomigran 0.5 [NV]

■ ANTIEPILEPTICS**ANTIEPILEPTICS***Barbiturates and derivatives*

■ PHENOBARBITONE

Restricted benefit

Epilepsy

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

phenobarbitone 30 mg tablet, 200

1850J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	4	..	16.94	18.09	Aspen Pharma Pty Ltd [QA]

phenobarbitone sodium 219 mg/mL injection, 5 x 1 mL ampoules

2138M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	39.36	37.70	Fawns and McAllan Proprietary Limited [FM]

■ PRIMIDONE

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

primidone 250 mg tablet, 200

1939C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	83.83	37.70	Mysoline [LM]

Hydantoin derivatives

■ PHENYTOIN

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

phenytoin 30 mg/5 mL oral liquid, 500 mL

2692Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	3	..	30.62	31.77	Dilantin [PF]

phenytoin 50 mg tablet: chewable, 200

1249R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	48.49	37.70	Dilantin Infatabs [PF]

phenytoin sodium 100 mg capsule, 200

1874P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	30.46	31.61	Dilantin Sodium [PF]

phenytoin sodium 30 mg capsule, 200

1873N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	29.52	30.67	Dilantin Sodium [PF]

Succinimide derivatives

■ ETHOSUXIMIDE

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

ethosuximide 250 mg capsule, 200

1413J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	66.18	37.70	Zarontin [PF]

ethosuximide 250 mg/5 mL oral liquid, 200 mL

1414K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	29.43	30.58	Zarontin [PF]

*Benzodiazepine derivatives***CLONAZEPAM****Restricted benefit**

Epilepsy

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

clonazepam 1 mg/mL injection [5 x 1 mL ampoules] (&) inert substance diluent [5 x 1 mL ampoules], 1 pack

1807D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	18.92	20.07	Rivotril [RO]

CLONAZEPAM**Caution**

Abuse of clonazepam has been reported. Refer to the current product information.

Authority required

Neurologically proven epilepsy

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

clonazepam 2 mg tablet, 100

1806C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	2	..	*31.40	32.55	^a Paxam 2 [AF]
			^B 3.86	*35.26	32.55	^a Rivotril [RO]

clonazepam 2.5 mg/mL oral liquid, 10 mL

1808E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*15.38	16.53	Rivotril [RO]

clonazepam 500 microgram tablet, 100

1805B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	2	..	*19.84	20.99	^a Paxam 0.5 [AF]
			^B 3.42	*23.26	20.99	^a Rivotril [RO]

NITRAZEPAM**Authority required**

Myoclonic epilepsy

Authority required

Malignant neoplasia (late stage)

Authority required

For use by patients who are receiving long-term nursing care on account of age, infirmity or other condition in hospitals, nursing homes or residential facilities and who have been demonstrated, within the past 6 months, to be benzodiazepine dependent by an unsuccessful attempt at gradual withdrawal

Authority required

For use by a patient who is receiving long-term nursing care and in respect of whom a Carer Allowance is payable as a disabled adult and who has been demonstrated, within the past 6 months, to be benzodiazepine dependent by an unsuccessful attempt at gradual withdrawal

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

nitrazepam 5 mg tablet, 25

2732T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*9.94	11.09	^a Alodorm [AF]

^B2.48 *12.42 11.09 ^a Mogadon [IA]

Carboxamide derivatives

■ CARBAMAZEPINE

CARBAMAZEPINE Tablet 100 mg, 100

5039F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	2	..	..	*18.84	19.99	^a Carbamazepine Sandoz [SZ]
			^B 2.96	*21.80	19.99	^a Tegretol 100 [NV]

carbamazepine 100 mg/5 mL oral liquid, 300 mL

5041H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	‡1	..	..	21.69	22.84	Tegretol Liquid [NV]

carbamazepine 200 mg tablet: modified release, 200 tablets

5038E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	29.82	30.97	Tegretol CR 200 [NV]

carbamazepine 400 mg tablet: modified release, 200 tablets

5037D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	49.37	37.70	Tegretol CR 400 [NV]

■ CARBAMAZEPINE

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

carbamazepine 100 mg/5 mL oral liquid, 300 mL

2427R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	21.69	22.84	Tegretol Liquid [NV]

carbamazepine 200 mg tablet: modified release, 200 tablets

2426Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	29.82	30.97	Tegretol CR 200 [NV]

carbamazepine 400 mg tablet: modified release, 200 tablets

2431Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	49.37	37.70	Tegretol CR 400 [NV]

■ CARBAMAZEPINE

Note

For item codes 5040G and 1724R, pharmaceutical benefits that have the form tablet 200 mg are equivalent for the purposes of substitution.

CARBAMAZEPINE Tablet 200 mg, 100

1724R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	2	..	..	*29.34	30.49	^a Carbamazepine Sandoz [SZ]
			^B 2.96	*32.30	30.49	^a Tegretol 200 [NV]

carbamazepine 200 mg tablet, 200

5040G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	29.33	30.48	^a Teril [AF]

■ CARBAMAZEPINE

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

CARBAMAZEPINE Tablet 100 mg, 100

2422L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	2	..	*18.84	19.99	^a Carbamazepine Sandoz [SZ]
			^B 2.96	*21.80	19.99	^a Tegretol 100 [NV]

■ CARBAMAZEPINE

Note

For item codes 2419H and 1706T, pharmaceutical benefits that have the form tablet 200 mg are equivalent for the purposes of substitution.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

CARBAMAZEPINE Tablet 200 mg, 100

1706T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	2	..	*29.34	30.49	^a Carbamazepine Sandoz [SZ]
			^B 2.96	*32.30	30.49	^a Tegretol 200 [NV]

carbamazepine 200 mg tablet, 200

2419H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	29.33	30.48	^a Teril [AF]

■ OXCARBAZEPINE

Authority required (STREAMLINED)**1587**

Treatment of partial epileptic seizures and primary generalised tonic-clonic seizures, which are not controlled satisfactorily by other anti-epileptic drugs

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

oxcarbazepine 150 mg tablet, 100

8584T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	72.61	37.70	Trileptal [NV]

oxcarbazepine 300 mg tablet, 100

8585W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	115.42	37.70	Trileptal [NV]

oxcarbazepine 60 mg/mL oral liquid, 250 mL

8588B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*138.46	37.70	Trileptal [NV]

oxcarbazepine 600 mg tablet, 100

8586X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	188.32	37.70	Trileptal [NV]

Fatty acid derivatives

■ TIAGABINE

Authority required (STREAMLINED)**4928**

Partial epileptic seizures

Clinical criteria:

The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs.

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

tiagabine 10 mg tablet, 50

8222R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*139.18	37.70	Gabitril [OA]

tiagabine 15 mg tablet, 50

8223T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*197.24	37.70	Gabitril [OA]

tiagabine 5 mg tablet, 50

8221Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*72.96	37.70	Gabitril [OA]

■ VALPROATE**Caution**

There are reports of fatal hepatotoxicity, particularly in children.

There is increasing evidence of dose-related teratogenesis from this drug.

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

valproate sodium 100 mg tablet, 100

2294R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	2	..	*32.34	33.49	Epilim [SW]

valproate sodium 200 mg tablet: enteric, 100

2289L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	2	..	*22.58	23.73	^a Sodium Valproate Sandoz [SZ] ^a Valpro 200 [AF]	^a Valprease 200 [QA] ^a Valproate Winthrop EC 200 [WA]
			^B 1.70	*24.28	23.73	^a Epilim EC [SW]	

valproate sodium 200 mg/5 mL oral liquid, 300 mL

2293Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	2	..	*38.92	37.70	Epilim Liquid [SW]

valproate sodium 200 mg/5 mL oral liquid, 300 mL

2295T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	2	..	*38.92	37.70	Epilim Syrup [SW]

valproate sodium 500 mg tablet: enteric, 100

2290M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	2	..	*38.08	37.70	^a Sodium Valproate Sandoz [SZ] ^a Valpro 500 [AF]	^a Valprease 500 [QA] ^a Valproate Winthrop EC 500 [WA]
			^B 1.96	*40.04	37.70	^a Epilim EC [SW]	

■ VIGABATRIN**Caution**

Visual field defects have been reported with this drug.

Authority required (STREAMLINED)**4929**

Epileptic seizures

Clinical criteria:

The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs.

Note**Continuing Therapy Only:**

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

vigabatrin 500 mg oral liquid: powder for, 60 x 500 mg sachets

2668K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	79.48	37.70	Sabril [SW]

vigabatrin 500 mg tablet, 100

2667J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	119.11	37.70	Sabril [SW]

*Other antiepileptics***■ GABAPENTIN****Authority required (STREAMLINED)**

2664

Treatment of partial epileptic seizures which are not controlled satisfactorily by other anti-epileptic drugs

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

gabapentin 100 mg capsule, 100

8505P

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	12.95	14.10	^a APO-Gabapentin [TX] ^a Gabapentin Aspen 100 [FM] ^a Nupentin 100 [AF]	^a Gabacor [NJ] ^a Neurontin [PF]

gabapentin 300 mg capsule, 100

1834M

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	27.43	28.58	^a Gabacor [NJ] ^a Gabapentin Aspen 300 [FM] ^a Gabapentin GH [GQ] ^a Gantin [GN] ^a Neurontin [PF]	^a Gabapentin 300 [CR] ^a Gabapentin-GA [UA] ^a Gabapentin Sandoz [SZ] ^a GenRx Gabapentin [GX] ^a Nupentin 300 [AF]

gabapentin 400 mg capsule, 100

1835N

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	34.94	36.09	^a Gabacor [NJ] ^a Gabapentin Aspen 400 [FM] ^a Gabapentin Sandoz [SZ] ^a GenRx Gabapentin [GX] ^a Nupentin 400 [AF]	^a Gabapentin 400 [CR] ^a Gabapentin GH [GQ] ^a Gantin [GN] ^a Neurontin [PF]

gabapentin 600 mg tablet, 100

8559L

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	50.16	37.70	^a Gabapentin AN [EA] ^a Gabaran [RA] ^a Neurontin [PF] ^a Pharmacor Gabapentin 600 [CR]	^a Gabapentin Aspen 600 [FM] ^a GenRx Gabapentin [GX] ^a Nupentin Tabs [AF]

gabapentin 800 mg tablet, 100

8389M

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	63.81	37.70	^a Gabapentin AN [EA] ^a Gabaran [RA] ^a GenRx Gabapentin [GX] ^a Nupentin Tabs [AF]	^a Gabapentin Aspen 800 [FM] ^a Gantin [GN] ^a Neurontin [PF] ^a Pharmacor Gabapentin 800 [CR]

■ LACOSAMIDE**Authority required (STREAMLINED)****4271**

Intractable partial epileptic seizures

Treatment Phase: Initial

Clinical criteria:

The treatment must be in combination with two or more anti-epileptic drugs which includes one second-line adjunctive agent, **AND**

The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs, which includes at least one first-line anti-epileptic agent and at least two second-line adjunctive anti-epileptic agents, **AND**

The treatment must be for dose titration purposes.

Population criteria:

Patient must be aged 16 years or older.

Treatment criteria:

Must be treated by a neurologist.

Note**Continuing Therapy Only:**

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

lacosamide 100 mg tablet, 14

9334G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	52.63	37.70	Vimpat [UC]

lacosamide 150 mg tablet, 14

9336J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	75.03	37.70	Vimpat [UC]

lacosamide 50 mg tablet, 14

9333F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	30.55	31.70	Vimpat [UC]

■ LACOSAMIDE**Authority required (STREAMLINED)****4264**

Intractable partial epileptic seizures

Treatment Phase: Initial

Clinical criteria:

The treatment must be in combination with two or more anti-epileptic drugs which includes one second-line adjunctive agent, **AND**

The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs, which includes at least one first-line anti-epileptic agent and at least two second-line adjunctive anti-epileptic agents.

Population criteria:

Patient must be aged 16 years or older.

Treatment criteria:

Must be treated by a neurologist.

Authority required (STREAMLINED)**4249**

Intractable partial epileptic seizures

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously been treated with PBS-subsidised lacosamide.

Population criteria:

Patient must be aged 16 years or older.

Note**Continuing Therapy Only:**

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

lacosamide 100 mg tablet, 56

9335H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	188.80	37.70	Vimpat [UC]

■ LACOSAMIDE**Authority required (STREAMLINED)****4240**

Intractable partial epileptic seizures

Treatment Phase: Initial

Clinical criteria:

The treatment must be in combination with two or more anti-epileptic drugs which includes one second-line adjunctive agent, **AND**

The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs, which includes at least one first-line anti-epileptic agent and at least two second-line adjunctive anti-epileptic agents.

Population criteria:

Patient must be aged 16 years or older.

Treatment criteria:

Must be treated by a neurologist.

Authority required (STREAMLINED)**4257**

Intractable partial epileptic seizures

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously been treated with PBS-subsidised lacosamide.

Population criteria:

Patient must be aged 16 years or older.

Note

No applications for increased maximum quantities will be authorised for the 56 tablet packs of the 150 mg and 200 mg strengths.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

lacosamide 150 mg tablet, 56

9337K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	273.00	37.70	Vimpat [UC]

lacosamide 200 mg tablet, 56

9338L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	355.72	37.70	Vimpat [UC]

■ LAMOTRIGINE**Authority required (STREAMLINED)****1426**

Treatment of epileptic seizures which are not controlled satisfactorily by other anti-epileptic drugs

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

lamotrigine 100 mg tablet, 56

2850B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	34.31	35.46	^a APO-Lamotrigine [TX] ^a Lamidus [RA] ^a Lamotrigine AN [EA] ^a Lamotrigine-GA [GN] ^a Lamotrigine Sandoz [SZ] ^a Logem [AL] ^a Seaze 100 [QA]	^a GenRx Lamotrigine [GX] ^a Lamogine [AF] ^a Lamotrigine Aspen 100 [FM] ^a Lamotrigine generichealth [GQ] ^a Lamotrust 100 [CR] ^a Reedos 100 [DO] ^a Torlemo DT 100 [UA]
			^b 2.67	36.98	35.46	^a Lamictal [AS]	

lamotrigine 200 mg tablet, 56

2851C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	51.52	37.70	^a APO-Lamotrigine [TX] ^a Lamidus [RA] ^a Lamotrigine AN [EA] ^a Lamotrigine-GA [GN] ^a Lamotrigine Sandoz [SZ] ^a Logem [AL] ^a Seaze 200 [QA]	^a GenRx Lamotrigine [GX] ^a Lamogine [AF] ^a Lamotrigine Aspen 200 [FM] ^a Lamotrigine generichealth [GQ] ^a Lamotrust 200 [CR] ^a Reedos 200 [DO] ^a Torlemo DT 200 [UA]
			^b 2.32	53.84	37.70	^a Lamictal [AS]	

lamotrigine 25 mg tablet, 56

2848X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.67	17.82	^a APO-Lamotrigine [TX] ^a Lamidus [RA] ^a Lamotrigine AN [EA] ^a Lamotrigine-GA [GN] ^a Lamotrigine Sandoz [SZ] ^a Logem [AL] ^a Seaze 25 [QA]	^a GenRx Lamotrigine [GX] ^a Lamogine [AF] ^a Lamotrigine Aspen 25 [FM] ^a Lamotrigine generichealth [GQ] ^a Lamotrust 25 [CR] ^a Reedos 25 [DO] ^a Torlemo DT 25 [UA]
			^b 2.89	19.56	17.82	^a Lamictal [AS]	

lamotrigine 5 mg tablet, 56

8063J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	11.21	12.36	^a Lamogine [AF] ^a Seaze 5 [QA]	^a Lamotrigine Aspen 5 [FM]
			^b 1.98	13.19	12.36	^a Lamictal [AS]	

lamotrigine 50 mg tablet, 56

2849Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	23.31	24.46	^a APO-Lamotrigine [TX] ^a Lamidus [RA] ^a Lamotrigine AN [EA] ^a Lamotrigine-GA [GN] ^a Lamotrigine Sandoz [SZ] ^a Logem [AL] ^a Seaze 50 [QA]	^a GenRx Lamotrigine [GX] ^a Lamogine [AF] ^a Lamotrigine Aspen 50 [FM] ^a Lamotrigine generichealth [GQ] ^a Lamotruster 50 [CR] ^a Reedos 50 [DO] ^a Torlemo DT 50 [UA]
			^B 2.55	25.86	24.46	^a Lamictal [AS]	

■ LEVETIRACETAM**Authority required (STREAMLINED)****2664**

Treatment of partial epileptic seizures which are not controlled satisfactorily by other anti-epileptic drugs

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

levetiracetam 1 g tablet, 60

8656N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	76.03	37.70	^a APO-Levetiracetam [TX] ^a Kepcet [GN] ^a Kerron 1000 [DO] ^a Levactam [ER] ^a Levetiracetam AN [EA] ^a Levetiracetam SZ [SZ] ^a Levitaccord [RA] ^a Terry White Chemists Levetiracetam [TW]	^a Chem mart Levetiracetam [CH] ^a Keppra [UC] ^a Kevtam [AF] ^a Levecetam 1000 [RZ] ^a Levetiracetam generichealth [GQ] ^a Levi 1000 [FM] ^a Levitam 1000 [QA]

levetiracetam 250 mg tablet, 60

8654L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	32.84	33.99	^a APO-Levetiracetam [TX] ^a Kepcet [GN] ^a Kerron 250 [DO] ^a Levactam [ER] ^a Levetiracetam AN [EA] ^a Levetiracetam SZ [SZ] ^a Levitaccord [RA] ^a Terry White Chemists Levetiracetam [TW]	^a Chem mart Levetiracetam [CH] ^a Keppra [UC] ^a Kevtam [AF] ^a Levecetam 250 [RZ] ^a Levetiracetam generichealth [GQ] ^a Levi 250 [FM] ^a Levitam 250 [QA]

levetiracetam 500 mg tablet, 60

8655M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	49.05	37.70	^a APO-Levetiracetam [TX] ^a Kepcet [GN] ^a Kerron 500 [DO] ^a Levactam [ER] ^a Levetiracetam AN [EA] ^a Levetiracetam SZ [SZ] ^a Levitaccord [RA] ^a Terry White Chemists Levetiracetam [TW]	^a Chem mart Levetiracetam [CH] ^a Keppra [UC] ^a Kevtam [AF] ^a Levecetam 500 [RZ] ^a Levetiracetam generichealth [GQ] ^a Levi 500 [FM] ^a Levitam 500 [QA]

■ LEVETIRACETAM**Authority required (STREAMLINED)****3291**

Treatment of partial epileptic seizures, which are not controlled satisfactorily by other anti-epileptic drugs in a patient unable to take a solid dose form of levetiracetam

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

levetiracetam 100 mg/mL oral liquid, 300 mL

9169N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	111.76	37.70	Keppra [UC]

■ PERAMPANEL

Authority required (STREAMLINED)

4656

Intractable partial epileptic seizures

Treatment Phase: Initial

Clinical criteria:

The treatment must be in combination with two or more anti-epileptic drugs which includes one second-line adjunctive agent, AND

The condition must have failed to be controlled satisfactorily by other anti-epileptic drugs, which includes at least one first-line anti-epileptic agent and at least two second-line adjunctive anti-epileptic agents.

Treatment criteria:

Must be treated by a neurologist.

perampanel 2 mg tablet, 7

10157N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	1	..	*52.64	37.70	Fycompa [EI]

■ PERAMPANEL

Authority required (STREAMLINED)

4658

Intractable partial epileptic seizures

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously been issued with an authority prescription for this drug.

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

perampanel 10 mg tablet, 28

10151G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	355.72	37.70	Fycompa [EI]

perampanel 12 mg tablet, 28

10159Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	355.72	37.70	Fycompa [EI]

perampanel 4 mg tablets, 28

10162W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	188.80	37.70	Fycompa [EI]

perampanel 6 mg tablet, 28

10163X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	273.00	37.70	Fycompa [EI]

perampanel 8 mg tablet, 28

10160R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	355.72	37.70	Fycompa [EI]

■ SULTHIAME

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

sulthiame 200 mg tablet, 200

2100M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	206.33	37.70	Ospolot [PL]

sulthiame 50 mg tablet, 200

2099L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	82.81	37.70	Ospolot [PL]

■ TOPIRAMATE**Authority required (STREAMLINED)****2797**

Treatment of partial epileptic seizures, primary generalised tonic-clonic epileptic seizures and seizures of the Lennox-Gastaut syndrome, which are not controlled satisfactorily by other anti-epileptic drugs

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

topiramate 100 mg tablet, 60

8165R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	47.17	37.70	^a APO-Topiramate [TX] ^a RBX Topiramate [RA] ^a Topamax [JC] ^a Topiramate GH [GQ]	^a Epiramax 100 [QA] ^a Tamate [AF] ^a Topiramate AN [EA] ^a Topiramate Sandoz [SZ]

topiramate 200 mg tablet, 60

8166T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	73.13	37.70	^a APO-Topiramate [TX] ^a RBX Topiramate [RA] ^a Topamax [JC] ^a Topiramate GH [GQ]	^a Epiramax 200 [QA] ^a Tamate [AF] ^a Topiramate AN [EA] ^a Topiramate Sandoz [SZ]

■ TOPIRAMATE**Authority required (STREAMLINED)****2798**

Treatment of partial epileptic seizures, primary generalised tonic-clonic epileptic seizures and seizures of the Lennox-Gastaut syndrome, which are not controlled satisfactorily by other anti-epileptic drugs in patients unable to take a solid dose form of topiramate

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

topiramate 15 mg capsule, 60

8371N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	18.40	19.55	Topamax Sprinkle [JC]

topiramate 25 mg capsule, 60

8372P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	22.49	23.64	Topamax Sprinkle [JC]

topiramate 50 mg capsule, 60

8520K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	32.98	34.13	Topamax Sprinkle [JC]

■ TOPIRAMATE**Authority required (STREAMLINED)****2797**

Treatment of partial epileptic seizures, primary generalised tonic-clonic epileptic seizures and seizures of the Lennox-Gastaut syndrome, which are not controlled satisfactorily by other anti-epileptic drugs

Authority required (STREAMLINED)**2799**

Prophylaxis of migraine in a patient who has experienced an average of 3 or more migraines per month over a period of at least 6 months, and who:

(a) has a contraindication to beta-blockers, as described in the relevant TGA-approved Product Information; OR
 (b) has experienced intolerance of a severity necessitating permanent withdrawal during treatment with a beta-blocker; AND
 (c) has a contraindication to pizotifen because the weight gain associated with this drug poses an unacceptable risk; OR
 (d) has experienced intolerance of a severity necessitating permanent withdrawal during treatment with pizotifen.
 Details of the contraindication and/or intolerance(s) must be documented in the patient's medical records when treatment is initiated

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

topiramate 25 mg tablet, 60

8163P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	22.75	23.90	^a APO-Topiramate [TX] ^a RBX Topiramate [RA] ^a Topamax [JC] ^a Topiramate GH [GQ]	^a Epiramax 25 [QA] ^a Tamate [AF] ^a Topiramate AN [EA] ^a Topiramate Sandoz [SZ]

topiramate 50 mg tablet, 60

8164Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	33.03	34.18	^a APO-Topiramate [TX] ^a RBX Topiramate [RA] ^a Topamax [JC] ^a Topiramate GH [GQ]	^a Epiramax 50 [QA] ^a Tamate [AF] ^a Topiramate AN [EA] ^a Topiramate Sandoz [SZ]

■ ZONISAMIDE**Authority required (STREAMLINED)****2664**

Treatment of partial epileptic seizures which are not controlled satisfactorily by other anti-epileptic drugs

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

zonisamide 100 mg capsule, 56

9390F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*93.80	37.70	Zonegran [SA]

zonisamide 25 mg capsule, 56

9388D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	23.14	24.29	Zonegran [SA]

zonisamide 50 mg capsule, 56

9389E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	34.06	35.21	Zonegran [SA]

■ ANTI-PARKINSON DRUGS**ANTICHOLINERGIC AGENTS***Tertiary amines***■ BENZHEXOL****benzhexol hydrochloride 2 mg tablet, 200**

1109J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	15.66	16.81	Artane [QA]

benzhexol hydrochloride 5 mg tablet, 200

1110K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	22.35	23.50	Artane [QA]

■ BIPERIDEN**Note**

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

biperiden hydrochloride 2 mg tablet, 100

2544X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	2	..	*21.22	22.37	Akineton [LM]

Ethers of tropine or tropine derivatives

■ BENZTROPINE

benztropine mesylate 2 mg tablet, 60

2362H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	15.47	16.62	Benztrop [PL]

benztropine mesylate 2 mg/2 mL injection, 5 x 2 mL ampoules

3038X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	103.93	37.70	Cogentin [FK]

benztropine mesylate 2 mg/2 mL injection, 5 x 2 mL ampoules

5031T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	103.93	37.70	Cogentin [FK]

DOPAMINERGIC AGENTS

Dopa and dopa derivatives

■ LEVODOPA + BENSERAZIDE

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

LEVODOPA with BENSERAZIDE Dispersible tablet 100 mg-25 mg, 100

8219N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	39.26	37.70	Madopar Rapid 125 [RO]

LEVODOPA with BENSERAZIDE Dispersible tablet 50 mg-12.5 mg, 100

8218M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	23.34	24.49	Madopar Rapid 62.5 [RO]

levodopa 100 mg + benserazide 25 mg capsule, 100

2225D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	39.26	37.70	Madopar 125 [RO]

levodopa 100 mg + benserazide 25 mg capsule: modified release, 100 capsules

2231K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	42.34	37.70	Madopar HBS [RO]

levodopa 100 mg + benserazide 25 mg tablet, 100

2229H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	39.26	37.70	Madopar 125 [RO]

levodopa 200 mg + benserazide 50 mg capsule, 100

2226E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	50.35	37.70	Madopar [RO]

levodopa 200 mg + benserazide 50 mg tablet, 100

2228G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	50.35	37.70	Madopar [RO]

levodopa 50 mg + benserazide 12.5 mg capsule, 100

2227F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	23.34	24.49	Madopar 62.5 [RO]

■ LEVODOPA + CARBIDOPA ANHYDROUS

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

levodopa 100 mg + carbidopa anhydrous 25 mg tablet, 100

1242J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	38.63	37.70	^a Kinson [AF]
			^b 5.19	43.82	37.70	^a Sinemet 100/25 [MK]

levodopa 250 mg + carbidopa anhydrous 25 mg tablet, 100

1245M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	45.43	37.70	Sinemet [MK]

■ LEVODOPA + CARBIDOPA ANHYDROUS

Authority required (STREAMLINED)

1257

Parkinson's disease where fluctuations in motor function are not adequately controlled by frequent dosing with conventional formulations of levodopa with decarboxylase inhibitor

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

levodopa 200 mg + carbidopa anhydrous 50 mg tablet: modified release, 100 tablets

1255C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	68.21	37.70	Sinemet CR [MK]

■ LEVODOPA + CARBIDOPA ANHYDROUS

Authority required

Maintenance therapy following treatment which was commenced in a hospital-based movement disorder clinic, of a patient with advanced Parkinson disease with severe disabling motor fluctuations not adequately controlled by oral therapy

Note

Patients should have adequate cognitive function to manage administration with a portable continuous infusion pump.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

levodopa 20 mg/mL + carbidopa monohydrate 5 mg/mL gel: intestinal, 7 x 100 mL bags

8970D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*11682.68	37.70	Duodopa [VE]

■ LEVODOPA + CARBIDOPA ANHYDROUS + ENTACAPONE

Authority required (STREAMLINED)

3305

Parkinson disease in patients being treated with levodopa—decarboxylase inhibitor combinations who are experiencing fluctuations in motor function due to end-of-dose effect

Authority required (STREAMLINED)

3306

Parkinson disease in patients stabilised on concomitant treatment with levodopa—decarboxylase inhibitor combinations and entacapone

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

levodopa 100 mg + carbidopa anhydrous 25 mg + entacapone 200 mg tablet, 100

8798C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	4	..	*342.26	37.70	Stalevo 100/25/200mg [NV]

levodopa 125 mg + carbidopa anhydrous 31.25 mg + entacapone 200 mg tablet, 100

9345W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	4	..	*354.30	37.70	Stalevo 125/31.25/200mg [NV]

levodopa 150 mg + carbidopa anhydrous 37.5 mg + entacapone 200 mg tablet, 100

8799D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	4	..	*372.30	37.70	Stalevo 150/37.5/200mg [NV]

levodopa 200 mg + carbidopa anhydrous 50 mg + entacapone 200 mg tablet, 100

9292C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	4	..	*399.96	37.70	Stalevo 200/50/200mg [NV]

levodopa 50 mg + carbidopa anhydrous 12.5 mg + entacapone 200 mg tablet, 100

8797B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	4	..	*312.22	37.70	Stalevo 50/12.5/200mg [NV]

levodopa 75 mg + carbidopa anhydrous 18.75 mg + entacapone 200 mg tablet, 100

9344T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	4	..	*325.46	37.70	Stalevo 75/18.75/200mg [NV]

Adamantane derivatives**■ AMANTADINE****Restricted benefit**

Parkinson's disease which is not drug induced

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

amantadine hydrochloride 100 mg capsule, 100

3016R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	44.64	37.70	Symmetrel 100 [NV]

Dopamine agonists**■ BROMOCRIPTINE****Restricted benefit**

Acromegaly

Restricted benefit

Parkinson's disease

Restricted benefit

Pathological hyperprolactinaemia where surgery is not indicated

Restricted benefit

Pathological hyperprolactinaemia where surgery has already been used with incomplete resolution

Restricted benefit

Pathological hyperprolactinaemia where radiotherapy is not indicated

Restricted benefit

Pathological hyperprolactinaemia where radiotherapy has already been used with incomplete resolution

Note

Care should be taken when treating patients with advanced age and significant cognitive impairment with dopamine agonists.

For item codes 1443Y and 1559C, pharmaceutical benefits that have the form tablet 2.5 mg (base) are equivalent for the purposes of substitution.

bromocriptine 2.5 mg tablet, 30

1443Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*31.76	32.91	^a Parlodel [NV]

bromocriptine 2.5 mg tablet, 60

1559C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	31.76	32.91	^a Kripton 2.5 [AF]

■ CABERGOLINE**Restricted benefit**

Parkinson's disease

Note

Care should be taken when treating patients with advanced age and significant cognitive impairment with dopamine agonists.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

cabergoline 1 mg tablet, 30

8393R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	60.12	37.70	^a Cabaser [PF]	^a Cobasol [GN]

cabergoline 2 mg tablet, 30

8394T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	78.28	37.70	^a Cabaser [PF]	^a Cobasol [GN]

■ PRAMIPEXOLE**Caution**

Episodes of sudden onset of sleep without warning, during activity, have been reported with this drug.

Restricted benefit

Parkinson disease

Note

Care should be taken when treating patients with advanced age and significant cognitive impairment with dopamine agonists.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

pramipexole hydrochloride monohydrate 1 mg tablet, 100

9153R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	129.16	37.70	^a APO-Pramipexole [TX] ^a Pramipexole GH [GQ] ^a Simipex 1 [QA]	^a Pramipexole AN [EA] ^a Sifrol [BY] ^a Simpral [AF]

pramipexole hydrochloride monohydrate 125 microgram tablet, 30

9151P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	11.23	12.38	^a APO-Pramipexole [TX] ^a Pramipexole GH [GQ] ^a Simipex 0.125 [QA]	^a Pramipexole AN [EA] ^a Sifrol [BY] ^a Simpral [AF]

pramipexole hydrochloride monohydrate 250 microgram tablet, 100

9152Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	36.07	37.22	^a APO-Pramipexole [TX] ^a Pramipexole GH [GQ] ^a Simipex 0.25 [QA]	^a Pramipexole AN [EA] ^a Sifrol [BY] ^a Simpral [AF]

■ PRAMIPEXOLE**Caution**

Episodes of sudden onset of sleep without warning, during activity, have been reported with this drug.

Restricted benefit

Parkinson disease

Note

Care should be taken when treating patients with advanced age and significant cognitive impairment with dopamine agonists.

No applications for increased maximum quantities and/or repeats will be approved for extended release pramipexole formulations.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

pramipexole hydrochloride monohydrate 1.5 mg tablet: modified release, 30 tablets

3420B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	57.24	37.70	Sifrol ER [BY]

pramipexole hydrochloride monohydrate 2.25 mg tablet: modified release, 30 tablets

5143Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	82.50	37.70	Sifrol ER [BY]

pramipexole hydrochloride monohydrate 3 mg tablet: modified release, 30 tablets

3421C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	116.91	37.70	Sifrol ER [BY]

pramipexole hydrochloride monohydrate 3.75 mg tablet: modified release, 30 tablets

5145T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	142.16	37.70	Sifrol ER [BY]

pramipexole hydrochloride monohydrate 375 microgram tablet: modified release, 30 tablets

3418X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	20.18	21.33	Sifrol ER [BY]

pramipexole hydrochloride monohydrate 4.5 mg tablet: modified release, 30 tablets

3422D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	172.00	37.70	Sifrol ER [BY]

pramipexole hydrochloride monohydrate 750 microgram tablet: modified release, 30 tablets

3419Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	33.14	34.29	Sifrol ER [BY]

■ PRAMIPEXOLE**Caution**

Episodes of sudden onset of sleep without warning, during activity, have been reported with this drug.

Restricted benefit

Treatment of severe primary Restless Legs Syndrome in a patient who manifests all 4 diagnostic criteria below and whose baseline International Restless Legs Syndrome Rating Scale (IRLSRS) score is greater than or equal to 21 points prior to initiation of pramipexole.

The date and IRLSRS score must be documented in the patient's medical records at the time pramipexole treatment is initiated.

The diagnostic criteria for Restless Legs Syndrome are:

- (a) An urge to move the legs usually accompanied or caused by unpleasant sensations in the legs; and
- (b) The urge to move or unpleasant sensations begin or worsen during periods of rest or inactivity such as lying or sitting; and
- (c) The urge to move or unpleasant sensations are partially or totally relieved by movement, such as walking or stretching, at least as long as the activity continues; and
- (d) The urge to move or unpleasant sensations are worse in the evening or night than during the day or only occur during the evening or night.

Pramipexole is not PBS-subsidised for Restless Legs Syndrome secondary to other causes

Note

Care should be taken when treating patients with advanced age and significant cognitive impairment with dopamine agonists.

No applications for increased maximum quantities and/or repeats will be authorised.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

pramipexole hydrochloride monohydrate 125 microgram tablet, 30

9393J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	11.23	12.38	Sifrol [BY]

pramipexole hydrochloride monohydrate 250 microgram tablet, 100

9394K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	36.07	37.22	Sifrol [BY]

■ ROTIGOTINE**Restricted benefit**

Parkinson disease

Clinical criteria:

The treatment must be as adjunctive therapy to a levodopa-decarboxylase inhibitor combination.

rotigotine 4 mg/24 hours patch, 28

2384L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	101.20	37.70	Neupro [UC]

rotigotine 6 mg/24 hours patch, 28

2410W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	113.92	37.70	Neupro [UC]

■ **ROTIGOTINE****Restricted benefit**

Parkinson disease

Clinical criteria:

The treatment must be as adjunctive therapy to a levodopa-decarboxylase inhibitor combination.

rotigotine 2 mg/24 hours patch, 28

2385M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	77.59	37.70	Neupro [UC]

Monoamine oxidase B inhibitors■ **RASAGILINE****Authority required (STREAMLINED)****4053**

Parkinson disease

Note

No applications for increased maximum quantities and/or repeats will be authorised.

RASAGILINE Tablet 1 mg (as mesilate), 30

1952R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	121.93	37.70	Azilect [LU]

■ **SELEGILINE****Restricted benefit**

Late stage Parkinson's disease as adjunctive therapy in patients being treated with levodopa—decarboxylase inhibitor combinations

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

selegiline hydrochloride 5 mg tablet, 100

1973W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	53.30	37.70	^a Eldepryl [AS]	^a Selgene [AF]

Other dopaminergic agents■ **ENTACAPONE****Authority required (STREAMLINED)****2067**

Parkinson's disease as adjunctive therapy in patients being treated with levodopa—decarboxylase inhibitor combinations who are experiencing fluctuations in motor function due to end-of-dose effect

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

entacapone 200 mg tablet, 100

8367J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	4	..	*282.16	37.70	Comtan [NV]

■ **PSYCHOLEPTICS****ANTIPSYCHOTICS***Phenothiazines with aliphatic side-chain*

■ CHLORPROMAZINE

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

chlorpromazine hydrochloride 10 mg tablet, 100

1196Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	11.21	12.36	Largactil [SW]

chlorpromazine hydrochloride 100 mg tablet, 100

1199D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	17.78	18.93	Largactil [SW]

chlorpromazine hydrochloride 25 mg tablet, 100

1197B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	11.83	12.98	Largactil [SW]

chlorpromazine hydrochloride 5 mg/mL oral liquid, 100 mL

1201F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	13.13	14.28	Largactil [SW]

chlorpromazine hydrochloride 50 mg/2 mL injection, 10 x 2 mL ampoules

1195X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	20.82	21.97	Largactil [SW]

Phenothiazines with piperazine structure

■ FLUPHENAZINE DECANOATE

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

fluphenazine decanoate 12.5 mg/0.5 mL injection, 5 x 0.5 mL ampoules

1046C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	19.56	20.71	Modecate [BQ]

fluphenazine decanoate 25 mg/mL injection, 5 x 1 mL ampoules

3098C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	26.72	27.87	Modecate [BQ]

fluphenazine decanoate 50 mg/2 mL injection, 5 x 2 mL ampoules

1001Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	37.99	37.70	Modecate [BQ]

■ TRIFLUOPERAZINE

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

trifluoperazine 1 mg tablet, 100

2185B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	16.85	18.00	Stelazine [GH]

trifluoperazine 2 mg tablet, 100

2386N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	21.78	22.93	Stelazine [GH]

trifluoperazine 5 mg tablet, 100

2186C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	23.86	25.01	Stelazine [GH]

*Phenothiazines with piperidine structure***■ PERICYAZINE****Note**

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

pericyazine 10 mg tablet, 100

3053Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	15.53	16.68	Neulactil [SW]

pericyazine 2.5 mg tablet, 100

3052P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	11.03	12.18	Neulactil [SW]

*Butyrophenone derivatives***■ HALOPERIDOL****Note**

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

haloperidol 1.5 mg tablet, 100

2767P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	11.25	12.40	Serenace [QA]

haloperidol 2 mg/mL oral liquid, 100 mL

2763K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	20.79	21.94	Serenace [QA]

haloperidol 5 mg tablet, 50

2770T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	11.02	12.17	Serenace [QA]

haloperidol 5 mg/mL injection, 10 x 1 mL ampoules

2768Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	22.62	23.77	Serenace [QA]

haloperidol 500 microgram tablet, 100

2761H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	10.90	12.05	Serenace [QA]

■ HALOPERIDOL DECANOATE**Note**

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

haloperidol (as decanoate) 150 mg/3 mL injection, 5 x 3 mL ampoules

2766N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	51.87	37.70	Haldol decanoate [JC]

haloperidol (as decanoate) 50 mg/mL injection, 5 x 1 mL vials

2765M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	30.06	31.21	Haldol decanoate [JC]

Indole derivatives

■ ZIPRASIDONE

Authority required (STREAMLINED)

1589

Schizophrenia

Authority required (STREAMLINED)

3084

Monotherapy, for up to 6 months, of an episode of acute mania or mixed episodes associated with bipolar I disorder

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

ziprasidone 20 mg capsule, 60

9070J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	66.05	37.70	^a APO-Ziprasidone [TX]	^a Zeldox [PF]

ziprasidone 40 mg capsule, 60

9071K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	125.54	37.70	^a APO-Ziprasidone [TX]	^a Zeldox [PF]

ziprasidone 60 mg capsule, 60

9072L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	184.30	37.70	^a APO-Ziprasidone [TX]	^a Zeldox [PF]

ziprasidone 80 mg capsule, 60

9073M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	240.24	37.70	^a APO-Ziprasidone [TX]	^a Zeldox [PF]

Thioxanthene derivatives

■ FLUPENTHIXOL DECANOATE

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

flupenthixol decanoate 100 mg/mL injection, 5 x 1 mL ampoules

2257T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	48.61	37.70	Fluanxol Concentrated Depot [LU]

flupenthixol decanoate 20 mg/mL injection, 5 x 1 mL ampoules

2255Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	20.85	22.00	Fluanxol Depot [LU]

■ ZUCLOPENTHIXOL DECANOATE

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

zuclopenthixol decanoate 200 mg/mL injection, 5 x 1 mL ampoules

8097E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	27.58	28.73	Clopixol Depot [LU]

Diazepines, oxazepines, thiazepines and oxepines

■ ASENAPINE

Authority required (STREAMLINED)

1589

Schizophrenia

Authority required (STREAMLINED)

3935

Treatment, for up to 6 months, of an episode of acute mania or mixed episodes associated with bipolar I disorder

Authority required (STREAMLINED)**3936**

Maintenance treatment, as monotherapy, of bipolar I disorder

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

asenapine 10 mg wafer: sublingual, 60 wafers

5141N

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	253.06	37.70	Saphris [LU]

asenapine 5 mg wafer: sublingual, 60 wafers

5140M

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	157.41	37.70	Saphris [LU]

■ OLANZAPINE**Authority required (STREAMLINED)****1589**

Schizophrenia

Authority required (STREAMLINED)**2044**

Maintenance treatment of bipolar I disorder

Note

Pharmaceutical benefits that have the form olanzapine tablet 2.5 mg and pharmaceutical benefits that have the form olanzapine tablet 2.5 mg (as benzoate) are equivalent for the purposes of substitution.

olanzapine 2.5 mg tablet, 28

1024X

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	17.19	18.34 ^a	Olanzapine generichealth 2.5 [GQ]

■ OLANZAPINE**Authority required (STREAMLINED)****1589**

Schizophrenia

Authority required (STREAMLINED)**2044**

Maintenance treatment of bipolar I disorder

Note

Pharmaceutical benefits that have the form olanzapine tablet 5 mg and pharmaceutical benefits that have the form olanzapine tablet 5 mg (as benzoate) are equivalent for the purposes of substitution.

olanzapine 5 mg tablet, 28

1037N

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	27.43	28.58 ^a	Olanzapine generichealth 5 [GQ]

■ OLANZAPINE**Authority required (STREAMLINED)****1589**

Schizophrenia

Authority required (STREAMLINED)**2044**

Maintenance treatment of bipolar I disorder

Note

Pharmaceutical benefits that have the form olanzapine tablet 7.5 mg and pharmaceutical benefits that have the form olanzapine tablet 7.5 mg (as benzoate) are equivalent for the purposes of substitution.

olanzapine 7.5 mg tablet, 28

1041T

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	38.06	37.70 ^a	Olanzapine generichealth 7.5 [GQ]

■ OLANZAPINE

Authority required (STREAMLINED)**1589**

Schizophrenia

Authority required (STREAMLINED)**2044**

Maintenance treatment of bipolar I disorder

Note

Pharmaceutical benefits that have the form olanzapine tablet 10 mg and pharmaceutical benefits that have the form olanzapine tablet 10 mg (as benzoate) are equivalent for the purposes of substitution.

olanzapine 10 mg tablet, 28

1042W

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	47.56	37.70	^a Olanzapine generichealth 10 [GQ]

■ OLANZAPINE

Authority required (STREAMLINED)**1589**

Schizophrenia

Authority required (STREAMLINED)**2044**

Maintenance treatment of bipolar I disorder

Note

Pharmaceutical benefits that have the form olanzapine tablet 5 mg (orally disintegrating) and pharmaceutical benefits that have the form olanzapine wafer 5 mg are equivalent for the purposes of substitution.

OLANZAPINE Tablet 5 mg (orally disintegrating), 28

3381Y

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	27.43	28.58	^a APO-Olanzapine ODT [TX]	^a Chem mart Olanzapine ODT [CH]
					^a Olanzapine AN ODT [EA]	^a Olanzapine-GA ODT [GN]
					^a Olanzapine ODT-DRLA [RZ]	^a Olanzapine ODT generichealth 5 [GQ]
					^a Olanzapine RBX ODT [RA]	^a Olanzapine Sandoz ODT 5 [SZ]
					^a Pharmacy Choice Olanzapine ODT [RI]	^a Terry White Chemists Olanzapine ODT [TW]

■ OLANZAPINE

Authority required (STREAMLINED)**1589**

Schizophrenia

Authority required (STREAMLINED)**2044**

Maintenance treatment of bipolar I disorder

Note

Pharmaceutical benefits that have the form olanzapine tablet 10 mg (orally disintegrating) and pharmaceutical benefits that have the form olanzapine wafer 10 mg are equivalent for the purposes of substitution.

OLANZAPINE Tablet 10 mg (orally disintegrating), 28

3382B

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	47.56	37.70	^a APO-Olanzapine ODT [TX]	^a Chem mart Olanzapine ODT [CH]
					^a Olanzapine AN ODT [EA]	^a Olanzapine-GA ODT [GN]
					^a Olanzapine ODT-DRLA [RZ]	^a Olanzapine ODT generichealth 10 [GQ]
					^a Olanzapine RBX ODT [RA]	^a Olanzapine Sandoz ODT 10 [SZ]
					^a Pharmacy Choice Olanzapine ODT [RI]	^a Terry White Chemists Olanzapine ODT [TW]

■ OLANZAPINE

Authority required (STREAMLINED)**1589**

Schizophrenia

Authority required (STREAMLINED)**2044**

Maintenance treatment of bipolar I disorder

Note

Pharmaceutical benefits that have the form olanzapine tablet 15 mg (orally disintegrating) and pharmaceutical benefits that have the form olanzapine wafer 15 mg are equivalent for the purposes of substitution.

olanzapine 15 mg tablet, 28

3384D

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	66.64	37.70	^a APO-Olanzapine ODT [TX] ^a Olanzapine AN ODT [EA]	^a Chem mart Olanzapine ODT [CH] ^a Terry White Chemists Olanzapine ODT [TW]

■ OLANZAPINE**Authority required (STREAMLINED)****1589**

Schizophrenia

Authority required (STREAMLINED)**2044**

Maintenance treatment of bipolar I disorder

Note

Pharmaceutical benefits that have the form olanzapine tablet 20 mg (orally disintegrating) and pharmaceutical benefits that have the form olanzapine wafer 20 mg are equivalent for the purposes of substitution.

olanzapine 20 mg tablet, 28

3385E

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	86.61	37.70	^a APO-Olanzapine ODT [TX] ^a Olanzapine AN ODT [EA]	^a Chem mart Olanzapine ODT [CH] ^a Terry White Chemists Olanzapine ODT [TW]

■ OLANZAPINE**Authority required (STREAMLINED)****1589**

Schizophrenia

Authority required (STREAMLINED)**2044**

Maintenance treatment of bipolar I disorder

Note

Pharmaceutical benefits that have the form olanzapine tablet 2.5 mg and pharmaceutical benefits that have the form olanzapine tablet 2.5 mg (as benzoate) are equivalent for the purposes of substitution.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

olanzapine 2.5 mg tablet, 28

8170B

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	17.19	18.34	^a APO-Olanzapine [TX] ^a Lanzek [EL] ^a Olanzapine-DRLA [RZ] ^a Olanzapine RBX [RA] ^a Ozin 2.5 [DO] ^a Pharmacy Choice Olanzapine [RI] ^a Zypine [AF]	^a Chem mart Olanzapine [CH] ^a Olanzapine AN [EA] ^a Olanzapine-GA [GN] ^a Olanzapine Sandoz [SZ] ^a Pharmacor Olanzapine 2.5 [CR] ^a Terry White Chemists Olanzapine [TW] ^a Zyprexa [LY]

■ OLANZAPINE**Authority required (STREAMLINED)****1589**

Schizophrenia

Authority required (STREAMLINED)**2044**

Maintenance treatment of bipolar I disorder

Note

Pharmaceutical benefits that have the form olanzapine tablet 5 mg and pharmaceutical benefits that have the form olanzapine tablet 5 mg (as benzoate) are equivalent for the purposes of substitution.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

olanzapine 5 mg tablet, 28

8185T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	27.43	28.58	^a APO-Olanzapine [TX] ^a Lanzek [EL] ^a Olanzapine-DRLA [RZ] ^a Olanzapine GH [GQ] ^a Olanzapine Sandoz [SZ] ^a Pharmacor Olanzapine 5 [CR] ^a Terry White Chemists Olanzapine [TW] ^a Zyprexa [LY]	^a Chem mart Olanzapine [CH] ^a Olanzapine AN [EA] ^a Olanzapine-GA [GN] ^a Olanzapine RBX [RA] ^a Ozin 5 [DO] ^a Pharmacy Choice Olanzapine [RI] ^a Zypine [AF]

■ OLANZAPINE**Authority required (STREAMLINED)****1589**

Schizophrenia

Authority required (STREAMLINED)**2044**

Maintenance treatment of bipolar I disorder

Note

Pharmaceutical benefits that have the form olanzapine tablet 7.5 mg and pharmaceutical benefits that have the form olanzapine tablet 7.5 mg (as benzoate) are equivalent for the purposes of substitution.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

olanzapine 7.5 mg tablet, 28

8186W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	38.06	37.70	^a APO-Olanzapine [TX] ^a Lanzek [EL] ^a Olanzapine-DRLA [RZ] ^a Olanzapine GH [GQ] ^a Olanzapine Sandoz [SZ] ^a Pharmacor Olanzapine 7.5 [CR] ^a Terry White Chemists Olanzapine [TW] ^a Zyprexa [LY]	^a Chem mart Olanzapine [CH] ^a Olanzapine AN [EA] ^a Olanzapine-GA [GN] ^a Olanzapine RBX [RA] ^a Ozin 7.5 [DO] ^a Pharmacy Choice Olanzapine [RI] ^a Zypine [AF]

■ OLANZAPINE**Authority required (STREAMLINED)****1589**

Schizophrenia

Authority required (STREAMLINED)**2044**

Maintenance treatment of bipolar I disorder

Note

Pharmaceutical benefits that have the form olanzapine tablet 10 mg and pharmaceutical benefits that have the form olanzapine tablet 10 mg (as benzoate) are equivalent for the purposes of substitution.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

olanzapine 10 mg tablet, 28

8187X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	47.56	37.70	^a APO-Olanzapine [TX] ^a Lanzek [EL] ^a Olanzapine-DRLA [RZ] ^a Olanzapine GH [GQ] ^a Olanzapine Sandoz [SZ]	^a Chem mart Olanzapine [CH] ^a Olanzapine AN [EA] ^a Olanzapine-GA [GN] ^a Olanzapine RBX [RA] ^a Ozin 10 [DO]

^a Pharmacor Olanzapine 10 [CR]
^a Terry White Chemists Olanzapine [TW]
^a Zyprexa [LY]

^a Pharmacy Choice Olanzapine [RI]
^a Zypine [AF]

■ OLANZAPINE

Authority required (STREAMLINED)

1589

Schizophrenia

Authority required (STREAMLINED)

2044

Maintenance treatment of bipolar I disorder

Note

Pharmaceutical benefits that have the form olanzapine tablet 5 mg (orally disintegrating) and pharmaceutical benefits that have the form olanzapine wafer 5 mg are equivalent for the purposes of substitution.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

olanzapine 5 mg wafer, 28

8433W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	27.43	28.58	^a Lanzek Zydis [EL] ^a Zyprexa Zydis [LY]	^a Zypine ODT [AF]

■ OLANZAPINE

Authority required (STREAMLINED)

1589

Schizophrenia

Authority required (STREAMLINED)

2044

Maintenance treatment of bipolar I disorder

Note

Pharmaceutical benefits that have the form olanzapine tablet 10 mg (orally disintegrating) and pharmaceutical benefits that have the form olanzapine wafer 10 mg are equivalent for the purposes of substitution.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

olanzapine 10 mg wafer, 28

8434X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	47.56	37.70	^a Lanzek Zydis [EL] ^a Zyprexa Zydis [LY]	^a Zypine ODT [AF]

■ OLANZAPINE

Authority required (STREAMLINED)

1589

Schizophrenia

Authority required (STREAMLINED)

2044

Maintenance treatment of bipolar I disorder

Note

Pharmaceutical benefits that have the form olanzapine tablet 15 mg (orally disintegrating) and pharmaceutical benefits that have the form olanzapine wafer 15 mg are equivalent for the purposes of substitution.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

olanzapine 15 mg wafer, 28

8952E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	66.64	37.70	^a Zypine ODT [AF]	^a Zyprexa Zydis [LY]

■ OLANZAPINE

Authority required (STREAMLINED)

1589

Schizophrenia

Authority required (STREAMLINED)**2044**

Maintenance treatment of bipolar I disorder

Note

Pharmaceutical benefits that have the form olanzapine tablet 20 mg (orally disintegrating) and pharmaceutical benefits that have the form olanzapine wafer 20 mg are equivalent for the purposes of substitution.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

olanzapine 20 mg wafer, 28

8953F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	86.61	37.70	^a Zypine ODT [AF]	^a Zyprexa Zydis [LY]

■ OLANZAPINE**Caution**

Monitor for post-injection syndrome for at least two hours after each injection.

Authority required (STREAMLINED)**4304**

Schizophrenia

Note

Special Pricing Arrangements apply.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

olanzapine 210 mg injection: modified release [1 x 210 mg vial] (&) inert substance diluent [1 x 3 mL vial], 1 pack

9294E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*500.12	37.70	Zyprexa Relprevv [LY]

olanzapine 300 mg injection: modified release [1 x 300 mg vial] (&) inert substance diluent [1 x 3 mL vial], 1 pack

9295F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*809.60	37.70	Zyprexa Relprevv [LY]

olanzapine 405 mg injection: modified release [1 x 405 mg vial] (&) inert substance diluent [1 x 3 mL vial], 1 pack

9303P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	500.12	37.70	Zyprexa Relprevv [LY]

■ QUETIAPINE**Authority required (STREAMLINED)****1589**

Schizophrenia

Authority required (STREAMLINED)**2765**

Monotherapy, for up to 6 months, of an episode of acute mania associated with bipolar I disorder

Authority required (STREAMLINED)**2044**

Maintenance treatment of bipolar I disorder

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

quetiapine 100 mg tablet, 90

8457D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	59.99	37.70	^a APO-Quetiapine [TX] ^a Delucon 100 [DO]	^a Chem mart Quetiapine [CH] ^a Kaptan [ER]

- ^a Pharmacor Quetiapine 100 [CR]
^a Quetia 100 [FM]
^a Quetiapine Actavis 100 [VN]
^a Quetiapine-DRLA [RZ]
^a Quetiapine GH 100 [GQ]
^a Quetiapine Sandoz [SZ]
^a Seroquel [AP]
^a Terry White Chemists Quetiapine [TW]
- ^a Pharmacy Choice Quetiapine [RI]
^a Quetiaccord [UA]
^a Quetiapine AN [EA]
^a Quetiapine-GA [GN]
^a Quetiapine RBX [RA]
^a Seronia 100 [QA]
^a Syquet [AF]

quetiapine 150 mg tablet: modified release, 60 tablets

5458G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	59.99	37.70	Seroquel XR [AP]

quetiapine 200 mg tablet, 60

8458E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	79.29	37.70	^a APO-Quetiapine [TX] ^a Delucon 200 [DO] ^a Pharmacor Quetiapine 200 [CR] ^a Quetia 200 [FM] ^a Quetiapine Actavis 200 [VN] ^a Quetiapine-DRLA [RZ] ^a Quetiapine GH 200 [GQ] ^a Quetiapine Sandoz [SZ] ^a Seroquel [AP] ^a Terry White Chemists Quetiapine [TW]	^a Chem mart Quetiapine [CH] ^a Kaptan [ER] ^a Pharmacy Choice Quetiapine [RI] ^a Quetiaccord [UA] ^a Quetiapine AN [EA] ^a Quetiapine-GA [GN] ^a Quetiapine RBX [RA] ^a Seronia 200 [QA] ^a Syquet [AF]

quetiapine 200 mg tablet: modified release, 60 tablets

9203J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	79.29	37.70	Seroquel XR [AP]

quetiapine 300 mg tablet, 60

8580N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	113.20	37.70	^a APO-Quetiapine [TX] ^a Delucon 300 [DO] ^a Pharmacor Quetiapine 300 [CR] ^a Quetia 300 [FM] ^a Quetiapine Actavis 300 [VN] ^a Quetiapine-DRLA [RZ] ^a Quetiapine GH 300 [GQ] ^a Quetiapine Sandoz [SZ] ^a Seroquel [AP] ^a Terry White Chemists Quetiapine [TW]	^a Chem mart Quetiapine [CH] ^a Kaptan [ER] ^a Pharmacy Choice Quetiapine [RI] ^a Quetiaccord [UA] ^a Quetiapine AN [EA] ^a Quetiapine-GA [GN] ^a Quetiapine RBX [RA] ^a Seronia 300 [QA] ^a Syquet [AF]

quetiapine 300 mg tablet: modified release, 60 tablets

9204K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	113.20	37.70	Seroquel XR [AP]

quetiapine 400 mg tablet: modified release, 60 tablets

9205L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	151.84	37.70	Seroquel XR [AP]

quetiapine 50 mg tablet: modified release, 60 tablets

9202H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	45.46	37.70	Seroquel XR [AP]

■ QUETIAPINE**Authority required (STREAMLINED)****4391**

Schizophrenia

Clinical criteria:

The treatment must be for dose titration purposes.

Authority required (STREAMLINED)

4396

Acute mania

Clinical criteria:The condition must be associated with bipolar I disorder, **AND**The treatment must be as monotherapy, **AND**

The treatment must be for dose titration purposes.

Authority required (STREAMLINED)**4385**

Bipolar I disorder

Clinical criteria:The treatment must be maintenance therapy, **AND**

The treatment must be for dose titration purposes.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

quetiapine 25 mg tablet, 60

8456C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	26.44	27.59	^a APO-Quetiapine [TX] ^a Delucon 25 [DO] ^a Pharmacor Quetiapine 25 [CR] ^a Quetia 25 [FM] ^a Quetiapine Actavis 25 [VN] ^a Quetiapine-DRLA [RZ] ^a Quetiapine GH 25 [GQ] ^a Quetiapine Sandoz [SZ] ^a Seroquel [AP] ^a Terry White Chemists Quetiapine [TW]	^a Chem mart Quetiapine [CH] ^a Kaptan [ER] ^a Pharmacy Choice Quetiapine [RI] ^a Quetiaccord [UA] ^a Quetiapine AN [EA] ^a Quetiapine-GA [GN] ^a Quetiapine RBX [RA] ^a Seronia 25 [QA] ^a Syquet [AF]

*Benzamides***■ AMISULPRIDE****Authority required (STREAMLINED)****1589**

Schizophrenia

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

amisulpride 100 mg tablet, 30

8594H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	19.21	20.36	^a Amisulpride 100 Winthrop [WA] ^a APO-Amisulpride [TX] ^a Sulprix [AF]	^a Amisulpride Sandoz [SZ] ^a Solian 100 [SW]

amisulpride 100 mg/mL oral liquid, 60 mL

8736T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*149.08	37.70	Solian Solution [SW]

amisulpride 200 mg tablet, 60

8595J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	58.03	37.70	^a Amisulpride 200 Winthrop [WA] ^a APO-Amisulpride [TX] ^a Sulprix [AF]	^a Amisulpride Sandoz [SZ] ^a Solian 200 [SW]

amisulpride 400 mg tablet, 60

8596K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	99.73	37.70	^a Amipride 400 [QA]	^a Amisulpride 400 Winthrop [WA]
						^a Amisulpride Sandoz [SZ]	^a APO-Amisulpride [TX]
						^a Solian 400 [SW]	^a Sulprix [AF]

Other antipsychotics■ **ARIPIRAZOLE****Authority required (STREAMLINED)****4246**

Schizophrenia

Note**Shared Care Model:**

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

aripiprazole 300 mg injection: modified release [1 x 300 mg vial] (&) inert substance diluent [1 vial], 1 pack

10224D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	324.91	37.70	Abilify Maintena [LU]

aripiprazole 400 mg injection: modified release [1 x 400 mg vial] (&) inert substance diluent [1 vial], 1 pack

10219W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	399.95	37.70	Abilify Maintena [LU]

■ **ARIPIRAZOLE****Authority required (STREAMLINED)****1589**

Schizophrenia

Note**Shared Care Model:**

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

aripiprazole 10 mg tablet, 30

8717T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	152.59	37.70	Abilify [BQ]

aripiprazole 15 mg tablet, 30

8718W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	212.90	37.70	Abilify [BQ]

aripiprazole 20 mg tablet, 30

8719X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	253.77	37.70	Abilify [BQ]

aripiprazole 30 mg tablet, 30

8720Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	303.83	37.70	Abilify [BQ]

■ **PALIPERIDONE****Authority required (STREAMLINED)****4246**

Schizophrenia

Note**Shared Care Model:**

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

paliperidone 100 mg injection: modified release, 1 syringe

5107T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	441.03	37.70	Invega Sustenna [JC]

paliperidone 150 mg injection: modified release, 1 syringe

5109X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	441.03	37.70	Invega Sustenna [JC]

paliperidone 25 mg injection: modified release, 1 syringe

5100K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	149.97	37.70	Invega Sustenna [JC]

paliperidone 3 mg tablet: modified release, 28 tablets

9140C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	79.93	37.70	Invega [JC]

paliperidone 50 mg injection: modified release, 1 syringe

5102M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	285.14	37.70	Invega Sustenna [JC]

paliperidone 6 mg tablet: modified release, 28 tablets

9141D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	154.60	37.70	Invega [JC]

paliperidone 75 mg injection: modified release, 1 syringe

5103N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	363.48	37.70	Invega Sustenna [JC]

paliperidone 9 mg tablet: modified release, 28 tablets

9142E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	226.35	37.70	Invega [JC]

■ RISPERIDONE**Authority required (STREAMLINED)****3083**

Treatment under the supervision of a paediatrician or psychiatrist, in combination with non-pharmacological measures, of severe behavioural disturbances in a patient aged less than 18 years with autism.

Continuing PBS-subsidised treatment under the supervision of a paediatrician or psychiatrist, in combination with non-pharmacological measures, of severe behavioural disturbances in a patient 18 years of age or older with autism who was commenced on PBS-subsidised treatment with risperidone prior to turning 18 years of age.

Behaviour disturbances are defined as severe aggression and injuries to self or others where non-pharmacological methods alone have been unsuccessful.

The diagnosis of autism must be made based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or ICD-10 international classification of mental and behavioural disorders

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

risperidone 2 mg tablet, 60

9079W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	37.02	37.70	^a APO-Risperidone [TX] ^a Rispa [QA] ^a Rispericor 2 [CR] ^a Risperidone AN [EA] ^a Risperidone-GA [GN] ^a Risperidone Sandoz [SZ] ^a Rixadone [AF]	^a Ozidal [RA] ^a Risperdal [JC] ^a Risperidone Actavis 2 [UA] ^a Risperidone-DRLA [RZ] ^a Risperidone generichealth [GQ] ^a Rispernia [ER]

risperidone 2 mg tablet: orally disintegrating, 28

9080X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	2	..	*37.60	37.70	Risperdal Quicklet [JC]

■ RISPERIDONE

Authority required (STREAMLINED)**1589**

Schizophrenia

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

risperidone 500 microgram tablet: orally disintegrating, 28

8870W

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
2	5	..	*14.42	15.57	Risperdal Quicklet [JC]

■ RISPERIDONE

Authority required (STREAMLINED)**1589**

Schizophrenia

Authority required (STREAMLINED)**2272**

Adjunctive therapy to mood stabilisers for up to 6 months, of an episode of acute mania associated with bipolar I disorder

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

risperidone 1 mg tablet, 60

3169T

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	19.97	21.12	^a APO-Risperidone [TX] ^a Rispa [QA] ^a Rispericor 1 [CR] ^a Risperidone AN [EA] ^a Risperidone-GA [GN] ^a Risperidone Sandoz [SZ] ^a Rixadone [AF]	^a Ozidal [RA] ^a Risperdal [JC] ^a Risperidone Actavis 1 [UA] ^a Risperidone-DRLA [RZ] ^a Risperidone generichealth [GQ] ^a Rispernia [ER]

risperidone 1 mg tablet: orally disintegrating, 28

8792R

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
2	5	..	*22.12	23.27	Risperdal Quicklet [JC]

risperidone 1 mg/mL oral liquid, 100 mL

8100H

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
±1	5	..	118.37	37.70	Risperdal [JC]

risperidone 2 mg tablet, 60

3170W

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	37.02	37.70	^a APO-Risperidone [TX] ^a Rispa [QA] ^a Rispericor 2 [CR] ^a Risperidone AN [EA] ^a Risperidone-GA [GN] ^a Risperidone Sandoz [SZ] ^a Rixadone [AF]	^a Ozidal [RA] ^a Risperdal [JC] ^a Risperidone Actavis 2 [UA] ^a Risperidone-DRLA [RZ] ^a Risperidone generichealth [GQ] ^a Rispernia [ER]

risperidone 2 mg tablet: orally disintegrating, 28

8794W

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
2	5	..	*37.60	37.70	Risperdal Quicklet [JC]

risperidone 3 mg tablet, 60

3171X

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	51.83	37.70	^a APO-Risperidone [TX] ^a Rispa [QA] ^a Rispericor 3 [CR] ^a Risperidone AN [EA]	^a Ozidal [RA] ^a Risperdal [JC] ^a Risperidone Actavis 3 [UA] ^a Risperidone-DRLA [RZ]

^a Risperidone-GA [GN]^a Risperidone generichealth [GQ]^a Risperidone Sandoz [SZ]^a Rispernia [ER]^a Rixadone [AF]**risperidone 3 mg tablet: orally disintegrating, 28**

9075P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*51.10	37.70	Risperdal Quicklet [JC]

risperidone 4 mg tablet, 60

3172Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	67.00	37.70	^a APO-Risperidone [TX] ^a Rispa [QA] ^a Rispericor 4 [CR] ^a Risperidone-DRLA [RZ] ^a Risperidone generichealth [GQ] ^a Rispernia [ER]	^a Ozidal [RA] ^a Risperdal [JC] ^a Risperidone AN [EA] ^a Risperidone-GA [GN] ^a Risperidone Sandoz [SZ] ^a Rixadone [AF]

risperidone 4 mg tablet: orally disintegrating, 28

9076Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*65.20	37.70	Risperdal Quicklet [JC]

■ RISPERIDONE**Authority required (STREAMLINED)****1589**

Schizophrenia

Authority required (STREAMLINED)**3841**

Maintenance treatment, in combination with lithium or sodium valproate, of treatment refractory bipolar I disorder

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

risperidone 25 mg injection: modified release [1 x 25 mg vial] (&) inert substance diluent [1 x 2 mL syringe], 1 pack

8780D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*277.44	37.70	Risperdal Consta [JC]

risperidone 37.5 mg injection: modified release [1 x 37.5 mg vial] (&) inert substance diluent [1 x 2 mL syringe], 1 pack

8781E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*353.78	37.70	Risperdal Consta [JC]

risperidone 50 mg injection: modified release [1 x 50 mg vial] (&) inert substance diluent [1 x 2 mL syringe], 1 pack

8782F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*429.32	37.70	Risperdal Consta [JC]

■ RISPERIDONE**Authority required (STREAMLINED)****1589**

Schizophrenia

Note

For item codes 8869T and 1846E, pharmaceutical benefits that have the form tablet 0.5 mg are equivalent for the purposes of substitution.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

risperidone 500 microgram tablet, 20

1846E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	3	5	..	*13.63	14.78	^a APO-Risperidone [TX]	^a Risperdal [JC]

risperidone 500 microgram tablet, 60

8869T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.63	14.78	^a Ozidal [RA] ^a Rispericor 0.5 [CR] ^a Risperidone AN [EA] ^a Risperidone-GA [GN] ^a Risperidone Sandoz [SZ] ^a Rixadone [AF]	^a Rispa [QA] ^a Risperidone Actavis 0.5 [UA] ^a Risperidone-DRLA [RZ] ^a Risperidone GH [GQ] ^a Rispernia [ER]

■ RISPERIDONE**Caution**

In placebo controlled trials in elderly patients with dementia there was a significantly higher incidence of cerebrovascular adverse events, such as stroke (including fatalities) and transient ischaemic attacks, in patients treated with risperidone compared with patients treated with placebo.

Authority required (STREAMLINED)**2061**

Behavioural disturbances characterised by psychotic symptoms and aggression in patients with dementia where non-pharmacological methods have been unsuccessful

Authority required (STREAMLINED)**3083**

Treatment under the supervision of a paediatrician or psychiatrist, in combination with non-pharmacological measures, of severe behavioural disturbances in a patient aged less than 18 years with autism.

Continuing PBS-subsidised treatment under the supervision of a paediatrician or psychiatrist, in combination with non-pharmacological measures, of severe behavioural disturbances in a patient 18 years of age or older with autism who was commenced on PBS-subsidised treatment with risperidone prior to turning 18 years of age.

Behaviour disturbances are defined as severe aggression and injuries to self or others where non-pharmacological methods alone have been unsuccessful.

The diagnosis of autism must be made based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or ICD-10 international classification of mental and behavioural disorders

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

risperidone 1 mg tablet, 60

8789N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	19.97	21.12	^a APO-Risperidone [TX] ^a Rispa [QA] ^a Rispericor 1 [CR] ^a Risperidone AN [EA] ^a Risperidone-GA [GN] ^a Risperidone Sandoz [SZ] ^a Rixadone [AF]	^a Ozidal [RA] ^a Risperdal [JC] ^a Risperidone Actavis 1 [UA] ^a Risperidone-DRLA [RZ] ^a Risperidone generichealth [GQ] ^a Rispernia [ER]

risperidone 1 mg tablet: orally disintegrating, 28

8790P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	2	..	*22.12	23.27	Risperdal Quicklet [JC]

risperidone 1 mg/mL oral liquid, 100 mL

9293D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	2	..	118.37	37.70	Risperdal [JC]

risperidone 500 microgram tablet: orally disintegrating, 28

8788M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	2	..	*14.42	15.57	Risperdal Quicklet [JC]

■ RISPERIDONE**Caution**

In placebo controlled trials in elderly patients with dementia there was a significantly higher incidence of cerebrovascular adverse events, such as stroke (including fatalities) and transient ischaemic attacks, in patients treated with risperidone compared with patients treated with placebo.

Authority required (STREAMLINED)**2061**

Behavioural disturbances characterised by psychotic symptoms and aggression in patients with dementia where non-pharmacological methods have been unsuccessful

Authority required (STREAMLINED)**3083**

Treatment under the supervision of a paediatrician or psychiatrist, in combination with non-pharmacological measures, of severe behavioural disturbances in a patient aged less than 18 years with autism.

Continuing PBS-subsidised treatment under the supervision of a paediatrician or psychiatrist, in combination with non-pharmacological measures, of severe behavioural disturbances in a patient 18 years of age or older with autism who was commenced on PBS-subsidised treatment with risperidone prior to turning 18 years of age.

Behaviour disturbances are defined as severe aggression and injuries to self or others where non-pharmacological methods alone have been unsuccessful.

The diagnosis of autism must be made based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or ICD-10 international classification of mental and behavioural disorders

Note

For item codes 8787L and 1842Y, pharmaceutical benefits that have the form tablet 0.5 mg are equivalent for the purposes of substitution.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

risperidone 500 microgram tablet, 20

1842Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	3	2	..	*13.63	14.78	^a APO-Risperidone [TX]	^a Risperdal [JC]

risperidone 500 microgram tablet, 60

8787L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	13.63	14.78	^a Ozidal [RA] ^a Rispericor 0.5 [CR] ^a Risperidone AN [EA] ^a Risperidone-GA [GN] ^a Risperidone Sandoz [SZ] ^a Rixadone [AF]	^a Rispa [QA] ^a Risperidone Actavis 0.5 [UA] ^a Risperidone-DRLA [RZ] ^a Risperidone GH [GQ] ^a Rispernia [ER]

ANXIOLYTICS*Benzodiazepine derivatives***■ ALPRAZOLAM****Authority required**

Panic disorder where other treatments have failed or are inappropriate

alprazolam 1 mg tablet, 50

2132F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	14.75	15.90	^a Alprax 1 [QA] ^a GenRx Alprazolam [GX] ^a Terry White Chemists Alprazolam [TW]	^a Chem mart Alprazolam [CH] ^a Kalma 1 [AF]

alprazolam 2 mg tablet, 50

8118G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	17.66	18.81	^a Alprax 2 [QA] ^a GenRx Alprazolam [GX] ^a Terry White Chemists Alprazolam [TW]	^a Chem mart Alprazolam [CH] ^a Kalma 2 [AF]

alprazolam 250 microgram tablet, 50

2130D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	11.34	12.49	^a Alprax 0.25 [QA]	^a Kalma 0.25 [AF]

alprazolam 500 microgram tablet, 50

2131E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	12.51	13.66	^a Alprax 0.5 [QA]	^a Kalma 0.5 [AF]

■ DIAZEPAM**diazepam 10 mg/2 mL injection, 5 x 2 mL ampoules**

5073B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	13.68	14.83	Hospira Pty Limited [HH]

diazepam 2 mg tablet, 50

5071X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	7.92	9.07	^a Antenex 2 [AF] ^a Ranzepam [RA]	^a APO-Diazepam [TX] ^a Valpam 2 [QA]

diazepam 5 mg tablet, 50

5072Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	8.04	9.19	^a Antenex 5 [AF] ^a Ranzepam [RA]	^a APO-Diazepam [TX] ^a Valpam 5 [QA]
			^b 2.52	10.56	9.19	^a Valium [RO]	

■ DIAZEPAM**Note**

Authorities for increased maximum quantities and/or repeats for the oral forms of diazepam will be granted only for

- (i) the treatment of disabling spasticity; or
- (ii) malignant neoplasia (late stage); or
- (iii) use by patients who are receiving long-term nursing care on account of age, infirmity or other condition in hospitals, nursing homes or residential facilities and who have been demonstrated, within the past six months, to be benzodiazepine dependent by an unsuccessful attempt at gradual withdrawal; or
- (iv) use by a patient who is receiving long-term nursing care and in respect of whom a Carer Allowance is payable as a disabled adult and who has been demonstrated, within the past six months, to be benzodiazepine dependent by an unsuccessful attempt at gradual withdrawal.

Up to six months' treatment (i.e. one month's treatment with five repeats) may be requested.

diazepam 10 mg/2 mL injection, 5 x 2 mL ampoules

2558P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	13.68	14.83	Hospira Pty Limited [HH]

diazepam 2 mg tablet, 50

3161J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	7.92	9.07	^a Antenex 2 [AF] ^a Ranzepam [RA]	^a APO-Diazepam [TX] ^a Valpam 2 [QA]

diazepam 5 mg tablet, 50

3162K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	8.04	9.19	^a Antenex 5 [AF] ^a Ranzepam [RA]	^a APO-Diazepam [TX] ^a Valpam 5 [QA]
			^b 2.52	10.56	9.19	^a Valium [RO]	

■ DIAZEPAM**Authority required**

Chronic spasticity

Population criteria:

Patient must be under 18 years of age.

diazepam 1 mg/mL oral liquid, 100 mL

2669L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	..	..	43.12	37.70	Diazepam Elixir [ON]

■ OXAZEPAM**oxazepam 15 mg tablet, 25**

5192G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	8.00	9.15	^a Alepam 15 [AF]
			^b 2.68	10.68	9.15	^a Serepax [QA]

oxazepam 30 mg tablet, 25

5193H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	8.00	9.15	^a Alepam 30 [AF] ^a Murelax [FM]	^a APO-Oxazepam [TX]
			^b 2.68	10.68	9.15	^a Serepax [QA]	

■ OXAZEPAM**Note**

Authorities for increased maximum quantities and/or repeats will not be granted except as detailed under the 'Authority required' listing of oxazepam below.

oxazepam 15 mg tablet, 25

3132W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	8.00	9.15	^a Alepam 15 [AF]
			^B 2.68	10.68	9.15	^a Serepax [QA]

oxazepam 30 mg tablet, 25

3133X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	8.00	9.15	^a Alepam 30 [AF]	^a APO-Oxazepam [TX]
			^B 2.68	10.68	9.15	^a Murelax [FM]	
						^a Serepax [QA]	

■ OXAZEPAM**Authority required**

Malignant neoplasia (late stage)

Authority required

For use by patients who are receiving long-term nursing care on account of age, infirmity or other condition in hospitals, nursing homes or residential facilities and who have been demonstrated, within the past 6 months, to be benzodiazepine dependent by an unsuccessful attempt at gradual withdrawal

Authority required

For use by a patient who is receiving long-term nursing care and in respect of whom a Carer Allowance is payable as a disabled adult and who has been demonstrated, within the past 6 months, to be benzodiazepine dependent by an unsuccessful attempt at gradual withdrawal

oxazepam 15 mg tablet, 25

3134Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*9.24	10.39	^a Alepam 15 [AF]
			^B 5.36	*14.60	10.39	^a Serepax [QA]

oxazepam 30 mg tablet, 25

3135B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*9.24	10.39	^a Alepam 30 [AF]	^a APO-Oxazepam [TX]
			^B 5.36	*14.60	10.39	^a Murelax [FM]	
						^a Serepax [QA]	

HYPNOTICS AND SEDATIVES*Benzodiazepine derivatives***■ NITRAZEPAM****nitrazepam 5 mg tablet, 25**

5189D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	8.35	9.50	^a Alodorm [AF]
			^B 1.24	9.59	9.50	^a Mogadon [IA]

■ NITRAZEPAM**Note**

Authorities for increased maximum quantities and/or repeats will not be granted except as detailed under the 'Authority required' listing of nitrazepam below.

nitrazepam 5 mg tablet, 25

2723H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	8.35	9.50	^a Alodorm [AF]
			^B 1.24	9.59	9.50	^a Mogadon [IA]

■ NITRAZEPAM**Authority required**

Myoclonic epilepsy

Authority required

Malignant neoplasia (late stage)

Authority required

For use by patients who are receiving long-term nursing care on account of age, infirmity or other condition in hospitals, nursing homes or residential facilities and who have been demonstrated, within the past 6 months, to be benzodiazepine dependent by an unsuccessful attempt at gradual withdrawal

Authority required

For use by a patient who is receiving long-term nursing care and in respect of whom a Carer Allowance is payable as a disabled adult and who has been demonstrated, within the past 6 months, to be benzodiazepine dependent by an unsuccessful attempt at gradual withdrawal

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

nitrazepam 5 mg tablet, 25

2732T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*9.94	11.09	^a Alodorm [AF]
			^B 2.48	*12.42	11.09	^a Mogadon [IA]

■ TEMAZEPAM**temazepam 10 mg tablet, 25**

5221T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
DP	1	..	..	7.69	8.84	^a APO-Temazepam [TX]	^a Temaze [AF]
			^B 4.00	11.69	8.84	^a Temtabs [FM]	
						^a Normison [QA]	

■ TEMAZEPAM**Note**

Authorities for increased maximum quantities and/or repeats will not be granted except as detailed under the 'Authority required' listing of temazepam below.

temazepam 10 mg tablet, 25

2089Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	7.69	8.84	^a APO-Temazepam [TX]	^a Temaze [AF]
			^B 4.00	11.69	8.84	^a Temtabs [FM]	
						^a Normison [QA]	

■ TEMAZEPAM**Authority required**

Malignant neoplasia (late stage)

Authority required

For use by patients who are receiving long-term nursing care on account of age, infirmity or other condition in hospitals, nursing homes or residential facilities and who have been demonstrated, within the past 6 months, to be benzodiazepine dependent by an unsuccessful attempt at gradual withdrawal

Authority required

For use by a patient who is receiving long-term nursing care and in respect of whom a Carer Allowance is payable as a disabled adult and who has been demonstrated, within the past 6 months, to be benzodiazepine dependent by an unsuccessful attempt at gradual withdrawal

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

temazepam 10 mg tablet, 25

2088X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*8.62	9.77	^a APO-Temazepam [TX]	^a Temaze [AF]
			^B 8.00	*16.62	9.77	^a Temtabs [FM]	
						^a Normison [QA]	

■ PSYCHOANALEPTICS**ANTIDEPRESSANTS**

Non-selective monoamine reuptake inhibitors

■ AMITRIPTYLINE**Note**

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

amitriptyline hydrochloride 10 mg tablet, 50

2417F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	9.65	10.80	^a APO-Amitriptyline 10 [TX]	^a Chem mart Amitriptyline [CH]

^a Endep 10 [AF]^a Terry White Chemists
Amitriptyline [TW]**amitriptyline hydrochloride 25 mg tablet, 50**

2418G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	9.87	11.02	^a APO-Amitriptyline 25 [TX] ^a Endep 25 [AF]	^a Chem mart Amitriptyline [CH] ^a Terry White Chemists Amitriptyline [TW]

amitriptyline hydrochloride 50 mg tablet, 50

2429W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	10.33	11.48	^a APO-Amitriptyline 50 [TX] ^a Endep 50 [AF]	^a Chem mart Amitriptyline [CH] ^a Terry White Chemists Amitriptyline [TW]

■ CLOMIPRAMINE**Restricted benefit**

Cataplexy associated with narcolepsy

Restricted benefit

Obsessive-compulsive disorder

Restricted benefit

Phobic disorders in adults

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

clomipramine hydrochloride 25 mg tablet, 50

1561E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	14.49	15.64	^a Chem mart Clomipramine [CH] ^a Placil [AF]	^a GenRx Clomipramine [GX] ^a Terry White Chemists Clomipramine [TW]
			^B 2.74	17.23	15.64	^a Anafranil 25 [NV]	

■ DOTHIEPIN**Note**

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

dothiepin hydrochloride 25 mg capsule, 50

1357K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	9.72	10.87	Dothep 25 [AF]

dothiepin hydrochloride 75 mg tablet, 30

1358L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	9.72	10.87	Dothep 75 [AF]

■ DOXEPIN**Note**

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

doxepin 10 mg capsule, 50

1011F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	10.26	11.41	Deptran 10 [AF]
			^B 2.86	13.12	11.41	Sinequan [PF]

doxepin 25 mg capsule, 50

1013H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	10.39	11.54	Deptran 25 [AF]
			^B 2.73	13.12	11.54	Sinequan [PF]

doxepin 50 mg tablet, 50

1012G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	11.36	12.51	Deptran 50 [AF]

■ IMIPRAMINE**Note**

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

imipramine hydrochloride 10 mg tablet, 50

2420J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	8.88	10.03	^a Tolerade 10 [PQ]
			^B 2.79	11.67	10.03	^a Tofranil 10 [LM]

imipramine hydrochloride 25 mg tablet, 50

2421K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	12.77	13.92	^a Tolerade 25 [PQ]
			^B 2.78	15.55	13.92	^a Tofranil 25 [LM]

■ NORTRIPTYLINE**Restricted benefit**

Major depression where other antidepressant therapy has failed

Restricted benefit

Major depression where other antidepressant therapy is contraindicated

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

nortriptyline 10 mg tablet, 50

2522R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	13.66	14.81	Allegron [AS]

nortriptyline 25 mg tablet, 50

2523T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	15.44	16.59	Allegron [AS]

Selective serotonin reuptake inhibitors**■ CITALOPRAM****Restricted benefit**

Major depressive disorders

citalopram 10 mg tablet, 28

8702B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	8.39	9.54	^a Celapram [AF] ^a Citalopram-GA [GN]	^a Citalopram Actavis [UA]

citalopram 20 mg tablet, 28

8220P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	9.23	10.38	^a APO-Citalopram [TX] ^a Celapram [AF] ^a Chem mart Citalopram [CH] ^a Citalopram Actavis [VN] ^a Citalopram-GA [GN] ^a Citalopram Sandoz [SZ] ^a Talam [QA]	^a Auro-Citalopram 20 [DO] ^a Celica [RA] ^a Ciazil [UA] ^a Citalopram AN [EA] ^a Citalopram generichealth [GQ] ^a Pharmacor Citalo 20 [CR] ^a Terry White Chemists Citalopram [TW]
			^B 5.70	14.93	10.38	^a Cipramil [LU]	

citalopram 40 mg tablet, 28

8703C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	10.95	12.10	^a APO-Citalopram [TX] ^a Celapram [AF]	^a Auro-Citalopram 40 [DO] ^a Citalopram Actavis [VN]

^a Citalopram AN [EA]
^a Citalopram Sandoz [SZ]

^a Citalopram-GA [GN]

■ ESCITALOPRAM

Restricted benefit

Major depressive disorders

escitalopram 10 mg tablet, 28

8700X

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	10.97	12.12	^a APO-Escitalopram [TX] ^a Cilopam-S [ER] ^a Escitalopram AN [EA] ^a Escitalopram GA [GN] ^a Esipram [UA] ^a Lexam 10 [QA] ^a Pharmacor Escitalopram 10 [CR]	^a Chem mart Escitalopram [CH] ^a Escicor 10 [RA] ^a Escitalopram-DRLA [RZ] ^a Escitalopram generichealth [GQ] ^a Esitalo [SZ] ^a LoxaLate [AF] ^a Terry White Chemists Escitalopram [TW]
		^B 4.28	15.25	12.12	^a Lexapro [LU]	

escitalopram 20 mg tablet, 28

8701Y

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	11.00	12.15	^a APO-Escitalopram [TX] ^a Cilopam-S [ER] ^a Escitalopram AN [EA] ^a Escitalopram GA [GN] ^a Esipram [UA] ^a Lexam 20 [QA] ^a Pharmacor Escitalopram 20 [CR]	^a Chem mart Escitalopram [CH] ^a Escicor 20 [RA] ^a Escitalopram-DRLA [RZ] ^a Escitalopram generichealth [GQ] ^a Esitalo [SZ] ^a LoxaLate [AF] ^a Terry White Chemists Escitalopram [TW]
		^B 4.95	15.95	12.15	^a Lexapro [LU]	

■ ESCITALOPRAM

Restricted benefit

Moderate to severe generalised anxiety disorder (GAD)

Clinical criteria:

The condition must be defined by Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) criteria, **AND** Patient must not have responded to non-pharmacological therapy, **AND**

Patient must be one for whom a GP Mental Health Care Plan, as described under items 2715 or 2717 of the Medicare Benefits Schedule, has been prepared.

Restricted benefit

Moderate to severe generalised anxiety disorder (GAD)

Clinical criteria:

The condition must be defined by Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) criteria, **AND** Patient must not have responded to non-pharmacological therapy, **AND**

Patient must have been assessed by a psychiatrist.

Restricted benefit

Moderate to severe social anxiety disorder (social phobia, SAD)

Clinical criteria:

The condition must be defined by Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) criteria, **AND** Patient must not have responded to non-pharmacological therapy, **AND**

Patient must be one for whom a GP Mental Health Care Plan, as described under items 2715 or 2717 of the Medicare Benefits Schedule, has been prepared.

Restricted benefit

Moderate to severe social anxiety disorder (social phobia, SAD)

Clinical criteria:

The condition must be defined by Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) criteria, **AND** Patient must not have responded to non-pharmacological therapy, **AND**

Patient must have been assessed by a psychiatrist.

escitalopram 10 mg tablet, 28

9432K

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	10.97	12.12	^a Esipram [UA]
		^B 4.28	15.25	12.12	^a Lexapro [LU]

escitalopram 20 mg tablet, 28

9433L

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	5	..	11.00	12.15	^a Esipram [UA]

^B4.95 15.95 12.15 ^a Lexapro [LU]

■ ESCITALOPRAM

Restricted benefit

Major depressive disorders

Restricted benefit

Moderate to severe generalised anxiety disorder (GAD)

Clinical criteria:

The condition must be defined by Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) criteria, **AND**

Patient must not have responded to non-pharmacological therapy, **AND**

Patient must be one for whom a GP Mental Health Care Plan, as described under items 2715 or 2717 of the Medicare Benefits Schedule, has been prepared.

Restricted benefit

Moderate to severe generalised anxiety disorder (GAD)

Clinical criteria:

The condition must be defined by Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) criteria, **AND**

Patient must not have responded to non-pharmacological therapy, **AND**

Patient must have been assessed by a psychiatrist.

Restricted benefit

Moderate to severe social anxiety disorder (social phobia, SAD)

Clinical criteria:

The condition must be defined by Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) criteria, **AND**

Patient must not have responded to non-pharmacological therapy, **AND**

Patient must be one for whom a GP Mental Health Care Plan, as described under items 2715 or 2717 of the Medicare Benefits Schedule, has been prepared.

Restricted benefit

Moderate to severe social anxiety disorder (social phobia, SAD)

Clinical criteria:

The condition must be defined by Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) criteria, **AND**

Patient must not have responded to non-pharmacological therapy, **AND**

Patient must have been assessed by a psychiatrist.

escitalopram 20 mg/mL oral liquid, 15 mL

10181W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	36.63	37.70	Lexapro [LU]

■ FLUOXETINE

Restricted benefit

Major depressive disorders

Restricted benefit

Obsessive-compulsive disorder

fluoxetine 20 mg capsule, 28

1434L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.35	13.50	^a Auscap Aspen [QA] ^a Fluoxetine 20 [CR] ^a Fluoxetine-GA [GN] ^a Fluoxetine RBX [RA] ^a GenRx Fluoxetine [GX] ^a Terry White Chemists Fluoxetine [TW]	^a Chem mart Fluoxetine [CH] ^a Fluoxetine AN [EA] ^a Fluoxetine generichealth [GQ] ^a Fluoxetine Sandoz [SZ] ^a Lovan [AL] ^a Zactin [AF]
			^B 1.78	14.13	13.50	^a Prozac 20 [LY]	

fluoxetine 20 mg tablet: dispersible, 28

8270G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.35	13.50	^a Lovan 20 Tab [AL]	^a Zactin Tablet [AF]
			^B 1.78	14.13	13.50	^a Prozac Tab [LY]	

■ FLUVOXAMINE

Restricted benefit

Major depressive disorders

Restricted benefit

Obsessive-compulsive disorder

fluvoxamine maleate 100 mg tablet, 30

8174F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	17.95	19.10	^a APO-Fluvoxamine [TX] ^a Fluvoxamine GA [GN]	^a Faverin 100 [QA] ^a Movox 100 [AF]

						^a Voxam [SZ]	
			^B 3.10	21.05	19.10	^a Luvox [GO]	
fluvoxamine maleate 50 mg tablet, 30							
8512B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	14.14	15.29	^a APO-Fluvoxamine [TX] ^a Fluvoxamine GA [GN] ^a Voxam [SZ]	^a Faverin 50 [QA] ^a Movox 50 [AL]
			^B 3.11	17.25	15.29	^a Luvox [GO]	

PAROXETINE

Restricted benefit

Major depressive disorders

Restricted benefit

Obsessive-compulsive disorder

Restricted benefit

Panic disorder

Note

Pharmaceutical benefits that have the form paroxetine tablet 20 mg (as hydrochloride) and pharmaceutical benefits that have the form paroxetine tablet 20 mg (as mesilate) are equivalent for the purposes of substitution.

paroxetine 20 mg tablet, 30

2242B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.44	13.59	^a Chem mart Paroxetine [CH] ^a GenRx Paroxetine [GX] ^a Paroxetine AN [EA] ^a Paroxetine GH [GQ] ^a Paxtine [AF] ^a Terry White Chemists Paroxetine [TW]	^a Extine 20 [QA] ^a Paroxetine Actavis [UA] ^a Paroxetine-GA [GN] ^a Paroxetine Sandoz [SZ] ^a Roxet 20 [DO]
			^B 2.52	14.96	13.59	^a Aropax [AS]	

paroxetine 20 mg tablet, 30

9197C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	
NP	1	5	..	12.44	13.59	^a Paroxetine generichealth [GQ]	

SERTRALINE

Restricted benefit

Major depressive disorders

sertraline 100 mg tablet, 30

2237R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	9.55	10.70	^a APO-Sertraline [TX] ^a Chem mart Sertraline [CH] ^a GenRx Sertraline [GX] ^a Sertracor 100 [CR] ^a Sertraline AN [EA] ^a Sertraline generichealth [GQ] ^a Setrona [RA] ^a Xydep 100 [GN]	^a Auro-Sertraline 100 [DO] ^a Eleva 100 [AF] ^a Sertra 100 [QA] ^a Sertraline Actavis [UA] ^a Sertraline-DRLA [RZ] ^a Sertraline Sandoz [SZ] ^a Terry White Chemists Sertraline [TW]
			^B 0.59	10.14	10.70	^a Zoloft [PF]	

sertraline 50 mg tablet, 30

2236Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	9.55	10.70	^a APO-Sertraline [TX] ^a Chem mart Sertraline [CH] ^a GenRx Sertraline [GX] ^a Sertracor 50 [CR] ^a Sertraline AN [EA] ^a Sertraline generichealth [GQ] ^a Setrona [RA] ^a Xydep 50 [GN]	^a Auro-Sertraline 50 [DO] ^a Eleva 50 [AF] ^a Sertra 50 [QA] ^a Sertraline Actavis [UA] ^a Sertraline-DRLA [RZ] ^a Sertraline Sandoz [SZ] ^a Terry White Chemists Sertraline [TW]
			^B 0.59	10.14	10.70	^a Zoloft [PF]	

SERTRALINE

Restricted benefit

Obsessive-compulsive disorder

Restricted benefit

Panic disorder where other treatments have failed or are inappropriate

sertraline 100 mg tablet, 30

8837D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	9.55	10.70	^a Auro-Sertraline 100 [DO] ^a Sertraline Actavis [UA] ^a Xydep 100 [GN]	^a Eleva 100 [AF] ^a Sertraline AN [EA]
			^B 0.59	10.14	10.70	^a Zoloft [PF]	

sertraline 50 mg tablet, 30

8836C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	9.55	10.70	^a Auro-Sertraline 50 [DO] ^a Sertraline Actavis [UA] ^a Xydep 50 [GN]	^a Eleva 50 [AF] ^a Sertraline AN [EA]
			^B 0.59	10.14	10.70	^a Zoloft [PF]	

Monoamine oxidase inhibitors, non-selective**■ PHENELZINE****Caution**

This drug is an irreversible monoamine oxidase inhibitor.

Restricted benefit

Depression where all other anti-depressant therapy has failed or is inappropriate

phenelzine 15 mg tablet, 100

2856H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	100.44	37.70	Nardil [LM]

■ TRANYLCPROMINE**Caution**

This drug is an irreversible monoamine oxidase inhibitor.

tranlycypromine 10 mg tablet, 50

2444P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	58.66	37.70	Parnate [GH]

Monoamine oxidase A inhibitors**■ MOCLOBEMIDE****Restricted benefit**

Major depressive disorders

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

moclobemide 150 mg tablet, 60

1900B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.14	14.29	^a Amira 150 [AF] ^a Clobemix [GN] ^a Moclobemide AN [EA] ^a Mohexal [HX]	^a Chem mart Moclobemide [CH] ^a GenRx Moclobemide [GX] ^a Moclobemide Sandoz [SZ] ^a Terry White Chemists Moclobemide [TW]
			^B 0.37	13.51	14.29	^a Aurorix [HM]	

moclobemide 300 mg tablet, 60

8003F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	19.04	20.19	^a Amira 300 [AF] ^a Clobemix [GN] ^a Moclobemide AN [EA] ^a Terry White Chemists Moclobemide [TW]	^a Chem mart Moclobemide [CH] ^a GenRx Moclobemide [GX] ^a Moclobemide Sandoz [SZ]
			^B 0.74	19.78	20.19	^a Aurorix 300 mg [HM]	

Other antidepressants**■ DESVENLAFAXINE****Restricted benefit**

Major depressive disorders

Note**Continuing Therapy Only:**

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

Pharmaceutical benefits that have the forms desvenlafaxine tablet (modified release) 50 mg, desvenlafaxine tablet (modified release) 50 mg (as benzoate) and desvenlafaxine tablet (extended release) 50 mg (as succinate) are equivalent for the purposes of substitution.

Pharmaceutical benefits that have the forms desvenlafaxine tablet (modified release) 100 mg, desvenlafaxine tablet (modified release) 100 mg (as benzoate) and desvenlafaxine tablet (extended release) 100 mg (as succinate) are equivalent for the purposes of substitution.

desvenlafaxine 100 mg tablet: modified release, 28 tablets

10231L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	42.75	37.70	^a Desfax [AF]	^a Desvenlafaxine Actavis [GN]

desvenlafaxine 100 mg tablet: modified release, 28 tablets

10245F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	42.75	37.70	^a Desvenlafaxine GH XR [GQ]

desvenlafaxine 100 mg tablet: modified release, 28 tablets

9367B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	42.75	37.70	^a Pristiq [PF]

desvenlafaxine 50 mg tablet: modified release, 28 tablets

10234P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	36.25	37.40	^a Desvenlafaxine GH XR [GQ]

desvenlafaxine 50 mg tablet: modified release, 28 tablets

10241B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	36.25	37.40	^a Desfax [AF]	^a Desvenlafaxine Actavis [GN]

desvenlafaxine 50 mg tablet: modified release, 28 tablets

9366Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	36.25	37.40	^a Pristiq [PF]

■ DULOXETINE**Restricted benefit**

Major depressive disorders

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

duloxetine 30 mg capsule: enteric, 28

9155W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	18.71	19.86	^a Andeptra [EL] ^a Chem mart Duloxetine [CH] ^a Cymbalta [LY] ^a Depreta 30 [DO] ^a Duloxetine AN [EA] ^a Duloxetine GH [GQ] ^a Pharmacor Duloxetine 30 [CR]	^a APO-Duloxetine [TX] ^a Coperin [AF] ^a Deotine 30 [SZ] ^a Drulox [GN] ^a Duloxetine-DRLA [RZ] ^a Duloxetine RBX [RA] ^a Terry White Chemists Duloxetine [TW]

duloxetine 60 mg capsule: enteric, 28

9156X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	23.81	24.96	^a Andeptra [EL] ^a Chem mart Duloxetine [CH] ^a Cymbalta [LY] ^a Depreta 60 [DO] ^a Duloxetine AN [EA] ^a Duloxetine GH [GQ] ^a Pharmacor Duloxetine 60 [CR]	^a APO-Duloxetine [TX] ^a Coperin [AF] ^a Deotine 60 [SZ] ^a Drulox [GN] ^a Duloxetine-DRLA [RZ] ^a Duloxetine RBX [RA] ^a Terry White Chemists Duloxetine [TW]

■ LITHIUM CARBONATE

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

lithium carbonate 250 mg tablet, 200

3059B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	17.23	18.38	Lithicarb [AS]

lithium carbonate 450 mg tablet: modified release, 100 tablets

8290H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	2	..	*34.64	35.79	Quilonum SR [AS]

■ MIANSERIN

Caution

Neutropenia and agranulocytosis are more frequent in the elderly, especially in the early months of therapy.

Restricted benefit

Severe depression

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

mianserin hydrochloride 10 mg tablet, 50

1627P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	15.73	16.88	Lumin 10 [AF]

mianserin hydrochloride 20 mg tablet, 50

1628Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	25.68	26.83	Lumin 20 [AF]

■ MIRTAZAPINE

Restricted benefit

Major depressive disorders

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

MIRTAZAPINE Tablet 15 mg (orally disintegrating), 30

8855C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	13.55	14.70	^a Milivin OD 15 [DO] ^a Mirtazapine Sandoz ODT 15 [SZ]	^a Mirtazapine AN ODT [EA] ^a Remeron SolTab [FR]
			^b 1.03	14.58	14.70	^a Avanza SolTab [MK]	

MIRTAZAPINE Tablet 30 mg (orally disintegrating), 30

8856D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	15.81	16.96	^a Milivin OD 30 [DO] ^a Mirtazapine Sandoz ODT 30 [SZ]	^a Mirtazapine AN ODT [EA] ^a Remeron SolTab [FR]
			^b 1.01	16.82	16.96	^a Avanza SolTab [MK]	

MIRTAZAPINE Tablet 45 mg (orally disintegrating), 30

8857E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	20.40	21.55	^a Milivin OD 45 [DO] ^a Mirtazapine Sandoz ODT 45 [SZ]	^a Mirtazapine AN ODT [EA] ^a Remeron SolTab [FR]
			^b 1.02	21.42	21.55	^a Avanza SolTab [MK]	

mirtazapine 15 mg tablet, 30

9365X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	10.69	11.84	^a APO-Mirtazapine [TX] ^a Mirtazapine AN [EA]	^a Axit 15 [AF]

mirtazapine 30 mg tablet, 30

8513C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	12.67	13.82	^a APO-Mirtazapine [TX] ^a Axit 30 [AF] ^a GenRx Mirtazapine [GX] ^a Mirtazapine-GA [GN] ^a Mirtazapine Sandoz [SZ] ^a Terry White Chemists Mirtazapine [TW]	^a Aurozapine 30 [DO] ^a Chem mart Mirtazapine [CH] ^a Mirtazapine AN [EA] ^a Mirtazapine GH [GQ] ^a Mirtazon [QA]
			^b 2.99	15.66	13.82	^a Avanza [MK]	

mirtazapine 45 mg tablet, 30

8883M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.60	17.75	^a APO-Mirtazapine [TX] ^a Axit 45 [AF] ^a Mirtazapine AN [EA] ^a Mirtazapine GH [GQ] ^a Mirtazon [QA]	^a Aurozapine 45 [DO] ^a Chem mart Mirtazapine [CH] ^a Mirtazapine-GA [GN] ^a Mirtazapine Sandoz [SZ] ^a Terry White Chemists Mirtazapine [TW]
			^b 2.99	19.59	17.75	^a Avanza [MK]	

REBOXETINE**Restricted benefit**

Major depressive disorders

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

reboxetine 4 mg tablet, 60

8583R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	39.10	37.70	Edronax [PF]

VENLAFAXINE**Restricted benefit**

Major depressive disorders

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

venlafaxine 150 mg capsule: modified release, 28 capsules

8302Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	18.81	19.96	^a Altven [FZ] ^a Blooms the Chemist Venlafaxine XR [IB] ^a Efexor-XR [PF] ^a Enlafax-XR [AF] ^a Venlafaxine Actavis XR [UA] ^a Venlafaxine generichealth XR [GQ] ^a Venlafaxine SR SCP 150 [CR] ^a Venlexor XR [GN]	^a APO-Venlafaxine XR [TX] ^a Chem mart Venlafaxine XR [CH] ^a Elaxine SR 150 [ZP] ^a Terry White Chemists Venlafaxine XR [TW] ^a Venlafaxine AN SR [EA] ^a Venlafaxine Sandoz XR [SZ] ^a Venla RBX [RA]

venlafaxine 37.5 mg capsule: modified release, 28 capsules

8868R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	12.36	13.51	^a Altven [FZ] ^a Elaxine SR 37.5 [ZP] ^a Venlafaxine AN SR [EA]	^a Efexor-XR [PF] ^a Venlafaxine Actavis XR [UA]

venlafaxine 75 mg capsule: modified release, 28 capsules

8301X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	16.65	17.80	^a Altven [FZ] ^a Blooms the Chemist Venlafaxine XR [IB] ^a Efexor-XR [PF] ^a Enlafax-XR [AF] ^a Venlafaxine Actavis XR [UA] ^a Venlafaxine generichealth XR [GQ] ^a Venlafaxine SR SCP 75 [CR] ^a Venlexor XR [GN]	^a APO-Venlafaxine XR [TX] ^a Chem mart Venlafaxine XR [CH] ^a Elaxine SR 75 [ZP] ^a Terry White Chemists Venlafaxine XR [TW] ^a Venlafaxine AN SR [EA] ^a Venlafaxine Sandoz XR [SZ] ^a Venla RBX [RA]

PSYCHOSTIMULANTS, AGENTS USED FOR ADHD AND NOOTROPICS*Centrally acting sympathomimetics***■ ATOMOXETINE****Authority required (STREAMLINED)****4591**

Attention deficit hyperactivity disorder

Treatment Phase: Initial treatment

Clinical criteria:

The condition must be or have been diagnosed by a paediatrician or psychiatrist according to the DSM-5 criteria, **AND** Patient must have a contraindication to dexamphetamine or methylphenidate as specified in TGA-approved product information; OR

Patient must have a comorbid mood disorder that has developed or worsened as a result of dexamphetamine or methylphenidate treatment and is of a severity necessitating treatment withdrawal; OR

Patient must be at an unacceptable medical risk of a severity necessitating permanent stimulant treatment withdrawal if given a stimulant treatment with another agent; OR

Patient must have experienced adverse reactions of a severity necessitating permanent treatment withdrawal following treatment with dexamphetamine and treatment with methylphenidate (not simultaneously).

Population criteria:

Patient must be or have been diagnosed between the ages of 6 and 18 years inclusive.

Authority required (STREAMLINED)**4578**

Attention deficit hyperactivity disorder

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have previously been issued with an authority prescription for this drug.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

atomoxetine 10 mg capsule, 28

9092M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*221.52	37.70	Strattera [LY]

atomoxetine 100 mg capsule, 28

9290Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	147.45	37.70	Strattera [LY]

atomoxetine 18 mg capsule, 28

9093N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*221.52	37.70	Strattera [LY]

atomoxetine 25 mg capsule, 28

9094P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*221.52	37.70	Strattera [LY]

atomoxetine 40 mg capsule, 28

9095Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*221.52	37.70	Strattera [LY]

atomoxetine 60 mg capsule, 28

9096R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*221.52	37.70	Strattera [LY]

atomoxetine 80 mg capsule, 28

9289X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	147.45	37.70	Strattera [LY]

■ DEXAMPHETAMINE**Authority required**

Use in attention deficit hyperactivity disorder, in accordance with State/Territory law

Authority required

Narcolepsy

Note

Care must be taken to comply with the provisions of State/Territory law when prescribing dexamphetamine.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

dexamphetamine sulfate 5 mg tablet, 100

1165H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	18.53	19.68	Aspen Pharma Pty Ltd [QA]

■ METHYLPHENIDATE**Authority required**

Treatment of attention deficit hyperactivity disorder (ADHD) in a patient diagnosed between the ages of 6 and 18 years inclusive, who has demonstrated a response to immediate release methylphenidate hydrochloride with no emergence of serious adverse events, and who requires continuous coverage over 12 hours

Note

Care must be taken to comply with the provisions of State/Territory law when prescribing methylphenidate hydrochloride.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

methylphenidate hydrochloride 18 mg tablet: modified release, 30 tablets

2387P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	51.66	37.70	Concerta [JC]

methylphenidate hydrochloride 27 mg tablet: modified release, 30 tablets

2172H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	55.80	37.70	Concerta [JC]

methylphenidate hydrochloride 36 mg tablet: modified release, 30 tablets

2388Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	60.03	37.70	Concerta [JC]

methylphenidate hydrochloride 54 mg tablet: modified release, 30 tablets

2432B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	70.09	37.70	Concerta [JC]

■ METHYLPHENIDATE**Authority required**

Treatment of attention deficit hyperactivity disorder (ADHD) in a patient diagnosed between the ages of 6 and 18 years inclusive, who has demonstrated a response to immediate release methylphenidate hydrochloride with no emergence of serious adverse events, and who requires continuous coverage over 8 hours

Note

Care must be taken to comply with the provisions of State/Territory law when prescribing methylphenidate hydrochloride.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

methylphenidate hydrochloride 10 mg capsule: modified release, 30 capsules

3440C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	34.39	35.54	Ritalin LA [NV]

methylphenidate hydrochloride 20 mg capsule: modified release, 30 capsules

2276T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	44.91	37.70	Ritalin LA [NV]

methylphenidate hydrochloride 30 mg capsule: modified release, 30 capsules

2280B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	52.37	37.70	Ritalin LA [NV]

methylphenidate hydrochloride 40 mg capsule: modified release, 30 capsules

2283E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	54.90	37.70	Ritalin LA [NV]

■ METHYLPHENIDATE**Authority required**

Use in attention deficit hyperactivity disorder, in accordance with State/Territory law

Note

Care must be taken to comply with the provisions of State/Territory law when prescribing methylphenidate hydrochloride.

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

methylphenidate hydrochloride 10 mg tablet, 100

8839F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	17.23	18.38	Ritalin 10 [NV]

■ MODAFINIL**Authority required**

Initial treatment, by a qualified sleep medicine practitioner or neurologist, of patients with narcolepsy where:

- (i) therapy with dexamphetamine sulfate poses an unacceptable medical risk; or
- (ii) intolerance to dexamphetamine sulfate of a severity necessitating treatment withdrawal develops.

The presence of any 1 of the following indicates treatment with dexamphetamine sulfate poses an unacceptable medical risk:

- (a) a psychiatric disorder;
- (b) a cardiovascular disorder;
- (c) a history of substance abuse;
- (d) glaucoma;
- (e) any other absolute contraindication to dexamphetamine sulfate as specified in the TGA-approved Product Information.

Patients must meet the following definition of narcolepsy:

Excessive daytime sleepiness, recurrent naps or lapses into sleep occurring almost daily for at least 3 months and:

- (i) a definite history of cataplexy;

or

a mean sleep latency less than or equal to 10 minutes on a Multiple Sleep Latency Test (MSLT). The MSLT must be preceded by nocturnal polysomnography. Sleep prior to the MSLT must be at least 6 hours in duration;

or

an electroencephalographic (EEG) recording showing the pathologically rapid development of REM sleep; and

- (ii) absence of any medical or psychiatric disorder that could otherwise account for the hypersomnia.

The authority application must be made in writing and must include the following:

- (a) a completed authority prescription form; and
- (b) a completed Modafinil (Modavigil) PBS Authority Application for Use in the Treatment of Narcolepsy - Supporting Information Form [www.medicareaustralia.gov.au]; and
- (c) details of the contraindication or intolerance to dexamphetamine sulfate; and
- (d) either:

- (i) the result and date of the polysomnography test and MSLT conducted by, or under the supervision of, a qualified sleep medicine practitioner; or
- (ii) the result and date of the EEG, conducted by, or under the supervision of, a neurologist.

The polysomnography, MSLT or EEG test reports must be provided with the authority application

Authority required

Continuing treatment of narcolepsy, where the patient has previously been issued with an authority prescription for this drug

Note

Any queries concerning the arrangements to prescribe modafinil may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authority to prescribe modafinil should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

Further prescribing information is on the Medicare Australia website at www.medicareaustralia.gov.au.

Modafinil is not PBS-subsidised when used in combination with PBS-subsidised dexamphetamine sulfate.

modafinil 100 mg tablet, 60

8816B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*347.32	37.70	Modavigil [CS]

ANTI-DEMENTIA DRUGS

Anticholinesterases

■ DONEPEZIL

Authority required (STREAMLINED)

4219

Mild to moderately severe Alzheimer disease

Treatment Phase: Continuing

Clinical criteria:

Patient must have received six months of sole PBS-subsidised initial therapy with this drug, **AND**

Patient must demonstrate a clinically meaningful response to the initial treatment, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

Prior to continuing treatment, a comprehensive assessment must be undertaken and documented, involving the patient, the patient's family or carer and the treating physician to establish agreement that treatment is continuing to produce worthwhile benefit.

Treatment should cease if there is no agreement of benefit as there is always the possibility of harm from unnecessary use.

Re-assessments for a clinically meaningful response are to be undertaken and documented every six months.

Clinically meaningful response to treatment is demonstrated in the following areas:

Patient's quality of life including but not limited to level of independence and happiness;

Patient's cognitive function including but not limited to memory, recognition and interest in environment;

Patient's behavioural symptoms, including but not limited to hallucination, delusions, anxiety, marked agitation or associated aggressive behaviour.

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

donepezil hydrochloride 10 mg tablet, 28

2479L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	39.64	37.70	^a APO-Donepezil [TX] ^a Aricept [PF] ^a Aridon APN 10 [FM] ^a Donepezil AN [EA] ^a Donepezil-GA [GN] ^a Donepezil RBX [RA] ^a Pharmacor Donepezil 10 [CR]	^a Arazil [AF] ^a Aridon 10 [QA] ^a Chem mart Donepezil [CH] ^a Donepezil-DRLA [RZ] ^a Donepezil generichealth [GQ] ^a Donepezil Sandoz [SZ] ^a Terry White Chemists Donepezil [TW]

donepezil hydrochloride 5 mg tablet, 28

2532G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	39.64	37.70	^a APO-Donepezil [TX] ^a Aricept [PF] ^a Aridon APN 5 [FM] ^a Donepezil AN [EA] ^a Donepezil-GA [GN] ^a Donepezil RBX [RA] ^a Pharmacor Donepezil 5 [CR]	^a Arazil [AF] ^a Aridon 5 [QA] ^a Chem mart Donepezil [CH] ^a Donepezil-DRLA [RZ] ^a Donepezil generichealth [GQ] ^a Donepezil Sandoz [SZ] ^a Terry White Chemists Donepezil [TW]

■ DONEPEZIL

Authority required

Mild to moderately severe Alzheimer disease

Treatment Phase: Initial

Clinical criteria:

Patient must have a baseline Mini-Mental State Examination (MMSE) or Standardised Mini-Mental State Examination (SMMSE) score of 10 or more, **AND**

The condition must be confirmed by, or in consultation with, a specialist/consultant physician (including a psychiatrist), **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

The authority application must include the result of the baseline MMSE or SMMSE. If this score is 25 - 30 points, the result of a baseline Alzheimer Disease Assessment Scale, cognitive sub-scale (ADAS-Cog) may also be specified.

The application must be made in writing, but initial supply may be sought by telephone.

For telephone applications, up to a maximum of 2 months' initial therapy will be authorised. This telephone application must be followed by a written authority application for no more than 1 month's therapy and sufficient repeats to complete a maximum of up to 6 months' initial treatment.

For written applications where no prior telephone approval has been issued, up to a maximum of 1 month's therapy plus 5 repeats will be authorised.

Authority required

Mild to moderately severe Alzheimer disease

Treatment Phase: Initial

Clinical criteria:

Patient must have a baseline Mini-Mental State Examination (MMSE) or Standardised Mini-Mental State Examination (SMMSE) score of 9 or less, **AND**

The condition must be confirmed by, or in consultation with, a specialist/consultant physician (including a psychiatrist), **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

A patient who is unable to register a score of 10 or more for reasons other than their Alzheimer disease, as specified below.

Such patients will need to be assessed using the Clinicians Interview Based Impression of Severity (CIBIS) scale. The authority application must include the result of the baseline (S)MMSE and specify to which group(s) (see below) the patient belongs.

Patients who qualify under this criterion are from 1 or more of the following groups:

(1) Unable to communicate adequately because of lack of competence in English, in people of non-English speaking background;

(2) Limited education, as defined by less than 6 years of education, or who are illiterate or innumerate;

(3) Aboriginal or Torres Strait Islanders who, by virtue of cultural factors, are unable to complete an (S)MMSE test;

(4) Intellectual (developmental or acquired) disability, eg Down's syndrome;

(5) Significant sensory impairment despite best correction, which precludes completion of an (S)MMSE test;

(6) Prominent dysphasia, out of proportion to other cognitive and functional impairment.

The application must be made in writing, but initial supply may be sought by telephone.

For telephone applications, up to a maximum of 2 months' initial therapy will be authorised. This telephone application must be followed by a written authority application for no more than 1 month's therapy and sufficient repeats to complete a maximum of up to 6 months' initial treatment.

For written applications where no prior telephone approval has been issued, up to a maximum of 1 month's therapy plus 5 repeats will be authorised.

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

donepezil hydrochloride 10 mg tablet, 28

8496E

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	39.64	37.70	^a APO-Donepezil [TX] ^a Aricept [PF] ^a Aridon APN 10 [FM] ^a Donepezil AN [EA] ^a Donepezil-GA [GN] ^a Donepezil RBX [RA] ^a Pharmacor Donepezil 10 [CR]	^a Arazil [AF] ^a Aridon 10 [QA] ^a Chem mart Donepezil [CH] ^a Donepezil-DRLA [RZ] ^a Donepezil generichealth [GQ] ^a Donepezil Sandoz [SZ] ^a Terry White Chemists Donepezil [TW]

donepezil hydrochloride 5 mg tablet, 28

8495D

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	39.64	37.70	^a APO-Donepezil [TX] ^a Aricept [PF] ^a Aridon APN 5 [FM] ^a Donepezil AN [EA] ^a Donepezil-GA [GN] ^a Donepezil RBX [RA] ^a Pharmacor Donepezil 5 [CR]	^a Arazil [AF] ^a Aridon 5 [QA] ^a Chem mart Donepezil [CH] ^a Donepezil-DRLA [RZ] ^a Donepezil generichealth [GQ] ^a Donepezil Sandoz [SZ] ^a Terry White Chemists Donepezil [TW]

■ GALANTAMINE

Authority required (STREAMLINED)

4219

Mild to moderately severe Alzheimer disease

Treatment Phase: Continuing

Clinical criteria:

Patient must have received six months of sole PBS-subsidised initial therapy with this drug, **AND**

Patient must demonstrate a clinically meaningful response to the initial treatment, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

Prior to continuing treatment, a comprehensive assessment must be undertaken and documented, involving the patient, the patient's family or carer and the treating physician to establish agreement that treatment is continuing to produce worthwhile benefit.

Treatment should cease if there is no agreement of benefit as there is always the possibility of harm from unnecessary use.

Re-assessments for a clinically meaningful response are to be undertaken and documented every six months.

Clinically meaningful response to treatment is demonstrated in the following areas:

Patient's quality of life including but not limited to level of independence and happiness;

Patient's cognitive function including but not limited to memory, recognition and interest in environment;

Patient's behavioural symptoms, including but not limited to hallucination, delusions, anxiety, marked agitation or associated aggressive behaviour.

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

galantamine 16 mg capsule: modified release, 28 capsules

2537M

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	51.20	37.70	^a APO-Galantamine MR [TX] ^a Galantyl [AF] ^a Reminyl [JC]	^a Galantamine AN SR [EA] ^a Gamine XR [QA]

galantamine 24 mg capsule: modified release, 28 capsules

2531F

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	59.12	37.70	^a APO-Galantamine MR [TX] ^a Galantyl [AF] ^a Reminyl [JC]	^a Galantamine AN SR [EA] ^a Gamine XR [QA]

galantamine 8 mg capsule: modified release, 28 capsules

2463P

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
1	5	..	43.91	37.70	^a APO-Galantamine MR [TX] ^a Galantyl [AF] ^a Reminyl [JC]	^a Galantamine AN SR [EA] ^a Gamine XR [QA]

■ GALANTAMINE

Authority required

Mild to moderately severe Alzheimer disease

Treatment Phase: Initial

Clinical criteria:

Patient must have a baseline Mini-Mental State Examination (MMSE) or Standardised Mini-Mental State Examination (SMMSE) score of 10 or more, **AND**

The condition must be confirmed by, or in consultation with, a specialist/consultant physician (including a psychiatrist), **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

The authority application must include the result of the baseline MMSE or SMMSE. If this score is 25 - 30 points, the result of a baseline Alzheimer Disease Assessment Scale, cognitive sub-scale (ADAS-Cog) may also be specified.

The application must be made in writing, but initial supply may be sought by telephone.

For telephone applications, up to a maximum of 2 months' initial therapy will be authorised. This telephone application must be followed by a written authority application for no more than 1 month's therapy and sufficient repeats to complete a maximum of up to 6 months' initial treatment.

For written applications where no prior telephone approval has been issued, up to a maximum of 1 month's therapy plus 5 repeats will be authorised.

Authority required

Mild to moderately severe Alzheimer disease

Treatment Phase: Initial

Clinical criteria:

Patient must have a baseline Mini-Mental State Examination (MMSE) or Standardised Mini-Mental State Examination (SMMSE) score of 9 or less, **AND**

The condition must be confirmed by, or in consultation with, a specialist/consultant physician (including a psychiatrist), **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

A patient who is unable to register a score of 10 or more for reasons other than their Alzheimer disease, as specified below. Such patients will need to be assessed using the Clinicians Interview Based Impression of Severity (CIBIS) scale. The authority application must include the result of the baseline (S)MMSE and specify to which group(s) (see below) the patient belongs.

Patients who qualify under this criterion are from 1 or more of the following groups:

- (1) Unable to communicate adequately because of lack of competence in English, in people of non-English speaking background;
- (2) Limited education, as defined by less than 6 years of education, or who are illiterate or innumerate;
- (3) Aboriginal or Torres Strait Islanders who, by virtue of cultural factors, are unable to complete an (S)MMSE test;
- (4) Intellectual (developmental or acquired) disability, eg Down's syndrome;
- (5) Significant sensory impairment despite best correction, which precludes completion of an (S)MMSE test;
- (6) Prominent dysphasia, out of proportion to other cognitive and functional impairment.

The application must be made in writing, but initial supply may be sought by telephone.

For telephone applications, up to a maximum of 2 months' initial therapy will be authorised. This telephone application must be followed by a written authority application for no more than 1 month's therapy and sufficient repeats to complete a maximum of up to 6 months' initial treatment.

For written applications where no prior telephone approval has been issued, up to a maximum of 1 month's therapy plus 5 repeats will be authorised.

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

galantamine 16 mg capsule: modified release, 28 capsules

8771P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	51.20	37.70	^a APO-Galantamine MR [TX] ^a Galantyl [AF] ^a Reminyl [JC]	^a Galantamine AN SR [EA] ^a Gamine XR [QA]

galantamine 24 mg capsule: modified release, 28 capsules

8772Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	59.12	37.70	^a APO-Galantamine MR [TX] ^a Galantyl [AF] ^a Reminyl [JC]	^a Galantamine AN SR [EA] ^a Gamine XR [QA]

galantamine 8 mg capsule: modified release, 28 capsules

8770N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	43.91	37.70	^a APO-Galantamine MR [TX] ^a Galantyl [AF] ^a Reminyl [JC]	^a Galantamine AN SR [EA] ^a Gamine XR [QA]

■ RIVASTIGMINE

Authority required (STREAMLINED)

4219

Mild to moderately severe Alzheimer disease

Treatment Phase: Continuing

Clinical criteria:

Patient must have received six months of sole PBS-subsidised initial therapy with this drug, **AND**

Patient must demonstrate a clinically meaningful response to the initial treatment, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

Prior to continuing treatment, a comprehensive assessment must be undertaken and documented, involving the patient, the patient's family or carer and the treating physician to establish agreement that treatment is continuing to produce worthwhile benefit.

Treatment should cease if there is no agreement of benefit as there is always the possibility of harm from unnecessary use.

Re-assessments for a clinically meaningful response are to be undertaken and documented every six months.

Clinically meaningful response to treatment is demonstrated in the following areas:

Patient's quality of life including but not limited to level of independence and happiness;

Patient's cognitive function including but not limited to memory, recognition and interest in environment;

Patient's behavioural symptoms, including but not limited to hallucination, delusions, anxiety, marked agitation or associated aggressive behaviour.

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

rivastigmine 1.5 mg capsule, 56

2475G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	96.18	37.70	Exelon [NV]

rivastigmine 2 mg/mL oral liquid, 120 mL

2476H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	96.18	37.70	Exelon [NV]

rivastigmine 3 mg capsule, 56

2493F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	96.18	37.70	Exelon [NV]

rivastigmine 4.5 mg capsule, 56

2494G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	96.18	37.70	Exelon [NV]

rivastigmine 4.6 mg/24 hours patch, 30

2477J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	102.56	37.70	Exelon Patch 5 [NV]

rivastigmine 6 mg capsule, 56

2526Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	96.18	37.70	Exelon [NV]

rivastigmine 9.5 mg/24 hours patch, 30

2551G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	102.56	37.70	Exelon Patch 10 [NV]

■ RIVASTIGMINE**Authority required**

Mild to moderately severe Alzheimer disease

Treatment Phase: Initial

Clinical criteria:Patient must have a baseline Mini-Mental State Examination (MMSE) or Standardised Mini-Mental State Examination (SMMSE) score of 10 or more, **AND**The condition must be confirmed by, or in consultation with, a specialist/consultant physician (including a psychiatrist), **AND** The treatment must be the sole PBS-subsidised therapy for this condition.

The authority application must include the result of the baseline MMSE or SMMSE. If this score is 25 - 30 points, the result of a baseline Alzheimer Disease Assessment Scale, cognitive sub-scale (ADAS-Cog) may also be specified.

The application must be made in writing, but initial supply may be sought by telephone.

For telephone applications, up to a maximum of 2 months' initial therapy will be authorised. This telephone application must be followed by a written authority application for no more than 1 month's therapy and sufficient repeats to complete a maximum of up to 6 months' initial treatment.

For written applications where no prior telephone approval has been issued, up to a maximum of 1 month's therapy plus 5 repeats will be authorised.

Authority required

Mild to moderately severe Alzheimer disease

Treatment Phase: Initial

Clinical criteria:Patient must have a baseline Mini-Mental State Examination (MMSE) or Standardised Mini-Mental State Examination (SMMSE) score of 9 or less, **AND**The condition must be confirmed by, or in consultation with, a specialist/consultant physician (including a psychiatrist), **AND** The treatment must be the sole PBS-subsidised therapy for this condition.

A patient who is unable to register a score of 10 or more for reasons other than their Alzheimer disease, as specified below. Such patients will need to be assessed using the Clinicians Interview Based Impression of Severity (CIBIS) scale. The authority application must include the result of the baseline (S)MMSE and specify to which group(s) (see below) the patient belongs.

Patients who qualify under this criterion are from 1 or more of the following groups:

- (1) Unable to communicate adequately because of lack of competence in English, in people of non-English speaking background;
- (2) Limited education, as defined by less than 6 years of education, or who are illiterate or innumerate;
- (3) Aboriginal or Torres Strait Islanders who, by virtue of cultural factors, are unable to complete an (S)MMSE test;
- (4) Intellectual (developmental or acquired) disability, eg Down's syndrome;
- (5) Significant sensory impairment despite best correction, which precludes completion of an (S)MMSE test;
- (6) Prominent dysphasia, out of proportion to other cognitive and functional impairment.

The application must be made in writing, but initial supply may be sought by telephone.

For telephone applications, up to a maximum of 2 months' initial therapy will be authorised. This telephone application must be followed by a written authority application for no more than 1 month's therapy and sufficient repeats to complete a maximum of up to 6 months' initial treatment.

For written applications where no prior telephone approval has been issued, up to a maximum of 1 month's therapy plus 5 repeats will be authorised.

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

rivastigmine 1.5 mg capsule, 56

8497F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	96.18	37.70	Exelon [NV]

rivastigmine 2 mg/mL oral liquid, 120 mL

8563Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	96.18	37.70	Exelon [NV]

rivastigmine 3 mg capsule, 56

8498G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	96.18	37.70	Exelon [NV]

rivastigmine 4.5 mg capsule, 56

8499H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	96.18	37.70	Exelon [NV]

rivastigmine 4.6 mg/24 hours patch, 30

9161E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	102.56	37.70	Exelon Patch 5 [NV]

rivastigmine 6 mg capsule, 56

8500J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	96.18	37.70	Exelon [NV]

rivastigmine 9.5 mg/24 hours patch, 30

9162F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	102.56	37.70	Exelon Patch 10 [NV]

Other anti-dementia drugs

■ MEMANTINE

Authority required (STREAMLINED)

4214

Moderately severe Alzheimer disease

Treatment Phase: Continuing

Clinical criteria:

Patient must have received six months of sole PBS-subsidised initial therapy with this drug, **AND**

Patient must demonstrate a clinically meaningful response to the initial treatment, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

Prior to continuing treatment, a comprehensive assessment must be undertaken and documented, involving the patient, the patient's family or carer and the treating physician to establish agreement that treatment is continuing to produce worthwhile benefit.

Treatment should cease if there is no agreement of benefit as there is always the possibility of harm from unnecessary use.

Re-assessments for a clinically meaningful response are to be undertaken and documented every six months.

Clinically meaningful response to treatment is demonstrated in the following areas:

Patient's quality of life including but not limited to level of independence and happiness;

Patient's cognitive function including but not limited to memory, recognition and interest in environment;

Patient's behavioural symptoms, including but not limited to hallucination, delusions, anxiety, marked agitation or associated aggressive behaviour.

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

memantine hydrochloride 10 mg tablet, 56

2492E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	67.08	37.70	^a APO-Memantine [TX] ^a Memantine generichealth [GQ] ^a Memanxa [QA]	^a Ebixa [LU] ^a Memantine RBX [RA]

memantine hydrochloride 20 mg tablet, 28

2513G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	67.08	37.70	^a APO-Memantine [TX] ^a Memantine generichealth [GQ]	^a Ebixa [LU] ^a Memantine RBX [RA]

MEMANTINE**Authority required**

Moderately severe Alzheimer disease

Treatment Phase: Initial

Clinical criteria:

Patient must have a baseline Mini-Mental State Examination (MMSE) or Standardised Mini-Mental State Examination (SMMSE) score of 10 to 14, **AND**

The condition must be confirmed by, or in consultation with, a specialist/consultant physician (including a psychiatrist), **AND**
The treatment must be the sole PBS-subsidised therapy for this condition.

The authority application must include the result of the baseline MMSE or SMMSE of 10 to 14.

The application must be made in writing, but initial supply may be sought by telephone.

For telephone applications, up to a maximum of 2 months' initial therapy will be authorised. This telephone application must be followed by a written authority application for no more than 1 month's therapy and sufficient repeats to complete a maximum of up to 6 months' initial treatment.

For written applications where no prior telephone approval has been issued, up to a maximum of 1 month's therapy plus 5 repeats will be authorised.

Authority required

Moderately severe Alzheimer disease

Treatment Phase: Initial

Clinical criteria:

Patient must have a baseline Mini-Mental State Examination (MMSE) or Standardised Mini-Mental State Examination (SMMSE) score of 9 or less, **AND**

The condition must be confirmed by, or in consultation with, a specialist/consultant physician (including a psychiatrist), **AND**
The treatment must be the sole PBS-subsidised therapy for this condition.

A patient who is unable to register a score of 10 to 14 for reasons other than their Alzheimer disease, as specified below.

Such patients will need to be assessed using the Clinicians Interview Based Impression of Severity (CIBIS) scale. The authority application must include the result of the baseline (S)MMSE and specify to which group(s) (see below) the patient belongs.

Patients who qualify under this criterion are from 1 or more of the following groups:

- (1) Unable to communicate adequately because of lack of competence in English, in people of non-English speaking background;
- (2) Limited education, as defined by less than 6 years of education, or who are illiterate or innumerate;
- (3) Aboriginal or Torres Strait Islanders who, by virtue of cultural factors, are unable to complete an (S)MMSE test;
- (4) Intellectual (developmental or acquired) disability, eg Down's syndrome;
- (5) Significant sensory impairment despite best correction, which precludes completion of an (S)MMSE test;
- (6) Prominent dysphasia, out of proportion to other cognitive and functional impairment.

The application must be made in writing, but initial supply may be sought by telephone.

For telephone applications, up to a maximum of 2 months' initial therapy will be authorised. This telephone application must be followed by a written authority application for no more than 1 month's therapy and sufficient repeats to complete a maximum of up to 6 months' initial treatment.

For written applications where no prior telephone approval has been issued, up to a maximum of 1 month's therapy plus 5 repeats will be authorised.

Note**Continuing Therapy Only:**

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

memantine hydrochloride 10 mg tablet, 56

1956Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	67.08	37.70	^a APO-Memantine [TX] ^a Memantine generichealth [GQ] ^a Memanxa [QA]	^a Ebixa [LU] ^a Memantine RBX [RA]

memantine hydrochloride 20 mg tablet, 28

9306T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	67.08	37.70	^a APO-Memantine [TX] ^a Memantine generichealth [GQ]	^a Ebixa [LU] ^a Memantine RBX [RA]

OTHER NERVOUS SYSTEM DRUGS

PARASYMPATHOMIMETICS

Anticholinesterases

■ PYRIDOSTIGMINE

PYRIDOSTIGMINE BROMIDE Tablet 10 mg, 50

2724J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*23.34	24.49	Mestinon [IA]

pyridostigmine bromide 180 mg tablet: modified release, 50 tablets

2608G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*149.56	37.70	Mestinon Timespan [IA]

pyridostigmine bromide 60 mg tablet, 150

1959D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	71.66	37.70	Mestinon [IA]

Choline esters

■ BETHANECHOL

bethanechol chloride 10 mg tablet, 100

1062X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	33.87	35.02	Uro-Carb [YN]

DRUGS USED IN ADDICTIVE DISORDERS

Drugs used in nicotine dependence

■ BUPROPION

Authority required

Completion of short-term, sole PBS-subsidised, therapy as an aid to achieving abstinence in a patient who has previously been issued with an authority prescription for this drug and who is enrolled in a comprehensive support and counselling program

Note

Only one course of PBS-subsidised bupropion hydrochloride will be authorised per 12 months. The period between commencing a course of bupropion hydrochloride and varenicline tartrate must be at least 6 months. A course of treatment with bupropion hydrochloride is 9 weeks. No increased maximum quantities or repeats will be authorised. Clinical review is recommended within 2 to 3 weeks of the original prescription being requested.

bupropion hydrochloride 150 mg tablet: modified release, 90 tablets

8710K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	176.50	37.70	^a Prexaton [GN]
			^b 0.96	177.46	37.70	^a Zyban [AS]

■ BUPROPION

Authority required

Commencement of short-term, sole PBS-subsidised, therapy as an aid to achieving abstinence in a patient who has indicated they are ready to cease smoking and who has entered a comprehensive support and counselling program. Details of the program must be specified in the authority application

Authority required

Commencement of short-term, sole PBS-subsidised, therapy as an aid to achieving abstinence in a patient who has indicated they are ready to cease smoking and who is entering a comprehensive support and counselling program during the consultation at which this authority is requested. Details of the program must be specified in the authority application

Note

Only one course of PBS-subsidised bupropion hydrochloride will be authorised per 12 months. The period between commencing a course of bupropion hydrochloride and varenicline tartrate must be at least 6 months. A course of treatment with bupropion hydrochloride is 9 weeks. No increased maximum quantities or repeats will be authorised. Clinical review is recommended within 2 to 3 weeks of the original prescription being requested.

bupropion hydrochloride 150 mg tablet: modified release, 30 tablets

8465M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	63.34	37.70	^a Prexaton [GN]
			^b 0.80	64.14	37.70	^a Zyban [AS]

■ NICOTINE**Authority required (STREAMLINED)****4348**

Nicotine dependence

Clinical criteria:The treatment must be the sole PBS-subsidised therapy for this condition, **AND**Patient must have indicated they are ready to cease smoking, **AND**Patient must have entered a comprehensive support and counselling program, **AND**

Patient must not receive more than 12 weeks of PBS-subsidised nicotine replacement therapy per 12-month period.

Details of the support and counselling program must be documented in the patient's medical records at the time treatment is initiated.

Authority required (STREAMLINED)**4307**

Nicotine dependence

Clinical criteria:The treatment must be the sole PBS-subsidised therapy for this condition, **AND**Patient must have indicated they are ready to cease smoking, **AND**Patient must be entering a comprehensive support and counselling program during the consultation at which this prescription is written, **AND**

Patient must not receive more than 12 weeks of PBS-subsidised nicotine replacement therapy per 12-month period.

Details of the support and counselling program must be documented in the patient's medical records at the time treatment is initiated.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

nicotine 14 mg/24 hours patch, 28

5572G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	55.56	37.70	Nicotinell Step 2 [NC]

nicotine 21 mg/24 hours patch, 28

3414Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	55.56	37.70	Nicotinell Step 1 [NC]

nicotine 7 mg/24 hours patch, 28

5573H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	55.56	37.70	Nicotinell Step 3 [NC]

■ NICOTINE**Authority required (STREAMLINED)****4344**

Nicotine dependence

Clinical criteria:

The treatment must be the sole PBS-subsidised therapy for this condition.

Population criteria:

Patient must be an Aboriginal or a Torres Strait Islander person.

Note

Only 2 courses of PBS-subsidised nicotine replacement therapy may be prescribed per 12-month period.

Benefit is improved if used in conjunction with a comprehensive support and counselling program.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

nicotine 21 mg/24 hours patch, 28

5571F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	55.56	37.70	Nicotinell Step 1 [NC]

■ NICOTINE**Authority required (STREAMLINED)****4344**

Nicotine dependence

Clinical criteria:

The treatment must be the sole PBS-subsidised therapy for this condition.

Population criteria:

Patient must be an Aboriginal or a Torres Strait Islander person.

Note

Only 2 courses of PBS-subsidised nicotine replacement therapy may be prescribed per 12-month period.
Benefit is improved if used in conjunction with a comprehensive support and counselling program.

Authority required (STREAMLINED)**4348**

Nicotine dependence

Clinical criteria:

The treatment must be the sole PBS-subsidised therapy for this condition, **AND**

Patient must have indicated they are ready to cease smoking, **AND**

Patient must have entered a comprehensive support and counselling program, **AND**

Patient must not receive more than 12 weeks of PBS-subsidised nicotine replacement therapy per 12-month period.

Details of the support and counselling program must be documented in the patient's medical records at the time treatment is initiated.

Authority required (STREAMLINED)**4307**

Nicotine dependence

Clinical criteria:

The treatment must be the sole PBS-subsidised therapy for this condition, **AND**

Patient must have indicated they are ready to cease smoking, **AND**

Patient must be entering a comprehensive support and counselling program during the consultation at which this prescription is written, **AND**

Patient must not receive more than 12 weeks of PBS-subsidised nicotine replacement therapy per 12-month period.

Details of the support and counselling program must be documented in the patient's medical records at the time treatment is initiated.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

nicotine 21 mg/24 hours patch, 28

5465P

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	2	..	55.56	37.70	Nicabate P [GC]

nicotine 25 mg/16 hours patch, 28

10076H

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	2	..	55.56	37.70	nicorette 16hr Invisipatch [JT]

■ VARENICLINE**Authority required**

Nicotine dependence

Treatment Phase: Completion of a short-term (24 weeks) course of treatment

Clinical criteria:

The treatment must be as an aid to achieving abstinence from smoking, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition, **AND**

Patient must have previously been issued with an authority prescription for this drug during this current course of treatment, **AND**

Patient must have ceased smoking in the process of completing an initial 12-weeks or ceased smoking following an initial 12-weeks of PBS-subsidised treatment with this drug in the current course of treatment.

Treatment criteria:

Patient must be undergoing concurrent counselling for smoking cessation through a comprehensive support and counselling program.

Note

A course of treatment with this drug is 12 weeks or up to 24 weeks, if initial treatment of 12 weeks has been successful.

A patient may only qualify for PBS-subsidised treatment under this treatment phase restriction once during a short-term course of treatment.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

varenicline 1 mg tablet, 56

5469W

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	2	..	120.76	37.70	Champix [PF]

■ VARENICLINE

Authority required

Nicotine dependence

Treatment Phase: Continuation of a short-term (12 weeks or 24 weeks) course of treatment

Clinical criteria:

The treatment must be as an aid to achieving abstinence from smoking, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition, **AND**

Patient must have previously been issued with an authority prescription for this drug during this current course of treatment.

Treatment criteria:

Patient must be undergoing concurrent counselling for smoking cessation through a comprehensive support and counselling program.

Note

A course of treatment with this drug is 12 weeks or up to 24 weeks, if initial treatment of 12 weeks has been successful.

A patient may only qualify for PBS-subsidised treatment under this treatment phase restriction once during a short-term course of treatment.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

varenicline 1 mg tablet, 56

9129L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*232.04	37.70	Champix [PF]

■ VARENICLINE

Authority required

Nicotine dependence

Treatment Phase: Commencement of a short-term (12 weeks or 24 weeks) course of treatment

Clinical criteria:

The treatment must be as an aid to achieving abstinence from smoking, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition, **AND**

Patient must have indicated they are ready to cease smoking.

Treatment criteria:

Patient must be undergoing concurrent counselling for smoking cessation through a comprehensive support and counselling program or is about to enter such a program at the time the Authority application is requested.

Details of the support and counselling program must be documented in the patient's medical records at the time treatment is initiated.

Clinical review is recommended within 2 to 3 weeks of the initial prescription being requested.

Note

A course of treatment with this drug is 12 weeks or up to 24 weeks, if initial treatment of 12 weeks has been successful.

The period between commencing varenicline and bupropion or a new course of varenicline must be at least 6 months.

A patient may only qualify for PBS-subsidised treatment under this treatment phase restriction once during a short-term course of treatment.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

varenicline 500 microgram tablet [11 tablets] (&) varenicline 1 mg tablet [42 tablets], 53

9128K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	..	..	103.46	37.70	Champix [PF]

Drugs used in alcohol dependence

■ ACAMPROSATE

Authority required (STREAMLINED)

2665

For use within a comprehensive treatment program for alcohol dependence with the goal of maintaining abstinence

Note

No applications for increased maximum quantities and/or repeats will be authorised.

acamprosate calcium 333 mg tablet: enteric, 180 tablets

8357W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	166.92	37.70	Campral [AF]

■ NALTREXONE

Caution

Naltrexone hydrochloride is contraindicated in patients receiving opioid drugs.

Authority required

For use within a comprehensive treatment program for alcohol dependence with the goal of maintaining abstinence

Note

No applications for increased maximum quantities and/or repeats will be authorised.

naltrexone hydrochloride 50 mg tablet, 30

8370M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	1	..	136.01	37.70	^a Naltrexone GH [GQ]	^a ReVia [BQ]

OTHER NERVOUS SYSTEM DRUGS*Other nervous system drugs***▪ DIMETHYL FUMARATE****Authority required**

Multiple sclerosis

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by accompanying written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**

The treatment must be as monotherapy, **AND**

Patient must have previously been issued with an authority prescription for this drug; OR

Patient must have been receiving treatment with this drug prior to 1 December 2013, **AND**

Patient must not show continuing progression of disability while on treatment with this drug.

Where applicable, the date of the magnetic resonance imaging scan must be provided with the authority application.

Note

Special Pricing Arrangements apply.

dimethyl fumarate 120 mg capsule: modified release, 14 capsules

2943X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	491.31	37.70	Tecfidera [BD]

▪ DIMETHYL FUMARATE**Authority required**

Multiple sclerosis

Treatment Phase: Initial treatment

Clinical criteria:

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by accompanying written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**

The treatment must be as monotherapy, **AND**

Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years, **AND**

Patient must be ambulatory (without assistance or support).

Where applicable, the date of the magnetic resonance imaging scan must be provided with the authority application.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

dimethyl fumarate 120 mg capsule: modified release, 14 capsules

2896K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	491.31	37.70	Tecfidera [BD]

▪ DIMETHYL FUMARATE**Authority required**

Multiple sclerosis

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by accompanying written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**

The treatment must be as monotherapy, **AND**

Patient must have previously been issued with an authority prescription for this drug; OR

Patient must have been receiving treatment with this drug prior to 1 December 2013, **AND**

Patient must not show continuing progression of disability while on treatment with this drug.

Where applicable, the date of the magnetic resonance imaging scan must be provided with the authority application.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

dimethyl fumarate 240 mg capsule: modified release, 56 capsules

2966D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	1880.00	37.70	Tecfidera [BD]

■ RILUZOLE

Authority required

Initial treatment of amyotrophic lateral sclerosis, as diagnosed by a neurologist, in patients with disease duration of 5 years or less and who have at least 60 percent of predicted forced vital capacity within 2 months prior to commencing riluzole therapy and who:

(1) are ambulatory, and

(a) have not undergone tracheostomy, and

(b) have not experienced respiratory failure; OR

(2) are not ambulatory, and

(a) have not undergone tracheostomy, and

(b) have not experienced respiratory failure, and

(c) are either able to use upper limbs or able to swallow.

The date of diagnosis and the date and results of spirometry (in terms of percent of predicted forced vital capacity) must be supplied with the initial authority application

Authority required

Continuing treatment of amyotrophic lateral sclerosis in patients who have previously been issued with an authority prescription for this drug and who:

(1) are ambulatory, and

(a) have not undergone tracheostomy, and

(b) have not experienced respiratory failure; OR

(2) are not ambulatory, and

(a) have not undergone tracheostomy, and

(b) have not experienced respiratory failure, and


(c) are either able to use upper limbs or able to swallow

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

riluzole 50 mg tablet, 56

8664B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	369.92	37.70	^a APO-Riluzole [TX] ^a Rilutek [SW]	^a Pharmacor Riluzole [CR] ^a Riluzole Sandoz [SZ]

■ TETRABENAZINE

Authority required (STREAMLINED)

1161


Hyperkinetic extrapyramidal disorders

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

tetrabenazine 25 mg tablet, 112

1330B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	364.25	37.70	iNova Pharmaceuticals (Australia) Pty Ltd [IA]

ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS

ANTIPROTOZOALS

AGENTS AGAINST AMOEBIASIS AND OTHER PROTOZOAL DISEASES

Other agents against amoebiasis and other protozoal diseases

ATOVAQUONE

Authority required (STREAMLINED)

1433

Treatment of mild to moderate *Pneumocystis carinii* pneumonia in adult patients who are intolerant of trimethoprim/sulfamethoxazole therapy

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

atovaquone 750 mg/5 mL oral liquid, 210 mL

8300W

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	1034.91	37.70	Wellvone [AS]

PYRIMETHAMINE

pyrimethamine 25 mg tablet, 50

1966L

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	16.72	17.87	Daraprim [AS]

ANTIMALARIALS

Biguanides

ATOVAQUONE + PROGUANIL

Authority required

Treatment of suspected or confirmed *Plasmodium falciparum* malaria in a patient aged 3 years or older where quinine containing regimens are inappropriate

Note

Atovaquone with proguanil hydrochloride is not PBS-subsidised for the prophylaxis of malaria.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

atovaquone 250 mg + proguanil hydrochloride 100 mg tablet, 12

9439T

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	67.34	37.70	Malarone [GK]

Methanolquinolines

QUININE

Caution

Severe thrombocytopenia has been reported with this drug.

Authority required (STREAMLINED)

2142

Malaria

quinine sulfate 300 mg tablet, 50

1975Y

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	2	..	14.48	15.63	Quinate [AS]

Artemisinin and derivatives, combinations

ARTEMETHER + LUMEFANTRINE

Authority required

Treatment of suspected or confirmed malaria due to *Plasmodium falciparum* in a patient unable to swallow a solid dosage form of artemether with lumefantrine

Note

Artemether with lumefantrine is not PBS-subsidised for prophylaxis of malaria.

artemether 20 mg + lumefantrine 120 mg tablet: dispersible, 18

5296R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	97.24	37.70	Riamet 20mg/120mg Dispersible [NV]

■ ARTEMETHER + LUMEFANTRINE**Authority required**

Treatment of suspected or confirmed malaria due to Plasmodium falciparum

Note

Artemether with lumefantrine is not PBS-subsidised for prophylaxis of malaria.

artemether 20 mg + lumefantrine 120 mg tablet, 24

9498X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	97.24	37.70	Riamet [NV]

■ ANTHELMINTICS**ANTITREMATODALS***Quinoline derivatives and related substances***■ PRAZIQUANTEL****Authority required (STREAMLINED)****3147**

Schistosomiasis

praziquantel 600 mg tablet, 8

9447F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	41.19	37.70	Biltricide [BN]

ANTINEMATODAL AGENTS*Benzimidazole derivatives***■ ALBENDAZOLE****Authority required (STREAMLINED)****1496**

For the treatment of hydatid disease in conjunction with surgery or when a surgical cure cannot be achieved or where surgery cannot be used

albendazole 400 mg tablet: chewable, 60

8459F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	185.59	37.70	Eskazole [AS]

■ ALBENDAZOLE**Authority required (STREAMLINED)****1525**

Treatment of tapeworm infestation

albendazole 200 mg tablet: chewable, 6

8503M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	33.44	34.59	Zentel [AS]

■ ALBENDAZOLE**Authority required (STREAMLINED)****2446**

Treatment of whipworm infestation in an Aboriginal or a Torres Strait Islander person

Authority required (STREAMLINED)**1388**

Strongyloidiasis

Authority required (STREAMLINED)**3241**

Treatment of hookworm infestation

albendazole 200 mg tablet: chewable, 6

9047E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	33.44	34.59	Zentel [AS]

Tetrahydropyrimidine derivatives

■ PYRANTEL

pyrantel 125 mg tablet, 6

3047J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	14.94	16.09	Anthel 125 [AF]

pyrantel 250 mg tablet, 6

3048K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	23.11	24.26	Anthel 250 [AF]

Avermectines

■ IVERMECTIN

Authority required (STREAMLINED)**4319**

Onchocerciasis

ivermectin 3 mg tablet, 4

8359Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	31.65	32.80	Stromectol [MK]

■ IVERMECTIN

Authority required (STREAMLINED)**4328**

Strongyloidiasis

Authority required (STREAMLINED)**4565**

Crusted (Norwegian) scabies

Clinical criteria:The condition must be established by clinical and/or parasitological examination, **AND**

Patient must be undergoing topical therapy for this condition; OR

Patient must have a contraindication to topical treatment.

Population criteria:Patient must weigh 15 kg or over, **AND**

Patient must be 5 years of age or older.

Authority required (STREAMLINED)**4566**

Human sarcoptic scabies

Clinical criteria:The condition must be established by clinical and/or parasitological examination, **AND**

Patient must have completed and failed sequential treatment with topical permethrin and benzyl benzoate and finished the most recent course of topical therapy at least 4 weeks prior to initiating oral therapy; OR

Patient must have a contraindication to topical treatment.

Population criteria:Patient must weigh 15 kg or over, **AND**

Patient must be 5 years of age or older.

Note

This drug is not PBS-subsidised for first line treatment of typical scabies.

ivermectin 3 mg tablet, 4

2868Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	2	..	*54.54	37.70	Stromectol [MK]

■ ECTOPARASITICIDES, INCL. SCABICIDES, INSECTICIDES AND REPELLENTS

ECTOPARASITICIDES, INCL. SCABICIDES

Pyrethrines, incl. synthetic compounds

■ PERMETHRIN

permethrin 5% cream, 30 g

3054R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	1	..	17.11	18.26	Lyclear [JT]

RESPIRATORY SYSTEM

NASAL PREPARATIONS

DECONGESTANTS AND OTHER NASAL PREPARATIONS FOR TOPICAL USE

Other nasal preparations

■ MUPIROCIN

Authority required (STREAMLINED)

3136

Nasal colonisation with *Staphylococcus aureus* in an Aboriginal or a Torres Strait Islander person

Note

No applications for increased maximum quantities and/or repeats will be authorised.

mupirocin 2% (20 mg/g) ointment, 3 g

9440W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	..	..	20.97	22.12	Bactroban [GK]

■ DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES

ADRENERGICS, INHALANTS

Selective beta-2-adrenoreceptor agonists

■ EFORMOTEROL

Restricted benefit

Patients with frequent episodes of asthma who are currently receiving treatment with oral corticosteroids

Restricted benefit

Patients with frequent episodes of asthma who are currently receiving treatment with optimal doses of inhaled corticosteroids

eformoterol fumarate dihydrate 12 microgram inhalation: powder for, 60 capsules

8136F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	37.67	37.70	Foradile [NV]

eformoterol fumarate dihydrate 12 microgram/actuation inhalation: powder for, 60 actuations

8240Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	36.78	37.70	Oxis Turbuhaler [AP]

eformoterol fumarate dihydrate 6 microgram/actuation inhalation: powder for, 60 actuations

8239P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	26.72	27.87	Oxis Turbuhaler [AP]

■ INDACATEROL

Restricted benefit

Chronic obstructive pulmonary disease

Note

Indacaterol is not PBS-subsidised for the treatment of asthma.

indacaterol 150 microgram inhalation: powder for, 30 capsules

5134F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	62.73	37.70	Onbrez [NV]

indacaterol 300 microgram inhalation: powder for, 30 capsules

5137J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	62.73	37.70	Onbrez [NV]

■ SALBUTAMOL

salbutamol 100 microgram/actuation inhalation: pressurised, 200

8288F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*14.14	15.29	^a APO-Salbutamol Inhaler [TX]	^a Asmol CFC-free [AL]
			^b 2.34	*16.48	15.29	^a Ventolin CFC-free [GK]	

salbutamol 200 microgram inhalation: powder for, 128 capsules

10143W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	4	..	*19.12	20.27	Ventolin Rotacaps [GK]

■ SALBUTAMOL

Restricted benefit

Patients unable to achieve co-ordinated use of other metered dose inhalers containing this drug

salbutamol Oral pressurised inhalation in breath actuated device 100 micrograms (base) per dose (200 doses), CFC-free formulation, 1

8354Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*38.94	37.70	Airomir Autohaler [IA]

■ SALBUTAMOL

Restricted benefit

Asthma in patients unable to use this drug delivered from an oral pressurised inhalation device via a spacer

Restricted benefit

Chronic obstructive pulmonary disease in patients unable to use this drug delivered from an oral pressurised inhalation device via a spacer

salbutamol 2.5 mg/2.5 mL inhalation: solution, 30 x 2.5 mL ampoules

2000G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*15.96	17.11	^a APO-Salbutamol [TX] ^a Butamol 2.5 [QA] ^a Pharmacor Salbutamol 2.5 [CR] ^a Salbutamol-GA [GN]	^a Asmol 2.5 uni-dose [AF] ^a GenRx Salbutamol [GX] ^a Salbutamol Actavis [UA] ^a Salbutamol Sandoz [SZ]
			^B 1.20	*17.16	17.11	^a Ventolin Nebules [GK]	

salbutamol 5 mg/2.5 mL inhalation: solution, 30 x 2.5 mL ampoules

2001H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*16.44	17.59	^a APO-Salbutamol [TX] ^a Butamol 5 [QA] ^a Pharmacor Salbutamol 5 [CR] ^a Salbutamol-GA [GN]	^a Asmol 5 uni-dose [AF] ^a GenRx Salbutamol [GX] ^a Salbutamol Actavis [UA] ^a Salbutamol Sandoz [SZ]
			^B 1.16	*17.60	17.59	^a Ventolin Nebules [GK]	

■ SALMETEROL

Restricted benefit

Patients with frequent episodes of asthma who are currently receiving treatment with oral corticosteroids

Restricted benefit

Patients with frequent episodes of asthma who are currently receiving treatment with optimal doses of inhaled corticosteroids

salmeterol 50 microgram/actuation inhalation: powder for, 60 actuations

8141L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	37.67	37.70	Serevent Accuhaler [GK]

■ TERBUTALINE

terbutaline sulfate 500 microgram/actuation inhalation: powder for, 100 actuations

2817G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*18.20	19.35	Bricanyl Turbuhaler [AP]

Adrenergics in combination with corticosteroids or other drugs, excl. anticholinergics

■ BUDESONIDE + EFORMOTEROL

Restricted benefit

Asthma

Clinical criteria:

Patient must have previously had frequent episodes of asthma while receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids; OR

Patient must have experienced frequent asthma symptoms while receiving treatment with oral or inhaled corticosteroids and require single maintenance and reliever therapy; OR

Patient must have experienced frequent asthma symptoms while receiving treatment with a combination of an inhaled corticosteroid and long acting beta-2 agonist and require single maintenance and reliever therapy.

Population criteria:

Patient must be aged 12 years or over.

budesonide 100 microgram/actuation + eformoterol fumarate dihydrate 6 microgram/actuation inhalation: powder for, 120 actuations

8796Y

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
±1	5	..	54.81	37.70	Symbicort Turbuhaler 100/6 [AP]

budesonide 200 microgram/actuation + eformoterol fumarate dihydrate 6 microgram/actuation inhalation: powder for, 120 actuations

8625Y

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
±1	5	..	59.11	37.70	Symbicort Turbuhaler 200/6 [AP]

■ BUDESONIDE + EFORMOTEROL**Restricted benefit**

Asthma

Clinical criteria:

Patient must have previously had frequent episodes of asthma while receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids; OR

Patient must have experienced frequent asthma symptoms while receiving treatment with oral or inhaled corticosteroids and require single maintenance and reliever therapy; OR

Patient must have experienced frequent asthma symptoms while receiving treatment with a combination of an inhaled corticosteroid and long acting beta-2 agonist.

Population criteria:

Patient must be aged 12 years or over.

budesonide 100 microgram/actuation + eformoterol fumarate dihydrate 3 microgram/actuation inhalation: pressurised, 120 actuations

10015D

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
2	5	..	*59.10	37.70	Symbicort Rapihaler 100/3 [AP]

budesonide 50 microgram/actuation + eformoterol fumarate dihydrate 3 microgram/actuation inhalation: pressurised, 120 actuations

10024N

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
2	5	..	*54.80	37.70	Symbicort Rapihaler 50/3 [AP]

■ BUDESONIDE + EFORMOTEROL**Restricted benefit**

Asthma

Clinical criteria:

Patient must have previously had frequent episodes of asthma while receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids.

Population criteria:

Patient must be aged 12 years or over.

Note

Symbicort 400/12 is not recommended nor PBS-subsidised for use as 'maintenance and reliever' therapy.

Restricted benefit

Chronic obstructive pulmonary disease (COPD)

Clinical criteria:

Patient must have a forced expiratory volume in 1 second (FEV1) less than 50% of predicted normal prior to therapy, **AND**

Patient must have a history of repeated exacerbations with significant symptoms despite regular beta-2 agonist bronchodilator therapy, **AND**

The treatment must be for symptomatic treatment.

Note

Patient must not be on a concomitant single agent long-acting beta-2 agonist.

This product is not indicated for the initiation of bronchodilator therapy in COPD.

budesonide 400 microgram/actuation + eformoterol fumarate dihydrate 12 microgram/actuation inhalation: powder for, 120 actuations

8750M

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
±1	5	..	89.37	37.70	Symbicort Turbuhaler 400/12 [AP]

■ BUDESONIDE + EFORMOTEROL**Restricted benefit**

Asthma

Clinical criteria:

Patient must have previously had frequent episodes of asthma while receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids.

Population criteria:

Patient must be aged 12 years or over.

Note

Unlike Symbicort Turbuhaler 200/6, Symbicort Rapihaler 200/6 is not recommended nor PBS-subsidised for use as 'maintenance and reliever' therapy as the approved Product Information does not specify such use.

Restricted benefit

Chronic obstructive pulmonary disease (COPD)

Clinical criteria:

Patient must have a forced expiratory volume in 1 second (FEV1) less than 50% of predicted normal prior to therapy, **AND** Patient must have a history of repeated exacerbations with significant symptoms despite regular beta-2 agonist bronchodilator therapy, **AND**

The treatment must be for symptomatic treatment.

Note

Patient must not be on a concomitant single agent long-acting beta-2 agonist.

This product is not indicated for the initiation of bronchodilator therapy in COPD.

budesonide 200 microgram/actuation + eformoterol fumarate dihydrate 6 microgram/actuation inhalation: pressurised, 120 actuations

10018G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*89.40	37.70	Symbicort Rapihaler 200/6 [AP]

■ FLUTICASONE + EFORMOTEROL
Restricted benefit

Asthma

Clinical criteria:

Patient must have previously had frequent episodes of asthma while receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids.

Population criteria:

Patient must be aged 12 years or over.

Note

Flutiform is not recommended nor PBS-subsidised for use as 'maintenance and reliever' therapy.

Flutiform is not indicated or PBS-subsidised for bronchodilator therapy in COPD.

fluticasone propionate 125 microgram/actuation + eformoterol fumarate dihydrate 5 microgram/actuation inhalation: pressurised, 120 actuations

10007Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	53.03	37.70	flutiform 125/5 [MF]

fluticasone propionate 250 microgram/actuation + eformoterol fumarate dihydrate 10 microgram/actuation inhalation: pressurised, 120 actuations

10008R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	73.01	37.70	flutiform 250/10 [MF]

fluticasone propionate 50 microgram/actuation + eformoterol fumarate dihydrate 5 microgram/actuation inhalation: pressurised, 120 actuations

2827T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	43.18	37.70	flutiform 50/5 [MF]

■ FLUTICASONE + SALMETEROL
Restricted benefit

Asthma

Clinical criteria:

Patient must have previously had frequent episodes of asthma while receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids.

Population criteria:

Patient must be aged 4 years or older.

fluticasone propionate 100 microgram/actuation + salmeterol 50 microgram/actuation inhalation: powder for, 60 actuations

8430Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	47.54	37.70	Seretide Accuhaler 100/50 [GK]

fluticasone propionate 125 microgram/actuation + salmeterol 25 microgram/actuation inhalation: pressurised, 120 actuations

8518H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	55.49	37.70	Seretide MDI 125/25 [GK]

fluticasone propionate 250 microgram/actuation + salmeterol 50 microgram/actuation inhalation: powder for, 60 actuations

8431R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	55.49	37.70	Seretide Accuhaler 250/50 [GK]

fluticasone propionate 50 microgram/actuation + salmeterol 25 microgram/actuation inhalation: pressurised, 120 actuations

8517G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	47.54	37.70	Seretide MDI 50/25 [GK]

■ FLUTICASONE + SALMETEROL**Restricted benefit**

Asthma

Clinical criteria:

Patient must have previously had frequent episodes of asthma while receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids.

Population criteria:

Patient must be aged 4 years or older.

Restricted benefit

Chronic obstructive pulmonary disease (COPD)

Clinical criteria:

Patient must have a forced expiratory volume in 1 second (FEV1) less than 50% of predicted normal prior to therapy, **AND**

Patient must have a history of repeated exacerbations with significant symptoms despite regular beta-2 agonist bronchodilator therapy, **AND**

The treatment must be for symptomatic treatment.

Note

Patient must not be on a concomitant single agent long-acting beta-2 agonist.

This product is not indicated for the initiation of bronchodilator therapy in COPD.

fluticasone propionate 250 microgram/actuation + salmeterol 25 microgram/actuation inhalation: pressurised, 120 actuations

8519J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	72.63	37.70	Seretide MDI 250/25 [GK]

fluticasone propionate 500 microgram/actuation + salmeterol 50 microgram/actuation inhalation: powder for, 60 actuations

8432T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	72.63	37.70	Seretide Accuhaler 500/50 [GK]

■ FLUTICASONE + VILANTEROL**Restricted benefit**

Asthma

Clinical criteria:

Patient must have previously had frequent episodes of asthma while receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids.

Population criteria:

Patient must be aged 12 years or over.

Note

This drug is not recommended nor PBS-subsidised for use as 'maintenance and reliever' therapy.

This drug is not PBS-subsidised for the treatment of chronic obstructive pulmonary disease (COPD).

fluticasone furoate 200 microgram/actuation + vilanterol 25 microgram/actuation inhalation: powder for, 30 actuations

10167D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	73.34	37.70	Breo Ellipta 200/25 [GK]

■ FLUTICASONE + VILANTEROL**Restricted benefit**

Asthma

Clinical criteria:

Patient must have previously had frequent episodes of asthma while receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids.

Population criteria:

Patient must be aged 12 years or over.

Note

This drug is not recommended nor PBS-subsidised for use as 'maintenance and reliever' therapy.

Restricted benefit

Chronic obstructive pulmonary disease (COPD)

Clinical criteria:

Patient must have a forced expiratory volume in 1 second (FEV₁) less than 50% of predicted normal prior to therapy, **AND**
 Patient must have a history of repeated exacerbations with significant symptoms despite regular beta-2 agonist bronchodilator therapy, **AND**

The treatment must be for symptomatic treatment.

Note

Patient must not be on a concomitant single agent long-acting beta-2 agonist.

This product is not indicated for the initiation of bronchodilator therapy in COPD.

fluticasone furoate 100 microgram/actuation + vilanterol 25 microgram/actuation inhalation: powder for, 30 actuations

10199T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	56.29	37.70	Breo Ellipta 100/25 [GK]

Adrenergics in combination with anticholinergics**■ INDACATEROL + GLYCOPYRRONIUM****Authority required (STREAMLINED)****4655**

Chronic obstructive pulmonary disease (COPD)

Clinical criteria:

Patient must have been stabilised on a combination of a long acting muscarinic antagonist and long acting beta-2 agonist.

Note

The treatment must not be used in combination with an ICS/LABA, or LAMA or LABA monotherapy.

A LAMA includes tiotropium, glycopyrronium, aclidinium or umeclidinium.

A LABA includes indacaterol, salmeterol, eformoterol or vilanterol.

This product is not PBS-subsidised for the treatment of asthma.

This product is not indicated for the initiation of bronchodilator therapy in COPD.

indacaterol 110 microgram + glycopyrronium 50 microgram inhalation: powder for, 30 capsules

10156M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	96.38	37.70	ultibro breezhale 110/50 [NV]

■ UMECLIDINIUM + VILANTEROL**Authority required (STREAMLINED)****4655**

Chronic obstructive pulmonary disease (COPD)

Clinical criteria:

Patient must have been stabilised on a combination of a long acting muscarinic antagonist and long acting beta-2 agonist.

Note

The treatment must not be used in combination with an ICS/LABA, or LAMA or LABA monotherapy.

A LAMA includes tiotropium, glycopyrronium, aclidinium or umeclidinium.

A LABA includes indacaterol, salmeterol, eformoterol or vilanterol.

This product is not PBS-subsidised for the treatment of asthma.

This product is not indicated for the initiation of bronchodilator therapy in COPD.

umeclidinium 62.5 microgram/actuation + vilanterol 25 microgram/actuation inhalation: powder for, 30 actuations

10188F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	96.38	37.70	Anoro Ellipta 62.5/25 [GK]

OTHER DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES, INHALANTS*Glucocorticoids***■ BECLOMETHASONE****beclomethasone dipropionate 100 microgram/actuation inhalation: pressurised, 200**

8407L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	33.80	34.95	Qvar 100 [IA]

beclomethasone dipropionate 50 microgram/actuation inhalation: pressurised, 200

8406K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	19.63	20.78	Qvar 50 [IA]

■ BECLOMETHASONE**Restricted benefit**

Patients unable to achieve co-ordinated use of other metered dose inhalers containing this drug

BECLOMETHASONE DIPROPIONATE Oral pressurised inhalation in breath actuated device 100 micrograms per dose (200 doses), CFC-free formulation, 1

8409N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	39.47	37.70	Qvar 100 Autohaler [IA]

BECLOMETHASONE DIPROPIONATE Oral pressurised inhalation in breath actuated device 50 micrograms per dose (200 doses), CFC-free formulation, 1

8408M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	28.21	29.36	Qvar 50 Autohaler [IA]

■ BUDESONIDE**budesonide 100 microgram/actuation inhalation: powder for, 200 actuations**

2070Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	23.68	24.83	Pulmicort Turbuhaler [AP]

budesonide 200 microgram/actuation inhalation: powder for, 200 actuations

2071B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	31.42	32.57	Pulmicort Turbuhaler [AP]

budesonide 400 microgram/actuation inhalation: powder for, 200 actuations

2072C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	46.18	37.70	Pulmicort Turbuhaler [AP]

■ BUDESONIDE**Authority required (STREAMLINED)****1351**

Severe chronic asthma in patients who require long-term steroid therapy and who are unable to use other forms of inhaled steroid therapy

budesonide 1 mg/2 mL inhalation: solution, 30 x 2 mL ampoules

2066R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	49.34	37.70	Pulmicort Respules [AP]

budesonide 500 microgram/2 mL inhalation: solution, 30 x 2 mL ampoules

2065Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	38.20	37.70	Pulmicort Respules [AP]

■ CICLESONIDE**ciclesonide 160 microgram/actuation inhalation: pressurised, 120 actuations**

8854B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	42.59	37.70	Alvesco 160 [NQ]

ciclesonide 80 microgram/actuation inhalation: pressurised, 120 actuations

8853Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	26.49	27.64	Alvesco 80 [NQ]

■ FLUTICASONE**fluticasone propionate 100 microgram/actuation inhalation: powder for, 60 actuations**

8147T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	17.43	18.58	Flixotide Junior Accuhaler [GK]

fluticasone propionate 125 microgram/actuation inhalation: pressurised, 120 actuations

8345F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	31.00	32.15	Flixotide [GK]

fluticasone propionate 250 microgram/actuation inhalation: powder for, 60 actuations

8148W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	31.00	32.15	Flixotide Accuhaler [GK]

fluticasone propionate 250 microgram/actuation inhalation: pressurised, 120 actuations

8346G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	1	..	50.06	37.70	Flixotide [GK]

fluticasone propionate 50 microgram/actuation inhalation: pressurised, 120

8516F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	17.43	18.58	Flixotide Junior [GK]

fluticasone propionate 500 microgram/actuation inhalation: powder for, 60 actuations

8149X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	1	..	50.06	37.70	Flixotide Accuhaler [GK]

Anticholinergics**■ ACLIDINIUM****Restricted benefit**

Chronic obstructive pulmonary disease (COPD)

aclidinium 322 microgram/actuation inhalation: powder for, 60 actuations

10124W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	62.73	37.70	Bretaris Genuair [FK]

■ GLYCOPYRRONIUM**Restricted benefit**

Chronic obstructive pulmonary disease (COPD)

glycopyrronium 50 microgram inhalation, 30 capsules

10059K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	62.73	37.70	seebri breezhaler [NV]

■ IPRATROPIUM**ipratropium bromide 20 microgram/actuation inhalation: pressurised, 200 actuations**

8671J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*34.18	35.33	Atrovent [BY]

■ IPRATROPIUM**Restricted benefit**

Asthma in patients unable to use this drug delivered from an oral pressurised inhalation device via a spacer

Restricted benefit

Chronic obstructive pulmonary disease in patients unable to use this drug delivered from an oral pressurised inhalation device via a spacer

ipratropium bromide 250 microgram/mL inhalation: solution, 30 x 1 mL ampoules

1542E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*28.28	29.43	^a Aeron 250 [QA]	^a APO-Ipratropium [TX]
						^a Ipratrin [AF]	
			^B 0.52	*28.80	29.43	^a Atrovent [BY]	

ipratropium bromide 500 microgram/mL inhalation: solution, 30 x 1 mL ampoules

8238N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	5	..	*32.20	33.35	^a Aeron 500 [QA] ^a Ipratrin Adult [AF]	^a APO-Ipratropium [TX]
			^b 0.48	*32.68	33.35	^a Atrovent Adult [BY]	

■ TIOTROPIUM**Restricted benefit**

Chronic obstructive pulmonary disease

tiotropium 18 microgram inhalation: powder for, 30 capsules

8626B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	62.73	37.70	Spiriva [BY]

■ UMECLIDINIUM**Restricted benefit**

Chronic obstructive pulmonary disease (COPD)

umeclidinium 62.5 microgram/actuation inhalation: powder for, 30 actuations

10187E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	62.73	37.70	Incruse Ellipta [GK]

*Antiallergic agents, excl. corticosteroids***■ CROMOGLYCATE****cromoglycate sodium 1 mg/actuation inhalation: pressurised, 200**

8767K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	33.84	34.99	Intal CFC-Free [SW]

cromoglycate sodium 20 mg inhalation: powder for, 100 capsules

2878L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	31.75	32.90	Intal Spincaps [GN]

cromoglycate sodium 5 mg/actuation inhalation: pressurised, 112

8334P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	38.65	37.70	Intal Forte CFC-Free [SW]

■ NEDOCROMIL**nedocromil sodium 2 mg/actuation inhalation: pressurised, 112 actuations**

8365G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	40.20	37.70	Tilade CFC-Free [SW]

ADRENERGICS FOR SYSTEMIC USE*Alpha- and beta-adrenoreceptor agonists***■ ADRENALINE****adrenaline 1 in 1000 (1 mg/mL) injection, 5 x 1 mL ampoules**

1016L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	1	..	20.68	21.83	Link Medical Products Pty Ltd [LM]

adrenaline 1 in 1000 (1 mg/mL) injection, 5 x 1 mL ampoules

5004J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	1	..	..	20.68	21.83	Link Medical Products Pty Ltd [LM]

■ ADRENALINE**Caution**

EpiPen and Anapen products have different administration techniques and should not be prescribed to the same patient without training in their use.

Authority required

Acute allergic reaction with anaphylaxis

Treatment Phase: Initial sole PBS-subsidised supply for anticipated emergency treatment

Clinical criteria:Patient must have been assessed to be at significant risk of anaphylaxis by, or in consultation with a clinical immunologist;
OR

Patient must have been assessed to be at significant risk of anaphylaxis by, or in consultation with an allergist; OR
 Patient must have been assessed to be at significant risk of anaphylaxis by, or in consultation with a paediatrician; OR
 Patient must have been assessed to be at significant risk of anaphylaxis by, or in consultation with a respiratory physician.
 The name of the specialist consulted must be provided at the time of application for initial supply.

Authority required

Acute allergic reaction with anaphylaxis

Treatment Phase: Initial sole PBS-subsidised supply for anticipated emergency treatment

Clinical criteria:

Patient must have been discharged from hospital or an emergency department after treatment with adrenaline for acute allergic reaction with anaphylaxis.

Authority required

Acute allergic reaction with anaphylaxis

Treatment Phase: Continuing sole PBS-subsidised supply for anticipated emergency treatment

Clinical criteria:

Patient must have previously been issued with an authority prescription for this drug.

Note

The auto-injector should be provided in the framework of a comprehensive anaphylaxis prevention program and an emergency action plan including training in recognition of the symptoms of anaphylaxis and the use of the auto-injector device. (For further information see the Australasian Society of Clinical Immunology and Allergy website at www.allergy.org.au.)

Authority approvals will be limited to a maximum quantity of 2 auto-injectors (Anapen or EpiPen) at any one time.

No applications for repeats will be authorised.

adrenaline 150 microgram/0.3 mL injection, 1 x 0.3 mL syringe

3408J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	106.34	37.70	Anapen Junior [LM]

adrenaline 150 microgram/0.3 mL injection, 1 x 0.3 mL syringe

8697R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	106.34	37.70	EpiPen Jr. [AL]

adrenaline 300 microgram/0.3 mL injection, 1 x 0.3 mL syringe

3409K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	106.34	37.70	Anapen [LM]

adrenaline 300 microgram/0.3 mL injection, 1 x 0.3 mL syringe

8698T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	106.34	37.70	EpiPen [AL]

Selective beta-2-adrenoreceptor agonists**■ SALBUTAMOL****salbutamol 2 mg/5 mL oral liquid, 150 mL**

1103C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*22.54	23.69	Ventolin [GK]

■ TERBUTALINE**terbutaline sulfate 500 microgram/mL injection, 5 x 1 mL ampoules**

1034K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	30.93	32.08	Bricanyl [AP]

OTHER SYSTEMIC DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES**Xanthines****■ THEOPHYLLINE****Caution**

Because of variable effects of food on absorption of sustained release theophylline preparations, patients stabilised on one brand should not be changed to another without appropriate monitoring.

Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

theophylline 133.3 mg/25 mL oral liquid, 500 mL

2614N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	12.65	13.80	Nuelin [IA]

theophylline 200 mg tablet: modified release, 100 tablets

8230E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	12.50	13.65	Nuelin-SR 200 [IA]

theophylline 250 mg tablet: modified release, 100 tablets

2634P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	13.66	14.81	Nuelin-SR 250 [IA]

theophylline 300 mg tablet: modified release, 100 tablets

8231F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	15.04	16.19	Nuelin-SR 300 [IA]

Leukotriene receptor antagonists**■ MONTELUKAST****Authority required (STREAMLINED)****2617**

First-line preventer medication, as the single preventer agent for children aged 2 to 5 years with frequent intermittent or mild persistent asthma, as an alternative to sodium cromoglycate or nedocromil sodium

Note

Montelukast sodium is not PBS-subsidised for use in a child aged 2 to 5 years with moderate to severe asthma. It is not intended as an alternative for a child aged 2 to 5 years who requires a corticosteroid as a preventer medication.

Montelukast sodium is not subsidised in a child aged 2 to 5 years for use in combination with other preventer medications. PBS subsidy for montelukast sodium will therefore cease for a child aged 2 to 5 years who requires a preventer medication in addition to montelukast sodium.

No applications for increased maximum quantities and/or repeats will be authorised.

montelukast 4 mg tablet: chewable, 28

8627C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	32.03	33.18	^a APO-Montelukast [TX] ^a Chem mart Montelukast [CH] ^a Montair 4 [GN] ^a Montelukast GH [GQ] ^a Montelukast Sandoz 4 [SZ] ^a Respikast 4 [QA] ^a Terry White Chemists Montelukast [TW]	^a Auro-Montelukast Tabs 4 [DO] ^a Lukair [FR] ^a Montelukast AN [EA] ^a Montelukast RBX [RA] ^a Pharmacor Montelukast 4 [CR] ^a Singulair [MK] ^a T Lukast [AF]

■ MONTELUKAST**Authority required (STREAMLINED)****2618**

First-line preventer medication, as the single preventer agent for children aged 6 to 14 years with frequent intermittent or mild persistent asthma, as an alternative to sodium cromoglycate or nedocromil sodium

Authority required (STREAMLINED)**3217**

Prevention of exercise-induced asthma, as an alternative to adding salmeterol xinafoate or eformoterol fumarate, in a child aged 6 to 14 years whose asthma is otherwise well controlled while receiving optimal dose inhaled corticosteroid, but who requires short-acting beta-2 agonist 3 or more times per week for prevention or relief of residual exercise-related symptoms

Note

Montelukast sodium is not PBS-subsidised for use in a patient aged 15 years or older, or for use in addition to a long-acting beta-agonist in any age group, or for use as a single second line preventer, as an alternative to corticosteroids, in a child aged 6 to 14 years with moderate to severe asthma.

No applications for increased maximum quantities and/or repeats will be authorised.

montelukast 5 mg tablet: chewable, 28

8628D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	5	..	30.51	31.66	^a APO-Montelukast [TX] ^a Chem mart Montelukast [CH] ^a Montair 5 [GN] ^a Montelukast GH [GQ] ^a Montelukast Sandoz 5 [SZ] ^a Respikast 5 [QA]	^a Auro-Montelukast Tabs 5 [DO] ^a Lukair [FR] ^a Montelukast AN [EA] ^a Montelukast RBX [RA] ^a Pharmacor Montelukast 5 [CR] ^a Singulair [MK]

COUGH AND COLD PREPARATIONS

COUGH SUPPRESSANTS, EXCL. COMBINATIONS WITH EXPECTORANTS

Opium alkaloids and derivatives

CODEINE

codeine phosphate 30 mg tablet, 20

1214X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	17.21	18.36	Fawns and McAllan Proprietary Limited [FM]

ANTI HISTAMINES FOR SYSTEMIC USE

ANTI HISTAMINES FOR SYSTEMIC USE

Phenothiazine derivatives

PROMETHAZINE

promethazine hydrochloride 50 mg/2 mL injection, 5 x 2 mL ampoules

1948M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*30.58	31.73	Hospira Pty Limited [HH]

SENSORY ORGANS

OPHTHALMOLOGICALS

ANTIINFECTIVES

Antibiotics

AZITHROMYCIN

Restricted benefit

Trachoma

Note

No applications for increased maximum quantities and/or repeats will be authorised.

azithromycin 200 mg/5 mL oral liquid: powder for, 15 mL

8201P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	..	..	#23.70	25.20	Zithromax [PF]

azithromycin 500 mg tablet, 2

8336R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	2	..	13.25	14.40	^a APO-Azithromycin [TX] ^a Azithromycin Sandoz [SZ] ^a Terry White Chemists Azithromycin [TW] ^a Zitrocin [GN]	^a Azithromycin-GA [UA] ^a Chem mart Azithromycin [CH] ^a Zithromax [PF]

CHLORAMPHENICOL

chloramphenicol 0.5% eye drops, 10 mL

2360F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP MW	±1	2	..	11.34	12.49	Chlorsig [QA]

chloramphenicol 0.5% eye drops, 10 mL

5055C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	±1	..	..	11.34	12.49	Chlorsig [QA]

chloramphenicol 0.5% eye drops, 10 mL

5512D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	±1	2	..	11.34	12.49	Chlorsig [QA]

chloramphenicol 1% eye ointment, 4 g

1171P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP MW	±1	..	..	10.10	11.25	Chlorsig [QA]

chloramphenicol 1% eye ointment, 4 g

5511C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	..	..	10.10	11.25	Chlorsig [QA]

▪ **GENTAMICIN**

Restricted benefit

Perioperative use in ophthalmic surgery

Restricted benefit

Suspected pseudomonal eye infection

gentamicin 0.3% eye drops, 5 mL

5566Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	2	..	18.63	19.78	Genoptic [AG]

▪ **GENTAMICIN**

Restricted benefit

Invasive ocular infection

Restricted benefit

Perioperative use in ophthalmic surgery

Restricted benefit

Suspected pseudomonal eye infection

gentamicin 0.3% eye drops, 5 mL

1441W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	18.63	19.78	Genoptic [AG]

▪ **TOBRAMYCIN**

Restricted benefit

Perioperative use in ophthalmic surgery

Restricted benefit

Suspected pseudomonal eye infection

tobramycin 0.3% (3 mg/mL) eye drops, 5 mL

5569D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	2	..	19.62	20.77	Tobrex [AQ]

tobramycin 0.3% eye ointment, 3.5 g

5570E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	..	..	22.72	23.87	Tobrex [AQ]

▪ **TOBRAMYCIN**

Restricted benefit

Invasive ocular infection

Restricted benefit

Perioperative use in ophthalmic surgery

Restricted benefit

Suspected pseudomonal eye infection

tobramycin 0.3% (3 mg/mL) eye drops, 5 mL

2328M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	19.62	20.77	Tobrex [AQ]

tobramycin 0.3% eye ointment, 3.5 g

2329N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	22.72	23.87	Tobrex [AQ]

Antivirals

▪ **ACICLOVIR**

Restricted benefit

Herpes simplex keratitis

aciclovir 3% eye ointment, 4.5 g

5501M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	..	..	37.80	37.70	Zovirax [GK]

■ ACICLOVIR

Restricted benefit

Herpes simplex keratitis

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

aciclovir 3% eye ointment, 4.5 g

1002R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	..	..	37.80	37.70	Zovirax [GK]

Fluoroquinolones

■ CIPROFLOXACIN

Authority required

Bacterial keratitis

Treatment criteria:

Must be treated by an ophthalmologist or in consultation with an ophthalmologist.

ciprofloxacin 0.3% eye drops, 5 mL

1217C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*28.82	29.97	^a CiloQuin [IQ]
			^B 2.06	*30.88	29.97	^a Ciloxan [AQ]

■ CIPROFLOXACIN

Authority required

Bacterial keratitis

Treatment criteria:

Must be treated by an ophthalmologist or in consultation with an ophthalmologist.

ciprofloxacin 0.3% eye drops, 5 mL

5564W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	2	..	..	*28.82	29.97	^a CiloQuin [IQ]
			^B 2.06	*30.88	29.97	^a Ciloxan [AQ]

■ OFLOXACIN

Authority required

Bacterial keratitis

Treatment criteria:

Must be treated by an ophthalmologist or in consultation with an ophthalmologist.

ofloxacin 0.3% (3 mg/mL) eye drops, 5 mL

5567B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	2	..	..	*35.64	36.79	Ocuflox [AG]

■ OFLOXACIN

Authority required

Bacterial keratitis

Treatment criteria:

Must be treated by an ophthalmologist or in consultation with an ophthalmologist.

ofloxacin 0.3% (3 mg/mL) eye drops, 5 mL

8383F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*35.64	36.79	Ocuflox [AG]

ANTIINFLAMMATORY AGENTS

Corticosteroids, plain

■ DEXAMETHASONE

DEXAMETHASONE Eye drops 1 mg per mL (0.1%), 5 mL, 1

1288T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	2	..	10.95	12.10	Maxidex [AQ]

■ DEXAMETHASONE

Note

No applications for increased maximum quantities and/or repeats will be authorised.

DEXAMETHASONE Eye drops 1 mg per mL (0.1%), 5 mL, 1

5565X

OP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
±1	10.95	12.10	Maxidex [AQ]

FLUOROMETHOLONE

fluorometholone 0.1% eye drops, 5 mL

1204J

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
±1	5	..	10.95	12.10	Flucon [AQ]	FML Liquifilm [AG]

FLUOROMETHOLONE

Note

No applications for increased maximum quantities and/or repeats will be authorised.

fluorometholone 0.1% eye drops, 5 mL

5513E

OP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
±1	10.95	12.10	Flucon [AQ]	FML Liquifilm [AG]

FLUOROMETHOLONE ACETATE

fluorometholone acetate 0.1% eye drops, 5 mL

1438Q

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
±1	2	..	10.95	12.10	Flarex [AQ]

FLUOROMETHOLONE ACETATE

Note

No applications for increased maximum quantities and/or repeats will be authorised.

fluorometholone acetate 0.1% eye drops, 5 mL

5533F

OP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
±1	10.95	12.10	Flarex [AQ]

HYDROCORTISONE ACETATE

hydrocortisone acetate 1% eye ointment, 5 g

2441L

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
±1	13.03	14.18	Hycor [QA]

HYDROCORTISONE ACETATE

Note

No applications for increased maximum quantities and/or repeats will be authorised.

hydrocortisone acetate 1% eye ointment, 5 g

5516H

OP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
±1	13.03	14.18	Hycor [QA]

Corticosteroids and mydriatics in combination

PHENYLEPHRINE + PREDNISOLONE ACETATE

Restricted benefit

Corneal grafts

Restricted benefit

Uveitis

phenylephrine hydrochloride 0.12% + prednisolone acetate 1% eye drops, 10 mL

3112T

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
±1	2	..	26.16	27.31	Prednefrin Forte [AG]

PHENYLEPHRINE + PREDNISOLONE ACETATE

Restricted benefit

Uveitis

Note

No applications for increased maximum quantities and/or repeats will be authorised.

phenylephrine hydrochloride 0.12% + prednisolone acetate 1% eye drops, 10 mL

5568C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	..	..	26.16	27.31	Prednefrin Forte [AG]

Antiinflammatory agents, non-steroids

▪ **FLURBIPROFEN**

flurbiprofen sodium 0.03% (120 microgram/0.4 mL) eye drops, 5 x 0.4 mL ampoules

5514F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	1	..	..	17.16	18.31	Ocufen [AG]

flurbiprofen sodium 0.03% (120 microgram/0.4 mL) eye drops, 5 x 0.4 mL ampoules

8699W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	17.16	18.31	Ocufen [AG]

ANTIGLAUCOMA PREPARATIONS AND MIOTICS

Sympathomimetics in glaucoma therapy¹⁾

▪ **APRACLONIDINE**

Restricted benefit

Intra-ocular pressure

Clinical criteria:

The treatment must be for short-term reduction of intra-ocular pressure, **AND**

Patient must already be on maximally tolerated anti-glaucoma therapy.

apraclonidine 0.5% eye drops, 10 mL

8083K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	42.11	37.70	lopidine 0.5% [AQ]

▪ **BRIMONIDINE**

brimonidine tartrate 0.15% eye drops, 5 mL

5298W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	20.48	21.63	Alphagan P 1.5 [AG]

brimonidine tartrate 0.2% eye drops, 5 mL

8351M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	20.48	21.63	^a Enidin [PE]
			^B 1.63	22.11	21.63	^a Alphagan [AG]

▪ **BRIMONIDINE**

Note

Shared Care Model:

For prescribing by optometrists where care of a patient is shared between an optometrist and ophthalmologist in a formalised arrangement with an agreed management plan. Further information can be found in the Guidelines for Shared Care of Glaucoma Patients.

brimonidine tartrate 0.15% eye drops, 5 mL

5563T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	20.48	21.63	Alphagan P 1.5 [AG]

brimonidine tartrate 0.2% eye drops, 5 mL

5534G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	20.48	21.63	^a Enidin [PE]
			^B 1.63	22.11	21.63	^a Alphagan [AG]

▪ **BRIMONIDINE + TIMOLOL**

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

The condition must have been inadequately controlled with monotherapy, **AND**

Patient must have open-angle glaucoma; OR

Patient must have ocular hypertension.

brimonidine tartrate 0.2% + timolol 0.5% eye drops, 5 mL

8826M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	26.37	27.52	Combigan [AG]

■ BRIMONIDINE + TIMOLOL
Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

The condition must have been inadequately controlled with monotherapy, **AND**

Patient must have open-angle glaucoma; OR

Patient must have ocular hypertension.

Note
Shared Care Model:

For prescribing by optometrists where care of a patient is shared between an optometrist and ophthalmologist in a formalised arrangement with an agreed management plan. Further information can be found in the Guidelines for Shared Care of Glaucoma Patients.

brimonidine tartrate 0.2% + timolol 0.5% eye drops, 5 mL

5535H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	26.37	27.52	Combigan [AG]

Parasympathomimetics
■ PILOCARPINE
pilocarpine hydrochloride 1% eye drops, 15 mL

2595N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	12.87	14.02	Isopto Carpine [AQ]

pilocarpine hydrochloride 2% eye drops, 15 mL

2596P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	14.12	15.27	Isopto Carpine [AQ]

pilocarpine hydrochloride 4% eye drops, 15 mL

2598R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	16.97	18.12	Isopto Carpine [AQ]

■ PILOCARPINE
Note
Shared Care Model:

For prescribing by optometrists where care of a patient is shared between an optometrist and ophthalmologist in a formalised arrangement with an agreed management plan. Further information can be found in the Guidelines for Shared Care of Glaucoma Patients.

pilocarpine hydrochloride 1% eye drops, 15 mL

5536J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	12.87	14.02	Isopto Carpine [AQ]

pilocarpine hydrochloride 2% eye drops, 15 mL

5537K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	14.12	15.27	Isopto Carpine [AQ]

pilocarpine hydrochloride 4% eye drops, 15 mL

5538L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	16.97	18.12	Isopto Carpine [AQ]

Carbonic anhydrase inhibitors
■ ACETAZOLAMIDE
Note

Continuing Therapy Only:

For prescribing by nurse practitioners as continuing therapy only, where the treatment of, and prescribing of medicine for, a patient has been initiated by a medical practitioner. Further information can be found in the Explanatory Notes for Nurse Practitioners.

acetazolamide 250 mg tablet, 100

1004W

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
1	3	..	24.13	25.28	Diamox [QA]

■ BRINZOLAMIDE

brinzolamide 1% eye drops, 5 mL

8483L

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
‡1	5	..	23.11	24.26	^a BrinzoQuin [IQ]
		^B 1.18	24.29	24.26	^a Azopt [AQ]

■ BRINZOLAMIDE

Note

Shared Care Model:

For prescribing by optometrists where care of a patient is shared between an optometrist and ophthalmologist in a formalised arrangement with an agreed management plan. Further information can be found in the Guidelines for Shared Care of Glaucoma Patients.

brinzolamide 1% eye drops, 5 mL

5540N

OP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
‡1	5	..	23.11	24.26	^a BrinzoQuin [IQ]
		^B 1.18	24.29	24.26	^a Azopt [AQ]

■ BRINZOLAMIDE + TIMOLOL

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

The condition must have been inadequately controlled with monotherapy, **AND**

Patient must have open-angle glaucoma; OR

Patient must have ocular hypertension.

brinzolamide 1% + timolol 0.5% eye drops, 5 mL

3438Y

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
‡1	5	..	27.22	28.37	Azarga [AQ]

■ BRINZOLAMIDE + TIMOLOL

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

The condition must have been inadequately controlled with monotherapy, **AND**

Patient must have open-angle glaucoma; OR

Patient must have ocular hypertension.

Note

Shared Care Model:

For prescribing by optometrists where care of a patient is shared between an optometrist and ophthalmologist in a formalised arrangement with an agreed management plan. Further information can be found in the Guidelines for Shared Care of Glaucoma Patients.

brinzolamide 1% + timolol 0.5% eye drops, 5 mL

5562R

OP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
‡1	5	..	27.22	28.37	Azarga [AQ]

■ DORZOLAMIDE

dorzolamide 2% (20 mg/mL) eye drops, 5 mL

8488R

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
‡1	5	..	19.26	20.41	^a Trusamide [QA]	^a Trusopt [MK]

■ DORZOLAMIDE

Note

Shared Care Model:

For prescribing by optometrists where care of a patient is shared between an optometrist and ophthalmologist in a formalised arrangement with an agreed management plan. Further information can be found in the Guidelines for Shared Care of Glaucoma Patients.

dorzolamide 2% (20 mg/mL) eye drops, 5 mL

5541P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
OP	‡1	5	..	19.26	20.41	^a Trusamide [QA]	^a Trusopt [MK]

▪ DORZOLAMIDE + TIMOLOL**Restricted benefit**

Elevated intra-ocular pressure

Clinical criteria:The condition must have been inadequately controlled with monotherapy, **AND**

Patient must have open-angle glaucoma; OR

Patient must have ocular hypertension.

dorzolamide 2% + timolol 0.5% eye drops, 5 mL

8567X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	‡1	5	..	24.19	25.34	^a Cosdor [QA] ^a Dorzolamide/Timolol Sandoz 20/5 [SZ]	^a Cosopt [MK]

▪ DORZOLAMIDE + TIMOLOL**Restricted benefit**

Elevated intra-ocular pressure

Clinical criteria:The condition must have been inadequately controlled with monotherapy, **AND**

Patient must have open-angle glaucoma; OR

Patient must have ocular hypertension.

Note**Shared Care Model:**

For prescribing by optometrists where care of a patient is shared between an optometrist and ophthalmologist in a formalised arrangement with an agreed management plan. Further information can be found in the Guidelines for Shared Care of Glaucoma Patients.

dorzolamide 2% + timolol 0.5% eye drops, 5 mL

5542Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
OP	‡1	5	..	24.19	25.34	^a Cosdor [QA] ^a Dorzolamide/Timolol Sandoz 20/5 [SZ]	^a Cosopt [MK]

*Beta blocking agents1)***▪ BETAXOLOL****betaxolol 0.25% eye drops, 5 mL**

2811Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	15.11	16.26	Betoptic S [AQ]

betaxolol 0.5% eye drops, 5 mL

2825Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	15.11	16.26	^a BetoQuin [IQ]
			^B 2.08	17.19	16.26	^a Betoptic [AQ]

▪ BETAXOLOL**Note****Shared Care Model:**

For prescribing by optometrists where care of a patient is shared between an optometrist and ophthalmologist in a formalised arrangement with an agreed management plan. Further information can be found in the Guidelines for Shared Care of Glaucoma Patients.

betaxolol 0.25% eye drops, 5 mL

5543R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	15.11	16.26	Betoptic S [AQ]

betaxolol 0.5% eye drops, 5 mL

5544T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	15.11	16.26	^a BetoQuin [IQ]
			^B 2.08	17.19	16.26	^a Betoptic [AQ]

■ TIMOLOL

timolol 0.1% eye gel, 5 g

8803H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	13.21	14.36	Nyogel [AS]

timolol 0.25% (2.5 mg/mL) eye drops, 2.5 mL

1925H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	11.88	13.03	Timoptol XE [MK]

timolol 0.5% (5 mg/mL) eye drops, 2.5 mL

1926J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	12.65	13.80	Timoptol XE [MK]

timolol 0.5% (5 mg/mL) eye drops, 5 mL

1279H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	12.65	13.80	^a Tenopt [QA]
			^B 3.03	15.68	13.80	^a Timoptol [FR]

■ TIMOLOL

Note

Shared Care Model:

For prescribing by optometrists where care of a patient is shared between an optometrist and ophthalmologist in a formalised arrangement with an agreed management plan. Further information can be found in the Guidelines for Shared Care of Glaucoma Patients.

timolol 0.1% eye gel, 5 g

5546X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	13.21	14.36	Nyogel [AS]


timolol 0.25% (2.5 mg/mL) eye drops, 2.5 mL

5549C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	11.88	13.03	Timoptol XE [MK]

timolol 0.5% (5 mg/mL) eye drops, 2.5 mL

5550D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	12.65	13.80	Timoptol XE [MK]

timolol 0.5% (5 mg/mL) eye drops, 5 mL

5548B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	12.65	13.80	^a Tenopt [QA]
			^B 3.03	15.68	13.80	^a Timoptol [FR]

Prostaglandin analogues¹⁾

■ BIMATOPROST

bimatoprost 0.03% eye drops, 3 mL

8620Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	42.48	37.70	Lumigan [AG]

bimatoprost 0.03% eye drops, 30 x 0.4 mL unit doses

10046R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	36.91	37.70	Lumigan PF [AG]

■ BIMATOPROST

Note

Shared Care Model:

For prescribing by optometrists where care of a patient is shared between an optometrist and ophthalmologist in a formalised arrangement with an agreed management plan. Further information can be found in the Guidelines for Shared Care of Glaucoma Patients.

bimatoprost 0.03% eye drops, 3 mL

5551E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	42.48	37.70	Lumigan [AG]

bimatoprost 0.03% eye drops, 30 x 0.4 mL unit doses

10053D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	36.91	37.70	Lumigan PF [AG]

▪ BIMATOPROST + TIMOLOL
Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

 The condition must have been inadequately controlled with monotherapy, **AND**

Patient must have open-angle glaucoma; OR

Patient must have ocular hypertension.

bimatoprost 0.03% + timolol 0.5% eye drops, 30 x 0.4 mL unit doses

10107Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	41.21	37.70	GANfort PF 0.3/5 [AG]

▪ BIMATOPROST + TIMOLOL
Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

 The condition must have been inadequately controlled with monotherapy, **AND**

Patient must have open-angle glaucoma; OR

Patient must have ocular hypertension.

bimatoprost 0.03% + timolol 0.5% eye drops, 3 mL

9464D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	46.94	37.70	Ganfort 0.3/5 [AG]

▪ BIMATOPROST + TIMOLOL
Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

 The condition must have been inadequately controlled with monotherapy, **AND**

Patient must have open-angle glaucoma; OR

Patient must have ocular hypertension.

Note
Shared Care Model:

For prescribing by optometrists where care of a patient is shared between an optometrist and ophthalmologist in a formalised arrangement with an agreed management plan. Further information can be found in the Guidelines for Shared Care of Glaucoma Patients.

bimatoprost 0.03% + timolol 0.5% eye drops, 3 mL

5558M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	46.94	37.70	Ganfort 0.3/5 [AG]

bimatoprost 0.03% + timolol 0.5% eye drops, 30 x 0.4 mL unit doses

10108B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	41.21	37.70	GANfort PF 0.3/5 [AG]

▪ LATANOPROST
latanoprost 0.005% eye drops, 2.5 mL

8243W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	‡1	5	..	24.06	25.21	^a APO-Latanoprost [TX] ^a Latanoprost Actavis [GN] ^a Latanoprost Pfizer [FZ] ^a Terry White Chemists Latanoprost [TW] ^a Xalatan [PF]	^a Chem mart Latanoprost [CH] ^a Latanoprost GH [GQ] ^a Latanoprost Sandoz [SZ] ^a Xalaprost [QA]

▪ LATANOPROST
Note
Shared Care Model:

For prescribing by optometrists where care of a patient is shared between an optometrist and ophthalmologist in a formalised arrangement with an agreed management plan. Further information can be found in the Guidelines for Shared Care of Glaucoma Patients.

latanoprost 0.005% eye drops, 2.5 mL

5552F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
OP	±1	5	..	24.06	25.21	^a APO-Latanoprost [TX] ^a Latanoprost Actavis [GN] ^a Latanoprost Pfizer [FZ] ^a Terry White Chemists Latanoprost [TW] ^a Xalatan [PF]	^a Chem mart Latanoprost [CH] ^a Latanoprost GH [GQ] ^a Latanoprost Sandoz [SZ] ^a Xalaprost [QA]

■ LATANOPROST + TIMOLOL

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

The condition must have been inadequately controlled with monotherapy, **AND**

Patient must have open-angle glaucoma; OR

Patient must have ocular hypertension.

latanoprost 0.005% + timolol 0.5% eye drops, 2.5 mL

8895E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	±1	5	..	41.21	37.70	^a APO-Latanoprost/Timolol 0.05/5 [TX] ^a Latanoprost/Timolol Sandoz 50/5 [SZ] ^a Xalamol 50/5 [QA]	^a Latanocom [FZ] ^a Xalacom [PF]

■ LATANOPROST + TIMOLOL

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

The condition must have been inadequately controlled with monotherapy, **AND**

Patient must have open-angle glaucoma; OR

Patient must have ocular hypertension.

Note

Shared Care Model:

For prescribing by optometrists where care of a patient is shared between an optometrist and ophthalmologist in a formalised arrangement with an agreed management plan. Further information can be found in the Guidelines for Shared Care of Glaucoma Patients.

latanoprost 0.005% + timolol 0.5% eye drops, 2.5 mL

5553G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
OP	±1	5	..	41.21	37.70	^a APO-Latanoprost/Timolol 0.05/5 [TX] ^a Latanoprost/Timolol Sandoz 50/5 [SZ] ^a Xalamol 50/5 [QA]	^a Latanocom [FZ] ^a Xalacom [PF]

■ TAFLUPROST

tafluprost 0.0015% eye drops, 30 x 0.3 mL unit doses

2755B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	5	..	34.16	35.31	Saflutan [MK]

■ TAFLUPROST

Note

Shared Care Model:

For prescribing by optometrists where care of a patient is shared between an optometrist and ophthalmologist in a formalised arrangement with an agreed management plan. Further information can be found in the Guidelines for Shared Care of Glaucoma Patients.

tafluprost 0.0015% eye drops, 30 x 0.3 mL unit doses

2748P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	±1	5	..	34.16	35.31	Saflutan [MK]

■ TIMOLOL + TRAVOPROST

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

The condition must have been inadequately controlled with monotherapy, **AND**
 Patient must have open-angle glaucoma; OR
 Patient must have ocular hypertension.

timolol 0.5% + travoprost 0.004% eye drops, 2.5 mL

9057Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	46.94	37.70	Duotrav [AQ]

■ TIMOLOL + TRAVOPROST

Restricted benefit

Elevated intra-ocular pressure

Clinical criteria:

The condition must have been inadequately controlled with monotherapy, **AND**

Patient must have open-angle glaucoma; OR

Patient must have ocular hypertension.

Note

Shared Care Model:

For prescribing by optometrists where care of a patient is shared between an optometrist and ophthalmologist in a formalised arrangement with an agreed management plan. Further information can be found in the Guidelines for Shared Care of Glaucoma Patients.

timolol 0.5% + travoprost 0.004% eye drops, 2.5 mL

5555J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	46.94	37.70	Duotrav [AQ]

■ TRAVOPROST

travoprost 0.004% (40 microgram/mL) eye drops, 2.5 mL

8597L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	42.48	37.70	Travatan [AQ]

■ TRAVOPROST

Note

Shared Care Model:

For prescribing by optometrists where care of a patient is shared between an optometrist and ophthalmologist in a formalised arrangement with an agreed management plan. Further information can be found in the Guidelines for Shared Care of Glaucoma Patients.

travoprost 0.004% (40 microgram/mL) eye drops, 2.5 mL

5554H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	42.48	37.70	Travatan [AQ]

MYDRIATICS AND CYCLOPLEGICS

Anticholinergics

■ ATROPINE

ATROPINE Eye drops containing atropine sulfate 10 mg per mL (1%), 15 mL, 1

1093M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	2	..	22.11	23.26	Atropt [QA]

■ HOMATROPINE

homatropine hydrobromide 2% eye drops, 15 mL

10063P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	2	..	19.15	20.30	Isopto Homatropine [AQ]

homatropine hydrobromide 2% eye drops, 15 mL

2541R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	2	..	19.15	20.30	Isopto Homatropine [AQ]

DECONGESTANTS AND ANTIALLERGICS

Other antiallergics

■ CROMOGLYCATE

Restricted benefit

Vernal kerato-conjunctivitis

cromoglycate sodium 2% eye drops, 10 mL

1127H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	14.55	15.70	Opticrom [SW]

cromoglycate sodium 2% eye drops, 10 mL

5529B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	±1	5	..	14.55	15.70	Opticrom [SW]

OCULAR VASCULAR DISORDER AGENTS

Antineovascularisation agents

■ AFLIBERCEPT

Authority required

Subfoveal choroidal neovascularisation (CNV)

Treatment Phase: Initial treatment

Clinical criteria:

The condition must be due to age-related macular degeneration (AMD), **AND**

The condition must be diagnosed by fluorescein angiography, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

Must be treated by an ophthalmologist.

Authority approval for initial treatment of each eye must be sought.

The first authority application for each eye must be made in writing or by telephone.

A written application must include:

- a completed authority prescription form;
- a completed Subfoveal Choroidal Neovascularisation (CNV) - PBS Supporting Information Form; and
- a copy of the fluorescein angiogram.

A telephone application must be made following submission by facsimile of a copy of a completed Subfoveal Choroidal Neovascularisation (CNV) - PBS Supporting Information Form and a copy of the fluorescein angiogram. The original documentation must be submitted to the Chief Executive Medicare by post after the application has been authorised.

Where a fluorescein angiogram cannot be performed due to a contraindication as listed in the TGA-approved product information, details of the contraindication must be provided. A copy of the report of an alternative method of diagnosis must be included in the application, for example, optical coherence tomography (OCT) or red free photography.

Note

The first authority application may be faxed to the Department of Human Services on 1300 093 177 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The Department will then contact the prescriber by telephone.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

Authority required

Subfoveal choroidal neovascularisation (CNV)

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must be due to age-related macular degeneration (AMD), **AND**

The treatment must be the sole PBS-subsidised therapy for this condition, **AND**

Patient must have previously been granted an authority prescription for the same eye.

Treatment criteria:

Must be treated by an ophthalmologist.

Note

Authority approvals will be administered by the Complex Drugs Unit of the Department of Human Services.

Authority applications for continuing treatment in the same eye may be made by telephone on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

No increase in the maximum number of repeats may be authorised.

Special Pricing Arrangements apply.

aflibercept 4 mg/0.1 mL injection, 1 x 0.1 mL vial

2168D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	1431.50	37.70	Eylea [BN]

▪ **RANIBIZUMAB**

Authority required

Subfoveal choroidal neovascularisation (CNV)

Treatment Phase: Initial treatment

Clinical criteria:

The condition must be due to age-related macular degeneration (AMD), **AND**

The condition must be diagnosed by fluorescein angiography, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

Treatment criteria:

Must be treated by an ophthalmologist.

Authority approval for initial treatment of each eye must be sought.

The first authority application for each eye must be made in writing or by telephone.

A written application must include:

a) a completed authority prescription form;

b) a completed Subfoveal Choroidal Neovascularisation (CNV) - PBS Supporting Information Form; and

c) a copy of the fluorescein angiogram.

A telephone application must be made following submission by facsimile of a copy of a completed Subfoveal Choroidal Neovascularisation (CNV) - PBS Supporting Information Form and a copy of the fluorescein angiogram. The original documentation must be submitted to the Chief Executive Medicare by post after the application has been authorised.

Where a fluorescein angiogram cannot be performed due to a contraindication as listed in the TGA-approved product information, details of the contraindication must be provided. A copy of the report of an alternative method of diagnosis must be included in the application, for example, optical coherence tomography (OCT) or red free photography.

Note

The first authority application may be faxed to the Department of Human Services on 1300 093 177 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The Department will then contact the prescriber by telephone.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Subfoveal choroidal neovascularisation (CNV)

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must be due to age-related macular degeneration (AMD), **AND**

The treatment must be the sole PBS-subsidised therapy for this condition, **AND**

Patient must have previously been granted an authority prescription for the same eye.

Treatment criteria:

Must be treated by an ophthalmologist.

Note

Authority applications for continuing treatment in the same eye may be made by telephone on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Special Pricing Arrangements apply.

Pharmaceutical benefits that have the form ranibizumab 0.165 mL injection syringe and pharmaceutical benefits that have the form ranibizumab 0.23 mL injection vial are equivalent for the purposes of substitution.

ranibizumab 1.65 mg/0.165 mL injection, 1 x 0.165 mL syringe

10138N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	1431.50	37.70	^a Lucentis [NV]

ranibizumab 2.3 mg/0.23 mL injection, 1 x 0.23 mL vial

1382R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	1431.50	37.70	^a Lucentis [NV]

■ VERTEPORFIN

Authority required

Initial treatment by an ophthalmologist, as the sole PBS-subsidised therapy, of predominantly (greater than or equal to 50%) classic, subfoveal choroidal neovascularisation (CNV) due to age-related macular degeneration (AMD), as diagnosed by fluorescein angiography, in a patient with a baseline visual acuity equal to or better than 6/60 (20/200).

Authority approvals will be administered by the PBS and Specialised Drugs Branch of Medicare Australia.

The first authority application for each eye must be made in writing, and must include:

- (a) a completed authority prescription form; and
- (b) a completed Subfoveal Choroidal Neovascularisation (CNV) - PBS Supporting Information Form [www.medicareaustralia.gov.au]; and
- (c) a copy of the fluorescein angiogram demonstrating that the CNV is predominantly classic (greater than or equal to 50%).

Written applications for authority to prescribe verteporfin should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Alternatively, the first authority application may be faxed to Medicare Australia on 1300 093 177 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Medicare Australia will then contact the prescriber by telephone. The original documentation must be posted to the above address after approval has been gained.

No more than 15 treatments (1 initial and 14 continuing) per eye will be authorised.

Medicare Australia should be notified if treatment is abandoned prior to completion of the laser activation step but after infusion of verteporfin. Telephone 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The reason treatment is abandoned must be provided. Where such notification has been made, the treatment so affected will not count towards the maximum

Authority required

Initial PBS-subsidised treatment by an ophthalmologist, as the sole PBS-subsidised therapy, of predominantly (greater than or equal to 50%) classic, subfoveal choroidal neovascularisation (CNV) due to macular degeneration where the patient has been authorised by the Angiogram Review Panel to receive treatment with verteporfin in the same eye under the MBS Visudyne Therapy Program.

Authority approvals will be administered by the PBS and Specialised Drugs Branch of Medicare Australia.

The first authority application for each eye must be made in writing, and must include:

- (a) a completed authority prescription form; and
- (b) a completed Subfoveal Choroidal Neovascularisation (CNV) - PBS Supporting Information Form [www.medicareaustralia.gov.au], which includes the date of review by the Angiogram Review Panel and the number of treatments administered in that eye under the MBS Visudyne Therapy Program; and
- (c) a copy of the fluorescein angiogram demonstrating that the CNV is predominantly classic (greater than or equal to 50%).

Written applications for authority to prescribe verteporfin should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Alternatively, the first authority application may be faxed to Medicare Australia on 1300 093 177 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Medicare Australia will then contact the prescriber by telephone. The original documentation must be posted to the above address after approval has been gained.

A patient is eligible for a total of 15 subsidised treatments per eye. This maximum includes treatments administered under the MBS Visudyne Therapy Program and the PBS.

Medicare Australia should be notified if treatment is abandoned prior to completion of the laser activation step but after infusion of verteporfin. Telephone 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The reason treatment is abandoned must be provided. Where such notification has been made, the treatment so affected will not count towards the maximum

Authority required

Continuing treatment by an ophthalmologist, as the sole PBS-subsidised therapy, of predominantly (greater than or equal to 50%) classic, subfoveal choroidal neovascularisation (CNV) due to macular degeneration where the patient has previously been granted an authority prescription for the same eye.

A patient is eligible for a total of 15 subsidised treatments per eye. This maximum includes treatments administered under the MBS Visudyne Therapy Program and the PBS.

Medicare Australia should be notified if treatment is abandoned prior to completion of the laser activation step but after infusion of verteporfin. Telephone 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The reason treatment is abandoned must be provided. Where such notification has been made, the treatment so affected will not count towards the maximum.

Authority approvals will be administered by the PBS and Specialised Drugs Branch of Medicare Australia. Authority applications for continuing treatment in the same eye may be made by telephone on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

verteporfin 15 mg injection, 1 x 15 mg vial

1349B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	2246.70	37.70	Visudyne [NV]

OTHER OPHTHALMOLOGICALS
Other ophthalmologicals
■ CARBOMER-974
Authority required

Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops

carbomer-974 0.3% eye gel, 30 x 500 mg unit doses

5502N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	3	5	..	*36.40	37.55	Poly Gel [AQ]

■ CARBOMER-974
Authority required (STREAMLINED)
1359

Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops

carbomer-974 0.3% eye gel, 30 x 500 mg unit doses

8514D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*36.40	37.55	Poly Gel [AQ]

■ CARBOMER-980
Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

carbomer-980 0.2% eye gel, 10 g

5503P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
OP	‡1	5	..	10.00	11.15	^a Optifresh eye gel [PP]	^a PAA [IQ]
			^B 1.84	11.84	11.15	^a Viscotears [AQ]	

carbomer-980 0.2% eye gel, 10 g

8384G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	‡1	5	..	10.00	11.15	^a Optifresh eye gel [PP]	^a PAA [IQ]
			^B 1.84	11.84	11.15	^a Viscotears [AQ]	

■ CARBOMER-980
Authority required

Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops

carbomer-980 0.2% (2 mg/g) eye drops, 30 x 0.6 mL unit doses

5504Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	3	5	..	*36.43	37.58	Viscotears Gel PF [AQ]

■ CARBOMER-980
Authority required (STREAMLINED)
1359

Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops

carbomer-980 0.2% (2 mg/g) eye drops, 30 x 0.6 mL unit doses

8578L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*36.43	37.58	Viscotears Gel PF [AQ]

■ CARBOMER-980
Restricted benefit

For use in patients who have severe dry eye syndrome, including Sjogren's syndrome, and who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

No applications for increased maximum quantities and/or repeats will be authorised.

carbomer-980 0.2% eye gel, 10 g

9210R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	‡1	11	..	10.00	11.15	^a Optifresh eye gel [PP]	^a PAA [IQ]
			^B 1.84	11.84	11.15	^a Viscotears [AQ]	

■ CARMELLOSE SODIUM

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

carmellose sodium 1% (10 mg/mL) eye drops, 15 mL

5508X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	10.93	12.08	Refresh Liquigel [AG]

carmellose sodium 1% (10 mg/mL) eye drops, 15 mL

8593G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	10.93	12.08	Refresh Liquigel [AG]

carmellose sodium 0.5% (5 mg/mL) eye drops, 15 mL

5507W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	10.93	12.08	Refresh Tears Plus [AG]

carmellose sodium 0.5% (5 mg/mL) eye drops, 15 mL

8548X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	10.93	12.08	Refresh Tears Plus [AG]

■ CARMELLOSE SODIUM

Authority required (STREAMLINED)

1359

Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops

carmellose sodium 1% (4 mg/0.4 mL) eye drops, 30 x 0.4 mL unit doses

2324H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*31.63	32.78	^a Optifresh Plus [PP]
			^B 4.77	*36.40	32.78	^a Celluvisc [AG]

carmellose sodium 0.25% (1.5 mg/0.6 mL) eye drops, 24 x 0.6 mL unit doses

8823J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*40.76	37.70	TheraTears [CX]

carmellose sodium 0.5% (2 mg/0.4 mL) eye drops, 30 x 0.4 mL unit doses

2338C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*31.63	32.78	^a Optifresh Tears [PP]
			^B 4.77	*36.40	32.78	^a Cellufresh [AG]

carmellose sodium 1% (6 mg/0.6 mL) eye gel, 28 x 0.6 mL unit doses

8824K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*34.42	35.57	TheraTears [CX]

■ CARMELLOSE SODIUM

Authority required

Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops

carmellose sodium 1% (4 mg/0.4 mL) eye drops, 30 x 0.4 mL unit doses

5505R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	3	5	..	*31.63	32.78	^a Optifresh Plus [PP]
			^B 4.77	*36.40	32.78	^a Celluvisc [AG]

carmellose sodium 0.25% (1.5 mg/0.6 mL) eye drops, 24 x 0.6 mL unit doses

5509Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	4	5	..	*40.76	37.70	TheraTears [CX]

carmellose sodium 0.5% (2 mg/0.4 mL) eye drops, 30 x 0.4 mL unit doses

5506T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	3	5	..	*31.63	32.78	^a Optifresh Tears [PP]
			^B 4.77	*36.40	32.78	^a Cellufresh [AG]

carmellose sodium 1% (6 mg/0.6 mL) eye gel, 28 x 0.6 mL unit doses

5510B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	3	5	..	*34.42	35.57	TheraTears [CX]

■ CARMELLOSE SODIUM

Restricted benefit

For use in patients who have severe dry eye syndrome, including Sjogren's syndrome, and who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

No applications for increased maximum quantities and/or repeats will be authorised.

carmellose sodium 1% (10 mg/mL) eye drops, 15 mL

9212W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	10.93	12.08	Refresh Liquigel [AG]

carmellose sodium 0.5% (5 mg/mL) eye drops, 15 mL

9211T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	10.93	12.08	Refresh Tears Plus [AG]

▪ **CARMELLOSE SODIUM + GLYCEROL**

Authority required

Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops

carmellose sodium 0.5% + glycerol 0.9% eye drops, 30 x 0.4 mL unit doses

5561Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	3	5	..	*36.40	37.55	Optive [AG]

▪ **CARMELLOSE SODIUM + GLYCEROL**

Authority required (STREAMLINED)

1359

Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops

carmellose sodium 0.5% + glycerol 0.9% eye drops, 30 x 0.4 mL unit doses

9307W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*36.40	37.55	Optive [AG]

▪ **CARMELLOSE SODIUM + GLYCEROL**

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

Note

The in-use shelf life of Optive is 6 months from the date of opening.

carmellose sodium 0.5% + glycerol 0.9% eye drops, 15 mL

5556K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	3	..	10.93	12.08	Optive [AG]

carmellose sodium 0.5% + glycerol 0.9% eye drops, 15 mL

9355J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	3	..	10.93	12.08	Optive [AG]

▪ **CARMELLOSE SODIUM + GLYCEROL**

Restricted benefit

For use in patients who have severe dry eye syndrome, including Sjogren's syndrome, and who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

No applications for increased maximum quantities and/or repeats will be authorised.

The in-use shelf life of Optive is 6 months from the date of opening.

carmellose sodium 0.5% + glycerol 0.9% eye drops, 15 mL

9356K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	7	..	10.93	12.08	Optive [AG]

▪ **DEXTRAN-70 + HYPROMELLOSE**

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

dextran-70 0.1% + hypromellose 0.3% eye drops, 15 mL

1509K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	10.83	11.98	^a Poly-Tears [IQ]
			^B 2.04	12.87	11.98	^a Tears Naturale [AQ]

dextran-70 0.1% + hypromellose 0.3% eye drops, 15 mL

5520M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	10.83	11.98	^a Poly-Tears [IQ]
			^B 2.04	12.87	11.98	^a Tears Naturale [AQ]

▪ DEXTRAN-70 + HYPROMELLOSE

Authority required

Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops

dextran-70 0.1% + hypromellose 0.3% eye drops, 28 x 0.4 mL unit doses

5521N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	3	5	..	*35.41	36.56	Bion Tears [AQ]

▪ DEXTRAN-70 + HYPROMELLOSE

Authority required (STREAMLINED)

1359

Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops

dextran-70 0.1% + hypromellose 0.3% eye drops, 28 x 0.4 mL unit doses

8299T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*35.41	36.56	Bion Tears [AQ]

▪ DEXTRAN-70 + HYPROMELLOSE

Restricted benefit

For use in patients who have severe dry eye syndrome, including Sjogren's syndrome, and who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

No applications for increased maximum quantities and/or repeats will be authorised.

dextran-70 0.1% + hypromellose 0.3% eye drops, 15 mL

9216C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	10.83	11.98	^a Poly-Tears [IQ]
			^B 2.04	12.87	11.98	^a Tears Naturale [AQ]

▪ HYPROMELLOSE

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

HYPROMELLOSE Eye drops 3 mg per mL (0.3%), 15 mL (contains sodium perborate as preservative), 1

5518K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	10.61	11.76	^a In a Wink Moisturising [IQ]
			^B 1.95	12.56	11.76	^a Genteal [AQ]

HYPROMELLOSE Eye drops 3 mg per mL (0.3%), 15 mL (contains sodium perborate as preservative), 1

8287E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	10.61	11.76	^a In a Wink Moisturising [IQ]
			^B 1.95	12.56	11.76	^a Genteal [AQ]

HYPROMELLOSE Eye drops 5 mg per mL (0.5%), 15 mL, 1

2956N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	10.61	11.76	Methopt [QA]

HYPROMELLOSE Eye drops 5 mg per mL (0.5%), 15 mL, 1

5517J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	10.61	11.76	Methopt [QA]

▪ HYPROMELLOSE

Restricted benefit

For use in patients who have severe dry eye syndrome, including Sjogren's syndrome, and who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

No applications for increased maximum quantities and/or repeats will be authorised.

HYPROMELLOSE Eye drops 3 mg per mL (0.3%), 15 mL (contains sodium perborate as preservative), 1

9213X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	10.61	11.76	^a In a Wink Moisturising [IQ]
			^B 1.95	12.56	11.76	^a Genteal [AQ]

HYPROMELLOSE Eye drops 5 mg per mL (0.5%), 15 mL, 1

9214Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	10.61	11.76	Methopt [QA]

■ HYPROMELLOSE + CARBOMER-980
Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

hypromellose 0.3% + carbomer-980 0.2% eye gel, 10 g

5519L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	10.61	11.76	^a HPMC PAA [IQ]
			^B 1.95	12.56	11.76	^a Genteal gel [AQ]

hypromellose 0.3% + carbomer-980 0.2% eye gel, 10 g

8564R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	10.61	11.76	^a HPMC PAA [IQ]
			^B 1.95	12.56	11.76	^a Genteal gel [AQ]

■ HYPROMELLOSE + CARBOMER-980
Restricted benefit

For use in patients who have severe dry eye syndrome, including Sjogren's syndrome, and who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

No applications for increased maximum quantities and/or repeats will be authorised.

hypromellose 0.3% + carbomer-980 0.2% eye gel, 10 g

9215B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	10.61	11.76	^a HPMC PAA [IQ]
			^B 1.95	12.56	11.76	^a Genteal gel [AQ]

■ PARAFFIN
paraffin 1 g/g eye ointment, 2 x 3.5 g tubes

1750D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	20.94	22.09	Poly Visc [IQ]
			^B 2.12	23.06	22.09	^a Ircal [PE]
						^a Refresh Night Time [AG]

paraffin 1 g/g eye ointment, 2 x 3.5 g tubes

5522P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	20.94	22.09	Poly Visc [IQ]
			^B 2.12	23.06	22.09	^a Ircal [PE]
						^a Refresh Night Time [AG]

paraffin 1 g/g eye ointment, 3.5 g

1754H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*21.58	22.73	^a Poly Visc [IQ]
			^B 2.54	*24.12	22.73	^a Duratears [AQ]

paraffin 1 g/g eye ointment, 3.5 g

5523Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	2	5	..	*21.58	22.73	^a Poly Visc [IQ]
			^B 2.54	*24.12	22.73	^a Duratears [AQ]

■ PARAFFIN
Restricted benefit

For use in patients who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

No applications for increased maximum quantities and/or repeats will be authorised.

paraffin 1 g/g eye ointment, 2 x 3.5 g tubes

9218E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	20.94	22.09	Poly Visc [IQ] ^a Ircal [PE]
			^B 2.12	23.06	22.09	^a Refresh Night Time [AG]

paraffin 1 g/g eye ointment, 3.5 g

9217D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*21.58	22.73	^a Poly Visc [IQ]
			^B 2.54	*24.12	22.73	^a Duratears [AQ]

▪ **PARAFFIN**

Note

The in-use shelf life of VitA-POS is 6 months from the date of opening.

paraffin + retinyl palmitate 138 microgram/g (equivalent to 250 units/g vitamin A) eye ointment, 5 g

2167C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	2	5	..	*21.58	22.73	VitA-POS [AE]

paraffin + retinyl palmitate 138 microgram/g (equivalent to 250 units/g vitamin A) eye ointment, 5 g

2222Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*21.58	22.73	VitA-POS [AE]

▪ **PARAFFIN**

Restricted benefit

For use in patients who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

Note

The in-use shelf life of VitA-POS is 6 months from the date of opening.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

paraffin + retinyl palmitate 138 microgram/g (equivalent to 250 units/g vitamin A) eye ointment, 5 g

2202X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*21.58	22.73	VitA-POS [AE]

▪ **POLYETHYLENE GLYCOL-400 + PROPYLENE GLYCOL**

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

polyethylene glycol-400 0.4% + propylene glycol 0.3% eye drops, 15 mL

5524R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	5	..	10.93	12.08	Systane [AQ]

polyethylene glycol-400 0.4% + propylene glycol 0.3% eye drops, 15 mL

8676P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	10.93	12.08	Systane [AQ]

▪ **POLYETHYLENE GLYCOL-400 + PROPYLENE GLYCOL**

Authority required

Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops

polyethylene glycol-400 0.4% + propylene glycol 0.3% eye drops, 28 x 0.8 mL unit doses

5532E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	2	5	..	*34.42	35.57	Systane [AQ]

▪ **POLYETHYLENE GLYCOL-400 + PROPYLENE GLYCOL**

Authority required (STREAMLINED)

1359

Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops

polyethylene glycol-400 0.4% + propylene glycol 0.3% eye drops, 28 x 0.8 mL unit doses

9170P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*34.42	35.57	Systane [AQ]

■ POLYETHYLENE GLYCOL-400 + PROPYLENE GLYCOL

Restricted benefit

For use in patients who have severe dry eye syndrome, including Sjogren's syndrome, and who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

No applications for increased maximum quantities and/or repeats will be authorised.

polyethylene glycol-400 0.4% + propylene glycol 0.3% eye drops, 15 mL

9219F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	11	..	10.93	12.08	Systane [AQ]

■ POLYVINYL ALCOHOL

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

polyvinyl alcohol 1.4% eye drops, 15 mL

2682E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	10.61	11.76	^a PVA Tears [PE]
			^B 1.60	12.21	11.76	^a Liquifilm Tears [AG]

polyvinyl alcohol 1.4% eye drops, 15 mL

5526W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	±1	5	..	10.61	11.76	^a PVA Tears [PE]
			^B 1.60	12.21	11.76	^a Liquifilm Tears [AG]

polyvinyl alcohol 1.4% eye drops, 15 mL

5527X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	±1	5	..	10.61	11.76	Vistil [AE]

polyvinyl alcohol 1.4% eye drops, 15 mL

8831T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	10.61	11.76	Vistil [AE]

polyvinyl alcohol 3% eye drops, 15 mL

5528Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	±1	5	..	10.61	11.76	Vistil Forte [AE]

polyvinyl alcohol 3% eye drops, 15 mL

8832W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	10.61	11.76	Vistil Forte [AE]

■ POLYVINYL ALCOHOL

Restricted benefit

For use in patients who have severe dry eye syndrome, including Sjogren's syndrome, and who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

No applications for increased maximum quantities and/or repeats will be authorised.

polyvinyl alcohol 1.4% eye drops, 15 mL

9220G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	11	..	10.61	11.76	^a PVA Tears [PE]
			^B 1.60	12.21	11.76	^a Liquifilm Tears [AG]

polyvinyl alcohol 1.4% eye drops, 15 mL

9221H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	11	..	10.61	11.76	Vistil [AE]

polyvinyl alcohol 3% eye drops, 15 mL

9223K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	11	..	10.61	11.76	Vistil Forte [AE]

■ SODIUM HYALURONATE

Authority required

Severe dry eye syndrome

Clinical criteria:

Patient must be sensitive to preservatives in multi-dose eye drops.

Note

The in-use shelf life of Hylo-Fresh and Hylo-Forte is 6 months from the date of opening.

sodium hyaluronate 0.1% (1 mg/mL) eye drops, 10 mL

2184Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	±1	5	..	33.96	35.11	Hylo-Fresh [AE]

sodium hyaluronate 0.2% (2 mg/mL) eye drops, 10 mL

2171G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	±1	5	..	33.96	35.11	Hylo-Forte [AE]

▪ **SODIUM HYALURONATE**

Authority required (STREAMLINED)

4105

Severe dry eye syndrome

Clinical criteria:

Patient must be sensitive to preservatives in multi-dose eye drops.

Note

The in-use shelf life of Hylo-Fresh and Hylo-Forte is 6 months from the date of opening.

sodium hyaluronate 0.1% (1 mg/mL) eye drops, 10 mL

2181T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	33.96	35.11	Hylo-Fresh [AE]

sodium hyaluronate 0.2% (2 mg/mL) eye drops, 10 mL

2253N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	5	..	33.96	35.11	Hylo-Forte [AE]

▪ **SOY LECITHIN + TOCOPHEROLS + VITAMIN A**

Authority required

Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops

soy lecithin 1% (10 mg/mL) + tocopherols 0.002% (20 microgram/mL) + vitamin A palmitate 0.025% (250 microgram/mL) eye spray, 100 actuations

5545W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	2	5	..	*36.40	37.55	tearsagain [RB]

▪ **SOY LECITHIN + TOCOPHEROLS + VITAMIN A**

Authority required (STREAMLINED)

1359

Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops

soy lecithin 1% (10 mg/mL) + tocopherols 0.002% (20 microgram/mL) + vitamin A palmitate 0.025% (250 microgram/mL) eye spray, 100 actuations

9448G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*36.40	37.55	tearsagain [RB]

▪ **OTOLOGICALS**

ANTIINFECTIVES

Antiinfectives

▪ **CIPROFLOXACIN**

Authority required

Treatment of chronic suppurative otitis media in an Aboriginal or a Torres Strait Islander person aged 1 month or older

Authority required

Treatment of chronic suppurative otitis media in a patient less than 18 years of age with perforation of the tympanic membrane

Authority required

Treatment of chronic suppurative otitis media in a patient less than 18 years of age with a grommet in situ

ciprofloxacin 0.3% ear drops, 5 mL

2480M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	1	..	19.62	20.77	Ciloxan [AQ]

CORTICOSTEROIDS AND ANTIINFECTIVES IN COMBINATION*Corticosteroids and antiinfectives in combination***■ DEXAMETHASONE + FRAMYCETIN SULFATE + GRAMICIDIN****dexamethasone 0.05% (500 microgram/mL) + framycetin sulfate 0.5% (5 mg/mL) + gramicidin 0.005% (50 microgram/mL) ear drops, 8 mL**

2781J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	2	..	10.28	11.43	^a Otodex [AV]
			^B 1.91	12.19	11.43	^a Sofradex [SW]

■ TRIAMCINOLONE + NEOMYCIN SULFATE + GRAMICIDIN + NYSTATIN**triamcinolone acetate 0.1% + neomycin sulfate 0.25% + gramicidin 0.025% + nystatin 100 000 international units/g ointment, 5 g**

2974M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	2	..	8.52	9.67	^a Otocomb Otic [FM]
			^B 1.95	10.47	9.67	^a Kenacomb Otic [QA]

triamcinolone acetate 0.1% + neomycin sulfate 0.25% + gramicidin 0.025% + nystatin 100 000 international units/mL ear drops, 7.5 mL

2971J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	2	..	11.43	12.58	^a Otocomb Otic [FM]
			^B 1.95	13.38	12.58	^a Kenacomb Otic [QA]

■ OPHTHALMOLOGICAL AND OTOLOGICAL PREPARATIONS**ANTIINFECTIVES***Antiinfectives***■ FRAMYCETIN SULFATE****framycetin sulfate 0.5% (5 mg/mL) eye/ear drops, 8 mL**

1440T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP MW	‡1	2	..	11.08	12.23	Soframycin [SW]

framycetin sulfate 0.5% (5 mg/mL) eye/ear drops, 8 mL

5557L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
OP	‡1	2	..	11.08	12.23	Soframycin [SW]

■ VARIOUS**■ ALLERGENS****ALLERGENS***Allergen extracts***■ BEE VENOM****bee venom 550 microgram injection [1 x 550 microgram vial] (&) inert substance diluent [4 vials], 1 pack**

2886X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	238.72	37.70	Albey Bee Venom [HL]

■ PAPER WASP VENOM**Note**

Paper wasp venom is not European wasp venom.

paper wasp venom 550 microgram injection [1 x 550 microgram vial] (&) inert substance diluent [4 vials], 1 pack

2918N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	238.72	37.70	Albey Paper Wasp Venom [HL]

■ VESPULE SPP VENOM**vespula spp venom 550 microgram injection [1 x 550 microgram vial] (&) inert substance diluent [4 vials], 1 pack**

2883R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	238.72	37.70	Albey Yellow Jacket Venom [HL]

ALL OTHER THERAPEUTIC PRODUCTS

ALL OTHER THERAPEUTIC PRODUCTS

Antidotes

NALOXONE

naloxone hydrochloride 400 microgram/mL injection, 1 x 1 mL syringe

2192J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	5	..	..	*105.16	37.70	Naloxone minijet [UC]

naloxone hydrochloride 400 microgram/mL injection, 1 x 1 mL syringe

2196N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
DP	5	..	..	*105.16	37.70	Naloxone minijet [UC]

Drugs for treatment of hyperkalemia and hyperphosphatemia

LANTHANUM

Authority required (STREAMLINED)

4827

Hyperphosphataemia

Treatment Phase: Maintenance following initiation and stabilisation

Clinical criteria:

The condition must not be adequately controlled by calcium, **AND**

Patient must have a serum phosphate of greater than 1.6 mmol per L at the commencement of therapy; OR

The condition must be where a serum calcium times phosphate product is greater than 4 at the commencement of therapy, **AND**

The treatment must not be used in combination with any other phosphate binding agents.

Treatment criteria:

Patient must be undergoing dialysis for chronic kidney disease.

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

LANTHANUM Tablet, chewable, 1000 mg (as carbonate hydrate), 90

9405B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	504.37	37.70	Fosrenol [ZI]

LANTHANUM Tablet, chewable, 500 mg (as carbonate hydrate), 90

9403X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	306.22	37.70	Fosrenol [ZI]

LANTHANUM Tablet, chewable, 750 mg (as carbonate hydrate), 90

9404Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	449.77	37.70	Fosrenol [ZI]

SEVELAMER

Authority required (STREAMLINED)

4827

Hyperphosphataemia

Treatment Phase: Maintenance following initiation and stabilisation

Clinical criteria:

The condition must not be adequately controlled by calcium, **AND**

Patient must have a serum phosphate of greater than 1.6 mmol per L at the commencement of therapy; OR

The condition must be where a serum calcium times phosphate product is greater than 4 at the commencement of therapy, **AND**

The treatment must not be used in combination with any other phosphate binding agents.

Treatment criteria:

Patient must be undergoing dialysis for chronic kidney disease.

Note

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

sevelamer hydrochloride 800 mg tablet, 180

2142R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	358.07	37.70	Renagel [GZ]

■ SUCROFERRIC OXYHYDROXIDE**Authority required (STREAMLINED)****4827**

Hyperphosphataemia

Treatment Phase: Maintenance following initiation and stabilisation

Clinical criteria:The condition must not be adequately controlled by calcium, **AND**

Patient must have a serum phosphate of greater than 1.6 mmol per L at the commencement of therapy; OR

The condition must be where a serum calcium times phosphate product is greater than 4 at the commencement of therapy, **AND**

The treatment must not be used in combination with any other phosphate binding agents.

Treatment criteria:

Patient must be undergoing dialysis for chronic kidney disease.

Note**Shared Care Model:**

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

iron (as sucroferriic oxyhydroxide) 500 mg tablet: chewable, 90

10250L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	429.82	37.70	Velphoro [FN]

*Detoxifying agents for antineoplastic treatment***■ FOLINIC ACID****folinic acid 1 g/100 mL injection, 1 x 100 mL vial**

8969C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	54.77	37.70	Calcium Folate Ebewe [SZ]

folinic acid 300 mg/30 mL injection, 1 x 30 mL vial

9041W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	4	1	..	*62.76	37.70	^a Calcium Folate Ebewe [SZ]	^a Leucovorin Calcium (Hospira Pty Limited) [HH]

■ FOLINIC ACID**Note**

For item codes 8740B and 1610R, pharmaceutical benefits that have the form injection equivalent to 50 mg folinic acid in 5 mL are equivalent for the purposes of substitution.

folinic acid 50 mg/5 mL injection, 1 x 5 mL vial

8740B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	10	2	..	*58.56	37.70	^a Leucovorin Calcium (Hospira Pty Limited) [HH]

folinic acid 50 mg/5 mL injection, 10 x 5 mL ampoules

1610R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	58.56	37.70	^a Leucovorin Calcium (Pfizer Australia Pty Ltd) [PF]

■ FOLINIC ACID**Note**

For item codes 8812T and 1704Q, pharmaceutical benefits that have the form injection equivalent to 100 mg folinic acid in 10 mL are equivalent for the purposes of substitution.

folinic acid 100 mg/10 mL injection, 1 x 10 mL vial

8812T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	10	1	..	*54.76	37.70	^a Calcium Folate Ebewe [SZ]

folinic acid 100 mg/10 mL injection, 10 x 10 mL ampoules

1704Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	54.81	37.70	^a Leucovorin Calcium (Pfizer Australia Pty Ltd) [PF]

▪ FOLINIC ACID**Restricted benefit**

Antidote to folic acid antagonists

folinic acid 15 mg tablet, 10

2308L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	96.65	37.70	Leucovorin Calcium (Hospira Pty Limited) [HH]

▪ MESNA**Restricted benefit**

Adjunctive therapy for use with ifosfamide or high dose cyclophosphamide

mesna 1 g/10 mL injection, 15 x 10 mL ampoules

8079F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	224.15	37.70	Uromitexan [BX]

mesna 400 mg/4 mL injection, 15 x 4 mL ampoules

8078E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	103.62	37.70	Uromitexan [BX]

*Drugs for treatment of hypercalcemia***▪ PHOSPHORUS****Authority required (STREAMLINED)****1099**

Familial hypophosphataemia

Authority required (STREAMLINED)**1157**

Hypercalcaemia

Authority required (STREAMLINED)**1167**

Hypophosphataemic rickets

Authority required (STREAMLINED)**1467**

Vitamin D-resistant rickets

phosphorus 500 mg tablet: effervescent, 100

2946C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	81.97	37.70	Phosphate Sandoz [NV]

*Other therapeutic products***▪ POLYLACTIC ACID****Authority required**

Initial PBS-subsidised treatment, for facial administration only, of severe facial lipoatrophy caused by therapy for HIV infection.

Accreditation following completion of injection administration training with Sanofi-Aventis is required to prescribe poly-L-lactic acid under the PBS. Patients must be referred from the HIV physician to the accredited injector

Note

Authority applications to prescribe poly-L-lactic acid may be made by telephone to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

No applications for increased maximum quantities and/or repeats will be authorised.

polylactic acid 150 mg injection, 1 x 150 mg vial

9475Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	4	..	*446.80	37.70	Sculptra [GA]

▪ POLYLACTIC ACID**Authority required**

Maintenance PBS-subsidised treatment, for facial administration only, of severe facial lipoatrophy caused by therapy for HIV infection.

Accreditation following completion of injection administration training with Sanofi-Aventis is required to prescribe poly-L-lactic acid under the PBS. Patients must be referred from the HIV physician to the accredited injector

Note

Authority applications to prescribe poly-L-lactic acid may be made by telephone to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

No applications for increased maximum quantities and/or repeats will be authorised.

Maintenance treatment is limited to one re-treatment (maximum 2 vials) every 2 years.

polylactic acid 150 mg injection, 1 x 150 mg vial

9476R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*446.80	37.70	Sculptra [GA]

■ DIAGNOSTIC AGENTS**URINE TESTS****■ GLUCOSE AND KETONE INDICATOR URINE****glucose and ketone indicator urine strip: diagnostic, 50 diagnostic strips**

3106L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	2	..	*17.64	18.79	Keto-Diabur- Test 5000 [RD]

glucose and ketone indicator urine strip: diagnostic, 50 diagnostic strips

3107M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	2	..	*17.76	18.91	Keto-Diastix [BN]

■ GLUCOSE AND KETONE INDICATOR URINE**Restricted benefit**

For use in patients who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

No applications for increased maximum quantities and/or repeats will be authorised.

glucose and ketone indicator urine strip: diagnostic, 50 diagnostic strips

9254C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	4	..	*17.64	18.79	Keto-Diabur- Test 5000 [RD]

glucose and ketone indicator urine strip: diagnostic, 50 diagnostic strips

9255D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	4	..	*17.76	18.91	Keto-Diastix [BN]

■ GLUCOSE INDICATOR URINE**glucose indicator urine strip: diagnostic, 50 diagnostic strips**

3104J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	2	..	*20.16	21.31	Diastix [BN]

■ GLUCOSE INDICATOR URINE**Restricted benefit**

For use in patients who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

No applications for increased maximum quantities and/or repeats will be authorised.

glucose indicator urine strip: diagnostic, 50 diagnostic strips

9253B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	4	..	*20.16	21.31	Diastix [BN]

OTHER DIAGNOSTIC AGENTS*Tests for diabetes***■ GLUCOSE INDICATOR BLOOD****glucose indicator blood strip: diagnostic, 100**

10101P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	53.50	37.70	GoodLife [JN]

glucose indicator blood strip: diagnostic, 100

10145Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	53.50	37.70	EasyMate II [WI]

glucose indicator blood strip: diagnostic, 100

10153J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	53.50	37.70	Contour next [IK]

glucose indicator blood strip: diagnostic, 100

10221Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	53.50	37.70	Dario [UH]

glucose indicator blood strip: diagnostic, 100

1503D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	53.50	37.70	Contour [IK]

glucose indicator blood strip: diagnostic, 100

1519Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	53.50	37.70	BGStar [SW]

glucose indicator blood strip: diagnostic, 100

2562W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	53.50	37.70	TRUEbalance [NX]

glucose indicator blood strip: diagnostic, 100

2575M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	53.50	37.70	TRUEtrack [NX]

glucose indicator blood strip: diagnostic, 100

2624D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	53.50	37.70	TRUEresult [NX]

glucose indicator blood strip: diagnostic, 100

2979T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	53.50	37.70	Accu-Chek Performa [RD]

glucose indicator blood strip: diagnostic, 100

3411M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	53.50	37.70	Accu-Chek Advantage/Sensor Comfort [RD]

glucose indicator blood strip: diagnostic, 100

8190C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	53.50	37.70	Accu-Chek Active [RD]

glucose indicator blood strip: diagnostic, 100

8522M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	53.50	37.70	FreeStyle Optium [MS]

glucose indicator blood strip: diagnostic, 100

9154T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	53.50	37.70	FreeStyle Lite [MS]

glucose indicator blood strip: diagnostic, 50

10147C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*53.52	37.70	EasyMate II [WI]

glucose indicator blood strip: diagnostic, 50

10216Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*53.52	37.70	Healthpro [IF]

glucose indicator blood strip: diagnostic, 50

10223C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*53.52	37.70	GluNEO [IF]

glucose indicator blood strip: diagnostic, 50

2263D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*53.52	37.70	Optium Omega [MS]

glucose indicator blood strip: diagnostic, 50

2673Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*53.52	37.70	OneTouch Select [JJ]

glucose indicator blood strip: diagnostic, 50

2860M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*53.52	37.70	Betachek G5 [NA]

glucose indicator blood strip: diagnostic, 50

2890D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*53.52	37.70	Betachek [NA]

glucose indicator blood strip: diagnostic, 50

2914J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*46.24	37.70	Glucoflex-R [NA]

glucose indicator blood strip: diagnostic, 50

3406G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*53.52	37.70	CareSens N [PB]

glucose indicator blood strip: diagnostic, 50

3441D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*53.52	37.70	OneTouch Verio [JJ]

glucose indicator blood strip: diagnostic, 50

5043K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*53.52	37.70	Accu-Chek Aviva [RD]

glucose indicator blood strip: diagnostic, 50

8739Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*53.52	37.70	Accu-Chek Go [RD]

glucose indicator blood strip: diagnostic, 50

8749L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*53.52	37.70	GlucoDr [OZ]

glucose indicator blood strip: diagnostic, 50

8759B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*53.52	37.70	CareSens [PB]

glucose indicator blood strip: diagnostic, 50

8795X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*53.52	37.70	SensoCard [PX]

glucose indicator blood strip: diagnostic, 50

9298J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*53.52	37.70	Bionime Rightest [QB]

glucose indicator blood strip: diagnostic, 50

9471L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*53.52	37.70	MyGlucoHealth [EH]

glucose indicator blood strip: diagnostic, 50

9485F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*53.52	37.70	Lifeline Attest [OI]

glucose indicator blood strip: diagnostic, 51 diagnostic strips

8806L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*53.52	37.70	Accu-Chek Integra [RD]

■ GLUCOSE INDICATOR BLOOD

Restricted benefit

For use in patients on insulin therapy

glucose indicator blood strip: diagnostic, 100

9300L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	5	..	53.50	37.70	Accu-Chek Mobile [RD]

■ GLUCOSE INDICATOR BLOOD

Restricted benefit

For use in patients on insulin therapy who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements

Note

No applications for increased maximum quantities and/or repeats will be authorised.

glucose indicator blood strip: diagnostic, 100

9301M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	53.50	37.70	Accu-Chek Mobile [RD]

■ GLUCOSE INDICATOR BLOOD

Restricted benefit

Blood glucose monitoring

Clinical criteria:

Patient must be receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

glucose indicator blood strip: diagnostic, 100

10099M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	53.50	37.70	GoodLife [JN]

glucose indicator blood strip: diagnostic, 100

10141R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	53.50	37.70	EasyMate II [WI]

glucose indicator blood strip: diagnostic, 100

10164Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	53.50	37.70	Contour next [IK]

glucose indicator blood strip: diagnostic, 100

10222B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	53.50	37.70	Dario [UH]

glucose indicator blood strip: diagnostic, 100

1518X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	53.50	37.70	Contour [IK]

glucose indicator blood strip: diagnostic, 100

1520B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	53.50	37.70	BGStar [SW]

glucose indicator blood strip: diagnostic, 100

2568E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	53.50	37.70	TRUEresult [NX]

glucose indicator blood strip: diagnostic, 100

2571H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	53.50	37.70	TRUEbalance [NX]

glucose indicator blood strip: diagnostic, 100

2602Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	53.50	37.70	TRUEtrack [NX]

glucose indicator blood strip: diagnostic, 100

3412N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	53.50	37.70	Accu-Chek Advantage/Sensor Comfort [RD]

glucose indicator blood strip: diagnostic, 100

9257F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	53.50	37.70	Accu-Chek Performa [RD]

glucose indicator blood strip: diagnostic, 100

9269W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	53.50	37.70	FreeStyle Lite [MS]

glucose indicator blood strip: diagnostic, 100

9270X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	53.50	37.70	FreeStyle Optium [MS]

glucose indicator blood strip: diagnostic, 100

9273C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	11	..	53.50	37.70	Accu-Chek Active [RD]

glucose indicator blood strip: diagnostic, 50

10139P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*53.52	37.70	EasyMate II [WI]

glucose indicator blood strip: diagnostic, 50

10215P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*53.52	37.70	Healthpro [IF]

glucose indicator blood strip: diagnostic, 50

10217R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*53.52	37.70	GluNEO [IF]

glucose indicator blood strip: diagnostic, 50

2697Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*53.52	37.70	OneTouch Select [JJ]

glucose indicator blood strip: diagnostic, 50

3407H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*53.52	37.70	CareSens N [PB]

glucose indicator blood strip: diagnostic, 50

3442E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*53.52	37.70	OneTouch Verio [JJ]

glucose indicator blood strip: diagnostic, 50

5053Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*53.52	37.70	Accu-Chek Aviva [RD]

glucose indicator blood strip: diagnostic, 50

9263M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*53.52	37.70	GlucoDr [OZ]

glucose indicator blood strip: diagnostic, 50

9267R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*53.52	37.70	Optium Omega [MS]

glucose indicator blood strip: diagnostic, 50

9274D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*53.52	37.70	Accu-Chek Go [RD]

glucose indicator blood strip: diagnostic, 50

9276F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*53.52	37.70	Betachek [NA]

glucose indicator blood strip: diagnostic, 50

9277G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*53.52	37.70	Betachek G5 [NA]

glucose indicator blood strip: diagnostic, 50

9278H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*53.52	37.70	CareSens [PB]

glucose indicator blood strip: diagnostic, 50

9279J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*46.24	37.70	Glucoflex-R [NA]

glucose indicator blood strip: diagnostic, 50

9281L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*53.52	37.70	SensoCard [PX]

glucose indicator blood strip: diagnostic, 50

9297H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*53.52	37.70	Bionime Rightest [QB]

glucose indicator blood strip: diagnostic, 50

9472M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*53.52	37.70	MyGlucoHealth [EH]

glucose indicator blood strip: diagnostic, 50

9486G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*53.52	37.70	Lifeline Attest [OI]

glucose indicator blood strip: diagnostic, 51 diagnostic strips

9275E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	11	..	*53.52	37.70	Accu-Chek Integra [RD]

GENERAL NUTRIENTS**OTHER NUTRIENTS****TRIGLYCERIDES LONG CHAIN****Restricted benefit**

Ketogenic diet

Clinical criteria:

Patient must have intractable seizures requiring treatment with a ketogenic diet; OR

Patient must have a glucose transport protein defect; OR

Patient must have pyruvate dehydrogenase deficiency.

Carbzero should only be used under strict supervision of a dietitian, together with a metabolic physician and/or neurologist.

Note

Carbzero is not nutritionally complete and is not intended for use as a sole source of nutrition.

triglycerides long chain oral liquid, 18 x 250 mL cartons

10037G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*300.16	37.70	carbzero [VF]

TRIGLYCERIDES MEDIUM CHAIN**Authority required**

Ketogenic diet

Clinical criteria:

Patient must have intractable seizures requiring treatment with a ketogenic diet; OR

Patient must have a glucose transport protein defect; OR

Patient must have pyruvate dehydrogenase deficiency.

Authority required

Dietary management of conditions requiring a source of medium chain triglycerides

Clinical criteria:

Patient must have chylous ascites; OR
 Patient must have chylothorax; OR
 Patient must have hyperlipoproteinaemia type 1; OR
 Patient must have long chain fatty acid oxidation disorders; OR
 Patient must have fat malabsorption due to liver disease; OR
 Patient must have fat malabsorption due to short gut syndrome; OR
 Patient must have fat malabsorption due to cystic fibrosis; OR
 Patient must have fat malabsorption due to gastrointestinal disorders.

Note

No increase in the maximum quantity or number of units may be authorised.
 No increase in the maximum number of repeats may be authorised.

triglycerides medium chain oral liquid, 18 x 250 mL cartons

10049X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*383.86	37.70	betaquik [VF]

■ TRIGLYCERIDES MEDIUM CHAIN**Authority required**

Chylous ascites

Authority required

Chylothorax

Authority required

Fat malabsorption due to liver disease, short gut syndrome, cystic fibrosis and gastrointestinal disorders

Authority required

Hyperlipoproteinaemia type 1

Authority required

Intractable childhood epilepsy or cerebrospinal fluid glucose transporter defect, requiring a ketogenic diet

Authority required

Long chain fatty acid oxidation disorders

Note

No applications for increased maximum quantities and/or repeats will be authorised.

triglycerides medium chain oil: oral, 500 mL

3128P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*52.72	37.70	MCT Oil [SB]

triglycerides medium chain oral liquid, 1 x 250 mL bottle

9327X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*214.76	37.70	Liquigen [SB]

Fat/carbohydrates/proteins/minerals/vitamins, combinations

■ AMINO ACID SYNTHETIC FORMULA**Authority required**

Eosinophilic oesophagitis

Treatment Phase: Initial treatment for up to 3 months

Clinical criteria:

Patient must require an amino acid based formula as a component of a dietary elimination program.

Population criteria:

Patient must be 18 years of age or less.

Treatment criteria:

Must be treated by a clinical immunologist, suitably qualified allergist or gastroenterologist.

Treatment with oral steroids should not be commenced during the period of initial treatment.

Eosinophilic oesophagitis is demonstrated by the following criteria:

- (i) Chronic symptoms of reflux that persisted despite a 2-month trial of a proton pump inhibitor or chronic dysphagia; and
- (ii) A lack of demonstrable anatomic abnormality with the exception of stricture, which can be attributable to eosinophilic oesophagitis; and

(iii) Eosinophilic infiltration of the oesophagus, demonstrated by oesophageal biopsy specimens obtained by endoscopy and where the most densely involved oesophageal biopsy had 20 or more eosinophils in any single 400 x high powered field, along with normal antral and duodenal biopsies.

The date of birth of the patient must be included in the authority application.

Authority required

Eosinophilic oesophagitis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have responded to an initial course of PBS-subsidised treatment.

Population criteria:

Patient must be 18 years of age or less.

Treatment criteria:

Must be treated by a clinical immunologist, suitably qualified allergist or gastroenterologist.

Response to initial treatment is demonstrated by oesophageal biopsy specimens obtained by endoscopy, where the most densely involved oesophageal biopsy had 5 or less eosinophils in any single 400 x high powered field, along with normal antral and duodenal biopsies. The response criteria will not be deemed to have been met if oral steroids were commenced during initial treatment.

Note

Authorities for increased maximum quantities, up to a maximum of 52, may be authorised.

amino acid synthetic formula oral liquid: powder for, 400 g

1521C

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
12	5	..	*532.00	37.70	Neocate Advance Vanilla [SB]

amino acid synthetic formula oral liquid: powder for, 400 g

2250K

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
12	5	..	*532.00	37.70	EleCare [AB]

■ AMINO ACID SYNTHETIC FORMULA**Authority required**

Cows' milk protein enteropathy

Treatment Phase: Initial treatment for up to 6 months

Clinical criteria:

The condition must not be isolated infant colic or reflux, **AND**

Patient must be intolerant to both soy protein and protein hydrolysate formulae, as demonstrated when the child has failed to respond to a strict cows' milk protein free and strict soy protein free diet with a protein hydrolysate (with or without medium chain triglycerides) as the principal formula.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe cows' milk protein enteropathy with failure to thrive

Treatment Phase: Initial treatment for up to 6 months

Clinical criteria:

The condition must not be isolated infant colic or reflux.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Combined intolerance to cows' milk protein, soy protein and protein hydrolysate formulae

Treatment Phase: Initial treatment for up to 6 months

Clinical criteria:

The condition must not be isolated infant colic or reflux.

Population criteria:

Patient must be older than 24 months of age.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Initial treatment for up to 6 months

Clinical criteria:

Patient must have failed a trial of protein hydrolysate formulae (with or without medium chain triglycerides).

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

amino acid synthetic formula oral liquid: powder for, 400 g

1180D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*361.48	37.70	Neocate Advance Vanilla [SB]

amino acid synthetic formula oral liquid: powder for, 400 g

8574G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*361.48	37.70	EleCare [AB]

amino acid synthetic formula oral liquid: powder for, 400 g

8754R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*361.48	37.70	Neocate Advance [SB]

■ AMINO ACID SYNTHETIC FORMULA**Authority required**

Cows' milk anaphylaxis

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist or clinical immunologist, or in consultation with a specialist allergist or clinical immunologist.

Anaphylaxis is defined as a severe and/or potentially life threatening allergic reaction.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Cows' milk protein enteropathy

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must not be isolated infant colic or reflux, **AND**

Patient must be intolerant to both soy protein and protein hydrolysate formulae, as demonstrated when the child has failed to respond to a strict cows' milk protein free and strict soy protein free diet with a protein hydrolysate (with or without medium chain triglycerides) as the principal formula.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or have an appointment to be assessed by one of these specialists.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe cows' milk protein enteropathy with failure to thrive

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must not be isolated infant colic or reflux, **AND**

Patient must have had failure to thrive prior to commencement with initial treatment.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or have been assessed at least once or have an appointment to be assessed by one of these specialists.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Combined intolerance to cows' milk protein, soy protein and protein hydrolysate formulae

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must not be isolated infant colic or reflux.

Population criteria:

Patient must be older than 24 months of age.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist at intervals not greater than 12 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have failed a trial of protein hydrolysate formulae (with or without medium chain triglycerides) prior to commencement with initial treatment.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist. The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe intestinal malabsorption including short bowel syndrome

Clinical criteria:

Patient must have failed to respond to protein hydrolysate formulae; OR

Patient must have been receiving parenteral nutrition.

Note

Authorities for increased maximum quantities, up to a maximum of 20, may be authorised.

amino acid synthetic formula oral liquid: powder for, 400 g

1192R

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
8	5	..	*361.48	37.70	Neocate Advance Vanilla [SB]

amino acid synthetic formula oral liquid: powder for, 400 g

8575H

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
8	5	..	*361.48	37.70	EleCare [AB]

amino acid synthetic formula oral liquid: powder for, 400 g

8755T

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
8	5	..	*361.48	37.70	Neocate Advance [SB]

■ AMINO ACID SYNTHETIC FORMULA SUPPLEMENTED WITH LONG CHAIN POLYUNSATURATED FATTY ACIDS

Authority required

Cows' milk protein enteropathy

Treatment Phase: Initial treatment for up to 6 months

Clinical criteria:

The condition must not be isolated infant colic or reflux, **AND**

Patient must be intolerant to both soy protein and protein hydrolysate formulae, as demonstrated when the child has failed to respond to a strict cows' milk protein free and strict soy protein free diet with a protein hydrolysate (with or without medium chain triglycerides) as the principal formula.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe cows' milk protein enteropathy with failure to thrive

Treatment Phase: Initial treatment for up to 6 months

Clinical criteria:

The condition must not be isolated infant colic or reflux.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Combined intolerance to cows' milk protein, soy protein and protein hydrolysate formulae

Treatment Phase: Initial treatment for up to 6 months

Clinical criteria:

The condition must not be isolated infant colic or reflux.

Population criteria:

Patient must be older than 24 months of age.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Initial treatment for up to 6 months

Clinical criteria:

Patient must have failed a trial of protein hydrolysate formulae (with or without medium chain triglycerides).

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids oral liquid: powder for, 400 g

2246F

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
8	5	..	*368.20	37.70	Neocate LCP [SB]

amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids oral liquid: powder for, 400 g

9339M

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
8	5	..	*368.20	37.70	EleCare LCP [AB]

■ AMINO ACID SYNTHETIC FORMULA SUPPLEMENTED WITH LONG CHAIN POLYUNSATURATED FATTY ACIDS

Authority required

Cows' milk anaphylaxis

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist or clinical immunologist, or in consultation with a specialist allergist or clinical immunologist.

Anaphylaxis is defined as a severe and/or potentially life threatening allergic reaction.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Cows' milk protein enteropathy

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must not be isolated infant colic or reflux, **AND**

Patient must be intolerant to both soy protein and protein hydrolysate formulae, as demonstrated when the child has failed to respond to a strict cows' milk protein free and strict soy protein free diet with a protein hydrolysate (with or without medium chain triglycerides) as the principal formula.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or have an appointment to be assessed by one of these specialists.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe cows' milk protein enteropathy with failure to thrive

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must not be isolated infant colic or reflux, **AND**

Patient must have had failure to thrive prior to commencement with initial treatment.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or have been assessed at least once or have an appointment to be assessed by one of these specialists.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Combined intolerance to cows' milk protein, soy protein and protein hydrolysate formulae

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must not be isolated infant colic or reflux.

Population criteria:

Patient must be older than 24 months of age.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist at intervals not greater than 12 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have failed a trial of protein hydrolysate formulae (with or without medium chain triglycerides) prior to commencement with initial treatment.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe intestinal malabsorption including short bowel syndrome

Clinical criteria:

Patient must have failed to respond to protein hydrolysate formulae; OR

Patient must have been receiving parenteral nutrition.

Note

Authorities for increased maximum quantities, up to a maximum of 20, may be authorised.

amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids oral liquid: powder for, 400 g

2560R

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
8	5	..	*368.20	37.70	Neocate LCP [SB]

amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids oral liquid: powder for, 400 g

9340N

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
8	5	..	*368.20	37.70	EleCare LCP [AB]

■ AMINO ACID SYNTHETIC FORMULA SUPPLEMENTED WITH LONG CHAIN POLYUNSATURATED FATTY ACIDS AND MEDIUM CHAIN TRIGLYCERIDES

Authority required

Eosinophilic oesophagitis

Treatment Phase: Initial treatment for up to 3 months

Clinical criteria:

Patient must require an amino acid based formula as a component of a dietary elimination program.

Population criteria:

Patient must be 18 years of age or less.

Treatment criteria:

Must be treated by a clinical immunologist, suitably qualified allergist or gastroenterologist.

Treatment with oral steroids should not be commenced during the period of initial treatment.

Eosinophilic oesophagitis is demonstrated by the following criteria:

- (i) Chronic symptoms of reflux that persisted despite a 2-month trial of a proton pump inhibitor or chronic dysphagia; and
- (ii) A lack of demonstrable anatomic abnormality with the exception of stricture, which can be attributable to eosinophilic oesophagitis; and

(iii) Eosinophilic infiltration of the oesophagus, demonstrated by oesophageal biopsy specimens obtained by endoscopy and where the most densely involved oesophageal biopsy had 20 or more eosinophils in any single 400 x high powered field, along with normal antral and duodenal biopsies.

The date of birth of the patient must be included in the authority application.

Authority required

Eosinophilic oesophagitis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have responded to an initial course of PBS-subsidised treatment.

Population criteria:

Patient must be 18 years of age or less.

Treatment criteria:

Must be treated by a clinical immunologist, suitably qualified allergist or gastroenterologist.

Response to initial treatment is demonstrated by oesophageal biopsy specimens obtained by endoscopy, where the most densely involved oesophageal biopsy had 5 or less eosinophils in any single 400 x high powered field, along with normal antral and duodenal biopsies. The response criteria will not be deemed to have been met if oral steroids were commenced during initial treatment.

Note

Authorities for increased maximum quantities, up to a maximum of 52, may be authorised.

amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids and medium chain triglycerides oral liquid: powder for, 400 g

1545H

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
12	5	..	*542.56	37.70	Neocate Gold [SB]

■ **AMINO ACID SYNTHETIC FORMULA SUPPLEMENTED WITH LONG CHAIN POLYUNSATURATED FATTY ACIDS AND MEDIUM CHAIN TRIGLYCERIDES**

Authority required

Cows' milk protein enteropathy

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must not be isolated infant colic or reflux, **AND**

Patient must be intolerant to both soy protein and protein hydrolysate formulae, as demonstrated when the child has failed to respond to a strict cows' milk protein free and strict soy protein free diet with a protein hydrolysate (with or without medium chain triglycerides) as the principal formula.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or have an appointment to be assessed by one of these specialists.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe cows' milk protein enteropathy with failure to thrive

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must not be isolated infant colic or reflux, **AND**

Patient must have had failure to thrive prior to commencement with initial treatment.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or have been assessed at least once or have an appointment to be assessed by one of these specialists.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Combined intolerance to cows' milk protein, soy protein and protein hydrolysate formulae

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must not be isolated infant colic or reflux.

Population criteria:

Patient must be older than 24 months of age.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist at intervals not greater than 12 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Cows' milk anaphylaxis

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist or clinical immunologist, or in consultation with a specialist allergist or clinical immunologist.

Anaphylaxis is defined as a severe and/or potentially life threatening allergic reaction.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have failed a trial of protein hydrolysate formulae (with or without medium chain triglycerides) prior to commencement with initial treatment.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist. The name of the specialist and the date of birth of the patient must be included in the authority application.

Note

Authorities for increased maximum quantities, up to a maximum of 20, may be authorised.

amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids and medium chain triglycerides oral liquid: powder for, 400 g

2900P



Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
8	5	..	*368.20	37.70	Alfamino [NT]

■ AMINO ACID SYNTHETIC FORMULA SUPPLEMENTED WITH LONG CHAIN POLYUNSATURATED FATTY ACIDS AND MEDIUM CHAIN TRIGLYCERIDES

Authority required

Cows' milk protein enteropathy

Treatment Phase: Initial treatment for up to 6 months

Clinical criteria:

The condition must not be isolated infant colic or reflux, **AND**

Patient must be intolerant to both soy protein and protein hydrolysate formulae, as demonstrated when the child has failed to respond to a strict cows' milk protein free and strict soy protein free diet with a protein hydrolysate (with or without medium chain triglycerides) as the principal formula.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist. The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe cows' milk protein enteropathy with failure to thrive

Treatment Phase: Initial treatment for up to 6 months

Clinical criteria:

The condition must not be isolated infant colic or reflux.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist. The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Combined intolerance to cows' milk protein, soy protein and protein hydrolysate formulae

Treatment Phase: Initial treatment for up to 6 months

Clinical criteria:

The condition must not be isolated infant colic or reflux.

Population criteria:

Patient must be older than 24 months of age.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist. The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Initial treatment for up to 6 months

Clinical criteria:

Patient must have failed a trial of protein hydrolysate formulae (with or without medium chain triglycerides).

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist. The name of the specialist and the date of birth of the patient must be included in the authority application.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids and medium chain triglycerides oral liquid: powder for, 400 g

2928D

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
8	5	..	*368.20	37.70	Alfamino [NT]

amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids and medium chain triglycerides oral liquid: powder for, 400 g

5466Q

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
8	5	..	*368.20	37.70	Neocate Gold [SB]

■ AMINO ACID SYNTHETIC FORMULA SUPPLEMENTED WITH LONG CHAIN POLYUNSATURATED FATTY ACIDS AND MEDIUM CHAIN TRIGLYCERIDES

Authority required

Cows' milk anaphylaxis

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist or clinical immunologist, or in consultation with a specialist allergist or clinical immunologist.

Anaphylaxis is defined as a severe and/or potentially life threatening allergic reaction.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Cows' milk protein enteropathy

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must not be isolated infant colic or reflux, **AND**

Patient must be intolerant to both soy protein and protein hydrolysate formulae, as demonstrated when the child has failed to respond to a strict cows' milk protein free and strict soy protein free diet with a protein hydrolysate (with or without medium chain triglycerides) as the principal formula.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or have an appointment to be assessed by one of these specialists.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe cows' milk protein enteropathy with failure to thrive

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must not be isolated infant colic or reflux, **AND**

Patient must have had failure to thrive prior to commencement with initial treatment.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or have been assessed at least once or have an appointment to be assessed by one of these specialists.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Combined intolerance to cows' milk protein, soy protein and protein hydrolysate formulae

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must not be isolated infant colic or reflux.

Population criteria:

Patient must be older than 24 months of age.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist at intervals not greater than 12 months.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have failed a trial of protein hydrolysate formulae (with or without medium chain triglycerides) prior to commencement with initial treatment.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist. The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Severe intestinal malabsorption including short bowel syndrome

Clinical criteria:

Patient must have failed to respond to protein hydrolysate formulae; OR

Patient must have been receiving parenteral nutrition.

Note

Authorities for increased maximum quantities, up to a maximum of 20, may be authorised.

amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids and medium chain triglycerides oral liquid: powder for, 400 g

5467R



Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
8	5	..	*368.20	37.70	Neocate Gold [SB]

■ PROTEIN HYDROLYSATE FORMULA WITH MEDIUM CHAIN TRIGLYCERIDES

Authority required

Cows' milk protein enteropathy and intolerance to soy protein

Treatment Phase: Initial treatment

Clinical criteria:

The condition must not be isolated infant colic or reflux, **AND**

Patient must have failed to respond to a strict soy-based cows' milk protein free diet.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist, specialist paediatrician or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist, specialist paediatrician or specialist paediatric gastroenterologist and hepatologist.

The date of birth of the patient must be included in the authority application.

Authority required

Cows' milk protein enteropathy and intolerance to soy protein

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must not be isolated infant colic or reflux, **AND**

Patient must have demonstrated a clinical improvement with the protein hydrolysate formula with medium chain triglycerides.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist, specialist paediatrician or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist, specialist paediatrician or specialist paediatric gastroenterologist and hepatologist.

The date of birth of the patient must be included in the authority application.

Authority required

Cows' milk protein enteropathy and intolerance to soy protein

Clinical criteria:

The condition must not be isolated infant colic or reflux, **AND**

Patient must have failed to respond to a strict soy-based cows' milk protein free diet.

Population criteria:

Patient must be older than 24 months of age.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist, specialist paediatrician or specialist paediatric gastroenterologist and hepatologist.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Initial treatment for up to 6 months

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Continuing treatment

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Biliary atresia

Authority required

Chronic liver failure with fat malabsorption

Authority required

Chylous ascites

Authority required

Cystic fibrosis

Authority required

Enterokinase deficiency

Authority required

Proven fat malabsorption

Authority required

Severe diarrhoea of greater than 2 weeks duration

Population criteria:

Patient must be aged less than 4 months.

The date of birth of the patient must be included in the authority application.

Authority required

Severe intestinal malabsorption including short bowel syndrome

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

protein hydrolysate formula with medium chain triglycerides oral liquid: powder for, 450 g

8259Q

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
8	5	..	*110.20	37.70	Karicare Aptamil Pepti-Junior Gold [NU]

■ PROTEIN HYDROLYSATE FORMULA WITH MEDIUM CHAIN TRIGLYCERIDES**Authority required**

Cows' milk protein enteropathy and intolerance to soy protein

Treatment Phase: Initial treatment

Clinical criteria:

The condition must not be isolated infant colic or reflux, **AND**

Patient must have failed to respond to a strict soy-based cows' milk protein free diet.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist, specialist paediatrician or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist, specialist paediatrician or specialist paediatric gastroenterologist and hepatologist.

The date of birth of the patient must be included in the authority application.

Authority required

Cows' milk protein enteropathy and intolerance to soy protein

Treatment Phase: Continuing treatment

Clinical criteria:

The condition must not be isolated infant colic or reflux, **AND**

Patient must have demonstrated a clinical improvement with the protein hydrolysate formula with medium chain triglycerides.

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist, specialist paediatrician or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist, specialist paediatrician or specialist paediatric gastroenterologist and hepatologist.

The date of birth of the patient must be included in the authority application.

Authority required

Cows' milk protein enteropathy and intolerance to soy protein

Clinical criteria:

The condition must not be isolated infant colic or reflux, **AND**

Patient must have failed to respond to a strict soy-based cows' milk protein free diet.

Population criteria:

Patient must be older than 24 months of age.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist, specialist paediatrician or specialist paediatric gastroenterologist and hepatologist.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Initial treatment for up to 6 months

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist, or in consultation with a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Proven combined immunoglobulin E (IgE) mediated allergy to cows' milk protein and soy protein

Treatment Phase: Continuing treatment

Population criteria:

Patient must be up to the age of 24 months.

Treatment criteria:

Must be treated by a specialist allergist, clinical immunologist or specialist paediatric gastroenterologist and hepatologist.

The name of the specialist and the date of birth of the patient must be included in the authority application.

Authority required

Biliary atresia

Authority required

Chronic liver failure with fat malabsorption

Authority required

Chylous ascites

Authority required

Cystic fibrosis

Authority required

Enterokinase deficiency

Authority required

Proven fat malabsorption

Authority required

Severe diarrhoea of greater than 2 weeks duration

Population criteria:

Patient must be aged less than 4 months.

The date of birth of the patient must be included in the authority application.

Authority required

Severe intestinal malabsorption including short bowel syndrome

Authority required

Chyllothorax

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

protein hydrolysate formula with medium chain triglycerides oral liquid: powder for, 400 g

2676W



Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
8	5	..	*172.28	37.70	Alfaré [NT]

■ TRIGLYCERIDES MEDIUM CHAIN FORMULA**Restricted benefit**

Dietary management of conditions requiring a source of medium chain triglycerides

Clinical criteria:

Patient must have fat malabsorption due to liver disease; OR

Patient must have fat malabsorption due to short gut syndrome; OR

Patient must have fat malabsorption due to cystic fibrosis; OR

Patient must have fat malabsorption due to gastrointestinal disorders.

Note

No increase in the maximum number of repeats may be authorised.

No increase in the maximum quantity or number of units may be authorised.

Not indicated for the treatment of intractable childhood epilepsy or cerebrospinal fluid glucose transporter defect requiring a ketogenic diet.

triglycerides medium chain formula oral liquid: powder for, 400 g

10152H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*421.64	37.70	Monogen [SB]

triglycerides medium chain formula oral liquid: powder for, 400 g

10154K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*411.80	37.70	Peptamen Junior [NT]

triglycerides medium chain formula oral liquid: powder for, 400 g

10155L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*443.16	37.70	Lipistart [VF]

▪ TRIGLYCERIDES MEDIUM CHAIN FORMULA

Restricted benefit

Hyperlipoproteinaemia type 1

Restricted benefit

Long chain fatty acid oxidation disorders

Restricted benefit

Chylous ascites

Restricted benefit

Chylothorax

Note

No increase in the maximum number of repeats may be authorised.

No increase in the maximum quantity or number of units may be authorised.

Not indicated for the treatment of intractable childhood epilepsy or cerebrospinal fluid glucose transporter defect requiring a ketogenic diet.

triglycerides medium chain formula oral liquid: powder for, 400 g

1938B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*443.16	37.70	Lipistart [VF]

triglycerides medium chain formula oral liquid: powder for, 400 g

8478F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*421.64	37.70	Monogen [SB]

Carbohydrates

▪ AMYLOPECTIN MODIFIED LONG CHAIN

Restricted benefit

Glycogen storage disease

amyopectin modified long chain oral liquid: powder for, 30 x 60 g sachets

9386B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*752.64	37.70	Glycosade [VF]

Milk substitutes

▪ MILK POWDER LACTOSE FREE FORMULA

Authority required

Acute lactose intolerance in infants up to the age of 12 months. The date of birth of the patient must be included in the authority application

Note

No applications for increased maximum quantities and/or repeats will be authorised. No more than 1 application per patient will be authorised.

milk powder lactose free formula oral liquid: powder for, 900 g

8282X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	5	..	..	*113.21	37.70	S-26 LF [AS]

▪ MILK POWDER LACTOSE FREE FORMULA

Authority required

Proven chronic lactose intolerance in infants up to the age of 12 months. The date of birth of the patient must be included in the authority application. Lactose intolerance must have been proven by either:

- (a) relief of symptoms on supervised withdrawal of lactose from the diet for 3 or 4 days and subsequent re-emergence of symptoms on rechallenge with lactose containing formulae or milk or food; or
 (b) not less than 0.5% reducing substance in stool exudate tested with copper sulfate diagnostic compound tablet; or
 (c) hydrogen breath test

Note

No applications for increased maximum quantities and/or repeats will be authorised.

milk powder lactose free formula oral liquid: powder for, 900 g

8283Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	5	5	..	*113.21	37.70	S-26 LF [AS]

▪ MILK POWDER LACTOSE FREE FORMULA PREDIGESTED**Authority required**

Chronic lactose intolerance

Clinical criteria:

The condition must be proven to be lactose intolerance.

Population criteria:

Patient must be up to the age of 12 months.

Lactose intolerance must have been proven by either:

- (a) relief of symptoms on supervised withdrawal of lactose from the diet for 3 or 4 days and subsequent re-emergence of symptoms on rechallenge with lactose containing formulae or milk or food; or
 (b) not less than 0.5% reducing substance in stool exudate tested with copper sulfate diagnostic compound tablet; or
 (c) hydrogen breath test.

The date of birth of the patient must be included in the authority application.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

milk powder lactose free formula predigested oral liquid: powder for, 900 g

2989H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	5	5	..	*95.76	37.70	Karicare Aptamil Gold De-Lact [NU]

▪ MILK POWDER LACTOSE FREE FORMULA PREDIGESTED**Authority required**

Acute lactose intolerance

Population criteria:

Patient must be up to the age of 12 months.

The date of birth of the patient must be included in the authority application.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

No more than 1 application per patient will be authorised.

milk powder lactose free formula predigested oral liquid: powder for, 900 g

2975N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	5	..	..	*95.76	37.70	Karicare Aptamil Gold De-Lact [NU]

▪ MILK POWDER LACTOSE MODIFIED PREDIGESTED**Authority required**

Proven chronic lactose intolerance in children aged 1 year and over who are significantly malnourished. The date of birth of the patient must be included in the authority application. Lactose intolerance must have been proven by either:

- (a) relief of symptoms on supervised withdrawal of lactose from the diet for 3 or 4 days and subsequent re-emergence of symptoms on rechallenge with lactose containing formulae or milk or food; or
 (b) not less than 0.5% reducing substance in stool exudate tested with copper sulfate diagnostic compound tablet; or
 (c) hydrogen breath test

Note

No applications for increased maximum quantities and/or repeats will be authorised.

milk powder lactose modified predigested oral liquid: powder for, 900 g

2357C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	10	..	*73.15	37.70	Digestelact [SJ]

▪ MILK POWDER LACTOSE MODIFIED PREDIGESTED

Authority required

Acute lactose intolerance in children aged 1 year and over. The date of birth of the patient must be included in the authority application

Note

No applications for increased maximum quantities and/or repeats will be authorised. No more than 1 application per patient will be authorised.

milk powder lactose modified predigested oral liquid: powder for, 900 g

2358D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	1	..	*73.15	37.70	Digestelact [SJ]

▪ MILK POWDER SYNTHETIC LOW CALCIUM

Authority required

Hypercalcaemia in children under the age of 4 years

Note

No applications for increased maximum quantities and/or repeats will be authorised.

milk powder synthetic low calcium oral liquid: powder for, 400 g

3092R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*381.72	37.70	Locasol [SB]

Other combinations of nutrients

▪ AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS AND TRACE ELEMENTS WITHOUT METHIONINE AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID

Restricted benefit

Pyridoxine non-responsive homocystinuria

amino acid formula with fat, carbohydrate, vitamins, minerals and trace elements without methionine and supplemented with docosahexaenoic acid oral liquid, 36 x 125 mL cans

3417W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*2508.32	37.70	HCU Anamix junior LQ [SB]

▪ AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS AND TRACE ELEMENTS WITHOUT PHENYLALANINE AND TYROSINE, AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID

Restricted benefit

Tyrosinaemia

amino acid formula with fat, carbohydrate, vitamins, minerals and trace elements without phenylalanine and tyrosine, and supplemented with docosahexaenoic acid oral liquid, 36 x 125 mL cans

9330C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*2508.32	37.70	TYR Anamix junior LQ [SB]

▪ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT LYSINE AND LOW IN TRYPTOPHAN

Restricted benefit

A patient aged 3 years or older with proven glutaric aciduria type 1

amino acid formula with vitamins and minerals without lysine and low in tryptophan oral liquid: powder for, 30 x 25 g sachets

5484P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*3154.76	37.70	GA express 15 [VF]

▪ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT LYSINE AND LOW IN TRYPTOPHAN

Restricted benefit

A child aged from 6 months up to 10 years with proven glutaric aciduria type 1

amino acid formula with vitamins and minerals without lysine and low in tryptophan oral liquid: powder for, 30 x 24 g sachets

9438R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*2114.72	37.70	GA gel [VF]

■ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT LYSINE AND LOW IN TRYPTOPHAN

Restricted benefit

A child aged less than 9 years with proven glutaric aciduria type 1

amino acid formula with vitamins and minerals without lysine and low in tryptophan oral liquid: powder for, 500 g

2646G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*1785.08	37.70	XLYS, LOW TRY Maxamaid [SB]

■ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT LYSINE AND LOW IN TRYPTOPHAN

Restricted benefit

An infant or young child with proven glutaric aciduria type 1

amino acid formula with vitamins and minerals without lysine and low in tryptophan oral liquid: powder for, 400 g

2650L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*769.64	37.70	GA1 Anamix infant [SB]

■ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT METHIONINE

Restricted benefit

Pyridoxine non-responsive homocystinuria

AMINO ACID FORMULA with VITAMINS and MINERALS without METHIONINE Oral liquid 125 mL, 30, 1

1548L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*3098.68	37.70	HCU Lophlex LQ 20 [SB]

amino acid formula with vitamins and minerals without methionine oral liquid, 30 x 130 mL cans

9133Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*3098.72	37.70	HCU cooler 15 [VF]

amino acid formula with vitamins and minerals without methionine oral liquid, 30 x 174 mL sachets

2640Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*4082.72	37.70	HCU cooler 20 [VF]

amino acid formula with vitamins and minerals without methionine oral liquid, 30 x 87 mL sachets

2639X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*2114.72	37.70	HCU cooler 10 [VF]

amino acid formula with vitamins and minerals without methionine oral liquid: powder for, 30 x 24 g sachets

8677Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*2114.72	37.70	HCU gel [VF]

amino acid formula with vitamins and minerals without methionine oral liquid: powder for, 30 x 25 g sachets

8744F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*3098.72	37.70	HCU express 15 [VF]

amino acid formula with vitamins and minerals without methionine oral liquid: powder for, 500 g

8328H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*1785.08	37.70	XMET Maxamaid [SB]

amino acid formula with vitamins and minerals without methionine oral liquid: powder for, 500 g

8416Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*2705.08	37.70	XMET Maxamum [SB]

■ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT METHIONINE

Restricted benefit

For infants and very young children with pyridoxine non-responsive homocystinuria

amino acid formula with vitamins and minerals without methionine oral liquid: powder for, 400 g

8417B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*769.64	37.70	HCU Anamix infant [SB]

■ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT METHIONINE, THREONINE AND VALINE AND LOW IN ISOLEUCINE

Restricted benefit

Methylmalonic acidaemia

Restricted benefit

Propionic acidaemia

AMINO ACID FORMULA with VITAMINS and MINERALS without METHIONINE, THREONINE and VALINE and low in ISOLEUCINE Oral liquid 130 mL, 30, 1

1923F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*3098.72	37.70	MMA/PA cooler 15 [VF]

amino acid formula with vitamins and minerals without methionine, threonine and valine and low in isoleucine oral liquid: powder for, 30 x 24 g sachets

3444G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*2114.72	37.70	MMA/PA gel [VF]

amino acid formula with vitamins and minerals without methionine, threonine and valine and low in isoleucine oral liquid: powder for, 30 x 25 g sachets

3443F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*3098.72	37.70	MMA/PA express 15 [VF]

amino acid formula with vitamins and minerals without methionine, threonine and valine and low in isoleucine oral liquid: powder for, 400 g

8058D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*769.64	37.70	MMA/PA Anamix infant [SB]

amino acid formula with vitamins and minerals without methionine, threonine and valine and low in isoleucine oral liquid: powder for, 500 g

8059E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*1785.08	37.70	XMTVI Maxamaid [SB]

amino acid formula with vitamins and minerals without methionine, threonine and valine and low in isoleucine oral liquid: powder for, 500 g

8061G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*2705.08	37.70	XMTVI Maxamum [SB]

■ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT PHENYLALANINE

Restricted benefit

Phenylketonuria

AMINO ACID FORMULA with VITAMINS and MINERALS without PHENYLALANINE Sachets 18.2 g, 60, 1

1411G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*1640.41	37.70	add-ins [SB]

AMINO ACID FORMULA with VITAMINS and MINERALS without PHENYLALANINE Sachets 34 g, 30, 1

1909L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*2054.36	37.70	PKU express 20 [VF]

amino acid formula with vitamins and minerals without phenylalanine oral liquid, 18 x 250 mL cans

8746H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	5	5	..	*1313.61	37.70	Easiphen [SB]

amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 125 mL cans

9021T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*1549.78	37.70	PKU Lophlex LQ 20 [SB]

amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 130 mL cans

8846N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*1548.68	37.70	PKU Cooler 15 [VF]

amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 174 mL cans

2474F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*2054.36	37.70	PKU Cooler 20 [VF]

amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 85 g sachets

5483N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*1058.96	37.70	PKU squeeze [VF]

amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 87 mL cans

2382J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*1035.12	37.70	PKU Cooler 10 [VF]

amino acid formula with vitamins and minerals without phenylalanine oral liquid, 36 x 125 mL cans

9396M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*1270.20	37.70	PKU Anamix Junior LQ [SB]

amino acid formula with vitamins and minerals without phenylalanine oral liquid, 60 x 62.5 mL cans

9397N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*1059.70	37.70	PKU Lophlex LQ 10 [SB]

amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 30 x 24 g sachets

8555G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*1058.96	37.70	PKU gel [VF]

amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 30 x 25 g sachets

8591E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*1549.48	37.70	PKU express 15 [VF]

amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 30 x 27.8 g sachets

8804J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*1549.78	37.70	Lophlex [SB]

amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 30 x 29 g sachets

8613H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*892.44	37.70	PKU Anamix Junior [SB]

amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 30 x 50 g sachets

8727H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*1512.40	37.70	XP Maxamum [SB]

amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 500 g

2738D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*884.36	37.70	XP Maxamaid [SB]

amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 500 g

2739E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*1352.76	37.70	XP Maxamum [SB]

amino acid formula with vitamins and minerals without phenylalanine oral semi-solid, 36 x 109 g jars

2806Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*1853.08	37.70	PKU Lophlex Sensation 20 [SB]

■ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT PHENYLALANINE**Restricted benefit**

Phenylketonuria

Note

Changes in vitamin D levels and amino acid composition have occurred with a recent formulation change.

amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 30 x 36 g sachets

10258X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*1060.16	37.70	PKU Anamix Junior [SB]

■ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT PHENYLALANINE AND TYROSINE**Restricted benefit**

Tyrosinaemia

AMINO ACID FORMULA with VITAMINS and MINERALS without PHENYLALANINE and TYROSINE Oral liquid 125 mL, 30, 1

1547K

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
3	5	..	*3098.68	37.70	TYR Lophlex LQ 20 [SB]

amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid, 30 x 130 mL cans

9132P

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
4	5	..	*3098.72	37.70	TYR cooler 15 [VF]

amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid, 30 x 174 mL sachets

2701E

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
4	5	..	*4082.72	37.70	TYR cooler 20 [VF]

amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid, 30 x 87 mL sachets

2674R

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
4	5	..	*2114.72	37.70	TYR cooler 10 [VF]

amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid: powder for, 30 x 24 g sachets

8631G

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
4	5	..	*2114.72	37.70	TYR gel [VF]

amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid: powder for, 30 x 25 g sachets

8667E

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
4	5	..	*3098.72	37.70	TYR express 15 [VF]

amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid: powder for, 30 x 29 g sachets

9395L

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
4	5	..	*1800.80	37.70	TYR Anamix Junior [SB]

amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid: powder for, 400 g

8445L

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
8	5	..	*769.64	37.70	TYR Anamix infant [SB]

amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid: powder for, 500 g

3078B

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
8	5	..	*2705.08	37.70	XPhen, Tyr Maxamum [SB]

amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid: powder for, 500 g

8446M

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
8	5	..	*1785.08	37.70	XPhen, Tyr Maxamaid [SB]

■ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT PHENYLALANINE AND TYROSINE**Restricted benefit**

Tyrosinaemia

Note

Changes in vitamin D levels and amino acid composition have occurred with a recent formulation change.

amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid: powder for, 30 x 36 g sachets

10260B

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
4	5	..	*2114.72	37.70	TYR Anamix Junior [SB]

■ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT VALINE, LEUCINE AND ISOLEUCINE**Restricted benefit**

Maple syrup urine disease

AMINO ACID FORMULA with VITAMINS and MINERALS without VALINE, LEUCINE and ISOLEUCINE Oral liquid 125 mL, 30, 1

1546J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	5	..	*3098.68	37.70	MSUD Lophlex LQ 20 [SB]

AMINO ACID FORMULA with VITAMINS and MINERALS without VALINE, LEUCINE and ISOLEUCINE Sachets 34 g, 30, 1

1914R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*4094.48	37.70	MSUD express 20 [VF]

amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid, 30 x 130 mL cans

2375B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*3098.72	37.70	MSUD cooler 15 [VF]

amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid, 30 x 174 mL pouches

2654Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*4082.72	37.70	MSUD cooler 20 [VF]

amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid, 30 x 87 mL pouches

2651M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*2114.72	37.70	MSUD cooler 10 [VF]

amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 30 x 24 g sachets

8592F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*2114.72	37.70	MSUD gel [VF]

amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 30 x 25 g sachets

8632H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*3098.72	37.70	MSUD express 15 [VF]

amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 30 x 29 g sachets

8745G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*1800.80	37.70	MSUD Anamix Junior [SB]

amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 400 g

2380G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*769.64	37.70	MSUD Anamix infant [SB]

amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 500 g

8057C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*2705.08	37.70	MSUD Maxamum [SB]

amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 500 g

8260R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*1785.08	37.70	MSUD Maxamaid [SB]

amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 500 g

8310J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*2672.32	37.70	MSUD AID III [SB]

■ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT VALINE, LEUCINE AND ISOLEUCINERestricted benefit

Maple syrup urine disease

Note

Changes in vitamin D levels and amino acid composition have occurred with a recent formulation change.

amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 30 x 36 g sachets

10259Y

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
4	5	..	*2114.72	37.70	MSUD Anamix Junior [SB]

■ AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT VALINE, LEUCINE AND ISOLEUCINE WITH FAT, CARBOHYDRATE AND TRACE ELEMENTS AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID**Restricted benefit**

Maple syrup urine disease

amino acid formula with vitamins and minerals without valine, leucine and isoleucine with fat, carbohydrate and trace elements and supplemented with docosahexaenoic acid oral liquid, 36 cans

9499Y

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
4	5	..	*2508.32	37.70	MSUD Anamix Junior LQ [SB]

■ AMINO ACID FORMULA WITH VITAMINS, MINERALS AND LONG CHAIN POLYUNSATURATED FATTY ACIDS WITHOUT PHENYLALANINE**Restricted benefit**

Phenylketonuria

amino acid formula with vitamins, minerals and long chain polyunsaturated fatty acids without phenylalanine oral liquid: powder for, 400 g

8479G

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
8	5	..	*703.96	37.70	PKU Anamix infant [SB]

■ AMINO ACID FORMULA WITHOUT PHENYLALANINE**Restricted benefit**

Phenylketonuria

amino acid formula without phenylalanine 1 g tablet, 75

8678R

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
24	5	..	*1427.32	37.70	Phlexy-10 [SB]

amino acid formula without phenylalanine 500 mg capsule, 200

8554F

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
16	5	..	*1276.68	37.70	Phlexy-10 [SB]

amino acid formula without phenylalanine oral liquid: powder for, 30 x 20 g sachets

2347M

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
7	5	..	*1463.25	37.70	Phlexy-10 Drink Mix [SB]

■ AMINO ACID FORMULA WITHOUT VALINE, LEUCINE AND ISOLEUCINE**Restricted benefit**

Maple syrup urine disease

amino acid formula without valine, leucine and isoleucine containing 5 g of protein equivalent oral liquid: powder for, 30 x 6 g sachets

10161T

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
12	5	..	*3098.68	37.70	MSUD amino5 [VF]

■ ARACHIDONIC ACID AND DOCOSAHEXAENOIC ACID WITH CARBOHYDRATE**Authority required**

Peroxisomal biogenesis disorders

arachidonic acid and docosahexaenoic acid with carbohydrate containing 200 mg arachidonic acid and 100 mg docosahexaenoic acid oral liquid: powder for, 30 x 4 g sachets

10036F

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
4	5	..	*371.16	37.70	keyomega [VF]

■ ARGININE WITH CARBOHYDRATE**Restricted benefit**

Urea cycle disorders

Note

Arginine with carbohydrate is not indicated for the treatment of arginase deficiency and other inborn errors of protein metabolism.

arginine with carbohydrate containing 2 g arginine oral liquid: powder for, 30 x 4 g sachets

5482M

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
4	5	..	*771.16	37.70	Arginine 2000 [VF]

arginine with carbohydrate containing 5 g arginine oral liquid: powder for, 30 x 7.6 g sachets

10093F

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
4	5	..	*1023.44	37.70	Arginine 5000 [VF]

arginine with carbohydrate containing 500 mg arginine oral liquid: powder for, 30 x 4 g sachets

9437Q

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
4	5	..	*516.36	37.70	Arginine 500 [VF]

■ CARBOHYDRATE, FAT, VITAMINS, MINERALS AND TRACE ELEMENTS**Restricted benefit**

Proven inborn errors of protein metabolism

Clinical criteria:

Patient must be unable to meet their energy requirements with permitted food and formulae.

carbohydrate, fat, vitamins, minerals and trace elements oral liquid: powder for, 400 g

8369L

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
8	5	..	*318.52	37.70	Energivit [SB]

■ CARBOHYDRATES, FAT, VITAMINS, MINERALS, TRACE ELEMENTS AND SUPPLEMENTED WITH ARACHIDONIC ACID AND DOCOSAHEXAENOIC ACID**Restricted benefit**

Proven inborn errors of protein metabolism

Clinical criteria:

Patient must be unable to meet their energy requirements with permitted food and formulae.

carbohydrates, fat, vitamins, minerals, trace elements and supplemented with arachidonic acid and docosahexaenoic acid providing 100 kilocalories oral liquid: powder for 30 x 21.5 g sachets

10050Y

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
4	5	..	*248.60	37.70	basecal 100 [VF]

carbohydrates, fat, vitamins, minerals, trace elements and supplemented with arachidonic acid and docosahexaenoic acid providing 200 kilocalories oral liquid: powder for, 30 x 43 g sachets

10039J

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
4	5	..	*472.48	37.70	basecal 200 [VF]

■ CITRULLINE WITH CARBOHYDRATE**Restricted benefit**

Urea cycle disorders in order to prevent low plasma arginine or citrulline levels

Note

Citrulline with carbohydrate is not indicated for the treatment of arginase deficiency and other inborn errors of protein metabolism.

citrulline with carbohydrate containing 1 g citrulline oral liquid: powder for, 30 x 4 g sachets

5481L

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
4	5	..	*516.36	37.70	Citrulline 1000 [VF]

■ CYSTINE WITH CARBOHYDRATE**Restricted benefit**

Pyridoxine non-responsive homocystinuria

cystine with carbohydrate containing 500 mg cystine oral liquid: powder for, 30 x 4 g sachets

9164H

NP

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
4	5	..	*516.36	37.70	Cystine 500 [VF]

■ DOCOSAHEXAENOIC ACID WITH CARBOHYDRATE**Authority required**

Peroxisomal biogenesis disorders

docosahexaenoic acid with carbohydrate containing 200 mg docosahexaenoic acid oral liquid: powder for, 30 x 4g sachets

10040K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*371.16	37.70	docomega [VF]

■ ESSENTIAL AMINO ACIDS FORMULA

Restricted benefit

Gyrate atrophy of the choroid and retina

Restricted benefit

Urea cycle disorders

essential amino acids formula oral liquid: powder for, 2 x 200 g cans

9329B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	6	5	..	*1200.88	37.70	Essential Amino Acid Mix [SB]

■ ESSENTIAL AMINO ACIDS FORMULA WITH MINERALS AND VITAMIN C

Restricted benefit

Gyrate atrophy of the choroid and retina

Restricted benefit

Urea cycle disorders

essential amino acids formula with minerals and vitamin C oral liquid: powder for, 400 g

2027Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	5	5	..	*634.51	37.70	Dialamine [SB]

■ ESSENTIAL AMINO ACIDS FORMULA WITH VITAMINS AND MINERALS

Restricted benefit

Gyrate atrophy of the choroid and retina

Restricted benefit

Urea cycle disorders

essential amino acids formula with vitamins and minerals oral liquid: powder for, 50 x 12.5 g sachets

9385Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*1516.84	37.70	EAA Supplement [VF]

■ GLYCINE WITH CARBOHYDRATE

Restricted benefit

Isovaleric acidaemia

glycine with carbohydrate containing 500 mg of glycine oral liquid: powder for, 30 x 4 g sachets

10195N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*516.36	37.70	Glycine500 [VF]

■ GLYCOMACROPEPTIDE AND ESSENTIAL AMINO ACIDS

Restricted benefit

Phenylketonuria

glycomacropeptide and essential amino acids oral liquid, 12 x 500 mL bottles

2712R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	12	5	..	*1270.48	37.70	Camino Pro Restore [QH]

■ GLYCOMACROPEPTIDE AND ESSENTIAL AMINO ACIDS WITH VITAMINS AND MINERALS

Restricted benefit

Phenylketonuria

glycomacropeptide and essential amino acids with vitamins and minerals bar, 7 x 54 g

2696X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	14	5	..	*866.78	37.70	Camino Pro Complete [QH]

glycomacropeptide and essential amino acids with vitamins and minerals bar, 7 x 81 g

2644E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	14	5	..	*1296.86	37.70	Camino Pro Complete [QH]

glycomacropeptide and essential amino acids with vitamins and minerals oral liquid: powder for, 28 x 49 g sachets

2685H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*1480.12	37.70	Camino Pro Bettermilk [QH]

■ HIGH FAT FORMULA WITH VITAMINS, MINERALS AND TRACE ELEMENTS AND LOW IN PROTEIN AND CARBOHYDRATE**Restricted benefit**

Ketogenic diet

Clinical criteria:

Patient must have intractable seizures requiring treatment with a ketogenic diet; OR

Patient must have a glucose transport protein defect; OR

Patient must have pyruvate dehydrogenase deficiency.

KetoCal 4:1 should only be used under strict supervision of a dietitian, together with a metabolic physician and/or neurologist.

Note

Authorities for increased maximum quantities, up to a maximum of 11, may be authorised.

high fat formula with vitamins, minerals and trace elements and low in protein and carbohydrate (4:1 ratio long chain fat to carbohydrate plus protein) oral liquid, 32 x 200 mL cartons

10185C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	5	5	..	*987.31	37.70	KetoCal 4:1 LQ [SB]

■ HIGH FAT FORMULA WITH VITAMINS, MINERALS AND TRACE ELEMENTS AND LOW IN PROTEIN AND CARBOHYDRATE**Restricted benefit**

Ketogenic diet

Clinical criteria:

Patient must have intractable seizures requiring treatment with a ketogenic diet; OR

Patient must have a glucose transport protein defect; OR

Patient must have pyruvate dehydrogenase deficiency.

KetoCal 3:1 should only be used under strict supervision of a dietitian, together with a metabolic physician and/or neurologist.

Note

Authorities for increased maximum quantities, up to a maximum of 48, may be authorised.

high fat formula with vitamins, minerals and trace elements and low in protein and carbohydrate (3:1 ratio long chain fat to carbohydrate plus protein) oral liquid: powder for, 300 g

2652N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	24	5	..	*1037.80	37.70	KetoCal 3:1 [SB]

■ HIGH FAT FORMULA WITH VITAMINS, MINERALS AND TRACE ELEMENTS AND LOW IN PROTEIN AND CARBOHYDRATE**Restricted benefit**

Ketogenic diet

Clinical criteria:

Patient must have intractable seizures requiring treatment with a ketogenic diet; OR

Patient must have a glucose transport protein defect; OR

Patient must have pyruvate dehydrogenase deficiency.

KetoCal 4:1 should only be used under strict supervision of a dietitian, together with a metabolic physician and/or neurologist.

Note

Authorities for increased maximum quantities, up to a maximum of 48, may be authorised.

high fat formula with vitamins, minerals and trace elements and low in protein and carbohydrate (4:1 ratio long chain fat to carbohydrate plus protein) oral liquid: powder for, 300 g

9446E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	24	5	..	*1037.80	37.70	KetoCal 4:1 [SB]

■ ISOLEUCINE WITH CARBOHYDRATE**Restricted benefit**

Maple syrup urine disease

isoleucine with carbohydrate containing 1 g isoleucine oral liquid: powder for, 30 x 4 g sachets

9436P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*567.32	37.70	Isoleucine 1000 [VF]

isoleucine with carbohydrate containing 50 mg isoleucine oral liquid: powder for, 30 x 4 g sachets

9134R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*516.36	37.70	Isoleucine 50 [VF]

■ MILK PROTEIN AND FAT FORMULA WITH VITAMINS AND MINERALS CARBOHYDRATE FREE**Restricted benefit**

Patients with intractable seizures requiring treatment with a ketogenic diet

Restricted benefit

Glucose transport protein defects

Restricted benefit

Pyruvate dehydrogenase deficiency

Restricted benefit

Infants and young children with glucose-galactose intolerance and multiple monosaccharide intolerance

milk protein and fat formula with vitamins and minerals carbohydrate free oral liquid: powder for, 225 g

8630F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	24	5	..	*648.76	37.70	Carbohydrate Free Mixture [SB]

■ PHENYLALANINE WITH CARBOHYDRATE**Restricted benefit**

Tyrosinaemia

phenylalanine with carbohydrate containing 50 mg phenylalanine oral liquid: powder for, 30 x 4 g sachets

9384X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*516.36	37.70	Phenylalanine 50 [VF]

■ SOY PROTEIN AND FAT FORMULA WITH VITAMINS AND MINERALS CARBOHYDRATE FREE**Restricted benefit**

Patients with intractable seizures requiring treatment with a ketogenic diet

Restricted benefit

Glucose transport protein defects

Restricted benefit

Pyruvate dehydrogenase deficiency

Restricted benefit

Infants and young children with glucose-galactose intolerance and multiple monosaccharide intolerance

soy protein and fat formula with vitamins and minerals carbohydrate free oral liquid, 1 x 384 mL can

8577K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	120	5	..	*670.36	37.70	RCF [AB]

■ TRIGLYCERIDES LONG CHAIN WITH GLUCOSE POLYMER**Restricted benefit**

Proven inborn errors of protein metabolism

Clinical criteria:

Patient must be unable to meet their energy requirements with permitted food and formulae.

triglycerides long chain with glucose polymer oral liquid, 27 x 200 mL cartons

10189G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	5	..	*192.18	37.70	Sno-Pro [SB]

■ TRIGLYCERIDES LONG CHAIN WITH GLUCOSE POLYMER**Restricted benefit**

Patients with proven inborn errors of protein metabolism who are unable to meet their energy requirements with permitted food and formulae

triglycerides long chain with glucose polymer oral liquid, 18 x 250 mL cans

9308X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	6	5	..	*340.12	37.70	ProZero [VF]

triglycerides long chain with glucose polymer oral liquid, 6 x 1000 mL bottles

9309Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*304.36	37.70	ProZero [VF]

▪ TRIGLYCERIDES MEDIUM CHAIN AND LONG CHAIN WITH GLUCOSE POLYMER**Restricted benefit**

Patients with proven inborn errors of protein metabolism who are unable to meet their energy requirements with permitted food and formulae

triglycerides medium chain and long chain with glucose polymer oral liquid: powder for, 400 g

3136C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	8	5	..	*295.88	37.70	Duocal [SB]

▪ TRIGLYCERIDES MEDIUM CHAIN FORMULA**Authority required**

Chylous ascites

Authority required

Chylothorax

Authority required

Fat malabsorption due to liver disease, short gut syndrome, cystic fibrosis and gastrointestinal disorders

Authority required

Hyperlipoproteinaemia type 1

Authority required

Long chain fatty acid oxidation disorders

Note

No applications for increased maximum quantities and/or repeats will be authorised.

MCT Pro-Cal is not indicated for the treatment of intractable childhood epilepsy or cerebrospinal fluid glucose transporter defect requiring a ketogenic diet.

triglycerides medium chain formula oral liquid: powder for, 30 x 16 g sachets

9383W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*253.96	37.70	MCT Pro-Cal [VF]

▪ TYROSINE WITH CARBOHYDRATE**Restricted benefit**

Phenylketonuria

tyrosine with carbohydrate containing 1 g tyrosine oral liquid: powder for, 30 x 4 g sachets

9165J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*516.36	37.70	Tyrosine 1000 [VF]

▪ VALINE WITH CARBOHYDRATE**Restricted benefit**

Maple syrup urine disease

valine with carbohydrate containing 1 g valine oral liquid: powder for, 30 x 4 g sachets

9434M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*567.32	37.70	Valine 1000 [VF]

valine with carbohydrate containing 50 mg valine oral liquid: powder for, 30 x 4 g sachets

9135T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*516.36	37.70	Valine 50 [VF]

▪ VITAMINS, MINERALS AND TRACE ELEMENTS WITH CARBOHYDRATE**Authority required**

Dietary management of conditions requiring a highly restrictive therapeutic diet

Clinical criteria:

Patient must have insufficient vitamin and mineral intake due to a specific diagnosis requiring a highly restrictive therapeutic diet, **AND**

Patient must be unable to adequately meet vitamin, mineral and trace element needs with other proprietary vitamin and mineral preparations.

Population criteria:

Patient must be aged 3 years or older.

Note

FruitiVits must only be used under strict supervision of a dietitian and a paediatrician.

vitamins, minerals and trace elements with carbohydrate oral liquid: powder for, 30 x 6 g sachets

10149E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	5	..	299.25	37.70	FruitiVits [VF]

■ VITAMINS, MINERALS AND TRACE ELEMENTS WITH CARBOHYDRATE**Authority required**

Dietary management of conditions requiring a highly restrictive therapeutic diet

Clinical criteria:

Patient must have insufficient vitamin and mineral intake due to a specific diagnosis requiring a highly restrictive therapeutic diet, **AND**

Patient must be unable to adequately meet vitamin, mineral and trace element needs with other proprietary vitamin and mineral preparations.

Population criteria:

Patient must be an infant or a child.

Note

Paediatric Seravit must only be used under strict supervision of a dietitian and a paediatrician.

vitamins, minerals and trace elements with carbohydrate oral liquid: powder for, 200 g

9328Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	6	5	..	*390.76	37.70	Paediatric Seravit [SB]

■ WHEY PROTEIN FORMULA SUPPLEMENTED WITH AMINO ACIDS, LONG CHAIN POLYUNSATURATED FATTY ACIDS, VITAMINS AND MINERALS, LOW IN PROTEIN, PHOSPHATE, POTASSIUM AND LACTOSE**Authority required**

Chronic renal failure

Clinical criteria:

Patient must require treatment with a low protein and a low phosphorus diet; OR

Patient must require treatment with a low protein, low phosphorus and low potassium diet.

Population criteria:

Patient must be an infant or a young child.

whey protein formula supplemented with amino acids, long chain polyunsaturated fatty acids, vitamins and minerals, low in protein, phosphate, potassium and lactose oral liquid: powder for, 10 x 100 g sachets

9382T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	9	5	..	*1485.91	37.70	RenaStart [VF]

whey protein formula supplemented with amino acids, long chain polyunsaturated fatty acids, vitamins and minerals, low in protein, phosphate, potassium and lactose oral liquid: powder for, 6 x 400 g cans

2870C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	5	..	*1584.60	37.70	Renastart [VF]

■ WHEY PROTEIN FORMULA SUPPLEMENTED WITH AMINO ACIDS, VITAMINS AND MINERALS, AND LOW IN PROTEIN, PHOSPHATE, POTASSIUM AND LACTOSE**Authority required**

Chronic renal failure

Clinical criteria:

Patient must require treatment with a low protein and a low phosphorus diet; OR

Patient must require treatment with a low protein, low phosphorus and low potassium diet.

Population criteria:

Patient must be an infant or a young child.

whey protein formula supplemented with amino acids, vitamins and minerals, and low in protein, phosphate, potassium and lactose oral liquid: powder for, 400 g

8587Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	16	5	..	*1066.28	37.70	Kindergen [SB]

Palliative Care

ALIMENTARY TRACT AND METABOLISM.....	588
STOMATOLOGICAL PREPARATIONS	588
STOMATOLOGICAL PREPARATIONS.....	588
Other agents for local oral treatment.....	588
DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS.....	588
BELLADONNA AND DERIVATIVES, PLAIN	588
Belladonna alkaloids, semisynthetic, quaternary ammonium compounds	588
DRUGS FOR CONSTIPATION	588
DRUGS FOR CONSTIPATION.....	588
Contact laxatives.....	588
Bulk-forming laxatives.....	589
Osmotically acting laxatives.....	589
Enemas.....	591
Peripheral opioid receptor antagonists.....	592
Other drugs for constipation.....	592
MUSCULO-SKELETAL SYSTEM.....	593
ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS.....	593
ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS, NON-STERIODS.....	593
Acetic acid derivatives and related substances.....	593
Propionic acid derivatives	595
NERVOUS SYSTEM.....	597
ANALGESICS.....	597
OPIOIDS	597
Natural opium alkaloids.....	597
Phenylpiperidine derivatives	598
Diphenylpropylamine derivatives	599
OTHER ANALGESICS AND ANTIPYRETICS	600
Anilides	600
ANTIEPILEPTICS.....	601
ANTIEPILEPTICS	601
Benzodiazepine derivatives	601
PSYCHOLEPTICS.....	602
ANXIOLYTICS	602
Benzodiazepine derivatives	602
HYPNOTICS AND SEDATIVES	603
Benzodiazepine derivatives	603

ALIMENTARY TRACT AND METABOLISM

STOMATOLOGICAL PREPARATIONS

STOMATOLOGICAL PREPARATIONS

Other agents for local oral treatment

BENZYDAMINE

Authority required (STREAMLINED)

3634

Initial supply, for up to 4 months, for a palliative care patient where a painful mouth is a problem

benzydamine hydrochloride 0.15% mouthwash, 500 mL

5385K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	3	..	22.60	23.75	Difflam [IA]

BENZYDAMINE

Authority required (STREAMLINED)

3635

Continuing supply for a palliative care patient where a painful mouth is a problem

Note

Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.

benzydamine hydrochloride 0.15% mouthwash, 500 mL

5386L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	..	..	22.60	23.75	Difflam [IA]

DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS

BELLADONNA AND DERIVATIVES, PLAIN

Belladonna alkaloids, semisynthetic, quaternary ammonium compounds

HYOSCINE BUTYLBROMIDE

Authority required (STREAMLINED)

3638

Initial supply, for up to 4 months, for a palliative care patient where colicky pain is a symptom

hyoscine butylbromide 20 mg/mL injection, 5 x 1 mL ampoules

5317W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	6	3	..	*108.88	37.70	Buscopan [BY]

HYOSCINE BUTYLBROMIDE

Authority required (STREAMLINED)

3639

Continuing supply for a palliative care patient where colicky pain is a symptom

Note

Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.

hyoscine butylbromide 20 mg/mL injection, 5 x 1 mL ampoules

5318X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	6	..	..	*108.88	37.70	Buscopan [BY]

DRUGS FOR CONSTIPATION

DRUGS FOR CONSTIPATION

Contact laxatives

BISACODYL

Authority required (STREAMLINED)

3642

Initial supply, for up to 4 months, for a palliative care patient where constipation is a problem

bisacodyl 10 mg suppository, 10

5303D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	3	..	*21.28	22.43	^a Petrus Bisacodyl Suppositories [PP]
			^B 1.50	*22.78	22.43	^a Dulcolax [BY]

bisacodyl 10 mg suppository, 12

5304E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	3	..	*18.67	19.82	Petrus Bisacodyl Suppositories [PP]

bisacodyl 5 mg tablet: enteric, 200 tablets

5301B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	14.45	15.60	Bisalax [AS]	Lax-Tab [AE]

■ BISACODYL**Authority required (STREAMLINED)****3643**

Continuing supply for a palliative care patient where constipation is a problem

Note

Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.

bisacodyl 10 mg suppository, 10

5307H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	..	..	*21.28	22.43	^a Petrus Bisacodyl Suppositories [PP]
			^B 1.50	*22.78	22.43	^a Dulcolax [BY]

bisacodyl 10 mg suppository, 12

5308J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	..	..	*18.67	19.82	Petrus Bisacodyl Suppositories [PP]

bisacodyl 5 mg tablet: enteric, 200 tablets

5305F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	14.45	15.60	Bisalax [AS]	Lax-Tab [AE]

Bulk-forming laxatives**■ RHAMNUS FRANGULA + STERCULIA****Authority required (STREAMLINED)****3642**

Initial supply, for up to 4 months, for a palliative care patient where constipation is a problem

rhamnus frangula 80 mg/g + sterculia 620 mg/g granules, 500 g

5322D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	3	..	26.71	27.86	Normacol Plus [NE]

■ RHAMNUS FRANGULA + STERCULIA**Authority required (STREAMLINED)****3643**

Continuing supply for a palliative care patient where constipation is a problem

Note

Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.

rhamnus frangula 80 mg/g + sterculia 620 mg/g granules, 500 g

5324F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	..	..	26.71	27.86	Normacol Plus [NE]

Osmotically acting laxatives**■ LACTULOSE****Authority required (STREAMLINED)****3642**

Initial supply, for up to 4 months, for a palliative care patient where constipation is a problem

LACTULOSE Mixture 3.34 g per 5 mL, 500 mL, 1

5387M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	3	3	..	*18.58	19.73	^a Genlac [QA]	
			^B 2.67	*21.25	19.73	^a Actilax [AF]	^a Dulose [FM]

■ LACTULOSE**Authority required (STREAMLINED)****3643**

Continuing supply for a palliative care patient where constipation is a problem

Note

Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.

LACTULOSE Mixture 3.34 g per 5 mL, 500 mL, 1

5388N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	3	..	..	*18.58	19.73	^a Genlac [QA]	
			^B 2.67	*21.25	19.73	^a Actilax [AF]	^a Dulose [FM]

■ MACROGOL-3350**Authority required (STREAMLINED)****4176**

Constipation

Treatment Phase: Initial treatment

Clinical criteria:Patient must be receiving palliative care, **AND**

Patient must not receive more than 4 months treatment under this restriction.

Note

Pharmaceutical benefits that have the form macrogol-3350 1 g/g oral liquid: powder for, 510 g and pharmaceutical benefits that have the form macrogol-3350 1 g/g oral liquid: powder for, 30 x 17 g sachets are equivalent for the purposes of substitution.

macrogol-3350 1 g/g oral liquid: powder for, 30 x 17 g sachets

2351R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*30.38	31.53	^a Herron ClearLax [ON]

macrogol-3350 1 g/g oral liquid: powder for, 510 g

5426N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*30.38	31.53	^a OsmoLax [KY]

■ MACROGOL-3350**Authority required (STREAMLINED)****4170**

Constipation

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must be receiving palliative care.

Note

Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.

Pharmaceutical benefits that have the form macrogol-3350 1 g/g oral liquid: powder for, 510 g and pharmaceutical benefits that have the form macrogol-3350 1 g/g oral liquid: powder for, 30 x 17 g sachets are equivalent for the purposes of substitution.

macrogol-3350 1 g/g oral liquid: powder for, 30 x 17 g sachets

2353W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*30.38	31.53	^a Herron ClearLax [ON]

macrogol-3350 1 g/g oral liquid: powder for, 510 g

5427P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*30.38	31.53	^a OsmoLax [KY]

■ MACROGOL-3350 + SODIUM CHLORIDE + POTASSIUM CHLORIDE + BICARBONATE**Authority required (STREAMLINED)****4595**

Constipation

Treatment Phase: Initial treatment

Clinical criteria:Patient must be receiving palliative care, **AND**

Patient must not receive more than 4 months treatment under this restriction.

macrogol-3350 13.12 g + sodium chloride 350.7 mg + potassium chloride 46.6 mg (0.63 mmol potassium) + sodium bicarbonate 178.5 mg solution, 30 sachets

5389P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	3	..	*30.38	31.53	^a APO-MACROGOL plus ELECTROLYTES [TX]	^a LaxaCon [GN]
						^a lax-sachets [AE]	^a Macrovic [QA]
						^a Molaxole [HM]	^a Movicol [NE]

macrogol-3350 13.12 g/25 mL + sodium chloride 350.7 mg/25 mL + potassium chloride 46.6 mg/25 mL (0.63 mmol/25 mL potassium) + sodium bicarbonate 178.5 mg/25 mL oral liquid, 500 mL

10127B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*22.52	23.67	Movicol Liquid [NE]

■ MACROGOL-3350 + SODIUM CHLORIDE + POTASSIUM CHLORIDE + BICARBONATE**Authority required (STREAMLINED)****4590**

Constipation

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must be receiving palliative care.

Note

Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.

macrogol-3350 13.12 g + sodium chloride 350.7 mg + potassium chloride 46.6 mg (0.63 mmol potassium) + sodium bicarbonate 178.5 mg solution, 30 sachets

5390Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	..	..	*30.38	31.53	^a APO-MACROGOL plus ELECTROLYTES [TX]	^a LaxaCon [GN]
						^a lax-sachets [AE]	^a Macrovic [QA]
						^a Molaxole [HM]	^a Movicol [NE]

macrogol-3350 13.12 g/25 mL + sodium chloride 350.7 mg/25 mL + potassium chloride 46.6 mg/25 mL (0.63 mmol/25 mL potassium) + sodium bicarbonate 178.5 mg/25 mL oral liquid, 500 mL

10112F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*22.52	23.67	Movicol Liquid [NE]

Enemas**■ BISACODYL****Authority required (STREAMLINED)****3642**

Initial supply, for up to 4 months, for a palliative care patient where constipation is a problem

bisacodyl 10 mg/5 mL enema, 25 x 5 mL

5302C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	3	..	38.28	37.70	Bisalax [AS]

■ BISACODYL**Authority required (STREAMLINED)****3643**

Continuing supply for a palliative care patient where constipation is a problem

Note

Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.

bisacodyl 10 mg/5 mL enema, 25 x 5 mL

5306G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	..	..	38.28	37.70	Bisalax [AS]

■ SORBITOL + CITRATE + LAURYL SULFOACETATE SODIUM**Authority required (STREAMLINED)****3642**

Initial supply, for up to 4 months, for a palliative care patient where constipation is a problem

sorbitol 3.125 g/5 mL + citrate sodium dihydrate 450 mg/5 mL + lauryl sulfoacetate sodium 45 mg/5 mL enema, 12 x 5 mL

5331N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	3	..	*32.62	33.77	^a Micolette [AE]	^a Microlax [JT]

▪ SORBITOL + CITRATE + LAURYL SULFOACETATE SODIUM

Authority required (STREAMLINED)

3643

Continuing supply for a palliative care patient where constipation is a problem

Note

Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.

sorbitol 3.125 g/5 mL + citrate sodium dihydrate 450 mg/5 mL + lauryl sulfoacetate sodium 45 mg/5 mL enema, 12 x 5 mL

5332P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	..	..	*32.62	33.77	^a Micolette [AE]	^a Microlax [JT]

Peripheral opioid receptor antagonists

▪ METHYLNALTREXONE

Authority required

Continuing supply, in combination with oral laxatives, for a palliative care patient with opioid-induced constipation who has demonstrated a response to methylnaltrexone

Note

For first continuing supply, applications for increased repeats may be authorised.

Where consultation with a palliative care specialist or service has occurred, applications for increased repeats may be authorised.

Special Pricing Arrangements apply.

METHYLNALTREXONE Solution for injection containing methylnaltrexone bromide 12 mg in 0.6 mL, 7

5424L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	288.18	37.70	Relistor [LM]

▪ METHYLNALTREXONE

Authority required

Initial supply, in combination with oral laxatives, for a palliative care patient with opioid-induced constipation who has failed to respond to laxatives

Note

No applications for repeats will be authorised.

Special Pricing Arrangements apply.

methylnaltrexone bromide 12 mg/0.6 mL injection, 1 x 0.6 mL vial

5423K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	..	..	*130.93	37.70	Relistor [LM]

Other drugs for constipation

▪ GLYCEROL

Authority required (STREAMLINED)

3642

Initial supply, for up to 4 months, for a palliative care patient where constipation is a problem

glycerol 1.4 g suppository, 12

5312N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	3	..	*21.55	22.70	Petrus Pharmaceuticals Pty Ltd [PP]

glycerol 2.8 g suppository, 12

5313P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	3	..	*22.15	23.30	Petrus Pharmaceuticals Pty Ltd [PP]

glycerol 700 mg suppository, 12

5311M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	3	..	*21.10	22.25	Petrus Pharmaceuticals Pty Ltd [PP]

■ GLYCEROL**Authority required (STREAMLINED)****3643**

Continuing supply for a palliative care patient where constipation is a problem

Note

Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.

glycerol 1.4 g suppository, 12

5315R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	..	..	*21.55	22.70	Petrus Pharmaceuticals Pty Ltd [PP]

glycerol 2.8 g suppository, 12

5316T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	..	..	*22.15	23.30	Petrus Pharmaceuticals Pty Ltd [PP]

glycerol 700 mg suppository, 12

5314Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	..	..	*21.10	22.25	Petrus Pharmaceuticals Pty Ltd [PP]

■ MUSCULO-SKELETAL SYSTEM**■ ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS****ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS, NON-STERIODS***Acetic acid derivatives and related substances***■ DICLOFENAC****Authority required (STREAMLINED)****3645**

Initial supply, for up to 4 months, for a palliative care patient where severe pain is a problem

diclofenac sodium 25 mg tablet: enteric, 50 tablets

5361E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	3	..	*10.62	11.77	^a APO-Diclofenac [TX] ^a Clonac 25 [QA] ^a Diclofenac-GA [GN] ^a Fenac 25 [AF]	^a Chem mart Diclofenac [CH] ^a Diclofenac AN [EA] ^a Diclofenac Sandoz [SZ] ^a Terry White Chemists Diclofenac [TW]
			^B 1.44	*12.06	11.77	^a Voltaren 25 [NV]	

diclofenac sodium 50 mg tablet: enteric, 50 tablets

5362F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	9.44	10.59	^a APO-Diclofenac [TX] ^a Clonac 50 [QA] ^a Diclofenac-GA [GN] ^a Fenac [AF]	^a Chem mart Diclofenac [CH] ^a Diclofenac AN [EA] ^a Diclofenac Sandoz [SZ] ^a Terry White Chemists Diclofenac [TW]
			^B 1.43	10.87	10.59	^a Voltaren 50 [NV]	

■ DICLOFENAC**Authority required**

Initial supply, for up to 4 months, for a palliative care patient where severe pain is a problem

diclofenac sodium 100 mg suppository, 20

5363G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*25.26	26.41	Voltaren 100 [NV]

■ DICLOFENAC**Authority required (STREAMLINED)****3646**

Continuing supply for a palliative care patient where severe pain is a problem

Note

Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.

diclofenac sodium 25 mg tablet: enteric, 50 tablets

5364H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	..	..	*10.62	11.77	^a APO-Diclofenac [TX] ^a Clonac 25 [QA] ^a Diclofenac-GA [GN] ^a Fenac 25 [AF]	^a Chem mart Diclofenac [CH] ^a Diclofenac AN [EA] ^a Diclofenac Sandoz [SZ] ^a Terry White Chemists Diclofenac [TW]
			^B 1.44	*12.06	11.77	^a Voltaren 25 [NV]	

diclofenac sodium 50 mg tablet: enteric, 50 tablets

5365J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	9.44	10.59	^a APO-Diclofenac [TX] ^a Clonac 50 [QA] ^a Diclofenac-GA [GN] ^a Fenac [AF]	^a Chem mart Diclofenac [CH] ^a Diclofenac AN [EA] ^a Diclofenac Sandoz [SZ] ^a Terry White Chemists Diclofenac [TW]
			^B 1.43	10.87	10.59	^a Voltaren 50 [NV]	

■ DICLOFENAC**Authority required**

Continuing supply for a palliative care patient where severe pain is a problem

Note

Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.

diclofenac sodium 100 mg suppository, 20

5366K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*25.26	26.41	Voltaren 100 [NV]

■ INDOMETHACIN**Authority required (STREAMLINED)****3645**

Initial supply, for up to 4 months, for a palliative care patient where severe pain is a problem

indomethacin 25 mg capsule, 50

5377B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*13.20	14.35	^a Arthrexin [AF]
			^B 4.64	*17.84	14.35	^a Indocid [AS]

■ INDOMETHACIN**Authority required**

Initial supply, for up to 4 months, for a palliative care patient where severe pain is a problem

indomethacin 100 mg suppository, 20

5378C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*22.84	23.99	Indocid [AS]

■ INDOMETHACIN**Authority required (STREAMLINED)****3646**

Continuing supply for a palliative care patient where severe pain is a problem

Note

Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.

indomethacin 25 mg capsule, 50

5379D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*13.20	14.35	^a Arthrexin [AF]
			^B 4.64	*17.84	14.35	^a Indocid [AS]

■ INDOMETHACIN**Authority required**

Continuing supply for a palliative care patient where severe pain is a problem

Note

Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.

indomethacin 100 mg suppository, 20

5380E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*22.84	23.99	Indocid [AS]

Propionic acid derivatives

▪ **IBUPROFEN**

Authority required

Initial supply, for up to 4 months, for a palliative care patient where severe pain is a problem

ibuprofen 400 mg tablet, 30

5368M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	3	..	*15.07	16.22	Brufen [GO]

▪ **IBUPROFEN**

Authority required

Continuing supply for a palliative care patient where severe pain is a problem

Note

Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.

ibuprofen 400 mg tablet, 30

5370P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	3	..	..	*15.07	16.22	Brufen [GO]

▪ **NAPROXEN**

Authority required (STREAMLINED)

4128

Severe pain

Treatment Phase: Initial treatment

Clinical criteria:

Patient must be unable to take a solid dose form of a non-steroidal anti-inflammatory agent, **AND**

Patient must not receive more than 4 months treatment under this restriction.

Treatment criteria:

Patient must be undergoing palliative care.

naproxen 125 mg/5 mL oral liquid, 474 mL

5397C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	‡1	3	..	127.96	37.70	Phebra Naproxen Suspension [PL]

▪ **NAPROXEN**

Authority required (STREAMLINED)

3645

Initial supply, for up to 4 months, for a palliative care patient where severe pain is a problem

naproxen 1 g tablet: modified release, 28

5348L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	3	..	14.30	15.45	^a Proxen SR 1000 [MD]
			^B 1.29	15.59	15.45	^a Naprosyn SR1000 [RO]

naproxen 250 mg tablet, 50

5345H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*13.68	14.83	^a Inza 250 [AF]
			^B 2.24	*15.92	14.83	^a Naprosyn [RO]

naproxen 500 mg tablet, 50

5346J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	3	..	12.94	14.09	^a Inza 500 [AF]
			^B 1.28	14.22	14.09	^a Naprosyn [RO]

naproxen 750 mg tablet: modified release, 28 tablets

5347K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	3	..	12.42	13.57	^a Proxen SR 750 [MD]
			^B 1.22	13.64	13.57	^a Naprosyn SR750 [RO]

■ NAPROXEN**Authority required (STREAMLINED)****3645**

Initial supply, for up to 4 months, for a palliative care patient where severe pain is a problem

Note

Naproxen sodium 550 mg is approximately equivalent to 500 mg of naproxen acid.

naproxen sodium 550 mg tablet, 50

5353R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	3	..	13.11	14.26	^a Crysanal [MD]
			^B 2.17	15.28	14.26	^a Anaprox 550 [RO]

■ NAPROXEN**Authority required (STREAMLINED)****4129**

Severe pain

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must be unable to take a solid dose form of a non-steroidal anti-inflammatory agent.

Treatment criteria:

Patient must be undergoing palliative care.

Note

Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.

naproxen 125 mg/5 mL oral liquid, 474 mL

5398D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	±1	..	..	127.96	37.70	Phebra Naproxen Suspension [PL]

■ NAPROXEN**Authority required (STREAMLINED)****3646**

Continuing supply for a palliative care patient where severe pain is a problem

Note

Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.

naproxen 1 g tablet: modified release, 28

5352Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	14.30	15.45	^a Proxen SR 1000 [MD]
			^B 1.29	15.59	15.45	^a Naprosyn SR1000 [RO]

naproxen 250 mg tablet, 50

5349M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*13.68	14.83	^a Inza 250 [AF]
			^B 2.24	*15.92	14.83	^a Naprosyn [RO]

naproxen 500 mg tablet, 50

5350N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	12.94	14.09	^a Inza 500 [AF]
			^B 1.28	14.22	14.09	^a Naprosyn [RO]

naproxen 750 mg tablet: modified release, 28 tablets

5351P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	12.42	13.57	^a Proxen SR 750 [MD]
			^B 1.22	13.64	13.57	^a Naprosyn SR750 [RO]

■ NAPROXEN**Authority required (STREAMLINED)****3646**

Continuing supply for a palliative care patient where severe pain is a problem

Note

Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.

Naproxen sodium 550 mg is approximately equivalent to 500 mg of naproxen acid.

naproxen sodium 550 mg tablet, 50

5354T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	13.11	14.26	^a Crysanal [MD]
			^b 2.17	15.28	14.26	^a Anaprox 550 [RO]

■ **NERVOUS SYSTEM**

■ **ANALGESICS**

OPIOIDS

Natural opium alkaloids

■ **MORPHINE**

Caution

The risk of drug dependence is high.

Authority required

Chronic severe disabling pain

Treatment Phase: Initial treatment, for up to 3 months

Clinical criteria:

Patient must be receiving palliative care, **AND**

The condition must be unresponsive to non-narcotic analgesics.

Note

Telephone approvals are limited to 1 month's therapy.

morphine sulfate 200 mg tablet: modified release, 28 tablets

5391R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	122.20	37.70	MS Contin [MF]

■ **MORPHINE**

Caution

The risk of drug dependence is high.

Authority required

Severe disabling pain

Treatment Phase: Initial treatment, for up to 3 months

Clinical criteria:

Patient must be receiving palliative care, **AND**

The condition must be unresponsive to non-narcotic analgesics.

Note

Telephone approvals are limited to 1 month's therapy.

morphine sulfate 10 mg tablet, 20

5393W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	14.66	15.81	Sevredol [MF]

morphine sulfate 20 mg tablet, 20

5394X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	15.60	16.75	Sevredol [MF]

■ **MORPHINE**

Caution

The risk of drug dependence is high.

Authority required

Chronic severe disabling pain

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must be receiving palliative care, **AND**

The condition must be unresponsive to non-narcotic analgesics.

Note

Where consultation with a palliative care specialist or service has occurred, applications for increased repeats for up to 3 months' supply may be authorised.
Telephone approvals are limited to 1 month's therapy.

morphine sulfate 200 mg tablet: modified release, 28 tablets

5392T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	122.20	37.70	MS Contin [MF]

▪ MORPHINE
Caution

The risk of drug dependence is high.

Authority required

Severe disabling pain

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must be receiving palliative care, **AND**

The condition must be unresponsive to non-narcotic analgesics.

Note

Where consultation with a palliative care specialist or service has occurred, applications for increased repeats for up to 3 months' supply may be authorised.

Telephone approvals are limited to 1 month's therapy.

morphine sulfate 10 mg tablet, 20

5395Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	14.66	15.81	Sevredol [MF]

morphine sulfate 20 mg tablet, 20

5396B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	15.60	16.75	Sevredol [MF]

Phenylpiperidine derivatives
▪ FENTANYL
Caution

The risk of drug dependence is high.

Authority required

Breakthrough pain

Treatment Phase: Initial treatment for dose titration

Clinical criteria:

Patient must have cancer, **AND**

Patient must be receiving opioids for their persistent pain, **AND**

Patient must be unable to tolerate further escalation in the dose of morphine for breakthrough pain due to adverse effects.

Treatment criteria:

Patient must be undergoing palliative care.

Note

No increase in the maximum number of repeats may be authorised.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

FENTANYL Lozenge 1200 micrograms (as citrate), 9

5405L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	99.95	37.70	Actiq [OA]

FENTANYL Lozenge 1600 micrograms (as citrate), 9

5406M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	99.95	37.70	Actiq [OA]

FENTANYL Lozenge 200 micrograms (as citrate), 9

5401G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	99.95	37.70	Actiq [OA]

FENTANYL Lozenge 400 micrograms (as citrate), 9

5402H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	99.95	37.70	Actiq [OA]

FENTANYL Lozenge 600 micrograms (as citrate), 9

5403J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	99.95	37.70	Actiq [OA]

FENTANYL Lozenge 800 micrograms (as citrate), 9

5404K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	99.95	37.70	Actiq [OA]

■ FENTANYL**Caution**

The risk of drug dependence is high.

Authority required

Breakthrough pain

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have cancer, **AND**

Patient must be receiving opioids for their persistent pain, **AND**

Patient must be unable to tolerate further escalation in the dose of morphine for breakthrough pain due to adverse effects.

Treatment criteria:

Patient must be undergoing palliative care.

Note

For first continuing supply, applications for increased repeats for up to 3 months' supply may be authorised.

Where consultation with a palliative care specialist or service has occurred, applications for increased repeats for up to 3 months' supply may be authorised.

Telephone approvals are limited to 1 month's therapy.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

FENTANYL Lozenge 1200 micrograms (as citrate), 30

5411T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*579.77	37.70	Actiq [OA]

FENTANYL Lozenge 1600 micrograms (as citrate), 30

5412W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*579.77	37.70	Actiq [OA]

FENTANYL Lozenge 200 micrograms (as citrate), 30

5407N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*579.77	37.70	Actiq [OA]

FENTANYL Lozenge 400 micrograms (as citrate), 30

5408P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*579.77	37.70	Actiq [OA]

FENTANYL Lozenge 600 micrograms (as citrate), 30

5409Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*579.77	37.70	Actiq [OA]

FENTANYL Lozenge 800 micrograms (as citrate), 30

5410R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*579.77	37.70	Actiq [OA]

Diphenylpropylamine derivatives**■ METHADONE****Caution**

The risk of drug dependence is high.

Authority required

Chronic severe disabling pain

Treatment Phase: Initial treatment, for up to 3 months

Clinical criteria:

Patient must be receiving palliative care, **AND**

The condition must be unresponsive to non-narcotic analgesics.

Note

Where consultation with a palliative care specialist or service has occurred, applications for increased repeats for up to 3 months' supply may be authorised.

Telephone approvals are limited to 1 month's therapy.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

methadone hydrochloride 5 mg/mL oral liquid, 200 mL

5399E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	2	..	19.25	20.40	Aspen Methadone Syrup [QA]

▪ **METHADONE**

Caution

The risk of drug dependence is high.

Authority required

Chronic severe disabling pain

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must be receiving palliative care, **AND**

The condition must be unresponsive to non-narcotic analgesics.

Note

Where consultation with a palliative care specialist or service has occurred, applications for increased repeats for up to 3 months' supply may be authorised.

Telephone approvals are limited to 1 month's therapy.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

methadone hydrochloride 5 mg/mL oral liquid, 200 mL

5400F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	19.25	20.40	Aspen Methadone Syrup [QA]

OTHER ANALGESICS AND ANTIPYRETICS

Anilides

▪ **PARACETAMOL**

Authority required (STREAMLINED)

4940

Analgesia or fever

Treatment Phase: Initial treatment, for up to 4 months

Clinical criteria:

Patient must be receiving palliative care, **AND**

Patient must be intolerant to alternative therapy.

paracetamol 500 mg suppository, 24

5319Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	3	..	*84.80	37.70	Panadol [GC]

paracetamol 665 mg tablet: modified release, 96 tablets

5343F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*15.34	16.49	^a Osteomol 665 Paracetamol [CR]
			^B 1.64	*16.98	16.49	^a Panadol Osteo [GC]

▪ **PARACETAMOL**

Authority required (STREAMLINED)

4950

Analgesia or fever

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must be receiving palliative care, **AND**
 Patient must be intolerant to alternative therapy.

Note

Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.

paracetamol 500 mg suppository, 24

5320B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	4	..	..	*84.80	37.70	Panadol [GC]

paracetamol 665 mg tablet: modified release, 96 tablets

5344G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*15.34	16.49	^a Osteomol 665 Paracetamol [CR]
			^B 1.64	*16.98	16.49	^a Panadol Osteo [GC]

■ ANTIEPILEPTICS

ANTIEPILEPTICS

Benzodiazepine derivatives

■ CLONAZEPAM

Authority required

Initial supply, for up to 4 months, for a palliative care patient for the prevention of epilepsy

Note

No applications for increased repeats will be authorised.

clonazepam 2 mg tablet, 100

5338Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	3	..	19.08	20.23	^a Paxam 2 [AF]
			^B 1.93	21.01	20.23	^a Rivotril [RO]

clonazepam 2.5 mg/mL oral liquid, 10 mL

5339B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*15.38	16.53	Rivotril [RO]

clonazepam 500 microgram tablet, 100

5337X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	3	..	13.30	14.45	^a Paxam 0.5 [AF]
			^B 1.71	15.01	14.45	^a Rivotril [RO]

■ CLONAZEPAM

Authority required

Continuing supply for a palliative care patient for the prevention of epilepsy

Note

Where consultation with a palliative care specialist or service has occurred, applications for increased repeats may be authorised.

clonazepam 2 mg tablet, 100

5341D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	19.08	20.23	^a Paxam 2 [AF]
			^B 1.93	21.01	20.23	^a Rivotril [RO]

clonazepam 2.5 mg/mL oral liquid, 10 mL

5342E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*15.38	16.53	Rivotril [RO]

clonazepam 500 microgram tablet, 100

5340C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	1	..	..	13.30	14.45	^a Paxam 0.5 [AF]
			^B 1.71	15.01	14.45	^a Rivotril [RO]

■ PSYCHOLEPTICS

ANXIOLYTICS

Benzodiazepine derivatives

■ DIAZEPAM

Authority required

Initial supply, for up to 4 months, for a palliative care patient where anxiety is a problem

Note

No applications for increased repeats will be authorised.

diazepam 2 mg tablet, 50

5355W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	7.92	9.07	^a Antenex 2 [AF] ^a Ranzepam [RA]	^a APO-Diazepam [TX] ^a Valpam 2 [QA]

diazepam 5 mg tablet, 50

5356X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	3	..	8.04	9.19	^a Antenex 5 [AF] ^a Ranzepam [RA]	^a APO-Diazepam [TX] ^a Valpam 5 [QA]
			^B 2.52	10.56	9.19	^a Valium [RO]	

■ DIAZEPAM

Authority required

Continuing supply for a palliative care patient where anxiety is a problem

Note

Where consultation with a palliative care specialist or service has occurred, applications for increased repeats may be authorised.

diazepam 2 mg tablet, 50

5357Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	7.92	9.07	^a Antenex 2 [AF] ^a Ranzepam [RA]	^a APO-Diazepam [TX] ^a Valpam 2 [QA]

diazepam 5 mg tablet, 50

5358B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	1	..	..	8.04	9.19	^a Antenex 5 [AF] ^a Ranzepam [RA]	^a APO-Diazepam [TX] ^a Valpam 5 [QA]
			^B 2.52	10.56	9.19	^a Valium [RO]	

■ OXAZEPAM

Authority required

Initial supply, for up to 4 months, for a palliative care patient where anxiety is a problem

Note

No applications for increased repeats will be authorised.

oxazepam 15 mg tablet, 25

5371Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	3	..	*9.24	10.39	^a Alepam 15 [AF]	
			^B 5.36	*14.60	10.39	^a Serepax [QA]	

oxazepam 30 mg tablet, 25

5372R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	3	..	*9.24	10.39	^a Alepam 30 [AF] ^a Murelax [FM]	^a APO-Oxazepam [TX]
			^B 5.36	*14.60	10.39	^a Serepax [QA]	

■ OXAZEPAM

Authority required

Continuing supply for a palliative care patient where anxiety is a problem

Note

Where consultation with a palliative care specialist or service has occurred, applications for increased repeats may be authorised.

oxazepam 15 mg tablet, 25

5373T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*9.24	10.39	^a Alepam 15 [AF]
			^B 5.36	*14.60	10.39	^a Serepax [QA]

oxazepam 30 mg tablet, 25

5374W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	..	..	*9.24	10.39	^a Alepam 30 [AF]	^a APO-Oxazepam [TX]
			^B 5.36	*14.60	10.39	^a Murelax [FM]	^a Serepax [QA]

HYPNOTICS AND SEDATIVES*Benzodiazepine derivatives***■ NITRAZEPAM****Authority required**

Initial supply, for up to 4 months, for a palliative care patient where insomnia is a problem

Note

No applications for increased repeats will be authorised.

nitrazepam 5 mg tablet, 25

5359C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	3	..	*9.94	11.09	^a Alodorm [AF]
			^B 2.48	*12.42	11.09	^a Mogadon [IA]

■ NITRAZEPAM**Authority required**

Continuing supply for a palliative care patient where insomnia is a problem

Note

Where consultation with a palliative care specialist or service has occurred, applications for increased repeats may be authorised.

nitrazepam 5 mg tablet, 25

5360D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
NP	2	..	..	*9.94	11.09	^a Alodorm [AF]
			^B 2.48	*12.42	11.09	^a Mogadon [IA]

■ TEMAZEPAM**Authority required**

Initial supply, for up to 4 months, for a palliative care patient where insomnia is a problem

Note

No applications for increased repeats will be authorised.

temazepam 10 mg tablet, 25

5375X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	3	..	*8.62	9.77	^a APO-Temazepam [TX]	^a Temaze [AF]
			^B 8.00	*16.62	9.77	^a Temtabs [FM]	^a Normison [QA]

■ TEMAZEPAM**Authority required**

Continuing supply for a palliative care patient where insomnia is a problem

Note

Where consultation with a palliative care specialist or service has occurred, applications for increased repeats may be authorised.

temazepam 10 mg tablet, 25

5376Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
NP	2	..	..	*8.62	9.77	^a APO-Temazepam [TX]	^a Temaze [AF]
			^B 8.00	*16.62	9.77	^a Temtabs [FM]	^a Normison [QA]

Highly Specialised Drugs Program (Private Hospital)

BLOOD AND BLOOD FORMING ORGANS	607
ANTHEMORRHAGICS.....	607
VITAMIN K AND OTHER HEMOSTATICS	607
Other systemic hemostatics	607
ANTIANEMIC PREPARATIONS	610
OTHER ANTIANEMIC PREPARATIONS	610
Other antianemic preparations.....	610
CARDIOVASCULAR SYSTEM.....	614
ANTIHYPERTENSIVES	614
OTHER ANTIHYPERTENSIVES	614
Antihypertensives for pulmonary arterial hypertension	614
SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS.....	647
PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES.....	647
HYPOTHALAMIC HORMONES.....	647
Somatostatin and analogues	647
CALCIUM HOMEOSTASIS	649
ANTI-PARATHYROID AGENTS.....	649
Other anti-parathyroid agents	649
ANTIINFECTIVES FOR SYSTEMIC USE	650
ANTIBACTERIALS FOR SYSTEMIC USE.....	650
MACROLIDES, LINCOSAMIDES AND STREPTOGRAMINS.....	650
Macrolides	650
ANTIMYCOBACTERIALS	650
DRUGS FOR TREATMENT OF TUBERCULOSIS.....	650
Antibiotics	650
ANTIVIRALS FOR SYSTEMIC USE	650
DIRECT ACTING ANTIVIRALS	650
Nucleosides and nucleotides excl. reverse transcriptase inhibitors	650
Phosphonic acid derivatives	651
Protease inhibitors	651
Nucleoside and nucleotide reverse transcriptase inhibitors	656
Non-nucleoside reverse transcriptase inhibitors	661
Antivirals for treatment of HIV infections, combinations	663
Other antivirals.....	665
ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	667

ANTINEOPLASTIC AGENTS	667
ANTIMETABOLITES	667
Pyrimidine analogues	667
CYTOTOXIC ANTIBIOTICS AND RELATED SUBSTANCES	668
Anthracyclines and related substances	668
IMMUNOSTIMULANTS	668
IMMUNOSTIMULANTS	668
Colony stimulating factors	668
Interferons	672
Other immunostimulants	684
IMMUNOSUPPRESSANTS	685
IMMUNOSUPPRESSANTS	685
Selective immunosuppressants	685
Tumor necrosis factor alpha (TNF-) inhibitors	701
Interleukin inhibitors	748
Calcineurin inhibitors	768
Other immunosuppressants	770
MUSCULO-SKELETAL SYSTEM	778
MUSCLE RELAXANTS	778
MUSCLE RELAXANTS, CENTRALLY ACTING AGENTS	778
Other centrally acting agents	778
DRUGS FOR TREATMENT OF BONE DISEASES	778
DRUGS AFFECTING BONE STRUCTURE AND MINERALIZATION	778
Bisphosphonates	778
NERVOUS SYSTEM	779
ANTI-PARKINSON DRUGS	779
DOPAMINERGIC AGENTS	779
Dopa and dopa derivatives	779
Dopamine agonists	780
PSYCHOLEPTICS	780
ANTIPSYCHOTICS	780
Diazepines, oxazepines, thiazepines and oxepines	780
RESPIRATORY SYSTEM	781
DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES	781
OTHER SYSTEMIC DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES	781
Other systemic drugs for obstructive airway diseases	781
COUGH AND COLD PREPARATIONS	784
EXPECTORANTS, EXCL. COMBINATIONS WITH COUGH SUPPRESSANTS	784
Mucolytics	784
OTHER RESPIRATORY SYSTEM PRODUCTS	786
OTHER RESPIRATORY SYSTEM PRODUCTS	786
Other respiratory system products	786
VARIOUS	789
ALL OTHER THERAPEUTIC PRODUCTS	789
ALL OTHER THERAPEUTIC PRODUCTS	789
Iron chelating agents	789
Drugs for treatment of hyperkalemia and hyperphosphatemia	790

■ BLOOD AND BLOOD FORMING ORGANS

■ ANTIHEMORRHAGICS

VITAMIN K AND OTHER HEMOSTATICS

Other systemic hemostatics

■ ELTROMBOPAG

Authority required

Initial (new patients)

Initial treatment, as the sole PBS-subsidised thrombopoietin receptor agonist (TRA), of severe thrombocytopenia in an adult patient with severe chronic immune (idiopathic) thrombocytopenic purpura (ITP) who is:

(1) Splenectomised and:

(a) has had an inadequate response to, or is intolerant to, corticosteroid therapy post splenectomy; and

(b) has had an inadequate response to, or is intolerant to, immunoglobulin therapy post splenectomy;

OR

(2) Not splenectomised and:

(a) has had an inadequate response, or is intolerant to, corticosteroid therapy at a dose equivalent to 0.5-2 mg/kg/day of prednisone for at least 4-6 weeks; and

(b) has had an inadequate response, or is intolerant to, immunoglobulin therapy; and

(c) in whom splenectomy is contraindicated for medical reasons.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of initial application:

(a) a platelet count of less than or equal to 20,000 million per L;

OR

(b) a platelet count of 20-30,000 million per L, where the patient is experiencing significant bleeding or has a history of significant bleeding in this platelet range.

The authority application must be made in writing and must include:

(1) a completed authority prescription form,

(2) a signed patient acknowledgement,

(3) a completed Idiopathic Thrombocytopenic Purpura Initial PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)],

(4) a copy of a full blood count pathology report supporting the diagnosis of ITP, and

(5) where the application is sought on the basis of a medical contraindication to surgery, a signed and dated letter from the clinician making this assessment which includes the date upon which the patient was assessed for surgery and the clinical grounds upon which surgery is contraindicated.

The full blood count must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with eltrombopag will be authorised under this criterion

Authority required

Initial (grandfather patients)

Initial treatment, as the sole PBS-subsidised thrombopoietin receptor agonist (TRA), of severe thrombocytopenia in an adult patient with severe chronic immune (idiopathic) thrombocytopenic purpura (ITP) who was receiving treatment with eltrombopag prior to 1 November 2011 and in whom the criteria for initial treatment can be demonstrated to have been met at the time eltrombopag was commenced.

The authority application must be made in writing and must include:

(1) a completed authority prescription form,

(2) a signed patient acknowledgement,

(3) a completed Idiopathic Thrombocytopenic Purpura Initial PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)], and

(4) where the application is sought on the basis of a medical contraindication to surgery, a signed and dated letter from the clinician making this assessment which includes the date upon which the patient was assessed for surgery and the clinical grounds upon which surgery is contraindicated.

A maximum of 24 weeks of treatment with eltrombopag will be authorised under this criterion

Authority required

Continuing therapy or re-initiation after a break in therapy

First period of PBS-subsidised continuing treatment or re-initiation of interrupted PBS-subsidised treatment, as the sole PBS-subsidised thrombopoietin receptor agonist (TRA), of severe thrombocytopenia in an adult patient with chronic immune (idiopathic) thrombocytopenic purpura (ITP) who has displayed a sustained platelet response to treatment with eltrombopag during the initial period of PBS-subsidised treatment.

For the purposes of this restriction, a sustained platelet response is defined as:

(a) use of rescue medication (corticosteroids or immunoglobulins) on no more than one occasion during the initial period of PBS-subsidised eltrombopag,

AND either of the following:

(b) a platelet count greater than or equal to 50,000 million per L on at least four (4) occasions, each at least one week apart;

OR

(c) a platelet count greater than 30,000 million per L and which is double the baseline (pre-treatment) platelet count on at least four (4) occasions, each at least one week apart.

Applications for the first period of continuing PBS-subsidised treatment or re-initiation of interrupted treatment must be made in writing and must include:

- (1) a completed authority prescription form, and
- (2) a completed Idiopathic Thrombocytopenic Purpura Continuing PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)], and
- (3) copies of the platelet count pathology reports (unless previously provided for patients re-initiating therapy).

The most recent platelet count must be no more than one month old at the time of application.

A maximum of 24 weeks of treatment with eltrombopag will be authorised under this criterion.

Where fewer than 5 repeats are initially requested with the authority prescription, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be made by telephone

Authority required

Second and subsequent applications for continuing therapy

Continuing treatment, as the sole PBS-subsidised thrombopoietin receptor agonist (TRA), of severe thrombocytopenia in an adult patient with chronic immune (idiopathic) thrombocytopenic purpura (ITP) who has previously received PBS-subsidised therapy with eltrombopag and who continues to display a response to treatment with eltrombopag.

For the purposes of this restriction, a continuing response to treatment with eltrombopag is defined as:

- (a) use of rescue medication (corticosteroids or immunoglobulins) on no more than one occasion during the most recent 24 week period of PBS-subsidised treatment with eltrombopag,

AND either of the following:

- (b) a platelet count greater than or equal to 50,000 million per L

OR

- (c) a platelet count greater than 30,000 million per L and which is double the baseline platelet count.

Platelet counts must be no more than 1 month old at the time of application.

Authority applications for second and subsequent periods of continuing therapy may be made by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

Note

Eltrombopag is not PBS-subsidised as an alternative to splenectomy.

Any queries concerning the arrangements to prescribe eltrombopag may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authority to prescribe eltrombopag should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826
HOBART TAS 7001

Further prescribing information is on the Medicare Australia website at www.medicareaustralia.gov.au.

Patients will be able to trial either eltrombopag and/or romiplostim within the initial 24 weeks treatment period. Patients who fail to demonstrate a response to treatment with either eltrombopag and/or romiplostim under the initial restriction will not be eligible to receive further PBS-subsidised treatment with either of these drugs.

No applications for increased repeats will be authorised.

No applications for increased repeats will be authorised.

eltrombopag 25 mg tablet, 28

5827Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	5	..	1558.76	Revolade [GK]

eltrombopag 50 mg tablet, 28

5828R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	5	..	3070.76	Revolade [GK]

■ ROMIPILOSTIM

Authority required

Initial (new patients)

Initial treatment, as the sole PBS-subsidised thrombopoietin receptor agonist (TRA), of severe thrombocytopenia in an adult patient with severe chronic immune (idiopathic) thrombocytopenic purpura (ITP) who is:

- (1) Splenectomised and:

- (a) has had an inadequate response to, or is intolerant to, corticosteroid therapy post splenectomy; and

- (b) has had an inadequate response to, or is intolerant to, immunoglobulin therapy post splenectomy;

OR

- (2) Not splenectomised and:

- (a) has had an inadequate response, or is intolerant to, corticosteroid therapy at a dose equivalent to 0.5-2 mg/kg/day of prednisone for at least 4-6 weeks; and

- (b) has had an inadequate response, or is intolerant to, immunoglobulin therapy; and

- (c) in whom splenectomy is contraindicated for medical reasons.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of initial application:

(a) a platelet count of less than or equal to 20,000 million per L;

OR

(b) a platelet count of 20-30,000 million per L, where the patient is experiencing significant bleeding or has a history of significant bleeding in this platelet range.

The authority application must be made in writing and must include:

- (1) a completed authority prescription form,
- (2) a signed patient acknowledgement,
- (3) a completed Idiopathic Thrombocytopenic Purpura Initial PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)],
- (4) a copy of a full blood count pathology report supporting the diagnosis of ITP, and
- (5) where the application is sought on the basis of a medical contraindication to surgery, a signed and dated letter from the clinician making this assessment which includes the date upon which the patient was assessed for surgery and the clinical grounds upon which surgery is contraindicated.

The full blood count must be no more than 1 month old at the time of application.

At the time of the written authority application, medical practitioners should request the appropriate quantity of vials of appropriate strength to provide sufficient drug for a single treatment at a dose of 1 microgram/kg. Up to 1 repeat may be requested with the initial written application.

Subsequently during the initial period of dose titration, authority applications for a single dose and up to 1 repeat may be made by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The dose (microgram/kg/week) must be provided at the time of application.

Once a patient's dose has been stable for a period of 4 weeks, authority approvals for sufficient vials of appropriate strength based on the weight of the patient and dose (microgram/kg/week) for up to 4 weeks of treatment and up to 4 repeats may be granted, as long as the total period of treatment authorised under this restriction does not exceed 24 weeks.

Authority approval will not be given for doses of higher than 10 micrograms/kg/week

Authority required

Initial (grandfather patients)

Initial PBS-subsidised treatment, as the sole PBS-subsidised thrombopoietin receptor agonist (TRA), of severe thrombocytopenia in an adult patient with severe chronic immune (idiopathic) thrombocytopenic purpura (ITP) who was receiving treatment with romiplostim prior to 1 April 2011 and in whom the criteria for initial treatment can be demonstrated to have been met at the time romiplostim was commenced.

The authority application must be made in writing and must include:

- (1) a completed authority prescription form,
- (2) a signed patient acknowledgement,
- (3) a completed Idiopathic Thrombocytopenic Purpura Initial PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)], and
- (4) where the application is sought on the basis of a medical contraindication to surgery, a signed and dated letter from the clinician making this assessment which includes the date upon which the patient was assessed for surgery and the clinical grounds upon which surgery is contraindicated.

For patients whose dose of romiplostim had been stable for at least 4 weeks at the time of the initial application for PBS-subsidy, the medical practitioner should request sufficient number of vials based on the weight of the patient and dose (microgram/kg/week) to provide up to 4 weeks of treatment. Up to a maximum of 5 repeats may be authorised.

Where the patient is in the titration phase of treatment with romiplostim, medical practitioners should request the appropriate quantity of vials of appropriate strength to provide sufficient drug for a single treatment at a dose of 1 microgram/kg. Up to 1 repeat may be requested with the initial written application.

Subsequently during the initial period of dose titration, authority applications for a single dose and up to 1 repeat may be made by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The dose (microgram/kg/week) must be provided at the time of application.

Once a patient's dose has been stable for a period of 4 weeks, authority approvals for sufficient vials of appropriate strength based on the weight of the patient and dose (microgram/kg/week) for up to 4 weeks of treatment and up to 4 repeats may be granted, as long as the total period of treatment authorised under this restriction does not exceed 24 weeks.

Authority approval will not be given for doses of higher than 10 micrograms/kg/week

Authority required

Continuing therapy or re-initiation after a break in therapy

First period of PBS-subsidised continuing treatment or re-initiation of interrupted PBS-subsidised treatment, as the sole PBS-subsidised thrombopoietin receptor agonist (TRA), of severe thrombocytopenia in an adult patient with chronic immune (idiopathic) thrombocytopenic purpura (ITP) who has displayed a sustained platelet response to treatment with romiplostim during the initial period of PBS-subsidised treatment.

For the purposes of this restriction, a sustained platelet response is defined as:

(a) use of rescue medication (corticosteroids or immunoglobulins) on no more than one occasion during the initial period of PBS-subsidised romiplostim,

AND either of the following:

(b) a platelet count greater than or equal to 50,000 million per L on at least four (4) occasions, each at least one week apart;

OR

(c) a platelet count greater than 30,000 million per L and which is double the baseline (pre-treatment) platelet count on at least four (4) occasions, each at least one week apart.

Applications for the first period of continuing PBS-subsidised treatment or re-initiation of interrupted treatment must be made in writing and must include:

- (1) a completed authority prescription form, and

- (2) a completed Idiopathic Thrombocytopenic Purpura Continuing PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)], and
(3) copies of the platelet count pathology reports (unless previously provided for patients re-initiating therapy).
The most recent platelet count must be no more than one month old at the time of application.

The medical practitioner should request sufficient number of vials of appropriate strength based on the weight of the patient and dose (microgram/kg/week) to provide 4 weeks of treatment. Up to a maximum of 5 repeats may be authorised.

Where fewer than 5 repeats are initially requested with the authority prescription, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be made by telephone.

Authority approval will not be given for doses of higher than 10 micrograms/kg/week

Authority required

Second and subsequent applications for continuing therapy

Continuing treatment, as the sole PBS-subsidised thrombopoietin receptor agonist (TRA), of severe thrombocytopenia in an adult patient with chronic immune (idiopathic) thrombocytopenic purpura (ITP) who has previously received PBS-subsidised therapy with romiplostim and who continues to display a response to treatment with romiplostim.

For the purposes of this restriction, a continuing response to treatment with romiplostim is defined as:

(a) use of rescue medication (corticosteroids or immunoglobulins) on no more than one occasion during the most recent 24 week period of PBS-subsidised treatment with romiplostim,

AND either of the following:

(b) a platelet count greater than or equal to 50,000 million per L

OR

(c) a platelet count greater than 30,000 million per L and which is double the baseline platelet count.

Platelet counts must be no more than 1 month old at the time of application.

Authority applications for second and subsequent periods of continuing therapy may be made by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

The medical practitioner should request sufficient number of vials of appropriate strength based on the weight of the patient and dose (microgram/kg/week) to provide 4 weeks of treatment. Up to a maximum of 5 repeats may be authorised.

Authority approval will not be given for doses of higher than 10 micrograms/kg/week

Note

Romiplostim is not PBS-subsidised as an alternative to splenectomy.

Any queries concerning the arrangements to prescribe romiplostim may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authority to prescribe romiplostim should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Further prescribing information is on the Medicare Australia website at www.medicareaustralia.gov.au.

Patients will be able to trial either eltrombopag and/or romiplostim within the initial 24 weeks treatment period. Patients who fail to demonstrate a response to treatment with either eltrombopag and/or romiplostim under the initial restriction will not be eligible to receive further PBS-subsidised treatment with either of these drugs.

Special Pricing Arrangements apply.

romiplostim 250 microgram injection, 1 x 250 microgram vial

9697J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	1023.36	Nplate [AN]

romiplostim 500 microgram injection, 1 x 500 microgram vial

9699L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	2001.76	Nplate [AN]

■ ANTIANEMIC PREPARATIONS

OTHER ANTIANEMIC PREPARATIONS

Other antianemic preparations

■ DARBEPOETIN ALFA

Authority required

Treatment of anaemia requiring transfusion, defined as a haemoglobin level of less than 100 g per L, where intrinsic renal disease, as assessed by a nephrologist, is the primary cause of the anaemia

darbepoetin alfa 10 microgram/0.4 mL injection, 4 x 0.4 mL syringes

6320P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*377.08	Aranesp [AN]

darbepoetin alfa 100 microgram/0.5 mL injection, 1 x 0.5 mL syringe

6492Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	8	5	..	*2667.24	Aranesp SureClick [AN]

darbepoetin alfa 100 microgram/0.5 mL injection, 4 x 0.5 mL syringes

6326Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2667.26	Aranesp [AN]

darbepoetin alfa 150 microgram/0.3 mL injection, 1 x 0.3 mL syringe

6493R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	8	5	..	*3951.24	Aranesp SureClick [AN]

darbepoetin alfa 150 microgram/0.3 mL injection, 4 x 0.3 mL syringes

6365B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3951.26	Aranesp [AN]

darbepoetin alfa 20 microgram/0.5 mL injection, 1 x 0.5 mL syringe

6488L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	8	5	..	*704.20	Aranesp SureClick [AN]

darbepoetin alfa 20 microgram/0.5 mL injection, 4 x 0.5 mL syringes

6321Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*704.20	Aranesp [AN]

darbepoetin alfa 30 microgram/0.3 mL injection, 4 x 0.3 mL syringes

6322R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*960.92	Aranesp [AN]

darbepoetin alfa 40 microgram/0.4 mL injection, 1 x 0.4 mL syringe

6489M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	8	5	..	*1160.36	Aranesp SureClick [AN]

darbepoetin alfa 40 microgram/0.4 mL injection, 4 x 0.4 mL syringes

6323T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1160.36	Aranesp [AN]

darbepoetin alfa 50 microgram/0.5 mL injection, 4 x 0.5 mL syringes

6324W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1423.54	Aranesp [AN]

darbepoetin alfa 60 microgram/0.3 mL injection, 1 x 0.3 mL syringe

6490N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	8	5	..	*1663.40	Aranesp SureClick [AN]

darbepoetin alfa 60 microgram/0.3 mL injection, 4 x 0.3 mL syringes

6325X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1663.42	Aranesp [AN]

darbepoetin alfa 80 microgram/0.4 mL injection, 1 x 0.4 mL syringe

6491P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	8	5	..	*2174.76	Aranesp SureClick [AN]

darbepoetin alfa 80 microgram/0.4 mL injection, 4 x 0.4 mL syringes

6438W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2174.76	Aranesp [AN]

■ EPOETIN ALFA**Authority required**

Treatment of anaemia requiring transfusion, defined as a haemoglobin level of less than 100 g per L, where intrinsic renal disease, as assessed by a nephrologist, is the primary cause of the anaemia

epoetin alfa 10 000 international units/mL injection, 6 x 1 mL syringes

6207Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2017.06	Eprex 10000 [JC]

epoetin alfa 1000 international units/0.5 mL injection, 6 x 0.5 mL syringes

6251B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*297.24	Eprex 1000 [JC]

epoetin alfa 20 000 international units/0.5 mL injection, 6 x 0.5 mL syringes

6434P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3922.76	Eprex 20,000 [JC]

epoetin alfa 2000 international units/0.5 mL injection, 6 x 0.5 mL syringes

6204M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*544.24	Eprex 2000 [JC]

epoetin alfa 3000 international units/0.3 mL injection, 6 x 0.3 mL syringes

6205N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*700.34	Eprex 3000 [JC]

epoetin alfa 40 000 international units/mL injection, 1 x 1 mL syringe

6339P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1300.76	Eprex 40,000 [JC]

epoetin alfa 4000 international units/0.4 mL injection, 6 x 0.4 mL syringes

6206P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*890.04	Eprex 4000 [JC]

epoetin alfa 5000 international units/0.5 mL injection, 6 x 0.5 mL syringes

6302Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1104.10	Eprex 5000 [JC]

epoetin alfa 6000 international units/0.6 mL injection, 6 x 0.6 mL syringes

6303R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1301.90	Eprex 6000 [JC]

epoetin alfa 8000 international units/0.8 mL injection, 6 x 0.8 mL syringes

6305W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1674.68	Eprex 8000 [JC]

■ EPOETIN BETA**Authority required**

Treatment of anaemia requiring transfusion, defined as a haemoglobin level of less than 100 g per L, where intrinsic renal disease, as assessed by a nephrologist, is the primary cause of the anaemia

epoetin beta 10 000 international units/0.6 mL injection, 6 x 0.6 mL syringes

6485H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2017.06	NeoRecormon [RO]

epoetin beta 2000 international units/0.3 mL injection, 6 x 0.3 mL syringes

6480C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*544.24	NeoRecormon [RO]

epoetin beta 3000 international units/0.3 mL injection, 6 x 0.3 mL syringes

6481D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*700.34	NeoRecormon [RO]

epoetin beta 4000 international units/0.3 mL injection, 6 x 0.3 mL syringes

6482E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*890.04	NeoRecormon [RO]

epoetin beta 5000 international units/0.3 mL injection, 6 x 0.3 mL syringes

6483F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1104.12	NeoRecormon [RO]

epoetin beta 6000 international units/0.3 mL injection, 6 x 0.3 mL syringes

6484G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1301.90	NeoRecormon [RO]

▪ **EPOETIN LAMBDA****Authority required**

Treatment of anaemia requiring transfusion, defined as a haemoglobin level of less than 100 g per L, where intrinsic renal disease, as assessed by a nephrologist, is the primary cause of the anaemia

Note

Epoetin lambda should only be administered by the intravenous route.

epoetin lambda 10 000 international units/mL injection, 6 x 1 mL syringes

9595B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1913.36	Novicrit [SZ]

epoetin lambda 1000 international units/0.5 mL injection, 6 x 0.5 mL syringes

9685R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*281.94	Novicrit [SZ]

epoetin lambda 2000 international units/mL injection, 6 x 1 mL syringes

9686T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*515.94	Novicrit [SZ]

epoetin lambda 3000 international units/0.3 mL injection, 6 x 0.3 mL syringes

9687W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*663.84	Novicrit [SZ]

epoetin lambda 4000 international units/0.4 mL injection, 6 x 0.4 mL syringes

9688X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*843.54	Novicrit [SZ]

epoetin lambda 5000 international units/0.5 mL injection, 6 x 0.5 mL syringes

9588P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1048.46	Novicrit [SZ]

epoetin lambda 6000 international units/0.6 mL injection, 6 x 0.6 mL syringes

9590R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1235.84	Novicrit [SZ]

epoetin lambda 8000 international units/0.8 mL injection, 6 x 0.8 mL syringes

9593X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1589.00	Novicrit [SZ]

▪ **METHOXY POLYETHYLENE GLYCOL-EPOETIN BETA****Authority required**

Treatment of anaemia requiring transfusion, defined as a haemoglobin level of less than 100 g per L, where intrinsic renal disease, as assessed by a nephrologist, is the primary cause of the anaemia

methoxy polyethylene glycol-epoetin beta 100 microgram/0.3 mL injection, 1 x 0.3 mL syringe

9577C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1205.58	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 120 microgram/0.3 mL injection, 1 x 0.3 mL syringe

9578D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1388.40	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 200 microgram/0.3 mL injection, 1 x 0.3 mL syringe

9579E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1971.06	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 30 microgram/0.3 mL injection, 1 x 0.3 mL syringe

9574X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*390.70	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 360 microgram/0.6 mL injection, 1 x 0.6 mL syringe

9580F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3373.28	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 50 microgram/0.3 mL injection, 1 x 0.3 mL syringe

9575Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*646.68	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 75 microgram/0.3 mL injection, 1 x 0.3 mL syringe

9576B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*938.62	Mircera [RO]

■ **CARDIOVASCULAR SYSTEM**■ **ANTIHYPERTENSIVES****OTHER ANTIHYPERTENSIVES***Antihypertensives for pulmonary arterial hypertension*■ **AMBRISENTAN****Caution**

This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**

Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**

Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR

Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**

Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the TGA-approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND** Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

- (i) RHC composite assessment; and
- (ii) ECHO composite assessment; and
- (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

- (i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or
- (ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR

Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and
- (3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents:

Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 7 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment.

Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent.

For eligible patients, applications to swap between the 7 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note

Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or Continuing treatment (all patients) – balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Continuing treatment (all patients) restriction to complete a maximum of six months of treatment, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**

The treatment must provide no more than the balance of up to six months treatment available under the above restrictions.

Note

Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authorisation under this criterion should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Continuing treatment (all patients)

Clinical criteria:

Patient must have received approval for initial PBS-subsidised treatment with this agent, **AND**

Patient must have been assessed by a physician from a designated hospital to have achieved a response to their most recent course of treatment with this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments plus 6MWT;
- (2) RHC plus ECHO composite assessments;
- (3) RHC composite assessment plus 6MWT;
- (4) ECHO composite assessment plus 6MWT;
- (5) RHC composite assessment only;
- (6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with each written continuing treatment application (i.e., every 6 months), except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

The assessment of the patient's response to the first and subsequent 6 month courses of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Applications for continuing treatment with a PAH agent should be made prior to the completion of the 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

ambrisentan 10 mg tablet, 30

9649W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	2923.23	Volibris [GK]

ambrisentan 5 mg tablet, 30

9648T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	2923.23	Volibris [GK]

■ BOSENTAN

Caution

This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND** Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**

Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR

Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**

Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) two completed authority prescription forms; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND** Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease; OR

Patient must have WHO Functional Class III or IV pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology), **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) two completed authority prescription forms; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

- (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR

Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) two completed authority prescription forms; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and
- (3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents:

Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 7 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment.

Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent.

For eligible patients, applications to swap between the 7 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note

Where the 62.5 mg tablet strength is required for the second authority prescription, please contact the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) for further advice.

The approved second authority prescription will be returned to the prescriber by the Department of Human Services two weeks after the date of the approval of the first authority prescription, to allow for the uninterrupted completion of the six months initial treatment course. The Department of Human Services will contact prescribers prior to dispatch of the second authority prescription to confirm the tablet strength required for the patient.

Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or Continuing treatment (all patients) – balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Continuing treatment (all patients) restriction to complete a maximum of six months of treatment, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**

The treatment must provide no more than the balance of up to six months treatment available under the above restrictions.

Note

Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authorisation under this criterion should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Continuing treatment (all patients)

Clinical criteria:

Patient must have received approval for initial PBS-subsidised treatment with this agent, **AND**

Patient must have been assessed by a physician from a designated hospital to have achieved a response to their most recent course of treatment with this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments plus 6MWT;
- (2) RHC plus ECHO composite assessments;
- (3) RHC composite assessment plus 6MWT;
- (4) ECHO composite assessment plus 6MWT;
- (5) RHC composite assessment only;
- (6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with each written continuing treatment application (i.e., every 6 months), except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

The assessment of the patient's response to the first and subsequent 6 month courses of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Applications for continuing treatment with a PAH agent should be made prior to the completion of the 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

bosentan 125 mg tablet, 60

6430K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	2923.23	Tracleer [AT]

■ BOSENTAN

Caution

This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**

Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**

Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR

Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**

Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) two completed authority prescription forms; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

- (i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or
- (ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**

Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease; OR

Patient must have WHO Functional Class III or IV pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology), **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) two completed authority prescription forms; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR

Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) two completed authority prescription forms; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and
- (3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents:

Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 7 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment.

Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent.

For eligible patients, applications to swap between the 7 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note

Where the 62.5 mg tablet strength is required for the second authority prescription, please contact the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) for further advice.

The approved second authority prescription will be returned to the prescriber by the Department of Human Services two weeks after the date of the approval of the first authority prescription, to allow for the uninterrupted completion of the six months initial treatment course. The Department of Human Services will contact prescribers prior to dispatch of the second authority prescription to confirm the tablet strength required for the patient.

Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or Continuing treatment (all patients) – balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Continuing treatment (all patients) restriction to complete a maximum of six months of treatment, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**

The treatment must provide no more than the balance of up to six months treatment available under the above restrictions.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Continuing treatment (all patients)

Clinical criteria:

Patient must have received approval for initial PBS-subsidised treatment with this agent, **AND**

Patient must have been assessed by a physician from a designated hospital to have achieved a response to their most recent course of treatment with this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;

(2) RHC plus ECHO composite assessments;

(3) RHC composite assessment plus 6MWT;

(4) ECHO composite assessment plus 6MWT;

(5) RHC composite assessment only;

(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with each written continuing treatment application (i.e., every 6 months), except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

The assessment of the patient's response to the first and subsequent 6 month courses of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Applications for continuing treatment with a PAH agent should be made prior to the completion of the 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Cessation of treatment (all patients)

Clinical criteria:

Patient must have received approval for initial PBS-subsidised treatment with this agent, **AND**

Patient must have not responded to prior PBS-subsidised therapy with this agent, **AND**

The treatment must be for the purpose of gradual dose reduction prior to ceasing therapy, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment. Treatment beyond 1 month will not be approved.

Note

Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authorisation under this criterion should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

bosentan 62.5 mg tablet, 60

6429J

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
1	2923.23	Tracleer [AT]

■ **EPOPROSTENOL**

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**

Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

- (i) RHC composite assessment; and
- (ii) ECHO composite assessment; and
- (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

- (i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or
- (ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (change or re-commencement of therapy for all patients)

Clinical criteria:

Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR

Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and must have received prior treatment with a PBS-subsidised PAH agent other than this agent; OR

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and must have failed to respond to a prior PBS-subsidised PAH agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and
- (3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent; and
- (4) for WHO Functional Class III patients, where this is the first application for this agent, assessment details of the PBS-subsidised PAH agent they have failed to respond to.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents:

Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 7 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment.

Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 7 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note

Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients) or Initial 2 (change or re-commencement of therapy for all patients) or Continuing treatment (all patients) – balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 2 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Continuing treatment (all patients) restriction to complete a maximum of six months of treatment, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**

The treatment must provide no more than the balance of up to six months treatment available under the above restrictions.

Note

Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authorisation under this criterion should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Continuing treatment (all patients)

Clinical criteria:

Patient must have received approval for initial PBS-subsidised treatment with this agent, **AND**

Patient must have been assessed by a physician from a designated hospital to have achieved a response to their most recent course of treatment with this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

- (i) RHC composite assessment; and
- (ii) ECHO composite assessment; and
- (iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments plus 6MWT;
- (2) RHC plus ECHO composite assessments;
- (3) RHC composite assessment plus 6MWT;
- (4) ECHO composite assessment plus 6MWT;
- (5) RHC composite assessment only;
- (6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with each written continuing treatment application (i.e., every 6 months), except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

The assessment of the patient's response to the first and subsequent 6 month courses of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Applications for continuing treatment with a PAH agent should be made prior to the completion of the 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Pharmaceutical benefits that have the form epoprostenol sodium powder for I.V. infusion 1.5 mg (base) infusion administration set and pharmaceutical benefits that have the form epoprostenol 1.5 mg injection vial are equivalent for the purposes of substitution.

Pharmaceutical benefits that have the form epoprostenol sodium powder for I.V. infusion 500 micrograms (base) infusion administration set and pharmaceutical benefits that have the form epoprostenol 500 microgram injection vial are equivalent for the purposes of substitution.

EPOPROSTENOL SODIUM Powder for I.V. infusion 1.5 mg (base) infusion administration set, 1

5042J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	77.31	^a Flolan Kit [GK]

EPOPROSTENOL SODIUM Powder for I.V. infusion 500 micrograms (base) infusion administration set, 1

5036C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	43.37	^a Flolan Kit [GK]

epoprostenol 1.5 mg injection, 1 x 1.5 mg vial

10129D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	77.31	^a Veletri [AT]

epoprostenol 500 microgram injection, 1 x 500 microgram vial

10111E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	43.37	^a Veletri [AT]

■ ILOPROST

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with this agent, **AND**

Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III drug-induced PAH, **AND**

Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR

Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**

Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

- (i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or
- (ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the TGA-approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**

Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III drug-induced PAH and a mean right atrial pressure greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR
 Patient must have WHO Functional Class III drug-induced PAH with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR
 Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH; OR
 Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease; OR
 Patient must have WHO Functional Class IV drug-induced PAH, **AND**
 The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

- (i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or
- (ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease or drug-induced PAH and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR

Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and must have received prior treatment with a PBS-subsidised PAH agent other than this agent; OR

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and must have failed to respond to a prior PBS-subsidised PAH agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and

(3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent; and
 (4) for WHO Functional Class III patients, where this is the first application for this agent, assessment details of the PBS-subsidised PAH agent they have failed to respond to.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents:

Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 7 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment.

Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent.

For eligible patients, applications to swap between the 7 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note

Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or Continuing treatment (all patients) – balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Continuing treatment (all patients) restriction to complete a maximum of six months of treatment, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**

The treatment must provide no more than the balance of up to six months treatment available under the above restrictions.

Note

Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authorisation under this criterion should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Continuing treatment (all patients)

Clinical criteria:

Patient must have received approval for initial PBS-subsidised treatment with this agent, **AND**

Patient must have been assessed by a physician from a designated hospital to have achieved a response to their most recent course of treatment with this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments plus 6MWT;
- (2) RHC plus ECHO composite assessments;
- (3) RHC composite assessment plus 6MWT;
- (4) ECHO composite assessment plus 6MWT;
- (5) RHC composite assessment only;
- (6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with each written continuing treatment application (i.e., every 6 months), except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

The assessment of the patient's response to the first and subsequent 6 month courses of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Applications for continuing treatment with a PAH agent should be made prior to the completion of the 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.
Special Pricing Arrangements apply.

iloprost 20 microgram/2 mL inhalation: solution, 30 x 2 mL ampoules

6456T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	1122.76	Ventavis [BN]

▪ **MACITENTAN**

Caution

This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**

Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**

Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR

Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**

Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

- (i) RHC composite assessment; and
- (ii) ECHO composite assessment; and
- (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

- (i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or
- (ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the TGA-approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**

Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease; OR

Patient must have WHO Functional Class III or IV pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology), **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

- (i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or
- (ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and
- (3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents:

Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 7 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment.

Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent.

For eligible patients, applications to swap between the 7 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note

Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or Continuing treatment (all patients) – balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Continuing treatment (all patients) restriction to complete a maximum of six months of treatment, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
The treatment must provide no more than the balance of up to six months treatment available under the above restrictions.

Note

Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authorisation under this criterion should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Continuing treatment (all patients)

Clinical criteria:

Patient must have received approval for initial PBS-subsidised treatment with this agent, **AND**

Patient must have been assessed by a physician from a designated hospital to have achieved a response to their most recent course of treatment with this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments plus 6MWT;
- (2) RHC plus ECHO composite assessments;
- (3) RHC composite assessment plus 6MWT;
- (4) ECHO composite assessment plus 6MWT;
- (5) RHC composite assessment only;
- (6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with each written continuing treatment application (i.e., every 6 months), except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

The assessment of the patient's response to the first and subsequent 6 month courses of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Applications for continuing treatment with a PAH agent should be made prior to the completion of the 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

macitentan 10mg tablet, 30

10134J

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
1	2923.23	Opsumit [AT]

■ SILDENAFIL

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**

Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**

Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR

Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**

Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated,

details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the TGA-approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**

Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

- (i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or
- (ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and
- (3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents:

Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 7 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment.

Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent.

For eligible patients, applications to swap between the 7 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note

Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or Continuing treatment (all patients) – balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR
 Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR
 Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR
 Patient must have received insufficient therapy with this agent under the Continuing treatment (all patients) restriction to complete a maximum of six months of treatment, **AND**
 The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
 The treatment must provide no more than the balance of up to six months treatment available under the above restrictions.

Note

Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authorisation under this criterion should be forwarded to:

Department of Human Services
 Prior Written Approval of Complex Drugs
 Reply Paid 9826
 GPO Box 9826

HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)
 Treatment Phase: Continuing treatment (all patients)

Clinical criteria:

Patient must have received approval for initial PBS-subsidised treatment with this agent, **AND**

Patient must have been assessed by a physician from a designated hospital to have achieved a response to their most recent course of treatment with this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments plus 6MWT;
- (2) RHC plus ECHO composite assessments;
- (3) RHC composite assessment plus 6MWT;
- (4) ECHO composite assessment plus 6MWT;
- (5) RHC composite assessment only;
- (6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with each written continuing treatment application (i.e., every 6 months), except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

The assessment of the patient's response to the first and subsequent 6 month courses of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Applications for continuing treatment with a PAH agent should be made prior to the completion of the 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

sildenafil 20 mg tablet, 90

9605M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	..	..	791.63	^a APO-Sildenafil PHT [TX] ^a Sildenafil AN PHT 20 [EA] ^a Sildenafil Sandoz PHT 20 [SZ]	^a Revatio [PF] ^a SILDENAFIL-DRx [RZ]

■ TADALAFIL

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**

Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**

Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR

Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**

Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

- (i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or
- (ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the TGA-approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**

Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

- (i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or
- (ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and
- (3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents:

Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 7 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment.

Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent.

For eligible patients, applications to swap between the 7 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note

Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or Continuing treatment (all patients) – balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Continuing treatment (all patients) restriction to complete a maximum of six months of treatment, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**

The treatment must provide no more than the balance of up to six months treatment available under the above restrictions.

Note

Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authorisation under this criterion should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Continuing treatment (all patients)

Clinical criteria:

Patient must have received approval for initial PBS-subsidised treatment with this agent, **AND**

Patient must have been assessed by a physician from a designated hospital to have achieved a response to their most recent course of treatment with this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments plus 6MWT;
- (2) RHC plus ECHO composite assessments;
- (3) RHC composite assessment plus 6MWT;
- (4) ECHO composite assessment plus 6MWT;
- (5) RHC composite assessment only;
- (6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with each written continuing treatment application (i.e., every 6 months), except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

The assessment of the patient's response to the first and subsequent 6 month courses of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Applications for continuing treatment with a PAH agent should be made prior to the completion of the 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

tadalafil 20 mg tablet, 56

1304P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	878.83	Addcirca [LY]

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES

HYPOTHALAMIC HORMONES

Somatostatin and analogues

LANREOTIDE

Authority required

Acromegaly

Clinical criteria:

The condition must be active, **AND**

Patient must have persistent elevation of mean growth hormone levels of greater than 2.5 micrograms per litre, **AND**

The treatment must be after failure of other therapy including dopamine agonists; OR

The treatment must be as interim treatment while awaiting the effects of radiotherapy and where treatment with dopamine agonists has failed; OR

The treatment must be in a patient who is unfit for or unwilling to undergo surgery and where radiotherapy is contraindicated, **AND**

The treatment must cease in a patient treated with radiotherapy if there is biochemical evidence of remission (normal IGF1) after lanreotide has been withdrawn for at least 4 weeks (6 weeks after the last dose), **AND**

The treatment must cease if IGF1 is not lower after 3 months of treatment.

In a patient treated with radiotherapy, lanreotide should be withdrawn every 2 years in the 10 years after radiotherapy for assessment of remission.

lanreotide 30 mg injection: modified release [1 x 30 mg vial] (&) inert substance diluent [1 x 2 mL ampoule], 1 pack

6332G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*1546.76	Somatuline LA [IS]

LANREOTIDE

Authority required

Acromegaly

Clinical criteria:

The condition must be active, **AND**

Patient must have persistent elevation of mean growth hormone levels of greater than 2.5 micrograms per litre, **AND**

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

The treatment must be after failure of other therapy including dopamine agonists; OR

The treatment must be as interim treatment while awaiting the effects of radiotherapy and where treatment with dopamine agonists has failed; OR

The treatment must be in a patient who is unfit for or unwilling to undergo surgery and where radiotherapy is contraindicated, **AND**

The treatment must cease in a patient treated with radiotherapy if there is biochemical evidence of remission (normal IGF1) after lanreotide has been withdrawn for at least 4 weeks (8 weeks after the last dose), **AND**

The treatment must cease if IGF1 is not lower after 3 months of treatment.

In a patient treated with radiotherapy, lanreotide should be withdrawn every 2 years in the 10 years after radiotherapy for assessment of remission.

Authority required

Functional carcinoid tumour

Clinical criteria:

The condition must be causing intractable symptoms, **AND**

Patient must have experienced on average over 1 week, 3 or more episodes per day of diarrhoea and/or flushing, which persisted despite the use of anti-histamines, anti-serotonin agents and anti-diarrhoea agents, **AND**

Patient must be one in whom surgery or antineoplastic therapy has failed or is inappropriate, **AND**

The treatment must cease if there is failure to produce a clinically significant reduction in the frequency and severity of symptoms after 3 months' therapy at a dose of 120 mg every 28 days.

Dosage and tolerance to the drug should be assessed regularly and the dosage should be titrated slowly downwards to determine the minimum effective dose.

lanreotide 120 mg injection, 1 syringe

6425E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*4526.76	Somatuline Autogel [IS]

lanreotide 60 mg injection, 1 syringe

6423C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2736.76	Somatuline Autogel [IS]

lanreotide 90 mg injection, 1 syringe

6424D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3626.76	Somatuline Autogel [IS]

■ OCTREOTIDE

Authority required

Active acromegaly in a patient with persistent elevation of mean growth hormone levels of greater than 2.5 micrograms per litre **AND**

(a) after failure of other therapy including dopamine agonists; or

(b) as interim treatment while awaiting the effects of radiotherapy and where treatment with dopamine agonists has failed; or

(c) if the patient is unfit for or unwilling to undergo surgery and where radiotherapy is contraindicated.

In a patient treated with radiotherapy, treatment must cease if there is biochemical evidence of remission (normal IGF1) after octreotide has been withdrawn for at least 4 weeks. Octreotide should be withdrawn every 2 years in the 10 years after radiotherapy for assessment of remission.

Treatment must cease if IGF1 is not lower after 3 months treatment at a dose of 100 micrograms 3 times daily

Authority required

Functional carcinoid tumour or vasoactive intestinal peptide secreting tumour (VIPoma) causing intractable symptoms. The patient must have experienced on average over 1 week, 3 or more episodes per day of diarrhoea and/or flushing, which persisted despite the use of anti-histamines, anti-serotonin agents and anti-diarrhoea agents, and surgery or antineoplastic therapy must have failed or be inappropriate.

Treatment must cease if there is failure to produce a clinically significant reduction in the frequency and severity of symptoms after 2 months' therapy. Dosage and tolerance to the drug should be assessed regularly and the dosage should be titrated slowly downwards to determine the minimum effective dose

octreotide 100 microgram/mL injection, 5 x 1 mL ampoules

6228T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	18	11	..	*1283.14	^a Hospira Pty Limited [HH] ^a Octreotide (SUN) [ZF]	^a Octreotide MaxRx [GQ] ^a Sandostatin 0.1 [NV]

octreotide 50 microgram/mL injection, 5 x 1 mL ampoules

6227R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	18	11	..	*650.62	^a Hospira Pty Limited [HH] ^a Octreotide (SUN) [ZF]	^a Octreotide MaxRx [GQ] ^a Sandostatin 0.05 [NV]

octreotide 500 microgram/mL injection, 5 x 1 mL ampoules

6229W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	18	11	..	*6241.24	^a Hospira Pty Limited [HH] ^a Octreotide (SUN) [ZF]	^a Octreotide MaxRx [GQ] ^a Sandostatin 0.5 [NV]

■ OCTREOTIDE

Authority required

Acromegaly

Clinical criteria:

The condition must be controlled with octreotide immediate release injections, **AND**

The treatment must cease in a patient treated with radiotherapy if there is biochemical evidence of remission (normal IGF1) after octreotide has been withdrawn for at least 4 weeks (8 weeks after the last dose), **AND**

The treatment must cease if IGF1 is not lower after 3 months of treatment.

In a patient treated with radiotherapy, octreotide should be withdrawn every 2 years in the 10 years after radiotherapy for assessment of remission

Authority required

Functional carcinoid tumour

Clinical criteria:

Patient must have achieved symptom control on octreotide immediate release injections, **AND**

The treatment must cease if there is failure to produce a clinically significant reduction in the frequency and severity of symptoms after 3 months' therapy at a dose of 30 mg every 28 days and having allowed adequate rescue therapy with octreotide immediate release injections.

Dosage and tolerance to the drug should be assessed regularly and the dosage should be titrated slowly downwards to determine the minimum effective dose.

Authority required

Vasoactive intestinal peptide secreting tumour (VIPoma)

Clinical criteria:

Patient must have achieved symptom control on octreotide immediate release injections, **AND**

The treatment must cease if there is failure to produce a clinically significant reduction in the frequency and severity of symptoms after 3 months' therapy at a dose of 30 mg every 28 days and having allowed adequate rescue therapy with octreotide immediate release injections.

Dosage and tolerance to the drug should be assessed regularly and the dosage should be titrated slowly downwards to determine the minimum effective dose.

octreotide 10 mg injection: modified release [1 x 10 mg vial] (&) inert substance diluent [1 x 2.5 mL syringe], 1 pack

6426F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2660.48	Sandostatin LAR [NV]

octreotide 20 mg injection: modified release [1 x 20 mg vial] (&) inert substance diluent [1 x 2.5 mL syringe], 1 pack

6427G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3526.38	Sandostatin LAR [NV]

octreotide 30 mg injection: modified release [1 x 30 mg vial] (&) inert substance diluent [1 x 2.5 mL syringe], 1 pack

6428H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*4401.68	Sandostatin LAR [NV]

■ CALCIUM HOMEOSTASIS

ANTI-PARATHYROID AGENTS

Other anti-parathyroid agents

■ CINACALCET

Authority required

Management, including initiation and stabilisation, by a nephrologist, of a patient with chronic kidney disease on dialysis who has sustained secondary hyperparathyroidism with iPTH of at least 50 pmol per L, not responding to conventional therapy

Authority required

Management, including initiation and stabilisation, by a nephrologist, of a patient with chronic kidney disease on dialysis who has sustained secondary hyperparathyroidism with iPTH of at least 15 pmol per L and less than 50 pmol per L AND an (adjusted) serum calcium concentration at least 2.6 mmol per L, not responding to conventional treatment

Note

During the titration phase, intact PTH should be monitored 4 weekly (measured at least 12 hours post dose) and dose titrated until an appropriate iPTH concentration is achieved. During the titration phase, approval will be limited to sufficient supply for 4 weeks treatment at a time, with doses between 30 and 180 mg per day according to the patient's response and tolerability.

During the maintenance phase, approval will be limited to provide sufficient quantity for 4 weeks treatment up to a maximum of 6 months supply for doses between 30 and 180 mg per day according to the patient's response and tolerability. Intact PTH should be monitored quarterly (measured at least 12 hours post dose) and dose adjusted as necessary to maintain an appropriate iPTH concentration.

ANTIINFECTIVES FOR SYSTEMIC USE

"Sustained" means the abnormality was detected on at least 2 blood samples collected over a period of 2 to 4 months.
Special Pricing Arrangements apply.

cinacalcet 30 mg tablet, 28

9625N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*408.12	Sensipar [AN]

cinacalcet 60 mg tablet, 28

9626P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*809.48	Sensipar [AN]

cinacalcet 90 mg tablet, 28

9627Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1204.52	Sensipar [AN]

■ ANTIINFECTIVES FOR SYSTEMIC USE

■ ANTIBACTERIALS FOR SYSTEMIC USE

MACROLIDES, LINCOSAMIDES AND STREPTOGRAMINS

Macrolides

■ AZITHROMYCIN

Authority required

Prophylaxis against Mycobacterium avium complex infections in HIV-positive patients with CD4 cell counts of less than 75 per cubic millimetre

azithromycin 600 mg tablet, 8

6221K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*139.94	Zithromax [PF]

■ CLARITHROMYCIN

Authority required

Treatment of Mycobacterium avium complex infections

clarithromycin 250 mg tablet, 100

6151R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	2	..	28.76	Klacid [GO]

clarithromycin 500 mg tablet, 100

6152T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	2	..	50.68	Klacid [GO]

■ ANTIMYCOBACTERIALS

DRUGS FOR TREATMENT OF TUBERCULOSIS

Antibiotics

■ RIFABUTIN

Authority required

Treatment of Mycobacterium avium complex infections in HIV-positive patients

Authority required

Prophylaxis against Mycobacterium avium complex infections in HIV-positive patients with CD4 cell counts of less than 75 per cubic millimetre

rifabutin 150 mg capsule, 30

6195C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	4	5	..	*680.00	Mycobutin [PF]

■ ANTIVIRALS FOR SYSTEMIC USE

DIRECT ACTING ANTIVIRALS

Nucleosides and nucleotides excl. reverse transcriptase inhibitors

■ GANCICLOVIR

Authority required

Cytomegalovirus retinitis in severely immunocompromised patients

Authority required

Prophylaxis of cytomegalovirus disease in bone marrow transplant patients at risk of cytomegalovirus disease

Authority required

Prophylaxis of cytomegalovirus disease in solid organ transplant patients at risk of cytomegalovirus disease

ganciclovir 500 mg injection, 5 x 500 mg vials

6136Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	1	..	*589.16	Cymevene [RO]

■ **VALACICLOVIR**

Authority required

Prophylaxis of cytomegalovirus (CMV) infection and disease following renal transplantation in patients at risk of CMV disease

valaciclovir 500 mg tablet, 100

6280M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	5	2	..	*637.01	^a APO-Valaciclovir [TX] ^a Valtrex [AS]	^a Valaciclovir RBX [RA] ^a Zelitrex [UA]

■ **VALGANCICLOVIR**

Authority required

Cytomegalovirus retinitis in patients with acquired immunodeficiency syndrome

Authority required

Prophylaxis of cytomegalovirus infection and disease in solid organ transplant patients at risk of cytomegalovirus disease

valganciclovir 450 mg tablet, 60

6357N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*4538.36	Valcyte [RO]

valganciclovir 50 mg/mL oral liquid: powder for, 100 mL

9675F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	11	5	..	*#4624.22	Valcyte [RO]

Phosphonic acid derivatives

■ **FOSCARNET**

Authority required

Treatment of cytomegalovirus retinitis in patients with AIDS

Authority required

Treatment of aciclovir-resistant herpes simplex virus infection in immunocompromised patients with HIV infection

FOSCARNET SODIUM I.V. infusion 24 mg per mL, 250 mL bottle, 6

6134W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	1	..	1224.26	Foscavir [IX]

Protease inhibitors

■ **ATAZANAVIR**

Authority required

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

atazanavir 150 mg capsule, 60

6451M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1090.58	Reyataz [BQ]

atazanavir 200 mg capsule, 60

6452N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1438.52	Reyataz [BQ]

atazanavir 300 mg capsule, 30

9614B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1090.58	Reyataz [BQ]

■ **BOCEPREVIR****Authority required**

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must have received no more than one prior treatment with interferon alfa or peginterferon alfa for hepatitis C, **AND**

The treatment must be in combination with peginterferon alfa and ribavirin, **AND**

The treatment must be limited to a maximum duration of 32 weeks in patients without hepatic cirrhosis who were partial responders or relapsers to the prior course of interferon based therapy for hepatitis C; OR

The treatment must be limited to a maximum duration of 44 weeks in patients without hepatic cirrhosis who were null responders to the prior course of interferon based therapy for hepatitis C; OR

The treatment must be limited to a maximum duration of 44 weeks for all patients with hepatic cirrhosis, **AND**

The treatment must cease after the first 8 weeks of boceprevir treatment if plasma HCV RNA is detectable by an HCV RNA qualitative assay at treatment week 12, **AND**

The treatment must cease after the first 20 weeks of boceprevir treatment if plasma HCV RNA is detectable by an HCV RNA qualitative assay at treatment week 24.

Population criteria:

Patient must be 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Chronic genotype 1 hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Patients who have received prior treatment with an NS3/4A protease inhibitor are not eligible to receive PBS-subsidised boceprevir, except where the patient has developed an intolerance to the other NS3/4A protease inhibitor of a severity necessitating permanent treatment withdrawal. Details of the intolerance must be documented in the patient's medical records.

For patients without hepatic cirrhosis who were partial responders or relapsers to the prior course of interferon based therapy, a maximum of 7 repeats may be prescribed.

For patients without hepatic cirrhosis who were null responders to the prior course of interferon based therapy, a maximum of 10 repeats may be prescribed.

For patients with hepatic cirrhosis, a maximum of 10 repeats may be prescribed.

Authority required

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**

The treatment must be in combination with peginterferon alfa and ribavirin, **AND**

The treatment must be limited to a maximum duration of 24 weeks in patients without hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 44 weeks in patients with hepatic cirrhosis, **AND**

The treatment must cease after the first 20 weeks of boceprevir treatment if plasma HCV RNA is detectable by an HCV RNA qualitative assay at treatment week 24.

Population criteria:

Patient must be 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic genotype 1 hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Patients who have received prior treatment with an NS3/4A protease inhibitor are not eligible to receive PBS-subsidised boceprevir, except where the patient has developed an intolerance to the other NS3/4A protease inhibitor of a severity necessitating permanent treatment withdrawal. Details of the intolerance must be documented in the patient's medical records.

For patients without hepatic cirrhosis, a maximum of 5 repeats may be prescribed.

For patients with hepatic cirrhosis, a maximum of 10 repeats may be prescribed.

Note

No increase in the maximum quantity or number of units may be authorised.

Treatment centres are required to have access to the following appropriate specialist facilities for the provision of clinical support services for hepatitis C:

- (a) a nurse educator/counsellor for patients; and
(b) 24-hour access by patients to medical advice; and

(c) an established liver clinic.

Boceprevir 200 mg capsule, 336 capsules

2435E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	10	..	3966.76	Victrelis [MK]

■ DARUNAVIR

Authority required

Human immunodeficiency virus (HIV) infection

Clinical criteria:

The treatment must be in addition to optimised background therapy, **AND**

The treatment must be in combination with other antiretroviral agents, **AND**

The treatment must be co-administered with 100 mg ritonavir, **AND**

Patient must have experienced virological failure or clinical failure or genotypic resistance after at least one antiretroviral regimen, **AND**

Patient must not have demonstrated darunavir resistance associated mutations detected on resistance testing.

Virological failure is defined as a viral load greater than 400 copies per mL on two consecutive occasions, while clinical failure is linked to emerging signs and symptoms of progressing HIV infection or treatment-limiting toxicity.

darunavir 800 mg tablet, 30

10000H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1445.04	Prezista [JC]

■ DARUNAVIR

Authority required

Treatment of HIV infection, in addition to optimised background therapy in combination with other antiretroviral agents, and co-administered with 100 mg ritonavir twice daily in an antiretroviral experienced patient who, after at least one antiretroviral regimen, has experienced virological failure or clinical failure or genotypic resistance.

Virological failure is defined as a viral load greater than 400 copies per mL on two consecutive occasions, while clinical failure is linked to emerging signs and symptoms of progressing HIV infection or treatment-limiting toxicity

darunavir 150 mg tablet, 240

9581G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	5	..	1095.47	Prezista [JC]

darunavir 600 mg tablet, 60

5000E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2144.18	Prezista [JC]

■ FOSAMPRENAVIR

Authority required

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

fosamprenavir 50 mg/mL oral liquid, 225 mL

6454Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	8	5	..	*851.72	Telzir [VI]

fosamprenavir 700 mg tablet, 60

6453P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*795.42	Telzir [VI]

■ INDINAVIR

Authority required

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

indinavir 400 mg capsule, 180

6202K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*953.16	Crixivan 400 mg [MK]

▪ **RITONAVIR**

Authority required

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

ritonavir 100 mg tablet, 30

9677H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	24	5	..	*1028.92	Norvir [VE]

ritonavir 600 mg/7.5 mL oral liquid, 90 mL

6494T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	10	5	..	*953.16	Norvir [VE]

▪ **SAQUINAVIR**

Authority required

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

saquinavir 500 mg tablet, 120

6498B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1057.88	Invirase [RO]

▪ **SIMEPREVIR**

Authority required

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**

The treatment must be in combination with peginterferon alfa and ribavirin, **AND**

The treatment must be limited to a maximum duration of 12 weeks, **AND**

The treatment must cease if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is 25 IU/mL or greater.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic genotype 1 hepatitis C infection (repeatedly anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Patients who have received prior treatment with an NS3/4A protease inhibitor are not eligible to receive PBS-subsidised simeprevir, except where the patient has developed an intolerance to the other NS3/4A protease inhibitor of a severity necessitating permanent treatment withdrawal. Details of the intolerance must be documented in the patient's medical records.

Authority required

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must have received prior treatment with interferon alfa or peginterferon alfa for hepatitis C, **AND**

The treatment must be in combination with peginterferon alfa and ribavirin, **AND**

The treatment must be limited to a maximum duration of 12 weeks, **AND**

The treatment must cease if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is 25 IU/mL or greater.

Population criteria:

Patient must be 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic genotype 1 hepatitis C infection (repeatedly anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Patients who have received prior treatment with an NS3/4A protease inhibitor are not eligible to receive PBS-subsidised simeprevir, except where the patient has developed an intolerance to the other NS3/4A protease inhibitor of a severity necessitating permanent treatment withdrawal. Details of the intolerance must be documented in the patient's medical records.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Treatment centres are required to have access to the following appropriate specialist facilities for the provision of clinical support services for hepatitis C:

- (a) a nurse educator/counsellor for patients; and
- (b) 24-hour access by patients to medical advice; and

- (c) an established liver clinic.

simeprevir sodium 150 mg capsule, 7

10197Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	6	..	..	*14912.50	Olysio [JC]

▪ **TELAPREVIR**

Authority required

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must not have received prior treatment with interferon alfa or peginterferon alfa for hepatitis C, **AND**

The treatment must be in combination with peginterferon alfa and ribavirin, **AND**

The treatment must be limited to a maximum duration of 12 weeks, **AND**

The treatment must cease if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than 1000 IU/mL.

Population criteria:

Patient must be 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic genotype 1 hepatitis C infection (repeatedly anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Patients who have received prior treatment with an NS3/4A protease inhibitor are not eligible to receive PBS-subsidised telaprevir, except where the patient has developed an intolerance to the other NS3/4A protease inhibitor of a severity

necessitating permanent treatment withdrawal. Details of the intolerance must be documented in the patient's medical records.

Authority required

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must have received prior treatment with interferon alfa or peginterferon alfa for hepatitis C, **AND**

The treatment must be in combination with peginterferon alfa and ribavirin, **AND**

The treatment must be limited to a maximum duration of 12 weeks, **AND**

The treatment must cease if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than 1000 IU/mL.

Population criteria:

Patient must be 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic genotype 1 hepatitis C infection (repeatedly anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Patients who have received prior treatment with an NS3/4A protease inhibitor are not eligible to receive PBS-subsidised telaprevir, except where the patient has developed an intolerance to the other NS3/4A protease inhibitor of a severity necessitating permanent treatment withdrawal. Details of the intolerance must be documented in the patient's medical records.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Treatment centres are required to have access to the following appropriate specialist facilities for the provision of clinical support services for hepatitis C:

- (a) a nurse educator/counsellor for patients; and
- (b) 24-hour access by patients to medical advice; and

- (c) an established liver clinic.

telaprevir 375 mg tablet, 42

2378E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	6	..	..	*14912.50	Incivo [JC]

▪ **TIPRANAVIR**

Authority required

Treatment of HIV infection, in addition to optimised background therapy in combination with other antiretroviral agents, and co-administered with 200 mg ritonavir twice daily in an antiretroviral experienced patient who, after each of at least three different antiretroviral regimens that have included one drug from at least 3 different antiretroviral classes, has experienced virological failure or clinical failure or genotypic resistance.

Virological failure is defined as a viral load greater than 400 copies per mL on two consecutive occasions, while clinical failure is linked to emerging signs and symptoms of progressing HIV infection or treatment-limiting toxicity

Note

Special Pricing Arrangements apply.

tipranavir 250 mg capsule, 120

9610T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2188.76	Aptivus [BY]

Nucleoside and nucleotide reverse transcriptase inhibitors

▪ **ABACAVIR**

Authority required

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

abacavir 20 mg/mL oral liquid, 240 mL

6265R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	8	5	..	*690.20	Ziagen [VI]

abacavir 300 mg tablet, 60

6264Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*593.32	Ziagen [VI]

■ ADEFOVIR DIPIVOXIL**Authority required**

Chronic hepatitis B in a patient without cirrhosis who has failed antihepadnaviral therapy and who satisfies all of the following criteria:

(a) Repeatedly elevated serum ALT levels while on concurrent antihepadnaviral therapy of greater than or equal to 6 months duration in conjunction with documented chronic hepatitis B infection; or

(b) Repeatedly elevated HBV DNA levels one log greater than the nadir value or failure to achieve a 1 log reduction in HBV DNA within 3 months, whilst on previous antihepadnaviral therapy except in patients with evidence of poor compliance

Authority required

Chronic hepatitis B in a patient with cirrhosis who has failed antihepadnaviral therapy and who has detectable HBV DNA. Persons with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy

Note

Patients may receive treatment in combination with lamivudine but not with other PBS-subsidised antihepadnaviral therapy.

adefovir dipivoxil 10 mg tablet, 30

6450L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*1096.76	^a APO-Adefovir [TX]	^a Hepsera [GI]

■ DIDANOSINE**Authority required**

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

didanosine 125 mg capsule: enteric, 30

6298L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*298.86	Videx EC [BQ]

didanosine 200 mg capsule: enteric, 30

6299M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*346.64	Videx EC [BQ]

didanosine 250 mg capsule: enteric, 30

6300N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*431.58	Videx EC [BQ]

didanosine 400 mg capsule: enteric, 30

6301P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*686.48	Videx EC [BQ]

■ EMTRICITABINE**Authority required**

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

emtricitabine 200 mg capsule, 30

6137B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*593.32	Emtriva [GI]

■ ENTECAVIR**Authority required**

Chronic hepatitis B in a patient without cirrhosis who satisfies all of the following criteria:

(1) Elevated HBV DNA levels - greater than 20,000 IU/mL (100,000 copies/mL) if HBeAg positive, or greater than 2,000 IU/mL (10,000 copies/mL) if HBeAg negative - in conjunction with documented chronic hepatitis B infection;

(2) Evidence of chronic liver injury as determined by:

(a) Confirmed elevated serum ALT; or

(b) Liver biopsy

Authority required

Chronic hepatitis B in a patient with cirrhosis who has detectable HBV DNA.

Persons with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy

Note

PBS-subsidised entecavir monohydrate must be used as monotherapy.

entecavir monohydrate 500 microgram tablet, 30

9602J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*806.10	Baraclude [BQ]

■ ENTECAVIR**Authority required**

Chronic hepatitis B in a patient without cirrhosis who has failed lamivudine and who satisfies all of the following criteria:

(a) Repeatedly elevated serum ALT levels while on concurrent antihepadnaviral therapy of greater than or equal to 6 months duration in conjunction with documented chronic hepatitis B infection; or

(b) Repeatedly elevated HBV DNA levels one log greater than the nadir value or failure to achieve a 1 log reduction in HBV DNA within 3 months, whilst on previous antihepadnaviral therapy except in patients with evidence of poor compliance

Authority required

Chronic hepatitis B in a patient with cirrhosis who has failed lamivudine and who has detectable HBV DNA.

Persons with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy

Note

PBS-subsidised entecavir monohydrate must be used as monotherapy.

entecavir monohydrate 1 mg tablet, 30

9603K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1296.76	Baraclude [BQ]

■ LAMIVUDINE**Authority required**

HIV infection

Treatment Phase: Initial

Clinical criteria:Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

lamivudine 10 mg/mL oral liquid, 240 mL

6194B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	8	5	..	*472.52	3TC [VI]

lamivudine 150 mg tablet, 60

6193Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*325.70	^a 3TC [VI] ^a Lamivudine RBX [RA]	^a Lamivudine Alphapharm [AF]

lamivudine 300 mg tablet, 30

6435Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*325.70	^a 3TC [VI] ^a Lamivudine RBX [RA]	^a Lamivudine Alphapharm [AF]

■ LAMIVUDINE**Authority required**

Chronic hepatitis B in a patient without cirrhosis who satisfies all of the following criteria:

(1) Elevated HBV DNA levels - greater than 20,000 IU/mL (100,000 copies/mL) if HBeAg positive, or greater than 2,000 IU/mL (10,000 copies/mL) if HBeAg negative - in conjunction with documented chronic hepatitis B infection;

(2) Evidence of chronic liver injury as determined by:

(a) Confirmed elevated serum ALT; or

(b) Liver biopsy

Authority required

Chronic hepatitis B in a patient with cirrhosis who has detectable HBV DNA.

Persons with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy

lamivudine 100 mg tablet, 28

6257H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*175.70	^a Zeffix [AS]	^a Zetlam [AF]

lamivudine 5 mg/mL oral liquid, 240 mL

6271C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	5	5	..	*242.06	Zeffix [AS]

■ STAVUDINE**Authority required**

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

stavudine 20 mg capsule, 60

6186N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*589.16	Zerit [BQ]

stavudine 30 mg capsule, 60

6189R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*700.82	Zerit [BQ]

stavudine 40 mg capsule, 60

6190T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*932.16	Zerit [BQ]

■ TELBIVUDINE**Authority required**

Treatment, as sole PBS-subsidised therapy, in a patient with chronic hepatitis B without cirrhosis who is nucleoside analogue naive and satisfies all of the following criteria:

- (1) Elevated HBV DNA levels - greater than 20,000 IU/mL (100,000 copies/mL) if HBeAg positive, or greater than 2,000 IU/mL (10,000 copies/mL) if HBeAg negative - in conjunction with documented hepatitis B infection;
- (2) Evidence of chronic liver injury as determined by:
- (a) Confirmed elevated serum ALT; or
- (b) Liver biopsy

Authority required

Treatment, as sole PBS-subsidised therapy, in a patient with chronic hepatitis B with cirrhosis who is nucleoside analogue naive and who has detectable HBV DNA.

Persons with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy

telbivudine 600 mg tablet, 28

9630W

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
2	5	..	*528.60	Sebivo [NV]

■ TENOFOVIR

Authority required

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

Chronic hepatitis B

Clinical criteria:

Patient must not have cirrhosis, **AND**

Patient must be nucleoside analogue naive, **AND**

Patient must have elevated HBV DNA levels greater than 20,000 IU/mL (100,000 copies/mL) if HBeAg positive, in conjunction with documented hepatitis B infection; OR

Patient must have elevated HBV DNA levels greater than 2,000 IU/mL (10,000 copies/mL) if HBeAg negative, in conjunction with documented hepatitis B infection, **AND**

Patient must have evidence of chronic liver injury determined by: (i) confirmed elevated serum ALT; or (ii) liver biopsy, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

Authority required

Chronic hepatitis B

Clinical criteria:

Patient must have cirrhosis, **AND**

Patient must be nucleoside analogue naive, **AND**

Patient must have detectable HBV DNA, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

Persons with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy.

Authority required

Chronic hepatitis B

Clinical criteria:

Patient must not have cirrhosis, **AND**

Patient must have failed antihepadnaviral therapy, **AND**

Patient must have repeatedly elevated serum ALT levels while on concurrent antihepadnaviral therapy of greater than or equal to 6 months duration, in conjunction with documented chronic hepatitis B infection; OR

Patient must have repeatedly elevated HBV DNA levels one log greater than the nadir value or failure to achieve a 1 log reduction in HBV DNA within 3 months whilst on previous antihepadnaviral therapy, except in patients with evidence of poor compliance.

Authority required

Chronic hepatitis B

Clinical criteria:

Patient must have cirrhosis, **AND**

Patient must have failed antihepadnaviral therapy, **AND**

Patient must have detectable HBV DNA.

Persons with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy.

Note

Patients may receive treatment in combination with lamivudine but not with other PBS-subsidised antihepadnaviral therapy.

tenofovir disoproxil fumarate 300 mg tablet, 30

6358P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1011.60	Viread [GI]

■ ZIDOVUDINE**Authority required**

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

zidovudine 100 mg capsule, 100

6153W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	4	5	..	*861.48	Retrovir [VI]

zidovudine 250 mg capsule, 40

6154X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	6	5	..	*1279.54	Retrovir [VI]

zidovudine 50 mg/5 mL oral liquid, 200 mL

6155Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	15	5	..	*706.96	Retrovir [VI]

Non-nucleoside reverse transcriptase inhibitors**■ EFAVIRENZ****Authority required**

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

efavirenz 200 mg tablet, 90

9618F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*571.64	Stocrin [MK]

efavirenz 30 mg/mL oral liquid, 180 mL

6372J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	7	5	..	*599.87	Stocrin [MK]

efavirenz 600 mg tablet, 30

6356M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*571.64	Stocrin [MK]

■ ETRAVIRINE**Authority required**

Treatment of HIV infection, in addition to optimised background therapy in combination with other antiretroviral agents in an antiretroviral experienced patient who, after each of at least three different antiretroviral regimens that have included one drug from at least 3 different antiretroviral classes, has experienced virological failure or clinical failure or genotypic resistance.

Virological failure is defined as a viral load greater than 400 copies per mL on two consecutive occasions, while clinical failure is linked to emerging signs and symptoms of progressing HIV infection or treatment-limiting toxicity

etravirine 200 mg tablet, 60

5062K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1279.76	Intelence [JC]

■ NEVIRAPINE

Authority required

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must have been stabilised on nevirapine immediate release, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

nevirapine 400 mg tablet: modified release, 30 tablets

1129K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*418.78	Viramune XR [BY]

■ NEVIRAPINE

Authority required

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

nevirapine 10 mg/mL oral liquid, 240 mL

9571R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	10	5	..	*1396.76	Viramune [BY]

nevirapine 200 mg tablet, 60

6215D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*418.78	^a Nevipin [GN] ^a Nevirapine RBX [RA]	^a Nevirapine Alphapharm [AF] ^a Viramune [BY]

■ RILPIVIRINE

Authority required

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

rilpivirine 25 mg tablet, 30

1170N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*571.64	Edurant [JC]

*Antivirals for treatment of HIV infections, combinations***▪ ABACAVIR + LAMIVUDINE****Authority required**

HIV infection

Treatment Phase: Initial

Clinical criteria:Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Population criteria:Patient must be aged 12 years or older, **AND**

Patient must weigh 40 kg or more.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

Population criteria:Patient must be aged 12 years or older, **AND**

Patient must weigh 40 kg or more.

abacavir 600 mg + lamivudine 300 mg tablet, 30

6458X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*912.26	Kivexa [VI]

▪ ABACAVIR + LAMIVUDINE + ZIDOVUDINE**Authority required**

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive.

Population criteria:Patient must be aged 12 years or older, **AND**

Patient must weigh 40 kg or more.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection.

Population criteria:Patient must be aged 12 years or older, **AND**

Patient must weigh 40 kg or more.

abacavir 300 mg + lamivudine 150 mg + zidovudine 300 mg tablet, 60

6327B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1404.04	Trizivir [VI]

▪ DOLUTEGRAVIR + ABACAVIR + LAMIVUDINE**Authority required**

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive.

Population criteria:Patient must be aged 12 years or older, **AND**

Patient must weigh 40 kg or more.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection.

Population criteria:Patient must be aged 12 years or older, **AND**

Patient must weigh 40 kg or more.

dolutegravir 50 mg + abacavir 600 mg + lamivudine 300 mg tablet, 30

10248J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2120.12	Triumeq [VI]

▪ EMTRICITABINE + RILPIVIRINE + TENOFOVIR**Authority required**

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection.

emtricitabine 200 mg + rilpivirine 25 mg + tenofovir disoproxil fumarate 300 mg tablet, 30

1490K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2120.12	Eviplera [GI]

▪ LAMIVUDINE + ZIDOVUDINE**Authority required**

HIV infection

Treatment Phase: Initial

Clinical criteria:Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

lamivudine 150 mg + zidovudine 300 mg tablet, 60

6234D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*825.72	^a Combivir [VI]	^a Lamivudine 150 mg + Zidovudine 300 mg Alphapharm [AF]

▪ LOPINAVIR + RITONAVIR**Authority required**

HIV infection

Treatment Phase: Initial

Clinical criteria:Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

lopinavir 100 mg + ritonavir 25 mg tablet, 60

9633B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*362.96	Kaletra [VE]

lopinavir 200 mg + ritonavir 50 mg tablet, 120

6495W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1416.76	Kaletra [VE]

lopinavir 400 mg/5 mL + ritonavir 100 mg/5 mL oral liquid, 60 mL

6341R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	10	5	..	*1336.76	Kaletra [VE]

▪ TENOFOVIR + EMTRICITABINE**Authority required**

HIV infection

Treatment Phase: Initial

Clinical criteria:Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

tenofovir disoproxil fumarate 300 mg + emtricitabine 200 mg tablet, 30

6468K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1576.96	Truvada [GI]

▪ TENOFOVIR + EMTRICITABINE + EFAVIRENZ**Authority required**

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection.

tenofovir disoproxil fumarate 300 mg + emtricitabine 200 mg + efavirenz 600 mg tablet, 30

9650X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2120.12	Atripla [GI]

▪ TENOFOVIR + EMTRICITABINE + ELVITEGRAVIR + COBICISTAT**Authority required**

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection.

tenofovir disoproxil fumarate 300 mg + emtricitabine 200 mg + elvitegravir 150 mg + cobicistat 150 mg tablet, 30

10085T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2120.12	Stribild [GI]

Other antiretrovirals**▪ DOLUTEGRAVIR****Authority required**

HIV infection

Treatment Phase: Initial

Clinical criteria:Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
The treatment must be in combination with other antiretroviral agents.

dolutegravir 50 mg tablet, 30

10070B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1377.86	Tivicay [VI]

▪ **ENFUVIRTIDE****Authority required**

Treatment of HIV infection, in addition to optimised background therapy in combination with other antiretroviral agents in an antiretroviral experienced patient who, after each of at least three different antiretroviral regimens that have included one drug from at least 3 different antiretroviral classes, has experienced virological failure or clinical failure or genotypic resistance.

Virological failure is defined as a viral load greater than 400 copies per mL on two consecutive occasions, while clinical failure is linked to emerging signs and symptoms of progressing HIV infection or treatment-limiting toxicity

enfuvirtide 90 mg injection [60 x 90 mg vials] (&) inert substance diluent [60 x 1.1 mL vials], 1 pack

6455R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*4472.76	Fuzeon [RO]

▪ **MARAVIROC****Authority required**

Treatment, in addition to optimised background therapy in combination with other antiretroviral agents, of an antiretroviral experienced patient infected with only CCR5-tropic HIV-1, who, after each of at least three different antiretroviral regimens that have included one drug from at least 3 different antiretroviral classes, has experienced virological failure or clinical failure or genotypic resistance. A tropism assay to determine CCR5 only strain status is required prior to initiation. Individuals with CXCR4 tropism demonstrated at any time point are not eligible.

Virological failure is defined as a viral load greater than 400 copies per mL on two consecutive occasions, while clinical failure is linked to emerging signs and symptoms of progressing HIV infection or treatment-limiting toxicity

maraviroc 150 mg tablet, 60

9572T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1882.16	Celsentri [VI]

maraviroc 300 mg tablet, 60

9573W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1882.16	Celsentri [VI]

▪ **RALTEGRAVIR****Authority required**

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

raltegravir 400 mg tablet, 60

9629T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1377.86	Isentress [MK]

▪ **RALTEGRAVIR****Authority required**

HIV infection

Treatment Phase: Initial

Clinical criteria:

The treatment must be in combination with other antiretroviral agents, **AND**

Patient must be antiretroviral experienced with at least 6 months therapy with 2 alternate classes of anti-retroviral therapy, **AND**

Patient must have a CD4 count of less than 500 per cubic millimetre; OR

Patient must have symptomatic HIV disease.

Population criteria:

Patient must be aged 2 years or older.

Authority required

HIV infection

Treatment Phase: Continuing

Clinical criteria:

The treatment must be in combination with other antiretroviral agents, **AND**

Patient must be antiretroviral experienced with at least 6 months therapy with 2 alternate classes of anti-retroviral therapy, **AND**

Patient must have previously received PBS-subsidised therapy for HIV infection.

Population criteria:

Patient must be aged 2 years or older.

raltegravir 100 mg tablet: chewable, 60

2754Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	6	5	..	*2071.78	Isentress [MK]

raltegravir 25 mg tablet: chewable, 60

2743J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	6	5	..	*533.32	Isentress [MK]

HSD (Private)

■ **ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS**

■ **ANTINEOPLASTIC AGENTS**

ANTIMETABOLITES

Pyrimidine analogues

■ **AZACITIDINE**

Authority required

Initial PBS-subsidised treatment of a patient with:

(1) Myelodysplastic syndrome classified as Intermediate-2 or high risk according to the International Prognostic Scoring System (IPSS); OR

(2) Chronic Myelomonocytic Leukaemia (10% to 29% marrow blasts without Myeloproliferative Disorder); OR

(3) Acute Myeloid Leukaemia with 20 to 30% marrow blasts and multi-lineage dysplasia, according to World Health Organisation (WHO) Classification.

Classification of a patient as Intermediate-2 requires a score of 1.5 to 2.0 on the IPSS, achieved with the possible combinations:

- 11% to 30% marrow blasts with good karyotypic status (normal, -Y alone, del(5q) alone, del(20q) alone), and 0 to 1 cytopenias; OR
- 11% to 20% marrow blasts with intermediate karyotypic status (other abnormalities), and 0 to 1 cytopenias; OR
- 11% to 20% marrow blasts with good karyotypic status (normal, -Y alone, del(5q) alone, del(20q) alone), and 2 to 3 cytopenias; OR
- 5% to 10% marrow blasts with poor karyotypic status (3 or more abnormalities or chromosome 7 anomalies), regardless of cytopenias; OR
- 5% to 10% marrow blasts with intermediate karyotypic status (other abnormalities), and 2 to 3 cytopenias; OR
- less than 5% marrow blasts with poor karyotypic status (3 or more abnormalities or chromosome 7 anomalies), and 2 to 3 cytopenias.

Classification of a patient as high risk requires a score of 2.5 or more on the IPSS, achieved with the possible combinations:

- 21% to 30% marrow blasts with good karyotypic status (normal, -Y alone, del(5q) alone, del(20q) alone), and 2 to 3 cytopenias; OR
- 21% to 30% marrow blasts with intermediate (other abnormalities) or poor karyotypic status (3 or more abnormalities or chromosome 7 anomalies), regardless of cytopenias; OR
- 11% to 20% marrow blasts with poor karyotypic status (3 or more abnormalities or chromosome 7 anomalies), regardless of cytopenias; OR
- 11% to 20% marrow blasts with intermediate karyotypic status (other abnormalities), and 2 to 3 cytopenias.

The first authority application must be made in writing and must include:

- a completed authority prescription form; and
- a completed Azacitidine PBS Authority Application - Supporting Information Form; and
- a copy of the bone marrow biopsy report demonstrating that the patient has myelodysplastic syndrome, chronic myelomonocytic leukaemia or acute myeloid leukaemia; and
- a copy of the full blood examination report; and
- for myelodysplastic syndrome, a copy of the pathology report detailing the cytogenetics demonstrating intermediate-2 or high risk disease according to the International Prognostic Scoring System (IPSS); and
- a signed patient acknowledgment form.

No more than three cycles will be authorised

Note

Any queries concerning the arrangements to prescribe azacitidine may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe azacitidine should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Special Pricing Arrangements apply.

azacitidine 100 mg injection, 1 x 100 mg vial

6100C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	14	2	..	*7746.80	Vidaza [CJ]

■ AZACITIDINE

Authority required

Continuing treatment of a patient with:

(1) Myelodysplastic syndrome classified as Intermediate-2 or high risk according to the International Prognostic Scoring System (IPSS); OR

(2) Chronic Myelomonocytic Leukaemia (10% to 29% marrow blasts without Myeloproliferative Disorder); OR

(3) Acute Myeloid Leukaemia with 20 to 30% blasts and multi-lineage dysplasia, according to World Health Organisation (WHO) Classification;

who has previously been issued with an authority prescription for azacitidine and does not have progressive disease.

Authority applications for continuing treatment may be made by telephone on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Up to six cycles will be authorised

Note

Any queries concerning the arrangements to prescribe azacitidine may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe azacitidine should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Special Pricing Arrangements apply.

azacitidine 100 mg injection, 1 x 100 mg vial

6138C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	14	5	..	*7746.80	Vidaza [CJ]

CYTOTOXIC ANTIBIOTICS AND RELATED SUBSTANCES

Anthracyclines and related substances

■ DOXORUBICIN HYDROCHLORIDE-PEGYLATED LIPOSOMAL

Authority required

Treatment of AIDS-related Kaposi's sarcoma in patients with CD4 cell counts of less than 200 per cubic millimetre and extensive mucocutaneous involvement

Authority required

Treatment of AIDS-related Kaposi's sarcoma in patients with CD4 cell counts of less than 200 per cubic millimetre and extensive visceral involvement

doxorubicin hydrochloride-pegylated liposomal 20 mg/10 mL injection, 1 x 10 mL vial

6249X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	4	5	..	*2140.00	^a Caelyx [JC]	^a Liposomal Doxorubicin SUN [ZF]

■ IMMUNOSTIMULANTS

IMMUNOSTIMULANTS

Colony stimulating factors

■ FILGRASTIM

Authority required

For use in a patient undergoing induction and consolidation therapy for acute myeloid leukaemia

Authority required

Mobilisation of peripheral blood progenitor cells to facilitate harvest of such cells for autologous transplantation into a patient with a non-myeloid malignancy who has had myeloablative or myelosuppressive therapy

Authority required

A patient receiving chemotherapy for myeloma who has had a prior episode of febrile neutropenia, and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required

A patient with severe congenital neutropenia (absolute neutrophil count of less than 100 million cells per litre measured on 3 occasions, with readings at least 2 weeks apart, and in whom a bone marrow examination has shown evidence of maturational arrest of the neutrophil lineage)

Authority required

A patient with severe chronic neutropenia (absolute neutrophil count of less than 1,000 million cells per litre measured on 3 occasions, with readings at least 2 weeks apart, or evidence of neutrophil dysfunction, and, either having experienced a life-threatening infectious episode requiring hospitalisation and treatment with intravenous antibiotics in the previous 12 months, or having recurrent clinically significant infections (a minimum of 3 in the previous 12 months))

Authority required

A patient with chronic cyclic neutropenia (absolute neutrophil count of less than 500 million cells per litre lasting for 3 days per cycle, measured over 3 separate cycles, and, either having experienced a life-threatening infectious episode requiring hospitalisation and treatment with intravenous antibiotics, or having recurrent clinically significant infections (a minimum of 3 in the previous 12 months))

Authority required

A patient with inoperable Stage III, IVa or IVb squamous cell carcinoma of the oral cavity, larynx, oropharynx or hypopharynx receiving neoadjuvant treatment with docetaxel in combination with cisplatin and fluorouracil who has had a prior episode of febrile neutropenia or prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required

Mobilisation of peripheral blood progenitor cells, in a normal volunteer, for use in allogeneic transplantation

Authority required

A patient receiving marrow-ablative chemotherapy and subsequent bone marrow transplantation

Authority required

A patient with a non-myeloid malignancy receiving marrow-ablative chemotherapy and subsequent autologous peripheral blood progenitor cell transplantation

Authority required

A patient with breast cancer receiving standard dose adjuvant chemotherapy who has had a prior episode of febrile neutropenia or prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required

A patient receiving chemotherapy for B-cell chronic lymphocytic leukaemia with fludarabine and cyclophosphamide who has had a prior episode of febrile neutropenia or prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required

A patient receiving first-line chemotherapy for Hodgkin disease who has had a prior episode of febrile neutropenia or prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in acute lymphoblastic leukaemia

Authority required

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in breast cancer (adjuvant chemotherapy with docetaxel in combination with an anthracycline and cyclophosphamide)

Authority required

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in germ cell tumours

Authority required

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in infants and children with CNS tumours

Authority required

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in neuroblastoma

Authority required

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in non-Hodgkin lymphoma (aggressive grades; or low grade receiving an anthracycline-containing regimen)

Authority required

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in relapsed Hodgkin disease

Authority required

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in sarcoma

Authority required

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in Hodgkin disease (first-line chemotherapy with escalated BEACOPP)

filgrastim 120 microgram/0.2 mL injection, 10 x 0.2 mL syringes

5830W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*894.18	Nivestim [HH]

filgrastim 300 microgram/0.5 mL injection, 10 x 0.5 mL syringes

1082Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*2179.94	TevaGrastim [AS]

filgrastim 300 microgram/0.5 mL injection, 10 x 0.5 mL syringes

6291D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*2179.94	Neupogen [AN]

filgrastim 300 microgram/0.5 mL injection, 10 x 0.5 mL syringes

9693E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*2179.94	Nivestim [HH]

filgrastim 300 microgram/0.5 mL injection, 5 x 0.5 mL syringes

2747N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	4	11	..	*2179.92	Zarzio [SZ]

filgrastim 300 microgram/mL injection, 10 x 1 mL vials

6126K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*2179.94	Neupogen [AN]

filgrastim 480 microgram/0.5 mL injection, 10 x 0.5 mL syringes

6292E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*3466.38	Neupogen [AN]

filgrastim 480 microgram/0.5 mL injection, 10 x 0.5 mL syringes

9695G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*3466.38	Nivestim [HH]

filgrastim 480 microgram/0.5 mL injection, 5 x 0.5 mL syringes

2733W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	4	11	..	*3466.36	Zarzio [SZ]

filgrastim 480 microgram/0.8 mL injection, 10 x 0.8 mL syringes

1113N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*3466.38	TevaGrastim [AS]

filgrastim 480 microgram/1.6 mL injection, 10 x 1.6 mL vials

6127L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*3466.38	Neupogen [AN]

▪ LENOGRASTIM**Authority required**

Mobilisation of peripheral blood progenitor cells to facilitate harvest of such cells for reinfusion into patients with non-myeloid malignancies who have had myeloablative or myelosuppressive therapy

Authority required

Mobilisation of peripheral blood progenitor cells, in normal volunteers, for use in allogeneic transplantation to facilitate harvest of such cells in healthy donors

Authority required

Patients with non-myeloid malignancies receiving marrow-ablative chemotherapy and subsequent peripheral blood progenitor cell or bone marrow transplantation

Authority required

Patients with breast cancer receiving standard dose adjuvant chemotherapy who have had a prior episode of febrile neutropenia or prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required

Patients receiving first-line chemotherapy for Hodgkin's disease who have had a prior episode of febrile neutropenia or prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required

Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in relapsed Hodgkin's disease

Authority required

Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in rhabdomyosarcoma

Authority required

Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in Ewing's sarcoma

Authority required

Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in germ cell tumours

Authority required

Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in infants and children with CNS tumours

Authority required

Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in neuroblastoma

Authority required

Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in non-Hodgkin's lymphoma (intermediate or high grade)

Authority required

Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in osteosarcoma

Authority required

Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in acute lymphoblastic leukaemia

LENOGRASTIM Powder for injection 13,400,000 i.u. (105 micrograms) vial, 10

6337M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*1071.76	Granocyte 13 [HH]

LENOGRASTIM Powder for injection 33,600,000 i.u. (263 micrograms) vial, 10

6338N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*2613.96	Granocyte 34 [HH]

▪ **PEGFILGRASTIM**

Authority required

For use in a patient undergoing induction and consolidation therapy for acute myeloid leukaemia

Authority required

A patient with breast cancer receiving standard dose adjuvant chemotherapy who has had a prior episode of febrile neutropenia or prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required

A patient receiving chemotherapy for B-cell chronic lymphocytic leukaemia with fludarabine and cyclophosphamide who has had a prior episode of febrile neutropenia or prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required

A patient receiving first-line chemotherapy for Hodgkin disease who has had a prior episode of febrile neutropenia or prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required

A patient receiving chemotherapy for myeloma who has had a prior episode of febrile neutropenia, and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required

A patient with inoperable Stage III, IVa or IVb squamous cell carcinoma of the oral cavity, larynx, oropharynx or hypopharynx receiving neoadjuvant treatment with docetaxel in combination with cisplatin and fluorouracil who has had a prior episode of febrile neutropenia or prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in acute lymphoblastic leukaemia

Authority required

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in breast cancer (adjuvant chemotherapy with docetaxel in combination with an anthracycline and cyclophosphamide)

Authority required

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in germ cell tumours

Authority required

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in infants and children with CNS tumours

Authority required

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in neuroblastoma

Authority required

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in non-Hodgkin lymphoma (aggressive grades; or low grade receiving an anthracycline-containing regimen)

Authority required

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in relapsed Hodgkin disease

Authority required

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in sarcoma

Authority required

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in Hodgkin disease (first-line chemotherapy with escalated BEACOPP)

pegfilgrastim 6 mg/0.6 mL injection, 1 x 0.6 mL syringe

6363X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	11	..	1971.76	Neulasta [AN]

Interferons

■ INTERFERON ALFA-2A

Caution

Treatment with interferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required

Use in the treatment of Philadelphia chromosome positive myelogenous leukaemia in the chronic phase

Authority required

Chronic hepatitis B in a patient without cirrhosis who satisfies all of the following criteria:

(1) Elevated HBV DNA levels - greater than 20,000 IU/mL (100,000 copies/mL) if HBeAg positive, or greater than 2,000 IU/mL (10,000 copies/mL) if HBeAg negative - in conjunction with documented chronic hepatitis B infection;

(2) Evidence of chronic liver injury as determined by:

(a) Confirmed elevated serum ALT; or

(b) Liver biopsy

Authority required

Chronic hepatitis B in a patient with cirrhosis who has detectable HBV DNA.

Persons with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy

interferon alfa-2a 3 million international units/0.5 mL injection, 1 x 0.5 mL syringe

6210W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	30	5	..	*936.46	Roferon-A [RO]

interferon alfa-2a 4.5 million international units/0.5 mL injection, 1 x 0.5 mL syringe

6211X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	30	5	..	*1387.66	Roferon-A [RO]

interferon alfa-2a 6 million international units/0.5 mL injection, 1 x 0.5 mL syringe

6212Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	30	5	..	*1834.06	Roferon-A [RO]

interferon alfa-2a 9 million international units/0.5 mL injection, 1 x 0.5 mL syringe

6213B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	30	5	..	*2728.06	Roferon-A [RO]

▪ **INTERFERON ALFA-2B**

Caution

Treatment with interferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required

Adjunctive therapy of malignant melanoma following surgery in patients with nodal involvement

Authority required

Use in the treatment of Philadelphia chromosome positive myelogenous leukaemia in the chronic phase

Authority required

Chronic hepatitis B in a patient without cirrhosis who satisfies all of the following criteria:

(1) Elevated HBV DNA levels - greater than 20,000 IU/mL (100,000 copies/mL) if HBeAg positive, or greater than 2,000 IU/mL (10,000 copies/mL) if HBeAg negative - in conjunction with documented chronic hepatitis B infection;

(2) Evidence of chronic liver injury as determined by:

(a) Confirmed elevated serum ALT; or

(b) Liver biopsy

Authority required

Chronic hepatitis B in a patient with cirrhosis who has detectable HBV DNA.

Persons with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy

interferon alfa-2b 10 million international units/mL injection, 5 x 1 mL vials

6246R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	3	5	..	*1536.25	Intron A [MK]

interferon alfa-2b 18 million international units/1.2 mL injection, 1 x 1.2 mL cartridge

6253D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*378.54	Intron A Redipen [MK]

interferon alfa-2b 18 million international units/3 mL injection, 1 x 3 mL vial

6218G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	15	5	..	*2727.91	Intron A [MK]

interferon alfa-2b 25 million international units/2.5 mL injection, 1 x 2.5 mL vial

6219H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	15	5	..	*3770.56	Intron A [MK]

interferon alfa-2b 30 million international units/1.2 mL injection, 1 x 1.2 mL cartridge

6254E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*626.40	Intron A Redipen [MK]

interferon alfa-2b 60 million international units/1.2 mL injection, 1 x 1.2 mL cartridge

6255F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1238.36	Intron A Redipen [MK]

▪ **INTERFERON GAMMA-1B**

Authority required

Treatment of chronic granulomatous disease in patients with frequent and severe infections despite adequate prophylaxis with antimicrobial agents

interferon gamma-1b 2 million international units (100 microgram/0.5 mL) injection, 6 x 0.5 mL vials

6148N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*2768.56	Imukin [BY]

▪ PEGINTERFERON ALFA-2A

Caution

Treatment with peginterferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required

Treatment, as sole PBS-subsidised therapy, in a patient with chronic hepatitis B without cirrhosis who satisfies all of the following criteria:

- (1) Elevated HBV DNA levels - greater than 20,000 IU/mL (100,000 copies/mL) if HBeAg positive, or greater than 2,000 IU/mL (10,000 copies/mL) if HBeAg negative - in conjunction with documented chronic hepatitis B infection;
- (2) Evidence of chronic liver injury as determined by:
 - (a) Confirmed elevated serum ALT; or
 - (b) Liver biopsy;
- (3) Has received no prior peginterferon alfa therapy for the treatment of hepatitis B

Authority required

Treatment, as sole PBS-subsidised therapy, in a patient with chronic hepatitis B with cirrhosis who has detectable HBV DNA. Persons with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy.

Treatment is limited to 1 course of treatment for a duration of up to 48 weeks

Authority required

Treatment, managed by an accredited treatment centre, of chronic hepatitis C in patients 18 years or older who have compensated liver disease and who have received no prior interferon alfa or peginterferon alfa treatment for hepatitis C and have a contraindication to ribavirin, who satisfy all of the following criteria:

- (1) Documented chronic hepatitis C infection (repeatedly anti-HCV positive and HCV RNA positive);
- (2) Female patients of child-bearing age are not pregnant, not breast-feeding, and are using an effective form of contraception.

The treatment course is limited to up to 48 weeks.

Patients may only continue treatment after the first 12 weeks if the result of an HCV RNA quantitative assay (performed at the same laboratory using the same test) shows that the plasma HCV RNA has become undetectable or the viral load has decreased by at least a 2 log drop

Note

Treatment centres are required to have access to the following appropriate specialist facilities for the provision of clinical support services for hepatitis C:

- (a) a nurse educator/counsellor for patients; and
- (b) 24 hour access by patients to medical advice; and
- (c) an established liver clinic; and
- (d) facilities for safe liver biopsy.

peginterferon alfa-2a 135 microgram/0.5 mL injection, 4 x 0.5 mL syringes

6439X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2378.56	Pegasys [RO]

peginterferon alfa-2a 180 microgram/0.5 mL injection, 4 x 0.5 mL syringes

6449K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2747.22	Pegasys [RO]

▪ PEGINTERFERON ALFA-2A (&) RIBAVIRIN

Caution

Treatment with peginterferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Ribavirin is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and during the 6 months period after cessation of treatment.

Authority required

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must have failed prior treatment with interferon based therapies (non-pegylated or pegylated), **AND**

Patient must have received no more than one prior treatment with interferon alfa or peginterferon alfa for hepatitis C if using peginterferon and ribavirin without an NS3 protease inhibitor, or, in triple combination therapy with boceprevir; OR

Patient must have received prior treatment with interferon alfa or peginterferon alfa for hepatitis C if using peginterferon and ribavirin in triple combination therapy with telaprevir; OR

Patient must have received prior treatment with interferon alfa or peginterferon alfa for hepatitis C if using peginterferon and ribavirin in triple combination therapy with simeprevir, **AND**

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with telaprevir who were prior treatment relapsers and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 4 and 12; OR

The treatment must be limited to a maximum duration of 36 weeks in patients using peginterferon and ribavirin in triple combination therapy with boceprevir who were prior treatment partial responders or relapsers and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 8 and 12; OR

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir who were prior treatment relapsers and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at week 4; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin without an NS3 protease inhibitor; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with boceprevir who: (i) were prior treatment null responders; or (ii) were prior treatment partial responders or relapsers and in whom plasma HCV RNA is detectable by an HCV RNA qualitative assay at week 8, and undetectable by an HCV RNA qualitative assay at week 12; or (iii) have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with telaprevir who: (i) were prior treatment partial or null responders; or (ii) were prior treatment relapsers and for whom the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is detectable but less than or equal to 1000 IU/mL; or (iii) have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir who: (i) were prior treatment partial or null responders; or (ii) were prior treatment relapsers and for whom the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is detectable but less than 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin without an NS3 protease inhibitor if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with boceprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with boceprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than 1000 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than or equal to 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic genotype 1 hepatitis C infection (repeatedly anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Authority required

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with telaprevir and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 4 and 12; OR

The treatment must be limited to a maximum duration of 28 weeks in patients using peginterferon and ribavirin in triple combination therapy with boceprevir and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 8 and 24; OR

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir and in whom plasma HCV RNA is undetectable by an HCV RNA quantitative assay at week 4; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin without an NS3 protease inhibitor; OR

The treatment must be limited to a maximum duration of 48 weeks in patients: (i) using peginterferon and ribavirin in triple combination therapy with boceprevir and in whom plasma HCV RNA is detectable by an HCV RNA qualitative assay at week 8, and undetectable by an HCV RNA qualitative assay at week 24; or (ii) using peginterferon and ribavirin in triple combination therapy with boceprevir who have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients: (i) using peginterferon and ribavirin in triple combination therapy with telaprevir and for whom the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is detectable but less than or equal to 1000 IU/mL; or (ii) using peginterferon and ribavirin in triple combination therapy with telaprevir who have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir and for whom the results of an HCV RNA qualitative assay at week 4 show that the plasma HCV RNA is detectable but less than 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin without an NS3 protease inhibitor unless the results of an HCV RNA quantitative assay at week 12 (performed at the same laboratory using the same test) show that plasma HCV RNA has become undetectable or the viral load has decreased by at least a 2 log drop, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with boceprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than 1000 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than or equal to 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

For patients using peginterferon and ribavirin without an NS3 protease inhibitor who are viral negative at week 12, an HCV RNA qualitative assay at week 24 is unnecessary.

Authority required

Chronic non-genotype 1 hepatitis C infection

Clinical criteria:

The treatment must be the sole PBS-subsidised treatment for hepatitis C, **AND**

Patient must have compensated liver disease, **AND**

The condition must be genotype 2, 3, 4, 5 or 6 hepatitis C, **AND**

Patient must have failed prior treatment with interferon based therapies (non-pegylated or pegylated), **AND**

Patient must have received no more than one prior treatment with interferon alfa or peginterferon alfa for hepatitis C, **AND**

The treatment must be limited to a maximum duration of 48 weeks, **AND**

The treatment must cease if HCV RNA is detectable by an HCV RNA qualitative assay at week 12.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Authority required

Chronic non-genotype 1 hepatitis C infection

Clinical criteria:

The treatment must be the sole PBS-subsidised treatment for hepatitis C, **AND**

Patient must have compensated liver disease, **AND**

Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**

The condition must be genotype 2, 3, 4, 5 or 6 hepatitis C, **AND**

The treatment must be limited to a maximum duration of 24 weeks for patients with genotype 2 or 3 hepatitis C without hepatic cirrhosis or bridging fibrosis; OR

The treatment must be limited to a maximum duration of 48 weeks for patients with genotype 4, 5 or 6 hepatitis C; OR

The treatment must be limited to a maximum duration of 48 weeks for patients with genotype 2 or 3 hepatitis C with hepatic cirrhosis or bridging fibrosis, **AND**

The treatment must cease in patients with genotype 4, 5, or 6 hepatitis C unless the results of an HCV RNA quantitative assay at week 12 (performed at the same laboratory using the same test) shows that plasma HCV RNA has become undetectable or the viral load has decreased by at least a 2 log drop, **AND**

The treatment must cease in patients eligible for 48 weeks of treatment if HCV RNA is detectable by an HCV RNA qualitative assay at week 24.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

For patients with genotype 4, 5, or 6 who are viral negative at week 12, an HCV RNA qualitative assay at week 24 is unnecessary.

For patients with genotype 2 or 3 without cirrhosis, an HCV RNA assay at week 12 is unnecessary because of the high likelihood of early viral response by week 12.

For patients who are eligible for 24 weeks of treatment, a maximum of 2 repeats may be prescribed.

For patients who are eligible for 48 weeks of treatment, a maximum of 5 repeats may be prescribed.

Note

Treatment centres are required to have access to the following appropriate specialist facilities for the provision of clinical support services for hepatitis C:

- (a) a nurse educator/counsellor for patients; and
- (b) 24-hour access by patients to medical advice; and

- (c) an established liver clinic.

peginterferon alfa-2a 135 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [168 tablets], 1 pack

6392K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3119.60	Pegasys RBV [RO]

peginterferon alfa-2a 180 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [112 tablets], 1 pack

6394M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3132.04	Pegasys RBV [RO]

peginterferon alfa-2a 180 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [140 tablets], 1 pack

6395N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3292.58	Pegasys RBV [RO]

peginterferon alfa-2a 180 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [168 tablets], 1 pack

6396P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3453.12	Pegasys RBV [RO]

▪ **PEGINTERFERON ALFA-2B (&) RIBAVIRIN**

Caution

Treatment with peginterferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Ribavirin is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and during the 6 months period after cessation of treatment.

Authority required

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must have failed prior treatment with interferon based therapies (non-pegylated or pegylated), **AND**

Patient must have received no more than one prior treatment with interferon alfa or peginterferon alfa for hepatitis C if using peginterferon and ribavirin without an NS3 protease inhibitor, or, in triple combination therapy with boceprevir; OR

Patient must have received prior treatment with interferon alfa or peginterferon alfa for hepatitis C if using peginterferon and ribavirin in triple combination therapy with telaprevir; OR

Patient must have received prior treatment with interferon alfa or peginterferon alfa for hepatitis C if using peginterferon and ribavirin in triple combination therapy with simeprevir, **AND**

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with telaprevir who were prior treatment relapsers and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 4 and 12; OR

The treatment must be limited to a maximum duration of 36 weeks in patients using peginterferon and ribavirin in triple combination therapy with boceprevir who were prior treatment partial responders or relapsers and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 8 and 12; OR

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir who were prior treatment relapsers and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at week 4; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin without an NS3 protease inhibitor; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with boceprevir who: (i) were prior treatment null responders; or (ii) were prior treatment partial responders or relapsers and in whom plasma HCV RNA is detectable by an HCV RNA qualitative assay at week 8, and undetectable by an HCV RNA qualitative assay at week 12; or (iii) have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with telaprevir who: (i) were prior treatment partial or null responders; or (ii) were prior treatment relapsers and for whom the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is detectable but less than or equal to 1000 IU/mL; or (iii) have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir who: (i) were prior treatment partial or null responders; or (ii) were prior treatment relapsers and for whom the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is detectable but less than 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin without an NS3 protease inhibitor if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with boceprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with boceprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than 1000 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than or equal to 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic genotype 1 hepatitis C infection (repeatedly anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Authority required

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with telaprevir and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 4 and 12; OR

The treatment must be limited to a maximum duration of 28 weeks in patients using peginterferon and ribavirin in triple combination therapy with boceprevir and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 8 and 24; OR

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir and in whom plasma HCV RNA is undetectable by an HCV RNA quantitative assay at week 4; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin without an NS3 protease inhibitor; OR

The treatment must be limited to a maximum duration of 48 weeks in patients: (i) using peginterferon and ribavirin in triple combination therapy with boceprevir and in whom plasma HCV RNA is detectable by an HCV RNA qualitative assay at week 8, and undetectable by an HCV RNA qualitative assay at week 24; or (ii) using peginterferon and ribavirin in triple combination therapy with boceprevir who have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients: (i) using peginterferon and ribavirin in triple combination therapy with telaprevir and for whom the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is detectable but less than or equal to 1000 IU/mL; or (ii) using peginterferon and ribavirin in triple combination therapy with telaprevir who have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir and for whom the results of an HCV RNA qualitative assay at week 4 show that the plasma HCV RNA is detectable but less than 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin without an NS3 protease inhibitor unless the results of an HCV RNA quantitative assay at week 12 (performed at the same laboratory using the same test) show that plasma HCV RNA has become undetectable or the viral load has decreased by at least a 2 log drop, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with boceprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than 1000 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than or equal to 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

For patients using peginterferon and ribavirin without an NS3 protease inhibitor who are viral negative at week 12, an HCV RNA qualitative assay at week 24 is unnecessary.

Authority required

Chronic non-genotype 1 hepatitis C infection

Clinical criteria:

The treatment must be the sole PBS-subsidised treatment for hepatitis C, **AND**

Patient must have compensated liver disease, **AND**

The condition must be genotype 2, 3, 4, 5 or 6 hepatitis C, **AND**

Patient must have failed prior treatment with interferon based therapies (non-pegylated or pegylated), **AND**

Patient must have received no more than one prior treatment with interferon alfa or peginterferon alfa for hepatitis C, **AND**

The treatment must be limited to a maximum duration of 48 weeks, **AND**

The treatment must cease if HCV RNA is detectable by an HCV RNA qualitative assay at week 12.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Authority required

Chronic non-genotype 1 hepatitis C infection

Clinical criteria:

The treatment must be the sole PBS-subsidised treatment for hepatitis C, **AND**

Patient must have compensated liver disease, **AND**

Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**

The condition must be genotype 2, 3, 4, 5 or 6 hepatitis C, **AND**

The treatment must be limited to a maximum duration of 24 weeks for patients with genotype 2 or 3 hepatitis C without hepatic cirrhosis or bridging fibrosis; OR

The treatment must be limited to a maximum duration of 48 weeks for patients with genotype 4, 5 or 6 hepatitis C; OR

The treatment must be limited to a maximum duration of 48 weeks for patients with genotype 2 or 3 hepatitis C with hepatic cirrhosis or bridging fibrosis, **AND**

The treatment must cease in patients with genotype 4, 5, or 6 hepatitis C unless the results of an HCV RNA quantitative assay at week 12 (performed at the same laboratory using the same test) shows that plasma HCV RNA has become undetectable or the viral load has decreased by at least a 2 log drop, **AND**

The treatment must cease in patients eligible for 48 weeks of treatment if HCV RNA is detectable by an HCV RNA qualitative assay at week 24.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

For patients with genotype 4, 5, or 6 who are viral negative at week 12, an HCV RNA qualitative assay at week 24 is unnecessary.

For patients with genotype 2 or 3 without cirrhosis, an HCV RNA assay at week 12 is unnecessary because of the high likelihood of early viral response by week 12.

For patients who are eligible for 24 weeks of treatment, a maximum of 2 repeats may be prescribed.

For patients who are eligible for 48 weeks of treatment, a maximum of 5 repeats may be prescribed.

Note

Treatment centres are required to have access to the following appropriate specialist facilities for the provision of clinical support services for hepatitis C:

- (a) a nurse educator/counsellor for patients; and
- (b) 24-hour access by patients to medical advice; and

- (c) an established liver clinic.

peginterferon alfa-2b 120 microgram injection [4 x 120 microgram cartridges] (&) ribavirin 200 mg capsule [140 capsules] (&) inert substance diluent [4 x 0.5 mL cartridges], 1 pack

6407F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3538.34	Pegatron [MK]

peginterferon alfa-2b 150 microgram injection [4 x 150 microgram cartridges] (&) ribavirin 200 mg capsule [140 capsules] (&) inert substance diluent [4 x 0.5 mL cartridges], 1 pack

6409H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*4126.28	Pegatron [MK]

peginterferon alfa-2b 150 microgram injection [4 x 150 microgram cartridges] (&) ribavirin 200 mg capsule [168 capsules] (&) inert substance diluent [4 x 0.5 mL cartridges], 1 pack

6410J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*4126.28	Pegatron [MK]

peginterferon alfa-2b 150 microgram injection [4 x 150 microgram cartridges] (&) ribavirin 200 mg capsule [196 capsules] (&) inert substance diluent [4 x 0.5 mL cartridges], 1 pack

9634C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*4411.24	Pegatron [MK]

peginterferon alfa-2b 80 microgram injection [4 x 80 microgram cartridges] (&) ribavirin 200 mg capsule [140 capsules] (&) inert substance diluent [4 x 0.5 mL cartridges], 1 pack

6402Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2754.42	Pegatron [MK]

▪ **PEGINTERFERON ALFA-2B (&) RIBAVIRIN**

Caution

Treatment with peginterferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Ribavirin is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and during the 6 months period after cessation of treatment.

Authority required

Chronic genotype 1 hepatitis C infection

Clinical criteria:

The treatment must be the sole PBS-subsidised treatment for hepatitis C, **AND**

Patient must have compensated liver disease, **AND**

Patient must have failed prior treatment with interferon based therapies (non-pegylated or pegylated), **AND**

Patient must have received no more than one prior treatment with interferon alfa or peginterferon alfa for hepatitis C, **AND**

The treatment must be limited to a maximum duration of 48 weeks, **AND**

The treatment must cease if HCV RNA is detectable by an HCV RNA qualitative assay at week 12.

Population criteria:

Patient must weigh at least 27 kg, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic genotype 1 hepatitis C infection (repeatedly anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Authority required

Chronic genotype 1 hepatitis C infection

Clinical criteria:

The treatment must be the sole PBS-subsidised treatment for hepatitis C, **AND**

Patient must have compensated liver disease, **AND**

Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**

The treatment must be limited to a maximum duration of 48 weeks, **AND**

The treatment must cease unless the results of an HCV RNA quantitative assay at week 12 (performed at the same laboratory using the same test) show that plasma HCV RNA has become undetectable or the viral load has decreased by at least a 2 log drop.

Population criteria:

Patient must weigh at least 27 kg, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

For patients who are viral negative at week 12, an HCV RNA qualitative assay at week 24 is unnecessary.

Authority required

Chronic non-genotype 1 hepatitis C infection

Clinical criteria:

The treatment must be the sole PBS-subsidised treatment for hepatitis C, **AND**

Patient must have compensated liver disease, **AND**

The condition must be genotype 2, 3, 4, 5 or 6 hepatitis C, **AND**

Patient must have failed prior treatment with interferon based therapies (non-pegylated or pegylated), **AND**

Patient must have received no more than one prior treatment with interferon alfa or peginterferon alfa for hepatitis C, **AND**

The treatment must be limited to a maximum duration of 48 weeks, **AND**

The treatment must cease if HCV RNA is detectable by an HCV RNA qualitative assay at week 12.

Population criteria:

Patient must weigh at least 27 kg, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Authority required

Chronic non-genotype 1 hepatitis C infection

Clinical criteria:

The treatment must be the sole PBS-subsidised treatment for hepatitis C, **AND**

Patient must have compensated liver disease, **AND**

Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**

The condition must be genotype 2, 3, 4, 5 or 6 hepatitis C, **AND**

The treatment must be limited to a maximum duration of 24 weeks for patients with genotype 2 or 3 hepatitis C without hepatic cirrhosis or bridging fibrosis; OR

The treatment must be limited to a maximum duration of 48 weeks for patients with genotype 4, 5 or 6 hepatitis C; OR

The treatment must be limited to a maximum duration of 48 weeks for patients with genotype 2 or 3 hepatitis C with hepatic cirrhosis or bridging fibrosis, **AND**

The treatment must cease in patients with genotype 4, 5, or 6 hepatitis C unless the results of an HCV RNA quantitative assay at week 12 (performed at the same laboratory using the same test) shows that plasma HCV RNA has become undetectable or the viral load has decreased by at least a 2 log drop, **AND**

The treatment must cease in patients eligible for 48 weeks of treatment if HCV RNA is detectable by an HCV RNA qualitative assay at week 24.

Population criteria:

Patient must weigh at least 27 kg, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

For patients with genotype 4, 5, or 6 who are viral negative at week 12, an HCV RNA qualitative assay at week 24 is unnecessary.

For patients with genotype 2 or 3 without cirrhosis, an HCV RNA assay at week 12 is unnecessary because of the high likelihood of early viral response by week 12.

For patients who are eligible for 24 weeks of treatment, a maximum of 2 repeats may be prescribed.

For patients who are eligible for 48 weeks of treatment, a maximum of 5 repeats may be prescribed.

Authority required

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must have failed prior treatment with interferon based therapies (non-pegylated or pegylated), **AND**

Patient must have received no more than one prior treatment with interferon alfa or peginterferon alfa for hepatitis C if using peginterferon and ribavirin without an NS3 protease inhibitor, or, in triple combination therapy with boceprevir; **OR**

Patient must have received prior treatment with interferon alfa or peginterferon alfa for hepatitis C if using peginterferon and ribavirin in triple combination therapy with telaprevir; **OR**

Patient must have received prior treatment with interferon alfa or peginterferon alfa for hepatitis C if using peginterferon and ribavirin in triple combination therapy with simeprevir, **AND**

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with telaprevir who were prior treatment relapsers and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 4 and 12; **OR**

The treatment must be limited to a maximum duration of 36 weeks in patients using peginterferon and ribavirin in triple combination therapy with boceprevir who were prior treatment partial responders or relapsers and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 8 and 12; **OR**

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir who were prior treatment relapsers and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at week 4; **OR**

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin without an NS3 protease inhibitor; **OR**

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with boceprevir who: (i) were prior treatment null responders; or (ii) were prior treatment partial responders or relapsers and in whom plasma HCV RNA is detectable by an HCV RNA qualitative assay at week 8, and undetectable by an HCV RNA qualitative assay at week 12; or (iii) have hepatic cirrhosis; **OR**

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with telaprevir who: (i) were prior treatment partial or null responders; or (ii) were prior treatment relapsers and for whom the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is detectable but less than or equal to 1000 IU/mL; or (iii) have hepatic cirrhosis; **OR**

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir who: (i) were prior treatment partial or null responders; or (ii) were prior treatment relapsers and for whom the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is detectable but less than 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin without an NS3 protease inhibitor if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with boceprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with boceprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than 1000 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than or equal to 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic genotype 1 hepatitis C infection (repeatedly anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Authority required

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with telaprevir and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 4 and 12; OR

The treatment must be limited to a maximum duration of 28 weeks in patients using peginterferon and ribavirin in triple combination therapy with boceprevir and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 8 and 24; OR

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir and in whom plasma HCV RNA is undetectable by an HCV RNA quantitative assay at week 4; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin without an NS3 protease inhibitor; OR

The treatment must be limited to a maximum duration of 48 weeks in patients: (i) using peginterferon and ribavirin in triple combination therapy with boceprevir and in whom plasma HCV RNA is detectable by an HCV RNA qualitative assay at week 8, and undetectable by an HCV RNA qualitative assay at week 24; or (ii) using peginterferon and ribavirin in triple combination therapy with boceprevir who have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients: (i) using peginterferon and ribavirin in triple combination therapy with telaprevir and for whom the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is detectable but less than or equal to 1000 IU/mL; or (ii) using peginterferon and ribavirin in triple combination therapy with telaprevir who have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir and for whom the results of an HCV RNA qualitative assay at week 4 show that the plasma HCV RNA is detectable but less than 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin without an NS3 protease inhibitor unless the results of an HCV RNA quantitative assay at week 12 (performed at the same laboratory using the same test) show that plasma HCV RNA has become undetectable or the viral load has decreased by at least a 2 log drop, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with boceprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than 1000 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than or equal to 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

For patients using peginterferon and ribavirin without an NS3 protease inhibitor who are viral negative at week 12, an HCV RNA qualitative assay at week 24 is unnecessary.

Authority required

Chronic non-genotype 1 hepatitis C infection

Clinical criteria:

The treatment must be the sole PBS-subsidised treatment for hepatitis C, **AND**

Patient must have compensated liver disease, **AND**

The condition must be genotype 2, 3, 4, 5 or 6 hepatitis C, **AND**

Patient must have failed prior treatment with interferon based therapies (non-pegylated or pegylated), **AND**

Patient must have received no more than one prior treatment with interferon alfa or peginterferon alfa for hepatitis C, **AND**

The treatment must be limited to a maximum duration of 48 weeks, **AND**

The treatment must cease if HCV RNA is detectable by an HCV RNA qualitative assay at week 12.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Authority required

Chronic non-genotype 1 hepatitis C infection

Clinical criteria:

The treatment must be the sole PBS-subsidised treatment for hepatitis C, **AND**

Patient must have compensated liver disease, **AND**

Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**

The condition must be genotype 2, 3, 4, 5 or 6 hepatitis C, **AND**

The treatment must be limited to a maximum duration of 24 weeks for patients with genotype 2 or 3 hepatitis C without hepatic cirrhosis or bridging fibrosis; OR

The treatment must be limited to a maximum duration of 48 weeks for patients with genotype 4, 5 or 6 hepatitis C; OR

The treatment must be limited to a maximum duration of 48 weeks for patients with genotype 2 or 3 hepatitis C with hepatic cirrhosis or bridging fibrosis, **AND**

The treatment must cease in patients with genotype 4, 5, or 6 hepatitis C unless the results of an HCV RNA quantitative assay at week 12 (performed at the same laboratory using the same test) shows that plasma HCV RNA has become undetectable or the viral load has decreased by at least a 2 log drop, **AND**

The treatment must cease in patients eligible for 48 weeks of treatment if HCV RNA is detectable by an HCV RNA qualitative assay at week 24.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

For patients with genotype 4, 5, or 6 who are viral negative at week 12, an HCV RNA qualitative assay at week 24 is unnecessary.

For patients with genotype 2 or 3 without cirrhosis, an HCV RNA assay at week 12 is unnecessary because of the high likelihood of early viral response by week 12.

For patients who are eligible for 24 weeks of treatment, a maximum of 2 repeats may be prescribed.

For patients who are eligible for 48 weeks of treatment, a maximum of 5 repeats may be prescribed.

Note

Treatment centres are required to have access to the following appropriate specialist facilities for the provision of clinical support services for hepatitis C:

(a) a nurse educator/counsellor for patients; and

(b) 24-hour access by patients to medical advice; and

(c) an established liver clinic.

peginterferon alfa-2b 100 microgram injection [4 x 100 microgram cartridges] (&) ribavirin 200 mg capsule [112 capsules] (&) inert substance diluent [4 x 0.5 mL cartridges], 1 pack

6405D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3146.38	Pegatron [MK]

peginterferon alfa-2b 50 microgram injection [4 x 50 microgram cartridges] (&) ribavirin 200 mg capsule [112 capsules] (&) inert substance diluent [4 x 0.5 mL cartridges], 1 pack

6400W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2166.50	Pegatron [MK]

peginterferon alfa-2b 80 microgram injection [4 x 80 microgram cartridges] (&) ribavirin 200 mg capsule [84 capsules] (&) inert substance diluent [4 x 0.5 mL cartridges], 1 pack

6401X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2469.48	Pegatron [MK]

Other immunostimulants

■ PLERIXAFOR

Authority required

Mobilisation of haematopoietic stem cells

Clinical criteria:

The treatment must be in combination with granulocyte-colony stimulating factor (G-CSF), **AND**

Patient must have lymphoma; OR

Patient must have multiple myeloma, **AND**

Patient must require autologous stem cell transplantation, **AND**

Patient must have failed previous stem cell collection; OR

Patient must be undergoing chemotherapy plus G-CSF mobilisation and their peripheral blood CD34+ count is less than 10,000 per millilitre or less than 10 million per litre on the day of planned collection; OR

Patient must be undergoing chemotherapy plus G-CSF mobilisation and the first apheresis has yielded less than 1 million CD34+ cells/kg.

Evidence that the patient meets the PBS restriction criteria must be recorded in the patient's medical records.

Note

Applications for increased maximum quantities will only be authorised for patients with body weight greater than 100 kg.

plerixafor 24 mg/1.2 mL injection: subcutaneous infusion, 1 x 1.2 mL vial

10084R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	1	..	7037.76	Mozobil [GZ]

■ IMMUNOSUPPRESSANTS

IMMUNOSUPPRESSANTS

Selective immunosuppressants

■ ABATACEPT

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Clinical criteria:

Patient must have severe active rheumatoid arthritis, **AND**

Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**

Patient must not have failed previous PBS-subsidised treatment with this drug for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDs which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

If methotrexate is contraindicated according to the TGA-approved Product Information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and
- (3) a signed patient acknowledgement.

At the time of authority application, medical practitioners should request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for a single infusion. Up to a maximum of 4 repeats will be authorised.

Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted no later than 1 month from the date of completion of this initial course of treatment.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

- (a) a total active joint count of at least 20 active (swollen and tender) joints; or
- (b) at least 4 active joints from the following list of major joints:
 - (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - (ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note

The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:

- (a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
- (b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;

- (c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Special Pricing Arrangements apply.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months).

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for a single infusion. Up to a maximum of 4 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to a treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

A patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) an active joint count of fewer than 10 active (swollen and tender) joints; or

(b) a reduction in the active (swollen and tender) joint count by at least 50% from baseline; or

(c) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note
TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

- a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,

- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and

- once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or

- (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
- (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the

baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply.

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment.

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have demonstrated an adequate response to treatment with this drug, **AND**

Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners should request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for a single infusion. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alpha antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alpha antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

- a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,
- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and
- once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alpha antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or
- (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
- (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a

minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply.

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

abatacept 250 mg injection, 1 x 250 mg vial

9621J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	531.37	Orencia [BQ]

■ ALEMTUZUMAB**Authority required**

Multiple sclerosis

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously been issued with an authority prescription for this drug, **AND**

Patient must not show continuing progression of disability while on treatment with this drug, **AND**

Patient must not receive more than one PBS-subsidised treatment per year, **AND**

The treatment must be as monotherapy, **AND**

Patient must have demonstrated compliance with, and an ability to tolerate this therapy.

Treatment criteria:

Must be treated by a neurologist.

Note

Neurologists prescribing PBS-subsidised alemtuzumab must be registered with the Lemtrada monitoring program.

Special Pricing Arrangements apply.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

alemtuzumab 12 mg/1.2 mL injection, 1 x 1.2 mL vial

10246G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	3	..	..	*34228.75	Lemtrada [GZ]

■ ALEMTUZUMAB**Authority required**

Multiple sclerosis

Treatment Phase: Initial

Clinical criteria:

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by accompanying written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**

The treatment must be as monotherapy, **AND**

Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years, **AND**

Patient must be ambulatory (without assistance or support).

Treatment criteria:

Must be treated by a neurologist.

Where applicable, the date of the magnetic resonance imaging scan must be provided with the authority application.

Note

Neurologists prescribing PBS-subsidised alemtuzumab must be registered with the Lemtrada monitoring program.

Special Pricing Arrangements apply.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

alemtuzumab 12 mg/1.2 mL injection, 1 x 1.2 mL vial

10243D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	5	..	..	*57016.76	Lemtrada [GZ]

▪ **ECULIZUMAB**

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Initial treatment 1 – New patient – Balance of Supply

Clinical criteria:

Patient must have received PBS-subsidised initial supply of eculizumab for this condition, **AND**

Patient must have ADAMTS-13 activity of greater than or equal to 10% on a blood sample, **AND**

Patient must not receive more than 20 weeks supply under this restriction.

Treatment criteria:

Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

ADAMTS-13 activity result must have been submitted to the Department of Human Services. In the case that a sample for ADAMTS-13 activity taken prior to plasma exchange or infusion was not available at the time of application for Initial Treatment 1 New Patient, ADAMTS-13 activity must have been measured 1-2 weeks following the last plasma exchange or infusion, and must have been submitted to the Department of Human Services within 27 days of commencement of eculizumab. The date and time that the sample for the ADAMTS-13 assay was collected, and the dates and times of the last, if any, plasma exchange or infusion that was undertaken in the two weeks prior to collection of the ADAMTS-13 assay must also have been provided to Department of Human Services.

Note

Serial haematological results (every 3 months while the patient is receiving treatment) must be provided with every subsequent application for treatment. This will assist DHS in the consideration of the patient's eligibility for further PBS subsidised treatment

At the time of authority application, medical practitioners must request the appropriate number of vials to provide sufficient drug for 4 weeks and up to 4 repeats, according to the specified dosage in the approved Product Information (PI).

Applications for treatment with eculizumab where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

eculizumab 300 mg/30 mL injection, 1 x 30 mL vial

10192K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	4	..	5984.26	Soliris [XI]

▪ **ECULIZUMAB**

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Initial treatment 1 – New patient

Clinical criteria:

Patient must have active and progressing thrombotic microangiopathy (TMA), **AND**

Patient must have ADAMTS-13 activity of greater than or equal to 10% on a blood sample taken prior to plasma exchange or infusion; or, if ADAMTS-13 activity was not collected prior to plasma exchange or infusion, patient must have platelet counts of greater than $30 \times 10^9/L$ and a serum creatinine of greater than $150 \mu\text{mol/L}$, **AND**

Patient must have a confirmed negative STEC (Shiga toxin-producing E.Coli) result if the patient has had diarrhoea in the preceding 14 days, **AND**

Patient must have clinical features of active organ damage or impairment, **AND**

Patient must not receive more than 4 weeks of treatment under this restriction.

Treatment criteria:

Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

Evidence of active and progressing TMA is defined by the following:

(1) a platelet count of less than $150 \times 10^9/L$; and evidence of two of the following:

- (i) presence of schistocytes on blood film;
- (ii) low or absent haptoglobin;
- (iii) lactate dehydrogenase (LDH) above normal range;

OR

(2) tissue biopsy confirming TMA in patients who don't have evidence of platelet consumption and haemolysis; AND

(3) evidence of at least one of the following clinical features of active TMA-related organ damage or impairment is defined as below:

(a) kidney impairment as demonstrated by one of the following:

- (i) a decline in estimated Glomerular Filtration Rate (eGFR) of greater than 20% in a patient who has pre-existing kidney impairment; and/or
- (ii) a serum creatinine (sCr) of greater than the upper limit of normal (ULN) in a patient who has no history of pre-existing kidney impairment; or
- (iii) a sCr of greater than the age-appropriate ULN in paediatric patients; or
- (iv) a renal biopsy

(b) onset of TMA-related neurological impairment;

(c) onset of TMA-related cardiac impairment;

(d) onset of TMA-related gastrointestinal impairment;

(e) onset of TMA-related pulmonary impairment

The authority application must be in writing and must include:

(1) A completed authority prescription form; and

(2) A completed aHUS eculizumab Authority Application Supporting Information Form- Initial PBS-subsidised eculizumab treatment; and

(3) A signed patient acknowledgement or an acknowledgement signed by a parent or authorised guardian, if applicable; and

(4) A copy of a current Certificate of vaccination; and

(5) A measurement of body weight at the time of application; and

(6) The result of ADAMTS-13 activity on a blood sample taken prior to plasma exchange or infusion; the date and time that the sample for the ADAMTS-13 assay was collected, and the dates and times of any plasma exchanges or infusions that were undertaken in the two weeks prior to collection of the ADAMTS-13 assay; and

(7) In the case that a sample for ADAMTS-13 assay was not collected prior to plasma exchange or infusion, measurement of ADAMTS-13 activity must be taken 1-2 weeks following the last plasma exchange or infusion. The ADAMTS-13 result must be submitted to the Department of Human Services within 27 days of commencement of eculizumab treatment in order for the patient to be considered as eligible for further PBS-subsidised eculizumab treatment, under Initial treatment 1-balance of supply; and

(8) A confirmed negative STEC result if the patient has had diarrhoea in the preceding 14 days; and

(9) Evidence of active and progressing TMA, including pathology results where relevant. Evidence of the onset of TMA-related neurological, cardiac, gastrointestinal or pulmonary impairment requires a supporting statement with clinical evidence in patient records. All tests must have been performed within one month of application; and

(10) For all patients, a recent measurement of eGFR, platelets and two of either LDH, haptoglobin or schistocytes of no more than 1 week old at the time of application.

Note

Serial haematological results (every 3 months while the patient is receiving treatment) must be provided with every subsequent application for treatment. This will assist DHS in the consideration of the patient's eligibility for further PBS subsidised treatment

At the time of authority application, medical practitioners must request the appropriate number of vials to provide sufficient drug for four weeks of treatment, according to the specified dosage in the approved Product Information (PI)

Applications for treatment with eculizumab where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

WARNING: Eculizumab increases the risk of meningococcal infections (septicaemia and/or meningitis)

> Vaccinate patients with a meningococcal vaccine at least 2 weeks prior to receiving the first dose of eculizumab; revaccinate according to current medical guidelines for vaccine use

> Patients less than 2 years of age and those who are treated with eculizumab less than 2 weeks after receiving a meningococcal vaccine must receive treatment with appropriate prophylactic antibiotics until 2 weeks after vaccination.

Monitor patients

for early signs of meningococcal infections, evaluate immediately if infection is suspected, and treat with antibiotics if necessary.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

eculizumab 300 mg/30 mL injection, 1 x 30 mL vial

10182X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	5984.26	Soliris [XI]

■ ECULIZUMAB

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Continuing treatment – New patient

Clinical criteria:

Patient must have received 24 weeks therapy under the initial restriction with PBS subsidised eculizumab for this condition, **AND**

Patient must have demonstrated on-going treatment response of PBS-subsidised eculizumab treatment for this condition, **AND**

Patient must not have experienced treatment failure with eculizumab including PBS-subsidised eculizumab for this condition, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Treatment criteria:

Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

A treatment response is defined as:

(1) Normalisation of haematology as demonstrated by at least 2 of the following: platelet count, haptoglobin, and LDH; **AND**

(2) One of the following:

a) An increase in eGFR of > 25% from baseline, where the baseline is the eGFR measurement immediately prior to commencing treatment with eculizumab or

b) an eGFR within +/- 25% from baseline; or

c) an avoidance of dialysis-dependence but worsening of kidney function with a reduction in eGFR 25% from baseline.

PBS-subsidised treatment with eculizumab will not be permitted if a patient has experienced treatment failure .

A treatment failure is defined as a patient who is:

(1) dialysis-dependent at the time of application and has failed to demonstrate significant resolution of extra-renal complications if originally presented; or

(2) on dialysis and has been on dialysis for 4 months of the previous 6 months while receiving PBS-subsidised eculizumab and has failed to demonstrate significant resolution of extra-renal complications if originally presented.

Serial haematological results (every 3 months while the patient is receiving treatment) must be provided.

The authority application must be in writing and must include:

(1) A completed authority prescription form; and

(2) A completed aHUS eculizumab Authority Application Supporting Information Form for Continuing treatment; and

(3) A copy of a current Certificate of vaccination; and

(4) A measurement of body weight at the time of application; and

(5) Evidence that the patient has had a treatment response including haematological results of no more than 1 week old at the time of application (platelet count, haptoglobin and LDH); and an eGFR level of no more than 1 week old at the time of application ; and

(6) Evidence that the patient has not experienced treatment failure, including a supporting statement with clinical evidence that the patient does not require dialysis, unless the indication for continuing eculizumab is severe extra-renal complications that have significantly improved; and

(7) If the indication for continuing eculizumab is severe extra-renal complications, then a supporting statement with clinical evidence that any initial extra-renal complications of TMA have significantly improved is required.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Continuing treatment – beyond initial 48 weeks of treatment

Clinical criteria:

Patient must have received 48 weeks of treatment under Initial treatment-New patient, Initial treatment-Balance of supply and Continuing treatment-New patient with PBS-subsidised eculizumab for this condition, **AND**

Patient must have demonstrated on-going treatment response with PBS-subsidised eculizumab for this condition, **AND**

Patient must not have ever experienced treatment failure with eculizumab including PBS-subsidised eculizumab for this condition, **AND**

Patient must have a TMA-related cardiomyopathy as evidenced by left ventricular ejection fraction < 40%; OR

Patient must have severe TMA-related neurological impairment; OR

Patient must have severe TMA-related gastrointestinal impairment; OR

Patient must have severe TMA-related pulmonary impairment; OR

Patient must have grade 4 or 5 chronic kidney disease (eGFR of less than 30 ml/min), **AND**

Patient must not receive more than 24 weeks of treatment under this restriction.

Treatment criteria:

Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

A treatment response is defined as:

(1) Normalisation of haematology as demonstrated by at least 2 of the following: platelet count, haptoglobin, and LDH; **AND**

(2) One of the following:

- a) An increase in eGFR of > 25% from baseline, where the baseline is the eGFR measurement immediately prior to commencing treatment with eculizumab or
- b) an eGFR within +/- 25% from baseline; or

c) an avoidance of dialysis-dependence but worsening of kidney function with a reduction in eGFR 25% from baseline.

PBS-subsidised treatment with eculizumab will not be permitted if a patient has experienced treatment failure. A treatment failure is defined as a patient who is:

(1) dialysis-dependent at the time of application and has failed to demonstrate significant resolution of extra-renal complications if originally presented; or

(2) on dialysis and has been on dialysis for 4 months of the previous 6 months while receiving PBS-subsidised eculizumab and has failed to demonstrate significant resolution of extra-renal complications if originally presented.

Serial haematological results (every 3 months while the patient is receiving treatment) must be provided with every subsequent application for treatment. This will assist DHS in the consideration of the patient's eligibility for further PBS subsidised treatment.

The authority application must be in writing and must include:

- (1) A completed authority prescription form; and
- (2) A completed aHUS eculizumab Authority Application Supporting Information Form for Continuing treatment; and
- (3) A copy of a current Certificate of vaccination; and
- (4) A measurement of body weight at the time of application; and
- (5) A supporting statement with clinical evidence of severe TMA-related cardiomyopathy (including current LVEF result), neurological impairment, gastrointestinal impairment or pulmonary impairment; and
- (6) Evidence that the patient has had a treatment response including haematological results of no more than 1 month old at the time of application (platelet count, haptoglobin and LDH); and an eGFR level of no more than 1 month old at the time of application; and
- (7) Evidence that the patient has not experienced treatment failure, including a supporting statement with clinical evidence that the patient does not require dialysis, unless the indication for continuing eculizumab is severe extra-renal complications that have significantly improved; and
- (8) If the indication for continuing eculizumab is severe extra-renal complications, then a supporting statement with clinical evidence that any initial extra-renal complications of TMA have significantly improved is required.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Initial treatment 2 – Recommencement of treatment after an initial 48-week period

Clinical criteria:

Patient must have demonstrated treatment response to previous 48 weeks of treatment with PBS-subsidised eculizumab for this condition, **AND**

Patient must not have ever experienced treatment failure with eculizumab including PBS-subsidised eculizumab for this condition, **AND**

Patient must have the following clinical conditions: (i) either significant haemolysis as measured by low/absent haptoglobin; or presence of schistocytes on the blood film; or lactate dehydrogenase (LDH) above normal; **AND** (ii) either platelet consumption as measured by either 25% decline from patient baseline or thrombocytopenia (platelet count <150 x 10⁹/L); **OR** (iii) TMA-related organ impairment including on recent biopsy, **AND**

Patient must not receive more than 24 weeks of treatment under this restriction.

Treatment criteria:

Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

A treatment response is defined as:

(1) Normalisation of haematology as demonstrated by at least 2 of the following: platelet count, haptoglobin, and LDH; **AND**

(2) One of the following:

- a) An increase in eGFR of > 25% from baseline, where the baseline is the eGFR measurement immediately prior to commencing treatment with eculizumab or
- b) an eGFR within +/- 25% from baseline; or

c) an avoidance of dialysis-dependence but worsening of kidney function with a reduction in eGFR 25% from baseline.

PBS-subsidised treatment with eculizumab will not be permitted if a patient has experienced treatment failure. A treatment failure is defined as a patient who is:

(1) dialysis-dependent at the time of application and has failed to demonstrate significant resolution of extra-renal complications if originally presented; or

(2) on dialysis and has been on dialysis for 4 months of the previous 6 months while receiving PBS-subsidised eculizumab and has failed to demonstrate significant resolution of extra-renal complications if originally presented.

Serial haematological results (every 3 months while the patient is receiving treatment) must be provided with every subsequent application for treatment. This will assist DHS in the consideration of the patient's eligibility for further PBS subsidised treatment.

The authority application must be in writing and must include:

- (1) A completed authority prescription form(s); and
- (2) A completed aHUS eculizumab Authority Application Supporting Information Form for Initial treatment 2 - Recommencement of treatment after an initial 48-week period; and
- (3) A signed patient acknowledgement or an acknowledgement signed by a parent or authorised guardian, if applicable; and
- (4) A copy of a current Certificate of vaccination; and
- (5) A measurement of body weight at the time of application, and

- (6) A supporting statement with clinical evidence of TMA-related organ damage including current (within one week of application) haematological results (platelet count, haptoglobin and LDH), eGFR level, and, if applicable, on recent biopsy;
- (7) Evidence that the patient has had a treatment response to their previous treatment with eculizumab ; and
- (8) Evidence that the patient has not experienced treatment failure, including a supporting statement with clinical evidence that the patient does not require dialysis, unless the indication for continuing eculizumab is severe extra-renal complications that have significantly improved; and
- (9) If the indication for continuing eculizumab is severe extra-renal complications, then a supporting statement with clinical evidence that any initial extra-renal complications of TMA have significantly improved is required.

Note

A raise in LDH alone is not a sufficient reason to re-commence eculizumab, but thrombocytopenia with one marker of haemolysis (such as raised LDH, presence of schistocytes, or low/absence of haptoglobin) is an accepted reason to consider re-commencement of eculizumab treatment.

Kidney transplantation/dialysis is not a contraindication to recommencement of eculizumab treatment.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Continuing treatment – following recommencement of treatment after an initial 48-week period

Clinical criteria:

Patient must have received Initial treatment 2-recommencement of treatment after an initial 48-week period with PBS-subsidised eculizumab for this condition, **AND**

Patient must have demonstrated ongoing treatment response to the previous 24 weeks of PBS-subsidised eculizumab for this condition, **AND**

Patient must not have experienced treatment failure with eculizumab including PBS-subsidised eculizumab for this condition, **AND**

Patient must not receive more than 24 weeks of treatment under this restriction.

Treatment criteria:

Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

A treatment response is defined as:

- (1) Normalisation of haematology as demonstrated by at least 2 of the following: platelet count, haptoglobin, and LDH; AND
- (2) One of the following:

a) An increase in eGFR of > 25% from baseline, where the baseline is the eGFR measurement immediately prior to commencing treatment with eculizumab or

b) an eGFR within +/- 25% from baseline; or

c) an avoidance of dialysis-dependence but worsening of kidney function with a reduction in eGFR 25% from baseline.

PBS-subsidised treatment with eculizumab will not be permitted if a patient has experienced treatment failure . A treatment failure is defined as a patient who is:

(1) dialysis-dependent at the time of application and has failed to demonstrate significant resolution of extra-renal complications if originally presented; or

(2) on dialysis and has been on dialysis for 4 months of the previous 6 months while receiving PBS-subsidised eculizumab and has failed to demonstrate significant resolution of extra-renal complications if originally presented.

Serial haematological results (every 3 months while the patient is receiving treatment) must be provided with every subsequent application for treatment. This will assist DHS in the consideration of the patient s eligibility for further PBS subsidised treatment.

The authority application must be in writing and must include:

- (1) A completed authority prescription form; and
- (2) A completed aHUS eculizumab Authority Application Supporting Information Form for Continuing treatment; and
- (3) A copy of a current Certificate of vaccination; and
- (4) A measurement of body weight at the time of application; and
- (5) Evidence that the patient has had a treatment response including haematological results of no more than 1 week old at the time of application (platelet count, haptoglobin and LDH); and an eGFR level of no more than 1 week old at the time of application ; and
- (6) Evidence that the patient has not experienced treatment failure, including a supporting statement with clinical evidence that the patient does not require dialysis, unless the indication for continuing eculizumab is severe extra-renal complications that have significantly improved; and
- (7) If the indication for continuing eculizumab is severe extra-renal complications, then a supporting statement with clinical evidence that any initial extra-renal complications of TMA have significantly improved is required.

Note

At the time of authority application, medical practitioners must request the appropriate number of vials to provide sufficient drug for 4 weeks and up to 5 repeats, according to the specified dosage in the approved Product Information (PI).

Applications for treatment with eculizumab where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Initial 3 - Grandfather eculizumab patients

Clinical criteria:

Patient must have had documented history of active and progressing thrombotic microangiopathy (TMA), **AND**

Patient must have had documented an ADAMTS-13 activity level consistent with a diagnosis of aHUS, **AND**

Patient must have received treatment with eculizumab for this condition prior to 1 December 2014, **AND**
 Patient must have received treatment with eculizumab within the last 6 months at the time of application, **AND**
 Patient must have demonstrated on-going treatment response as specified in the Continuing treatment New Patient criteria for PBS-subsidised treatment with eculizumab for this condition, if the patient has received adequate therapy in order to demonstrate response, **AND**
 Patient must not have experienced treatment failure with eculizumab for this condition as specified in the Continuing treatment New Patient criteria for PBS-subsidised treatment with eculizumab for this condition, **AND**
 Patient must have clinical features of active organ damage or impairment at the time of a diagnosis of aHUS episode that required treatment with eculizumab, **AND**
 Patient must not receive more than 24 weeks of treatment under this restriction.

Treatment criteria:

Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

Evidence of active and progressing TMA is defined by the following:

(1) a platelet count of less than $150 \times 10^9/L$; and evidence of two of the following:

- (i) presence of schistocytes on blood film;
- (ii) low or absent haptoglobin;
- (iii) lactate dehydrogenase (LDH) above normal range;

OR

(2) tissue biopsy confirming TMA in patients who don't have evidence of platelet consumption and haemolysis; **AND**
 (3) evidence of at least one of the following clinical features of active TMA-related organ damage or impairment is defined as below:

(a) kidney impairment as demonstrated by one of the following:

- (i) a decline in estimated Glomerular Filtration Rate (eGFR) of greater than 20% in a patient who has pre-existing kidney impairment; and/or
- (ii) a serum creatinine (sCr) of greater than the upper limit of normal (ULN) in a patient who has no history of pre-existing kidney impairment; or
- (iii) a sCr of greater than the age-appropriate ULN in paediatric patients; or

(iv) a renal biopsy

- (b) onset of TMA-related neurological impairment;
- (c) onset of TMA-related cardiac impairment;
- (d) onset of TMA-related gastrointestinal impairment;
- (e) onset of TMA-related pulmonary impairment

A treatment response is defined as:

(1) Normalisation of haematology as demonstrated by at least 2 of the following: platelet count, haptoglobin, and LDH; **AND**

(2) One of the following:

a) An increase in eGFR of $> 25\%$ from baseline, where the baseline is the eGFR measurement immediately prior to commencing treatment with eculizumab or

b) an eGFR within $\pm 25\%$ from baseline; or

c) an avoidance of dialysis-dependence but worsening of kidney function with a reduction in eGFR 25% from baseline.

PBS-subsidised treatment with eculizumab will not be permitted if a patient has experienced treatment failure. A treatment failure is defined as a patient who is:

(1) dialysis-dependent at the time of application and has failed to demonstrate significant resolution of extra-renal complications if originally presented; or

(2) on dialysis and has been on dialysis for 4 months of the previous 6 months while receiving PBS-subsidised eculizumab and has failed to demonstrate significant resolution of extra-renal complications if originally presented.

The authority application must be in writing and must include:

- (1) A completed authority prescription form; and
- (2) A completed aHUS eculizumab Authority Application Supporting Information Form for initial PBS-subsidised eculizumab treatment; and
- (3) A signed patient acknowledgement or an acknowledgement signed by a parent or authorised guardian, if applicable; and
- (4) A copy of a current Certificate of vaccination; and
- (5) A measurement of body weight at the time of application; and
- (6) The result of ADAMTS-13 activity on a blood sample at the time this condition was diagnosed; and
- (7) Evidence that the patient has previously received treatment with eculizumab for this condition within the last 6 months at the time of application; and
- (8) Evidence that the patient has had a treatment response including haematological results of no more than 1 week old at the time of application (platelet count, haptoglobin and LDH); and an eGFR level of no more than 1 week old at the time of application; or clinical reasons to justify the commencing of treatment with PBS-subsidised eculizumab; and
- (9) Evidence that the patient has not experienced treatment failure, including a supporting statement with clinical evidence that the patient does not require dialysis, unless the indication for continuing eculizumab is severe extra-renal complications that have significantly improved; and
- (10) A confirmed negative STEC (Shiga toxin-producing E.Coli) result if available at the time of diagnosis; or evidence that the diagnosis was not associated with an infection; and
- (11) Where available in the week prior to commencing eculizumab results demonstrating:
 - (a) a platelet count of less than $150 \times 10^9/L$; and evidence of two of the following:
 - (i) presence of schistocytes on blood film;

- (ii) low or absent haptoglobin;
 (iii) lactate dehydrogenase (LDH) above normal range;
 OR
 (b) tissue biopsy confirming TMA in patients who don't have evidence of platelet consumption and haemolysis; AND
 (c) evidence of at least one of the following clinical features of active TMA-related organ damage or impairment is defined as below:
 (a) kidney impairment as demonstrated by one of the following:
 (i) a decline in estimated Glomerular Filtration Rate (eGFR) of greater than 20% in a patient who has pre-existing kidney impairment; and/or
 (ii) a serum creatinine (sCr) of greater than the upper limit of normal (ULN) in a patient who has no history of pre-existing kidney impairment; or
 (iii) a sCr of greater than the age-appropriate ULN in paediatric patients; or
 (iv) a renal biopsy
 (b) onset of TMA-related neurological impairment;
 (c) onset of TMA-related cardiac impairment;
 (d) onset of TMA-related gastrointestinal impairment;
 (e) onset of TMA-related pulmonary impairment; and
 (12) Where available within one month prior to commencement of eculizumab, evidence of active and progressing TMA, including pathology results where relevant. Evidence of the onset of TMA-related neurological, cardiac, gastrointestinal or pulmonary impairment requires a supporting statement with clinical evidence in patient records.
 Serial haematological results (every 3 months while the patient is receiving treatment) must be provided with every subsequent application for treatment. This will assist DHS in the consideration of the patient's eligibility for further PBS subsidised treatment.

Note

WARNING: Eculizumab increases the risk of meningococcal infections (septicaemia and/or meningitis)

> Vaccinate patients with a meningococcal vaccine at least 2 weeks prior to receiving the first dose of eculizumab; revaccinate according to current medical guidelines for vaccine use

> Patients less than 2 years of age and those who are treated with eculizumab less than 2 weeks after receiving a meningococcal vaccine must receive treatment with appropriate prophylactic antibiotics until 2 weeks after vaccination. Monitor patients

for early signs of meningococcal infections, evaluate immediately if infection is suspected, and treat with antibiotics if necessary.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

eculizumab 300 mg/30 mL injection, 1 x 30 mL vial

10194M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	5	..	5984.26	Soliris [XI]

■ EVEROLIMUS

Caution

Careful monitoring of patients is mandatory.

Authority required

Management of rejection, under the supervision and direction of a transplant unit, in patients receiving this drug for prophylaxis of renal allograft rejection. Management includes initiation, stabilisation and review of therapy as required

Authority required

Management of rejection, under the supervision and direction of a transplant unit, in patients receiving this drug for prophylaxis of cardiac allograft rejection. Management includes initiation, stabilisation and review of therapy as required

everolimus 1 mg tablet, 60

9582H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	4	5	..	*3891.56	Certican [NV]

everolimus 250 microgram tablet, 60

6459Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*506.58	Certican [NV]

everolimus 500 microgram tablet, 60

6460B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1006.40	Certican [NV]

everolimus 750 microgram tablet, 60

6461C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	4	5	..	*2930.36	Certican [NV]

■ MYCOPHENOLATE**Caution**

Careful monitoring of patients is mandatory.

Authority required

Management of rejection, under the supervision and direction of a transplant unit, in patients receiving this drug for prophylaxis of renal allograft rejection. Management includes initiation, stabilisation and review of therapy as required

Authority required

Management of rejection, under the supervision and direction of a transplant unit, in patients receiving this drug for prophylaxis of cardiac allograft rejection. Management includes initiation, stabilisation and review of therapy as required

mycophenolate mofetil 1 g/5 mL oral liquid: powder for, 165 mL

6364Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*#517.97	CellCept [RO]

mycophenolate mofetil 500 mg tablet, 50

6209T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	6	5	..	*572.56	^a APO-Mycophenolate [TX] ^a Ceptolate [AF] ^a Pharmacor Mycophenolate 500 [CR]	^a CellCept [RO] ^a Mycophenolate Sandoz [SZ]

■ MYCOPHENOLATE**Caution**

Careful monitoring of patients is mandatory.

Authority required

Prophylaxis of renal allograft rejection

Treatment Phase: Management

Clinical criteria:

The treatment must be under the supervision and direction of a transplant unit.

Authority required

WHO Class III, IV or V lupus nephritis

Treatment Phase: Management

Clinical criteria:

The condition must be proven by biopsy.

Treatment criteria:

Must be treated by a nephrologist or in consultation with a nephrologist.

The name of the consulting nephrologist must be included in the patient medical records.

Note

Management includes initiation, stabilisation and review of therapy as required.

mycophenolate 180 mg tablet: enteric, 120 tablets

6369F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*233.08	Myfortic [NV]

mycophenolate 360 mg tablet: enteric, 120 tablets

6370G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*459.38	Myfortic [NV]

■ MYCOPHENOLATE**Caution**

Careful monitoring of patients is mandatory.

Authority required

Management of rejection, under the supervision and direction of a transplant unit, in patients receiving this drug for prophylaxis of renal allograft rejection. Management includes initiation, stabilisation and review of therapy as required

Authority required

Management of rejection, under the supervision and direction of a transplant unit, in patients receiving this drug for prophylaxis of cardiac allograft rejection. Management includes initiation, stabilisation and review of therapy as required

Note

For item codes 6208R and 1837Q, pharmaceutical benefits that have the form capsule 250 mg are equivalent for the purposes of substitution.

mycophenolate Capsule 250 mg, 50

1837Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	12	5	..	*572.56	^a Ceptolate [AF]

mycophenolate mofetil 250 mg capsule, 100

6208R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	6	5	..	*572.62	^a APO-Mycophenolate [TX] ^a Mycophenolate Sandoz [SZ]	^a CellCept [RO] ^a Pharmacor Mycophenolate 250 [CR]

▪ NATALIZUMAB
Caution

Progressive multifocal leukoencephalopathy has been reported with this drug.

Authority required

Initial treatment, as monotherapy, by a neurologist, of clinically definite relapsing-remitting multiple sclerosis in an ambulatory (without assistance or support) patient 18 years of age or older, who has experienced at least 2 documented attacks of neurological dysfunction, believed to be due to multiple sclerosis, in the preceding 2 years.

The diagnosis must be confirmed by magnetic resonance imaging of the brain and/or spinal cord and the date of the scan included in the authority application, unless the authority application is accompanied by written certification provided by a radiologist that an MRI scan is contraindicated because of the risk of physical (not psychological) injury to the patient

Authority required

Continuing treatment, as monotherapy, of clinically definite relapsing-remitting multiple sclerosis in a patient previously issued with an authority prescription for this drug who does not show continuing progression of disability while on treatment with this drug, and who has demonstrated compliance with, and an ability to tolerate, this therapy

Note

Neurologists prescribing natalizumab under the PBS listing must be registered with the Tysabri Australian Prescribing Program.

Special Pricing Arrangements apply.

natalizumab 300 mg/15 mL injection, 1 x 15 mL vial

9624M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	5	..	1614.80	Tysabri [BD]

▪ SIROLIMUS
Caution

Careful monitoring of patients is mandatory.

Authority required

Management of rejection, under the supervision and direction of a transplant unit, in patients receiving this drug for prophylaxis of renal allograft rejection. Management includes initiation, stabilisation and review of therapy as required

sirolimus 1 mg tablet, 100

6436R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1493.42	Rapamune [PF]

sirolimus 1 mg/mL oral liquid, 60 mL

6437T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*980.20	Rapamune [PF]

sirolimus 2 mg tablet, 100

6457W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2940.10	Rapamune [PF]

sirolimus 500 microgram tablet, 100

9748C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*759.04	Rapamune [PF]

Tumor necrosis factor alpha (TNF-) inhibitors
▪ ADALIMUMAB
Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months)

Clinical criteria:

Patient must have severe active juvenile idiopathic arthritis, **AND**

Patient must have received no prior PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition; OR

Patient must not have received PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in the previous 12 months, **AND**

Patient must have demonstrated severe intolerance of, or toxicity due to, methotrexate; OR

Patient must have demonstrated failure to achieve an adequate response to 1 or more of the following treatment regimens: (i) oral or parenteral methotrexate at a dose of at least 20 mg per square metre weekly, alone or in combination with oral or intra-articular corticosteroids, for a minimum of 3 months; or (ii) oral methotrexate at a dose of at least 10 mg per square metre weekly together with at least 1 other disease modifying anti-rheumatic drug (DMARD), alone or in combination with corticosteroids, for a minimum of 3 months, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be under 18 years of age and a parent or authorised guardian must have signed a patient acknowledgement.

Treatment criteria:

Must be treated by a paediatric rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

Severe intolerance to methotrexate is defined as intractable nausea and vomiting and general malaise unresponsive to manoeuvres, including reducing or omitting concomitant non-steroidal anti-inflammatory drugs (NSAIDs) on the day of methotrexate administration, use of folic acid supplementation, or administering the dose of methotrexate in 2 divided doses over 24 hours.

Toxicity due to methotrexate is defined as evidence of hepatotoxicity with repeated elevations of transaminases, bone marrow suppression temporally related to methotrexate use, pneumonitis, or serious sepsis.

If treatment with methotrexate alone or in combination with another DMARD is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

(a) an active joint count of at least 20 active (swollen and tender) joints; OR

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count assessment must be performed preferably whilst still on DMARD treatment, but no longer than 4 weeks following cessation of the most recent prior treatment.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form; and

(3) an acknowledgement signed by a parent or authorised guardian.

At the time of authority application, medical practitioners must request the appropriate number of injections of appropriate strength, based on the weight of the patient, to provide sufficient for two doses. Up to a maximum of 3 repeats will be authorised.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle. A patient may re-trial adalimumab after a minimum of 12 months have elapsed between the date the last PBS-subsidised bDMARD was stopped and the date of the first application under a new treatment cycle.

Note

Use of alternative DMARDs in children is dependent on approval by the Therapeutic Goods Administration as age restrictions may apply.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (change or recommencement of treatment after break of less than 12 months)

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**

Patient must have received prior PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in this treatment cycle, **AND**

Patient must not have failed PBS-subsidised therapy with adalimumab for this condition in the current treatment cycle, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be under 18 years of age.

Treatment criteria:

Must be treated by a paediatric rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of injections of appropriate strength, based on the weight of the patient, to provide sufficient for two doses. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with adalimumab in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised adalimumab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised adalimumab treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised adalimumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

If a patient fails to respond to PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months) or Initial 2 (change or recommencement of treatment after break of less than 12 months) – balance of supply

Clinical criteria:

Patient must have received insufficient adalimumab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 12 months) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient adalimumab therapy under the Initial 2 (change or recommencement of treatment after break of less than 12 months) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a paediatric rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Note

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**

Patient must have demonstrated an adequate response to treatment with adalimumab, **AND**

Patient must have received adalimumab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Determination of whether a response has been demonstrated to initial and subsequent courses of treatment will be based on the baseline measurement of joint count submitted with the initial treatment application.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of injections of appropriate strength, based on the weight of the patient, to provide sufficient for two doses. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with adalimumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with adalimumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.

From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:

(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and

(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the

date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.

(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.

(5) Withdrawal of treatment after sustained remission.

Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment – balance of supply

Clinical criteria:

Patient must have received insufficient adalimumab therapy under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

adalimumab 20 mg/0.4 mL injection, 2 x 0.4 mL syringes

9678J

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
1	1676.76	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

9680L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	1676.76	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

9679K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	1676.76	Humira [VE]

■ ETANERCEPT**Authority required**

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months)

Clinical criteria:

Patient must have severe active juvenile idiopathic arthritis, **AND**

Patient must have received no prior PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition; OR

Patient must not have received PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in the previous 12 months, **AND**

Patient must have demonstrated severe intolerance of, or toxicity due to, methotrexate; OR

Patient must have demonstrated failure to achieve an adequate response to 1 or more of the following treatment regimens:

(i) oral or parenteral methotrexate at a dose of at least 20 mg per square metre weekly, alone or in combination with oral or intra-articular corticosteroids, for a minimum of 3 months; or (ii) oral methotrexate at a dose of at least 10 mg per square metre weekly together with at least 1 other disease modifying anti-rheumatic drug (DMARD), alone or in combination with corticosteroids, for a minimum of 3 months, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be under 18 years of age and a parent or authorised guardian must have signed a patient acknowledgement.

Treatment criteria:

Must be treated by a paediatric rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

Severe intolerance to methotrexate is defined as intractable nausea and vomiting and general malaise unresponsive to manoeuvres, including reducing or omitting concomitant non-steroidal anti-inflammatory drugs (NSAIDs) on the day of methotrexate administration, use of folic acid supplementation, or administering the dose of methotrexate in 2 divided doses over 24 hours.

Toxicity due to methotrexate is defined as evidence of hepatotoxicity with repeated elevations of transaminases, bone marrow suppression temporally related to methotrexate use, pneumonitis, or serious sepsis.

If treatment with methotrexate alone or in combination with another DMARD is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

(a) an active joint count of at least 20 active (swollen and tender) joints; OR

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count assessment must be performed preferably whilst still on DMARD treatment, but no longer than 4 weeks following cessation of the most recent prior treatment.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form; and

(3) an acknowledgement signed by a parent or authorised guardian.

At the time of authority application, medical practitioners must request the appropriate number of injections to provide sufficient for four weeks of treatment. Up to a maximum of 3 repeats will be authorised.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle. A patient may re-trial etanercept after a minimum of 12 months have elapsed between the date the last PBS-subsidised bDMARD was stopped and the date of the first application under a new treatment cycle.

Note

Use of alternative DMARDs in children is dependent on approval by the Therapeutic Goods Administration as age restrictions may apply.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (change or recommencement of treatment after break of less than 12 months)

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**

Patient must have received prior PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in this treatment cycle, **AND**

Patient must not have failed PBS-subsidised therapy with etanercept for this condition in the current treatment cycle, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be under 18 years of age.

Treatment criteria:

Must be treated by a paediatric rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of injections to provide sufficient for four weeks of treatment. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with etanercept in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised etanercept treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised etanercept treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised etanercept treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept.

If a patient fails to respond to PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months) or Initial 2 (change or recommencement of treatment after break of less than 12 months) – balance of supply

Clinical criteria:

Patient must have received insufficient etanercept therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 12 months) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient etanercept therapy under the Initial 2 (change or recommencement of treatment after break of less than 12 months) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a paediatric rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Note

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**

Patient must have demonstrated an adequate response to treatment with etanercept, **AND**

Patient must have received etanercept as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Determination of whether a response has been demonstrated to initial and subsequent courses of treatment will be based on the baseline measurement of joint count submitted with the initial treatment application.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of injections to provide sufficient for four weeks of treatment. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with etanercept must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with etanercept, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.

From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:

(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and

(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.

(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.

(5) Withdrawal of treatment after sustained remission.

Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment – balance of supply

Clinical criteria:

Patient must have received insufficient etanercept therapy under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

9641K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	1676.77	Enbrel [PF]

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

9615C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	1676.77	Enbrel [PF]

etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

6367D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	854.36	Enbrel [PF]

■ INFLIXIMAB

Authority required

Acute severe ulcerative colitis

Clinical criteria:

Patient must have received an infusion of infliximab for the treatment of this condition as a hospital inpatient no more than two weeks prior to the date of the authority application, **AND**

Patient must be an adult aged 18 years or older, and prior to initiation of infliximab treatment in hospital must have been experiencing six or more bloody stools per day, plus at least one of the following: (i) Temperature greater than 37.8 degrees Celsius; (ii) Pulse rate greater than 90 beats per minute; (iii) Haemoglobin less than 105 g/L; (iv) Erythrocyte sedimentation rate greater than 30 mm/h; OR

Patient must be a child aged 6 to 17 years inclusive, and prior to initiation of infliximab treatment in hospital must have had a Paediatric Ulcerative Colitis Activity Index (PUCAI) greater than or equal to 65, with the diagnosis confirmed by a gastroenterologist, or a consultant physician as specified below, **AND**

Patient must have failed to achieve an adequate response to at least 72 hours treatment with intravenous corticosteroids prior to initiation of infliximab treatment in hospital.

Population criteria:

Patient must be 6 years of age or older.

Treatment criteria:

Must be treated by a gastroenterologist; OR

Must be treated by a consultant physician [internal medicine specialising in gastroenterology, or general medicine specialising in gastroenterology].

For adults aged 18 years or older, failure to achieve an adequate response to intravenous corticosteroid treatment is defined by the Oxford criteria where:

(i) If assessed on day 3, patients pass 8 or more stools per day or 3 or more stools per day with a C-reactive protein (CRP) greater than 45 mg/L

(ii) If assessed on day 7, patients pass 3 or more stools per day with visible blood.

For children aged 6 to 17 years, failure to achieve an adequate response to intravenous corticosteroids means a PUCAI score greater than 45 at 72 hours.

At the time of authority application, prescribers should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg.

Before administering infliximab to a child aged 6 to 17 years, the treating clinician must have consulted with a paediatric gastroenterologist or with an institution experienced in performance of paediatric colectomy. The name of the specialist or institution must be included in the patient's medical records.

Evidence that the patient meets the PBS restriction criteria must be recorded in the patient's medical records.

Note

No increase in the maximum number of repeats may be authorised.

infliximab 100 mg injection, 1 x 100 mg vial

10057H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	1	..	788.53	Remicade [JC]

■ INFLIXIMAB

Authority required

Initial treatment of Crohn disease in a paediatric patient.

Initial PBS-subsidised treatment by a gastroenterologist, paediatrician or consultant physician as specified in the NOTE below, of a patient aged 6 to 17 years inclusive with moderate to severe refractory Crohn disease who satisfies the following criteria:

- (a) has confirmed Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or consultant physician as specified in the NOTE below; and
- (b) whose parent or authorised guardian has signed a patient acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and
- (c) has failed to achieve an adequate response to 2 of the following 3 conventional prior therapies including:
 - (i) a tapered course of steroids, starting at a dose of at least 1 mg per kg or 40 mg (whichever is the lesser) prednisolone (or equivalent), over a 6 week period;
 - (ii) an 8 week course of enteral nutrition;
 - (iii) immunosuppressive therapy including:
 - azathioprine at a dose of at least 2 mg per kg daily for 3 or more months; or
 - 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months; or
 - methotrexate at a dose of at least 10 mg per square metre weekly for 3 or more months.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of the accepted toxicities including severity can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criterion indicates failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

- (a) severity of disease activity which results in a Paediatric Crohn Disease Activity Index (PCDAI) Score greater than or equal to 30 as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.
- (b) The most recent PCDAI assessment must be no more than 1 month old at the time of application.

All tests and assessments should be performed preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed current Paediatric Crohn Disease Activity Index (PCDAI) calculation sheet including the date of assessment of the patient's condition; and
 - (ii) details of previous systemic drug therapy [dosage, date of commencement and duration of therapy], or dates of enteral nutrition; and
 - (iii) the signed patient acknowledgement.

A maximum quantity and number of repeats to provide for an initial course of infliximab consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete the 3 doses of infliximab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

A PCDAI assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

Authority required

Continuing treatment of Crohn disease in a patient initiated on PBS-subsidised treatment as a paediatric patient.

Continuing PBS-subsidised treatment with infliximab by a gastroenterologist, paediatrician, consultant physician as specified in the NOTE below or other consultant physician in consultation with a gastroenterologist, of a patient who:

- (a) has a documented history of moderate to severe refractory Crohn disease; and
- (b) has demonstrated or sustained an adequate response to treatment with infliximab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to infliximab treatment is defined as a reduction in Paediatric Crohn Disease Activity Index (PCDAI) Score by at least 15 points as compared to baseline AND a total PCDAI score of 30 points or less.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the completed Paediatric Crohn Disease Activity Index (PCDAI) calculation sheet along with the date of the assessment of the patient's condition.

The PCDAI assessment must be no more than 1 month old at the time of application.

If the application is the first application for continuing treatment with infliximab, a PCDAI assessment of the patient's response must be made up to 12 weeks after the first dose so that there is adequate time for a response to be demonstrated.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

Patients who fail to demonstrate or sustain a response to treatment with infliximab for Crohn disease as specified in the criteria for continuing treatment with infliximab, will not be eligible to receive PBS-subsidised treatment with this drug within 12 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

Authority required

Initial PBS-subsidised treatment of Crohn disease in a paediatric patient who has previously received non-PBS-subsidised therapy with infliximab.

Initial PBS-subsidised supply for continuing treatment with infliximab by a gastroenterologist, paediatrician, consultant physician as specified in the NOTE below or other consultant physician in consultation with a gastroenterologist, of a patient aged 6 to 17 years inclusive who:

(a) has a documented history of moderate to severe refractory Crohn disease and was receiving treatment with infliximab prior to 4 July 2007; and

(b) had a Paediatric Crohn Disease Activity Index (PCDAI) Score of greater than 30 prior to commencing treatment with infliximab. Where a baseline CDAI assessment is not available, please call Medicare Australia on 1800 700 270 to discuss; and

(c) whose parent or authorised guardian has signed a patient acknowledgement indicating that they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and

(d) has demonstrated or sustained an adequate response to treatment with infliximab. For advice please contact Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to infliximab treatment is defined as a reduction in Paediatric Crohn Disease Activity Index (PCDAI) Score by at least 15 points as compared to baseline AND a total PCDAI score of 30 points or less.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the completed current and baseline Paediatric Crohn Disease Activity Index (PCDAI) calculation sheet along with the date of the assessment of the patient's condition; and

(ii) the signed patient acknowledgement.

The current PCDAI assessment must be no more than 1 month old at the time of application. The baseline PCDAI assessment must be from immediately prior to commencing treatment with infliximab.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

Patients who fail to demonstrate or sustain a response to treatment with infliximab for Crohn disease as specified in the criteria for continuing treatment with infliximab, will not be eligible to recommence PBS-subsidised treatment with this drug within 12 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Patients may qualify for PBS-subsidised treatment under this restriction once only

Note

Any queries concerning the arrangements to prescribe infliximab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe infliximab should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

infliximab 100 mg injection, 1 x 100 mg vial

9612X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	788.53	Remicade [JC]

■ INFLIXIMAB

Authority required

Initial 1

Initial treatment of complex refractory FISTULISING CROHN DISEASE.

Initial PBS-subsidised treatment with infliximab by a gastroenterologist or a consultant physician as specified in the NOTE below, of a patient with complex refractory fistulising Crohn disease who:

(a) has confirmed Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or a consultant physician as specified in the NOTE below; and

(b) has an externally draining enterocutaneous or rectovaginal fistula; and

(c) has signed a patient acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

Authority applications must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) a completed current Fistula Assessment Form including the date of assessment of the patient's condition; and

(ii) a signed patient acknowledgement.

The most recent fistula assessment must be no more than 1 month old at the time of application.

A maximum quantity and number of repeats to provide for an initial course of infliximab consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6 will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete 3 doses of infliximab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

An assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (up to 6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

Authority required

Initial 2

Change or re-commencement of treatment of complex refractory FISTULISING CROHN DISEASE.

Initial PBS-subsidised treatment with infliximab of complex refractory fistulising Crohn disease by a gastroenterologist or a consultant physician as specified in the NOTE below, of a patient with complex refractory fistulising Crohn disease who:

(a) has a documented history of complex refractory fistulising Crohn disease; and

(b) in this treatment cycle, has received prior PBS-subsidised treatment with adalimumab or infliximab for a draining enterocutaneous or rectovaginal fistula; and

(c) has not failed PBS-subsidised therapy with infliximab for this condition more than once in the current treatment cycle.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of TNF-alfa antagonist therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised TNF-alfa antagonist treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks therapy for

adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of TNF-alfa antagonist treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of TNF-alfa antagonist.

Authority applications must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) a completed current Fistula Assessment Form including the date of assessment of the patient's condition; and
 - (ii) details of prior TNF-alfa antagonist treatment including details of date and duration of treatment.

The most recent fistula assessment must be no more than 1 month old at the time of application.

A maximum quantity and number of repeats to provide for an initial course of infliximab consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete 3 doses of infliximab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

An assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (up to 6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

Authority required

Initial 3 (grandfather)

Initial PBS-subsidised treatment of complex refractory FISTULISING CROHN DISEASE in a patient who has previously received non-PBS-subsidised therapy with infliximab.

Initial PBS-subsidised supply for continuing treatment with infliximab by a gastroenterologist, a consultant physician as specified in the NOTE below, or other consultant physician in consultation with a gastroenterologist of a patient who satisfies the following criteria:

- (a) has a documented history of complex refractory fistulising Crohn disease and was receiving treatment with infliximab prior to 1 March 2010; and
- (b) had a draining enterocutaneous or rectovaginal fistula(e) prior to commencing treatment with infliximab; and
- (c) has signed a patient acknowledgement indicating that they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and
- (d) is receiving treatment with infliximab at the time of application; and
- (e) has demonstrated or sustained an adequate response to treatment with infliximab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to infliximab treatment is defined as:

- (a) a decrease from baseline in the number of open draining fistulae of greater than or equal to 50%; and/or
- (b) a marked reduction in drainage of all fistula(e) from baseline, together with less pain and induration as reported by the patient.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) a completed current and baseline Fistula Assessment form including the date of assessment of the patient's condition; and
 - (ii) a signed patient acknowledgement.

The current fistula assessment must be no more than 1 month old at the time of application.

The baseline fistula assessment must be from immediately prior to commencing treatment with infliximab.

An assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criteria.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Patients may qualify for PBS-subsidised treatment under this restriction once only

Authority required

Continuing treatment of complex refractory FISTULISING CROHN DISEASE.

Continuing PBS-subsidised treatment with infliximab by a gastroenterologist, a consultant physician as specified in the NOTE below or other consultant physician in consultation with a gastroenterologist, of a patient who:

- (a) has a documented history of complex refractory fistulising Crohn disease; and
- (b) has demonstrated or sustained an adequate response to treatment with infliximab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response is defined as:

- (a) a decrease from baseline in the number of open draining fistulae of greater than or equal to 50%; and/or
- (b) a marked reduction in drainage of all fistula(e) from baseline, together with less pain and induration as reported by the patient.

Authority applications must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes a completed Fistula Assessment form including the date of the assessment of the patient's condition.

The fistula assessment must be no more than 1 month old at the time of application.

If the application is the first application for continuing treatment with infliximab, an assessment of the patient's response must be made up to 12 weeks after the first dose so that there is adequate time for a response to be demonstrated.

An assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criteria.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

Note

Any queries concerning the arrangements to prescribe infliximab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe infliximab should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

TREATMENT OF COMPLEX REFRACTORY FISTULISING CROHN DISEASE

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab and infliximab for patients with complex refractory fistulising Crohn disease. Where the term 'tumour necrosis factor (TNF) alfa antagonist' appears in the following NOTES and restrictions, it refers to adalimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any 1 time.

From 1 April 2011, under the PBS, all patients will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.

A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 April 2011 is considered to be in their first cycle as of 1 April 2011.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised TNF-alfa antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alfa antagonist under the new treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised TNF-alfa antagonist therapy after 1 April 2011.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised TNF-alfa antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
- (ii) a patient has received prior PBS-subsidised (initial or continuing) TNF-alfa antagonist therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iii) a patient wishes to re-commence treatment with a specific TNF-alfa antagonist following a break in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab and 14 weeks of therapy for infliximab.

From 1 April 2011, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab, and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Adalimumab only: Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific TNF-alfa antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing TNF-alfa antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF-alfa antagonist supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised TNF-alfa antagonist is approved, a patient may swap if eligible to the alternate TNF-alfa antagonist within the same treatment cycle.

A patient may trial the alternate TNF-alfa antagonist at any time, regardless of whether they are receiving therapy (initial or continuing) with a TNF-alfa antagonist at the time of the application. However, they cannot swap to a particular TNF-alfa antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to the alternate TNF-alfa antagonist should be accompanied by the approved authority prescription or remaining repeats for the TNF-alfa antagonist the patient is ceasing.

(3) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated based on the baseline measurements submitted with the first authority application for a TNF-alfa antagonist. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and Medicare Australia will assess response according to these revised baseline measurements.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF-alfa antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity.

(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab or infliximab.

A patient who commenced treatment with adalimumab for complex refractory fistulising Crohn disease prior to 4 November 2010 or infliximab prior to 1 March 2010 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction.

A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab or infliximab will be authorised under this criterion.

Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab or infliximab will be assessed under the continuing treatment restriction.

'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

infliximab 100 mg injection, 1 x 100 mg vial

9674E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	788.53	Remicade [JC]

• INFLIXIMAB

Authority required

Initial treatment [Initial 1, Whole body (New patients — No prior biological agent)]

Initial treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over who:

- (a) have severe chronic plaque psoriasis where lesions have been present for at least 6 months from the time of initial diagnosis; and
- (b) have not received any prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle; and
- (c) have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (whole body); and
- (d) have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments:
 - (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or
 - (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or
 - (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or
 - (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks.

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity to necessitate permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of acceptable toxicities including severity, associated with phototherapy, methotrexate, cyclosporin and acitretin, can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criterion indicates failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

- (a) A current Psoriasis Area and Severity Index (PASI) score of greater than 15, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.
- (b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.
- (c) The most recent PASI assessment must be no more than 1 month old at the time of application.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]]; and
 - (ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and
 - (iii) the signed patient and prescriber acknowledgements.

A maximum of 22 weeks of treatment with infliximab will be authorised under this restriction.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats will be authorised.

Where fewer than 3 repeats are requested at the time of the initial application, authority approvals for sufficient repeats to complete a maximum of 22 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period beyond 22 weeks.

A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

Authority required

Initial or re-Treatment [Initial 2, Whole body (Received prior biological agent under PBS)]

Treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over who:

- (a) have a documented history of severe chronic plaque psoriasis; and
 - (b) have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle; and
 - (c) have not failed PBS-subsidised therapy with infliximab for the treatment of this condition in the current Treatment Cycle.
- Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]]; and
 - (ii) details of prior biological treatment, including dosage, date and duration of treatment.

Applications for patients who have demonstrated a response to PBS-subsidised infliximab treatment within this Treatment Cycle and who wish to re-commence infliximab treatment within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised infliximab treatment has been submitted to Medicare Australia within 1 month of cessation of treatment.

A maximum of 22 weeks of treatment with infliximab will be authorised under this restriction.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats will be authorised.

Where fewer than 3 repeats are requested at the time of the initial application, authority approvals for sufficient repeats to complete a maximum of 22 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period beyond 22 weeks.

A PASI assessment of the patient's response to this course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Authority required

Continuing treatment (Whole body)

Continuing PBS-subsidised treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over:

- (a) who have a documented history of severe chronic plaque psoriasis; and
- (b) whose most recent course of PBS-subsidised biological treatment for this condition in this Treatment Cycle was with infliximab; and
- (c) who have demonstrated an adequate response to their most recent course of treatment with infliximab.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-biological treatment baseline value for this Treatment Cycle.

This assessment must be provided to Medicare Australia no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with infliximab, the assessment of response must be after a minimum of 12 weeks of treatment with an initial course.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet along with the date of the assessment of the patient's condition.

The most recent PASI assessment must be no more than 1 month old at the time of application.

Approval will be based on the PASI assessment of response to the most recent course of treatment with infliximab.

A maximum of 24 weeks of treatment with infliximab will be authorised under this restriction.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for continuing authority applications, or for treatment that would otherwise extend the treatment period beyond 24 weeks.

A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment

Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle

Authority required

Initial treatment [Initial 1, Face, hand, foot (New patients — No prior biological agent)]

Initial treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over who:

(a) have severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis; and

(b) have not received any prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle; and

(c) have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (face, hand, foot); and

(d) have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments:

(i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or

(ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or

(iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or

(iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks.

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity to necessitate permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of acceptable toxicities including severity, associated with phototherapy, methotrexate, cyclosporin and acitretin, can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criterion indicates failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

(a) Chronic plaque psoriasis classified as severe due to a plaque or plaques on the face, palm of a hand or sole of a foot where:

(i) at least 2 of the 3 Psoriasis Area and Severity Index (PASI) symptom subscores for erythema, thickness and scaling are rated as severe or very severe, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment; or

(ii) the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]]; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

A maximum of 22 weeks of treatment with infliximab will be authorised under this restriction.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats will be authorised.

Where fewer than 3 repeats are requested at the time of the initial application, authority approvals for sufficient repeats to complete a maximum of 22 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period beyond 22 weeks.

A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment.

The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline

Authority required

Initial or re-Treatment [Initial 2, Face, hand, foot (Received prior biological agent under PBS)]

Treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over who:

(a) have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot; and
(b) have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle; and
(c) have not failed PBS-subsidised therapy with infliximab for the treatment of this condition in the current Treatment Cycle.
Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]]; and

(ii) details of prior biological treatment, including dosage, date and duration of treatment.

Applications for patients who have demonstrated a response to PBS-subsidised infliximab treatment within this Treatment Cycle and who wish to re-commence infliximab treatment within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised infliximab treatment has been submitted to Medicare Australia within 1 month of cessation of treatment.

A maximum of 22 weeks of treatment with infliximab will be authorised under this restriction.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats will be authorised.

Where fewer than 3 repeats are requested at the time of the initial application, authority approvals for sufficient repeats to complete a maximum of 22 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period beyond 22 weeks.

A PASI assessment of the patient's response to this course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment.

The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle

Authority required

Continuing treatment (Face, hand, foot)

Continuing PBS-subsidised treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over:

(a) who have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot; and
(b) whose most recent course of PBS-subsidised biological treatment for this condition in this Treatment Cycle was with infliximab; and

(c) who have demonstrated an adequate response to treatment with infliximab.

An adequate response to infliximab treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

(i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or
(ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

This assessment must be provided to Medicare Australia no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with infliximab, the assessment of response must be after a minimum of 12 weeks of treatment with an initial course.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet and face, hand, foot area diagrams along with the date of the assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]].

The most recent PASI assessment must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with infliximab will be authorised under this restriction.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for continuing authority applications, or for treatment that would otherwise extend the treatment period beyond 24 weeks.

A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for further continuing treatment must be submitted to Medicare Australia no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment.

The PASI assessment for continuing treatment must be performed on the same affected area assessed at baseline.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle

Note

Any queries concerning the arrangements to prescribe infliximab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe infliximab should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab and ustekinumab, for adult patients with severe chronic plaque psoriasis. Therefore, where the term 'biological agents' appears in the following NOTES and restrictions, it only refers to adalimumab, etanercept, infliximab and ustekinumab.

From 1 March 2010, all patients will be able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial adalimumab, etanercept, infliximab or ustekinumab without having to meet the initial treatment criteria, that is they will not need to experience a disease flare when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

A patient who received PBS-subsidised biological agent treatment for chronic plaque psoriasis prior to 1 March 2010 is considered to be in their first Cycle as of 1 March 2010.

Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.

Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment. A patient who, prior to 1 March 2010, was authorised to receive PBS-subsidised initial treatment for chronic plaque psoriasis with the same agent twice, is exempt from this condition in respect of applications approved prior to 1 March 2010.

Patients must be assessed for response to each course of continuing treatment according to the criteria included in the relevant continuing treatment restriction.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.

Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe chronic plaque psoriasis after 1 March 2010.

There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made in the following situations:

- (i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
- (ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
- (iii) patients who wish to re-commence treatment following a break in PBS-subsidised therapy with that agent (Initial 2).

All applications for initial treatment will be limited to provide for a maximum of 16 weeks of treatment in the case of

adalimumab and etanercept, 22 weeks of treatment in the case of infliximab and 28 weeks of treatment in the case of ustekinumab.

(2) Assessment of response to initial treatment.

When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to Medicare Australia within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.

(3) Application for continuing treatment.

Following the completion of an initial treatment course of a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.

For second and subsequent courses of PBS-subsidised treatment with adalimumab, etanercept, infliximab or ustekinumab it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Where a response assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to sustain a response to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

(4) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.

Patients who commenced treatment with adalimumab prior to 1 June 2009 or ustekinumab prior to 1 March 2010 access these interchangeability arrangements in the same way as patients who have not.

To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the approved authority prescription or remaining repeats for the agent being ceased.

(5) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatment applications.

(6) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

No applications for increased repeats will be authorised.

infliximab 100 mg injection, 1 x 100 mg vial

9617E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	788.53	Remicade [JC]

INFLIXIMAB

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Initial treatment (new patient)

Clinical criteria:

Patient must have failed to achieve an adequate response to a 5-aminosalicylate oral preparation in a standard dose for induction of remission for 3 or more months or have intolerance necessitating permanent treatment withdrawal, **AND**

Patient must have failed to achieve an adequate response to azathioprine at a dose of at least 2 mg per kg daily for 3 or more months or have intolerance necessitating permanent treatment withdrawal; OR

Patient must have failed to achieve an adequate response to 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months or have intolerance necessitating permanent treatment withdrawal; OR

Patient must have failed to achieve an adequate response to a tapered course of oral steroids, starting at a dose of at least 40 mg (for a child, 1 to 2 mg/kg up to 40 mg) prednisolone (or equivalent), over a 6 week period or have intolerance necessitating permanent treatment withdrawal, **AND**

Patient must have a Mayo clinic score greater than or equal to 6 if an adult patient; OR

Patient must have a partial Mayo clinic score greater than or equal to 6, provided the rectal bleeding and stool frequency subscores are both greater than or equal to 2 (endoscopy subscore is not required for a partial Mayo clinic score); OR Patient must have a Paediatric Ulcerative Colitis Activity Index (PUCAI) Score greater than or equal to 30 if aged 6 to 17 years.

Population criteria:

Patient must be 6 years of age or older.

Treatment criteria:

Must be treated by a gastroenterologist (code 87) or a consultant physician [internal medicine specialising in gastroenterology (code 81)] or a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR Must be treated by a paediatrician or specialist paediatric gastroenterologist if aged between 6 to 17 years.

Applications for authorisation of initial treatment must be in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Ulcerative Colitis PBS Authority Application - Supporting Information Form which includes the following:
 - (i) the completed current Mayo clinic or partial Mayo clinic or Paediatric Ulcerative Colitis Activity Index (PUCAI) calculation sheet including the date of assessment of the patient's condition; and
 - (ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and
 - (iii) the signed patient acknowledgement.

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

All tests and assessments should be performed preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment. The most recent Mayo clinic, partial Mayo clinic or PUCAI score must be no more than 1 month old at the time of application.

Patients who fail to achieve a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1, or a PUCAI score less than 10 within the first 12 weeks of receiving this drug for ulcerative colitis, or have failed to maintain a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1, or have failed to maintain a PUCAI score less than 10 (if aged 6 to 17 years) with continuing treatment with this drug, will not be eligible to receive further PBS-subsidised treatment with this drug.

A partial Mayo clinic or PUCAI assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

The patient or guardian (required if patient aged 6 to 17 years) must have signed a patient acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application. If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application.

Patients may qualify for PBS-subsidised treatment under this restriction once only.

Note

Details of the toxicities, including severity, which will be accepted for the purposes of administering this restriction can be found on the Department of Human Services website at www.humanservices.gov.au

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Initial PBS-subsidised treatment of moderate to severe ulcerative colitis in a patient who has previously received non-PBS-subsidised therapy with this drug (grandfather)

Clinical criteria:

Patient must have been receiving treatment with this drug prior to 1 December 2014, **AND**

Patient must have had a Mayo clinic score greater than or equal to 6 prior to commencing treatment with this drug; OR Patient must have had a partial Mayo clinic score greater than or equal to 6, provided the rectal bleeding and stool frequency subscores were both greater than or equal to 2 (endoscopy subscore is not required for a partial Mayo score) prior to commencing treatment with this drug; OR

Patient must have had a Paediatric Ulcerative Colitis Activity Index (PUCAI) Score greater than or equal to 30 prior to commencing treatment with this drug; OR

Patient must have a documented history of moderate to severe refractory ulcerative colitis prior to having commenced treatment with this drug where a Mayo clinic, partial Mayo clinic or PUCAI baseline assessment is not available, **AND**

Patient must have demonstrated or sustained an adequate response to treatment by having a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1 while receiving treatment with this drug; OR

Patient must have demonstrated or sustained an adequate response to treatment by having a Paediatric Ulcerative Colitis Activity Index (PUCAI) score less than 10 while receiving treatment with this drug if aged 6 to 17 years.

Population criteria:

Patient must be 6 years of age or older.

Treatment criteria:

Must be treated by a gastroenterologist (code 87) or a consultant physician [internal medicine specialising in gastroenterology (code 81)] or a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR Must be treated by a paediatrician or specialist paediatric gastroenterologist if aged between 6 to 17 years.

Applications for authorisation of initial treatment must be in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Ulcerative Colitis PBS Authority Application - Supporting Information Form which includes the following:

- (i) the completed current and baseline Mayo clinic or partial Mayo clinic or Paediatric Ulcerative Colitis Activity Index (PUCAI) calculation sheet including the date of assessment of the patient's condition and
- (ii) the date of commencement of this drug and
- (iii) the signed patient acknowledgement.

The current Mayo clinic or partial Mayo clinic or PUCAI assessment must be no more than 1 month old at the time of application. The baseline assessment must be from immediately prior to commencing treatment with this drug.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to be sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

The patient or guardian (required if patient aged 6 to 17 years) must have signed a patient acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

Patients may qualify for PBS-subsidised treatment under this restriction once only. For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

Note

Where a baseline assessment is not available, please call the Department of Human Services on 1800 700 270 to discuss (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Initial treatment (new patient) restriction to complete the 3 doses (i.e. the initial infusion regimen at weeks 0, 2 and 6 weeks); OR

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks of treatment; OR

Patient must have received insufficient therapy with this drug to complete 24 weeks of treatment under the Initial PBS-subsidised treatment restriction for patients who had previously received non-PBS subsidised treatment (Grandfathered patient), **AND**

The treatment must provide no more than the balance of up to 3 doses (new patients) or 2 repeats (Continuing patients or Grandfathered patients).

Population criteria:

Patient must be 6 years of age or older.

Treatment criteria:

Must be treated by a gastroenterologist (code 87) or a consultant physician [internal medicine specialising in gastroenterology (code 81)] or a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR

Must be treated by a paediatrician or specialist paediatric gastroenterologist if aged between 6 to 17 years.

Note

Authority approval for sufficient therapy to complete a maximum of 3 initial doses or 2 repeats may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authority approval for sufficient therapy to complete a maximum of 3 initial doses or 2 repeats should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**

Patient must have demonstrated or sustained an adequate response to treatment by having a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1 while receiving treatment with this drug; OR

Patient must have demonstrated or sustained an adequate response to treatment by having a Paediatric Ulcerative Colitis Activity Index (PUCAI) score less than 10 while receiving treatment with this drug if aged 6 to 17 years.

Treatment criteria:

Must be treated by a gastroenterologist (code 87) or a consultant physician [internal medicine specialising in gastroenterology (code 81)] or a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR
Must be treated by a paediatrician or specialist paediatric gastroenterologist if aged between 6 to 17 years.

Patients who have failed to maintain a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1, or, patients who have failed to maintain a PUCAI score less than 10 (if aged 6 to 17 years) with continuing treatment with this drug, will not be eligible to receive further PBS-subsidised treatment with this drug.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Special Pricing Arrangements apply.

infliximab 100 mg injection, 1 x 100 mg vial

10184B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	788.53	Remicade [JC]

■ **INFLIXIMAB**

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Clinical criteria:

Patient must have severe active rheumatoid arthritis, **AND**

Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**

Patient must have not failed previous PBS-subsidised treatment with infliximab for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDs which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**

Patient must not receive more than 22 weeks of treatment under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

If methotrexate is contraindicated according to the TGA-approved product information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance including severity to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances including severity.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance including severity and dose for each DMARD must be provided in the authority application including severity.

The authority application must be made in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and
- (3) a signed patient acknowledgement.

At the time of authority application, medical practitioners should request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for a single infusion at a dose of 3 mg per kg. Up to a maximum of 3 repeats will be authorised.

Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted no later than 1 month from the date of completion of this initial course of treatment.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

Applications for a patient who has received PBS-subsidised treatment with infliximab and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised infliximab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised infliximab treatment was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised infliximab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with infliximab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

- (a) a total active joint count of at least 20 active (swollen and tender) joints; or
- (b) at least 4 active joints from the following list of major joints:
 - (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - (ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note

The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:

- (a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
- (b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;

- (c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Special Pricing Arrangements apply.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months).

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**

Patient must not receive more than 22 weeks of treatment under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners should request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for single infusion at a dose of 3 mg per kg. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with infliximab and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised infliximab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised infliximab treatment was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised infliximab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

If a patient fails to demonstrate a response to a treatment with infliximab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

A patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply.

Clinical criteria:

Patient must have received insufficient infliximab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 22 weeks treatment; OR

Patient must have received insufficient infliximab therapy under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 22 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 22 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 22 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 22 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis
Treatment Phase: Continuing treatment.

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have demonstrated an adequate response to treatment with infliximab, **AND**

Patient must have received infliximab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners should request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for single infusion at a dose of 3 mg per kg. Up to a maximum of 2 repeats will be authorised.

All applications for continuing treatment with infliximab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with infliximab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

If a patient fails to demonstrate a response to treatment with infliximab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,

a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing)

with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialed and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply.

Clinical criteria:

Patient must have received insufficient infliximab therapy under the Continuing Treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

infliximab 100 mg injection, 1 x 100 mg vial

6397Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	788.53	Remicade [JC]

■ INFLIXIMAB

Authority required

Active ankylosing spondylitis

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

The condition must be radiographically (plain X-ray) confirmed Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis, **AND**

Patient must not have received any PBS-subsidised treatment with either adalimumab, certolizumab pegol, etanercept, golimumab or infliximab in this treatment cycle, **AND**

Patient must have at least 2 of the following: (i) low back pain and stiffness for 3 or more months that is relieved by exercise but not by rest; or (ii) limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by a score of at least 1 on each of the lumbar flexion and lumbar side flexion measurements of the Bath Ankylosing Spondylitis Metrology Index (BASMI); or (iii) limitation of chest expansion relative to normal values for age and gender, **AND**

Patient must have failed to achieve an adequate response following treatment with at least 2 non-steroidal anti-inflammatory drugs (NSAIDs), whilst completing an appropriate exercise program, for a total period of 3 months.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

The application must include details of the NSAIDs trialled, their doses and duration of treatment.

If the NSAID dose is less than the maximum recommended dose in the relevant TGA-approved Product Information, the application must include the reason a higher dose cannot be used.

If treatment with NSAIDs is contraindicated according to the relevant TGA-approved Product Information, the application must provide details of the contraindication.

If intolerance to NSAID treatment develops during the relevant period of use which is of a severity to necessitate permanent treatment withdrawal, the application must provide details of the nature and severity of this intolerance.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of the initial application:

(a) a Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 4 on a 0-10 scale; **AND**

(b) an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 10 mg per L.

The BASDAI must be determined at the completion of the 3 month NSAID and exercise trial, but prior to ceasing NSAID treatment. The BASDAI must be no more than 1 month old at the time of initial application.

Both ESR and CRP measures should be provided with the initial treatment application and both must be no more than 1 month old. If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reason this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form which must include the following:

(i) a copy of the radiological report confirming Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis; and

(ii) a completed BASDAI Assessment Form; and

(iii) a completed Exercise Program Self Certification Form included in the supporting information form; and

(iv) a signed patient acknowledgment.

The assessment of the patient's response to the initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted no later than 4 weeks from the cessation of that treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

A maximum of 18 weeks of treatment with this drug will be approved under this criterion.

At the time of authority application, the doctor should request the appropriate number of vials, based on the weight of the patient, to provide for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats will be authorised.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) was approved in this cycle and the date of the first application under a new cycle.

Note

Details of the toxicities, including severity, which will be accepted for the purposes of administering this restriction can be found on the Department of Human Services website at www.humanservices.gov.au

For details on the appropriate minimum exercise program that will be accepted for the purposes of administering this restriction, please refer to the Department of Human Services website at www.humanservices.gov.au

Authority required

Ankylosing spondylitis

Treatment Phase: Initial 2 (change or recommencement for all patients)

Clinical criteria:

Patient must have a documented history of active ankylosing spondylitis, **AND**

Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition in this treatment cycle, **AND**

Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle, **AND**

Patient must be eligible to receive further bDMARD therapy.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

Where the most recent course of PBS-subsidised bDMARD treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised bDMARD therapy or, under this restriction, for patients who have

received previous PBS-subsidised bDMARD therapy) the patient must have been assessed for response to that course following a minimum of 12 weeks of treatment. These assessments must be provided to the Department of Human Services no later than 4 weeks from the date the course was ceased. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, patients must have been assessed for response, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

The authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

A maximum of 18 weeks of treatment with this drug will be approved under this criterion.

At the time of authority application, the doctor should request the appropriate number of vials, based on the weight of the patient, to provide for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats will be authorised.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Authority required

Ankylosing spondylitis

Treatment Phase: Initial treatment – Initial 1 (new patients) or Initial 2 (change or recommencement for all patients) – balance of supply

Clinical criteria:

Patient must have active, or a documented history of active, ankylosing spondylitis, **AND**

Patient must have received insufficient therapy with this drug under the Initial 1 (new patients) restriction to complete 18 weeks treatment; OR

Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement for all patients) restriction to complete 18 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 18 weeks treatment available under the above restrictions.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

Note

Authority approval for sufficient therapy to complete a maximum of 18 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 18 weeks of treatment should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of active ankylosing spondylitis, **AND**

Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**

Patient must have demonstrated an adequate response to treatment with this drug.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

An adequate response is defined as an improvement from baseline of at least 2 of the BASDAI and 1 of the following:

- (a) an ESR measurement no greater than 25 mm per hour; or
- (b) a CRP measurement no greater than 10 mg per L; or
- (c) an ESR or CRP measurement reduced by at least 20% from baseline.

Where only 1 acute phase reactant measurement is supplied in the first application for PBS-subsidised treatment, that same marker must be measured and supplied in all subsequent continuing treatment applications.

The authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

All measurements provided must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.

At the time of authority application, the doctor should request the appropriate number of vials, based on the weight of the patient, to provide for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats will be authorised.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment following an initial treatment course it must be made following a minimum of 12 weeks of treatment with this drug. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab and infliximab for adult patients with active ankylosing spondylitis.

Where the term 'bDMARD' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 5 bDMARDs at any 1 time.

From 1 March 2007, under the PBS, all patients will be able to commence a treatment cycle where they may trial PBS-subsidised bDMARDs without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.

A patient who received PBS-subsidised bDMARD treatment prior to 1 March 2007 is considered to be in their first cycle as of 1 March 2007.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once. A patient who, prior to 1 March 2007, was authorised to receive PBS-subsidised initial treatment for ankylosing spondylitis with the same agent twice, is exempt from this condition in respect of applications approved prior to 1 March 2007.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 2).

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure

uninterrupted bDMARD supply.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.

However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.

For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment – balance of supply

Clinical criteria:

Patient must have a documented history of active ankylosing spondylitis, **AND**

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

infliximab 100 mg injection, 1 x 100 mg vial

6448J

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
1	788.53	Remicade [JC]

■ INFLIXIMAB

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

Patient must have severe active psoriatic arthritis, **AND**

Patient must have received no prior PBS-subsidised treatment with a biological agent for this condition; OR

Patient must have received no PBS-subsidised treatment with a biological agent for at least 5 years if they have previously received PBS-subsidised treatment with a biological agent for this condition, **AND**
 Patient must have failed to achieve an adequate response to methotrexate at a dose of at least 20 mg weekly for a minimum period of 3 months, **AND**
 Patient must have failed to achieve an adequate response to sulfasalazine at a dose of at least 2 g per day for a minimum period of 3 months; OR
 Patient must have failed to achieve an adequate response to leflunomide at a dose of up to 20 mg daily for a minimum period of 3 months, **AND**
 Patient must not receive more than 22 weeks of treatment under this restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab or infliximab.

Where treatment with methotrexate, sulfasalazine or leflunomide is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

Where intolerance to treatment with methotrexate, sulfasalazine or leflunomide developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following initiation criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; and

either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats may be authorised.

Note

Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 3 months treatment with methotrexate and 3 months treatment with sulfasalazine or leflunomide can be found on the Department of Human Services website (www.humanservices.gov.au)

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 2 (change or recommencement of treatment)

Clinical criteria:

Patient must have a documented history of severe active psoriatic arthritis, **AND**

Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**

Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents within this Treatment Cycle, **AND**

Patient must not have failed, or ceased to respond to, PBS-subsidised treatment with this drug during the current Treatment Cycle, **AND**

Patient must not receive more than 22 weeks of treatment under this restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab or infliximab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats may be authorised.

Applications for a patient who has previously received PBS-subsidised treatment with this drug within this Treatment Cycle and who wishes to recommence therapy with this drug within this same Cycle, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug.

Where the most recent course of PBS-subsidised treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised biological therapy or, under this restriction, for patients who have received previous PBS-subsidised biological therapy), the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must have been submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment was not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note

The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2 (change or recommencement of treatment) - balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 22 weeks treatment; OR

Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment) restriction to complete 22 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 22 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 22 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 22 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active psoriatic arthritis, **AND**

Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**

Patient must demonstrate, at the time of application, an adequate response to treatment with this drug, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab or infliximab.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats may be authorised.

Note

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab and infliximab for adult patients with severe active psoriatic arthritis.

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.

Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab and infliximab only.

Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restriction for each agent.

Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].

The duration of the break in therapy will be measured from the date the last approval for PBS-subsidised treatment was granted in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.

Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.

Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle. There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe active psoriatic arthritis.

(1) Initial treatment.

Applications for initial treatment should be made where:

- (i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and
- (ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and
- (iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 2).

All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept and golimumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), and 22 weeks of therapy for infliximab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.

Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

Grandfather patients - certolizumab pegol only.

For patients who commenced treatment with certolizumab pegol for psoriatic arthritis prior to 1 April 2015, applications for initial PBS-subsidised treatment as continuing therapy may be made under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with any biological agent prior to PBS listing of that agent.

Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment for all agents. Approval will be based on the criteria included in the relevant restriction.

(2) Continuing treatment.

Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

(3) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.

Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.

Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:

- (i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
- (ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
- (iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.

To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the approved authority prescription or remaining repeats for the biological agent the patient is ceasing.

(4) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.

(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment with respect to both the indices of disease severity. Patients must have received treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment - balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

infliximab 100 mg injection, 1 x 100 mg vial

6496X

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
1	788.53	Remicade [JC]

▪ **INFLIXIMAB**

Authority required

Initial 1 (new patients)

Initial treatment of Crohn disease in a patient assessed by CDAI.

Initial PBS-subsidised treatment with infliximab by a gastroenterologist or a consultant physician as specified in the NOTE below, of a patient with severe refractory Crohn disease who satisfies the following criteria:

(a) has confirmed Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or a consultant physician as specified in the NOTE below; and

(b) has signed a patient acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and

(c) has failed to achieve an adequate response to prior systemic therapy including:

(i) a tapered course of steroids, starting at a dose of at least 40 mg prednisolone (or equivalent), over a 6 week period; and

(ii) immunosuppressive therapy including:

— azathioprine at a dose of at least 2 mg per kg daily for 3 or more months; or

— 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months; or

— methotrexate at a dose of at least 15 mg weekly for 3 or more months.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of the accepted toxicities including severity can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criterion indicates failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

(a) have a severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 300 as assessed.

All tests and assessments should be performed preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

The most recent CDAI assessment must be no more than 1 month old at the time of application.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the completed current Crohn Disease Activity Index (CDAI) calculation sheet including the date of assessment of the patient's condition; and

(ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and

(iii) the signed patient acknowledgement.

A maximum quantity and number of repeats to provide for an initial course of infliximab consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete the 3 doses of infliximab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours

of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

A CDAI assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

Authority required

Initial 2

Change or re-commencement of treatment of Crohn disease in a patient assessed by CDAI.

Initial PBS-subsidised treatment with infliximab by a gastroenterologist or a consultant physician as specified in the NOTE below of a patient who:

- (a) has a documented history of severe refractory Crohn disease; and
- (b) in this treatment cycle, has received prior PBS-subsidised treatment with infliximab or adalimumab for this condition; and
- (c) has not failed PBS-subsidised therapy with infliximab for this condition more than once in the current treatment cycle.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of TNF-alfa antagonist therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised TNF-alfa antagonist treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of TNF-alfa antagonist treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of TNF-alfa antagonist.

Authority applications must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed current Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition; and
 - (ii) details of prior TNF alfa antagonist treatment including details of date and duration of treatment.

A maximum quantity and number of repeats to provide for an initial course of infliximab consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete the 3 doses of infliximab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

A CDAI assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

Authority required

Continuing treatment of Crohn disease in a patient assessed by CDAI.

Continuing PBS-subsidised treatment with infliximab by a gastroenterologist, a consultant physician as specified in the NOTE below or other consultant physician in consultation with a gastroenterologist, of a patient who:

- (a) has a documented history of severe refractory Crohn disease; and
- (b) has demonstrated or sustained an adequate response to treatment with infliximab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to infliximab treatment is defined as a reduction in Crohn Disease Activity Index (CDAI) Score to a level no greater than 150.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition.

The CDAI assessment must be no more than 1 month old at the time of application.

If the application is the first application for continuing treatment with infliximab, a CDAI assessment of the patient's response must be made up to 12 weeks after the first dose so that there is adequate time for a response to be demonstrated.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

Authority required

Initial 1

Initial treatment of Crohn disease in a patient with short gut syndrome or an ostomy patient.

Initial PBS-subsidised treatment with infliximab by a gastroenterologist, or consultant physician as specified in the NOTE below of a patient who satisfies the following criteria:

- (a) has confirmed Crohn disease defined by standard clinical, endoscopic and/or imaging features, including histological evidence with the diagnosis confirmed by a gastroenterologist or consultant physician as specified in the NOTE below; and
- (b) has diagnostic imaging or surgical evidence of short gut syndrome or has an ileostomy or colostomy; and
- (c) has evidence of intestinal inflammation; and

(d) has signed a patient acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and

(e) has failed to achieve an adequate response to prior systemic drug therapy including:

- (i) a tapered course of steroids, starting at a dose of at least 40 mg prednisolone (or equivalent), over a 6 week period; and
- (ii) immunosuppressive therapy including:
 - azathioprine at a dose of at least 2 mg per kg daily for 3 or more months; or
 - 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months; or
 - methotrexate at a dose of at least 15 mg weekly for 3 or more months.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of the accepted toxicities including severity can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

(a) have evidence of intestinal inflammation, including:

- (i) blood: higher than normal platelet count, or, an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour, or, a C-reactive protein (CRP) level greater than 15 mg per L; AND/OR
- (ii) faeces: higher than normal lactoferrin or calprotectin level; AND/OR
- (iii) diagnostic imaging: demonstration of increased uptake of intravenous contrast with thickening of the bowel wall or mesenteric lymphadenopathy or fat streaking in the mesentery;

AND/OR

(b) be assessed clinically as being in a high faecal output state;

AND/OR

(c) be assessed clinically as requiring surgery or total parenteral nutrition (TPN) as the next therapeutic option, in the absence of infliximab.

All tests and assessments should be performed preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

Any one of the baseline criteria may be used to determine response to an initial course of treatment and eligibility for continued therapy, according to the criteria included in the continuing treatment restriction. However, the same criterion must be used for any subsequent determination of response to treatment, for the purpose of eligibility for continuing PBS-subsidised therapy.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and
 - (ii) reports and dates of the pathology or diagnostic imaging test(s) nominated as the response criterion, if relevant; and
 - (iii) date of the most recent clinical assessment; and
 - (iv) the signed patient acknowledgement.

All assessments, pathology tests and diagnostic imaging studies must be made within 1 month of the date of application.

A maximum quantity and number of repeats to provide for an initial course of infliximab consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete the 3 doses of infliximab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

The assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

Authority required

Initial 2

Change or re-commencement of treatment of Crohn disease in a patient with short gut syndrome, an ostomy patient or a patient with extensive small intestine disease.

Initial PBS-subsidised treatment with infliximab by a gastroenterologist or a consultant physician as specified in the NOTE below of a patient who:

- (a) has a documented history of severe refractory Crohn disease; and
- (b) in this treatment cycle, has received prior PBS-subsidised treatment with infliximab or adalimumab for this condition; and
- (c) has not failed PBS-subsidised therapy with infliximab for this condition more than once in the current treatment cycle.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of TNF-alfa antagonist therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised TNF-alfa antagonist treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of TNF-alfa antagonist treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of TNF-alfa antagonist.

Authority applications must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) reports and dates of the pathology or diagnostic imaging test(s) nominated as the response criteria, if relevant; and
 - (ii) details of prior TNF alfa antagonist treatment including details of date and duration of treatment.

A maximum quantity and number of repeats to provide for an initial course of infliximab consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of therapy so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

Authority required

Continuing treatment of Crohn disease in a patient with short gut syndrome or an ostomy patient.

Continuing PBS-subsidised treatment with infliximab by a gastroenterologist, a consultant physician as specified in the NOTE below or other consultant physician in consultation with a gastroenterologist, of a patient who:

- (a) has a documented history of severe refractory Crohn disease with intestinal inflammation and with short gut syndrome or with an ileostomy or colostomy; and
- (b) has demonstrated or sustained an adequate response to treatment with infliximab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to infliximab treatment is defined as:

- (a) improvement of intestinal inflammation as demonstrated by:

- (i) blood: normalisation of the platelet count, or an erythrocyte sedimentation rate (ESR) level no greater than 25 mm per hour, or a C-reactive protein (CRP) level no greater than 15 mg per L; AND/OR
- (ii) faeces: normalisation of lactoferrin or calprotectin level; AND/OR

- (iii) evidence of mucosal healing, as demonstrated by diagnostic imaging findings, compared to the baseline assessment; or
- (b) reversal of high faecal output state; or
- (c) avoidance of the need for surgery or total parenteral nutrition (TPN).

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the reports and dates of the pathology or diagnostic imaging test(s) used to assess response to therapy or the date of clinical assessment.

The patient's assessment must be no more than 1 month old at the time of application.

If the application is the first application for continuing treatment with infliximab, an assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

Authority required

Initial 1

Initial treatment of Crohn disease in a patient with extensive small intestine disease.

Initial PBS-subsidised treatment with infliximab by a gastroenterologist or a consultant physician as specified in the NOTE below, of a patient with severe refractory Crohn disease who satisfies the following criteria:

- (a) has confirmed Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or consultant physician as specified in the NOTE below; and
- (b) has extensive small intestinal disease with radiological evidence of intestinal inflammation affecting more than 50 cm of the small intestine; and

(c) has signed a patient acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and

(d) has failed to achieve an adequate response to prior systemic therapy including:

- (i) a tapered course of steroids, starting at a dose of at least 40 mg prednisolone (or equivalent), over a 6 week period; and
- (ii) immunosuppressive therapy including:

— azathioprine at a dose of at least 2 mg per kg daily for 3 or more months; or

— 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months; or

— methotrexate at a dose of at least 15 mg weekly for 3 or more months.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of the accepted toxicities including severity can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

- (a) have severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 220;

AND/OR

- (b) have evidence of active intestinal inflammation, including:

(i) blood: higher than normal platelet count, or, an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour, or, a C-reactive protein (CRP) level greater than 15 mg per L; AND/OR

(ii) faeces: higher than normal lactoferrin or calprotectin level; AND/OR

(iii) diagnostic imaging: demonstration of increased uptake of intravenous contrast with thickening of the bowel wall or mesenteric lymphadenopathy or fat streaking in the mesentery;

AND/OR

- (c) be assessed clinically as being in a high faecal output state;

AND/OR

- (d) be assessed clinically as requiring surgery or total parenteral nutrition (TPN) as the next therapeutic option, in the absence of infliximab.

All tests and assessments should be performed preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

Any one of the baseline criteria may be used to determine response to an initial course of treatment and eligibility for continued therapy, according to the criteria included in the continuing treatment restriction. However, the same criterion must be used for any subsequent determination of response to treatment, for the purpose of eligibility for continuing PBS-subsidised therapy.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and
 - (ii) (1) reports and dates of the pathology or diagnostic imaging test(s) nominated as the response criterion, if relevant; or (2) the completed current Crohn Disease Activity Index (CDAI) calculation sheet including the dates of assessment of the patient's condition, if relevant; and
 - (iii) date of the most recent clinical assessment; and
 - (iv) the signed patient acknowledgement.

All assessments, pathology tests and diagnostic imaging studies must be made within 1 month of the date of application.

A maximum quantity and number of repeats to provide for an initial course of infliximab consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete the 3 doses of infliximab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

The assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

Authority required

Continuing treatment of Crohn disease in a patient with extensive small intestine disease.

Continuing PBS-subsidised treatment with infliximab by a gastroenterologist, or consultant physician as specified in the NOTE below or other consultant physician in consultation with a gastroenterologist, of a patient who:

- (a) has a documented history of severe refractory Crohn disease with extensive intestinal inflammation affecting more than 50 cm of the small intestine; and
- (b) has demonstrated or sustained an adequate response to treatment with infliximab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to infliximab treatment is defined as:

- (a) a reduction in Crohn Disease Activity Index (CDAI) Score to no greater than 150; or
- (b) improvement of intestinal inflammation as demonstrated by:
 - (i) blood: normalisation of the platelet count, or an erythrocyte sedimentation rate (ESR) level no greater than 25 mm per hour, or a C-reactive protein (CRP) level no greater than 15 mg per L; AND/OR
 - (ii) faeces: normalisation of lactoferrin or calprotectin level; AND/OR
 - (iii) evidence of mucosal healing, as demonstrated by diagnostic imaging findings, compared to the baseline assessment; or
 - (c) reversal of high faecal output state; or
 - (d) avoidance of the need for surgery or total parenteral nutrition (TPN).

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition; or
 - (ii) the reports and dates of the pathology test or diagnostic imaging test(s) used to assess response to therapy; or
 - (iii) the date of clinical assessment.

All assessments must be no more than 1 month old at the time of application.

If the application is the first application for continuing treatment with infliximab, an assessment of the patient's response must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

Authority required

Initial 3 (grandfather)

Initial PBS-subsidised treatment of Crohn disease in a patient assessed by CDAI who has previously received non-PBS-subsidised therapy with infliximab.

Initial PBS-subsidised supply for continuing treatment with infliximab by a gastroenterologist, a consultant physician as specified in the NOTE below, or other consultant physician in consultation with a gastroenterologist of a patient who:

- (a) has a documented history of severe refractory Crohn disease and was receiving treatment with infliximab prior to 7 March 2007; and
- (b) had a Crohn Disease Activity Index (CAI) Score of greater than or equal to 300 prior to commencing treatment with infliximab. Where a baseline CDAI assessment is not available, please call Medicare Australia on 1800 700 270 to discuss; and
- (c) has signed a patient acknowledgement indicating that they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and

(d) has demonstrated or sustained an adequate response to treatment with infliximab. For advice please contact Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to infliximab treatment is defined as a reduction in Crohn Disease Activity Index (CAI) Score to no greater than 150.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed current and baseline Crohn Disease Activity Index (CAI) Score calculation sheet including the date of the assessment of the patient's condition; and
 - (ii) the signed patient acknowledgement.

The current CDAI assessment must be no more than 1 month old at the time of application. The baseline CDAI assessment must be from immediately prior to commencing treatment with infliximab.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Patients may qualify for PBS-subsidised treatment under this restriction once only

Authority required

Initial 3

Initial PBS-subsidised treatment of Crohn disease in a patient with short gut syndrome, an ostomy patient, or a patient with extensive small intestine disease, who has previously received non-PBS-subsidised therapy with infliximab.

Initial PBS-subsidised supply for continuing treatment with infliximab by a gastroenterologist, a consultant physician as specified in the NOTE below, or other consultant physician in consultation with a gastroenterologist, of a patient who:

- (a) has a documented history of severe refractory Crohn disease and was receiving treatment with infliximab prior to 7 March 2007; and
- (b) (1) has a history of extensive small intestinal disease with radiological evidence of intestinal inflammation affecting more than 50 cm of the small intestine; or
- (2) has diagnostic imaging or surgical evidence of short gut syndrome or has an ileostomy or colostomy with a documented history of intestinal inflammation; and
- (c) has signed a patient acknowledgement indicating that they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and
- (d) has demonstrated or sustained an adequate response to treatment with infliximab according to the criteria included in the relevant continuation restriction. For advice please contact Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)]. The same criteria used to determine an inadequate response to prior treatment at baseline must be used to determine response to treatment and eligibility for continuing therapy, according to the criteria included in the continuing treatment restriction.

An adequate response to infliximab treatment is defined as:

- (a) a reduction in Crohn Disease Activity Index (CDAI) Score to no greater than 150; or
- (b) improvement of intestinal inflammation as demonstrated by:
 - (i) blood: normalisation of the platelet count, or an erythrocyte sedimentation rate (ESR) level no greater than 25 mm per hour, or a C-reactive protein (CRP) level no greater than 15 mg per L; AND/OR
 - (ii) faeces: normalisation of lactoferrin or calprotectin level; AND/OR
 - (iii) evidence of mucosal healing, as demonstrated by diagnostic imaging findings, compared to the baseline assessment; or
 - (c) reversal of high faecal output state; or
 - (d) avoidance of the need for surgery or total parenteral nutrition (TPN).

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) (1) the completed current and baseline Crohn Disease Activity Index (CDAI) Score calculation sheet, where relevant, including the date of the assessment of the patient's condition; or
 - (2) the reports and dates of the current and baseline pathology or diagnostic imaging test(s) in order to assess response to therapy; or
 - (3) the date of clinical assessment(s); and
 - (ii) the signed patient acknowledgement.

The patient's assessment must be no more than 1 month old at the time of application. The baseline CDAI assessments must be from immediately prior to commencing treatment with infliximab. Where a baseline assessment is not available, please call Medicare Australia on 1800 700 270 to discuss.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Patients may qualify for PBS-subsidised treatment under this restriction once only

Note

Any queries concerning the arrangements to prescribe infliximab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe infliximab should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE REFRACTORY CROHN DISEASE

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab and infliximab for adult patients with severe refractory Crohn disease. Where the term 'tumour necrosis factor (TNF) alfa antagonist' appears in the following NOTES and restrictions, it refers to adalimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any 1 time.

From 1 August 2008, under the PBS, all patients will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.

A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 August 2008 is considered to be in their first cycle as of 1 August 2008.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised

TNF- α antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF- α antagonist under the new treatment cycle.

A patient who has failed fewer than 3 trials of TNF- α antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of TNF- α antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised TNF- α antagonist therapy after 1 August 2008.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised TNF- α antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient has received prior PBS-subsidised (initial or continuing) TNF- α antagonist therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iii) a patient wishes to re-commence treatment with a specific TNF- α antagonist following a break in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab and 14 weeks of therapy for infliximab.

From 1 August 2008, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab, and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF- α antagonist.

For second and subsequent courses of PBS-subsidised TNF- α antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Adalimumab only: Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific TNF- α antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing TNF- α antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF- α antagonist supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF- α antagonist.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised TNF- α antagonist is approved, a patient may swap if eligible to the alternate TNF- α antagonist within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Crohn Disease Activity Index (CDAI) Score, evidence of intestinal inflammation), or the prior corticosteroid therapy and immunosuppressive therapy.

A patient may trial the alternate TNF- α antagonist at any time, regardless of whether they are receiving therapy (initial or continuing) with a TNF- α antagonist at the time of the application. However, they cannot swap to a particular TNF- α antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to the alternate TNF- α antagonist should be accompanied by the approved authority prescription or remaining repeats for the TNF- α antagonist the patient is ceasing.

(3) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated based on the baseline measurements of the CDAI or evidence of intestinal inflammation submitted with the first authority application for a TNF- α antagonist. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and Medicare Australia will assess response according to these revised baseline measurements.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF- α antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with a corticosteroid and at least 1 immunosuppressive agent, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the CDAI score or the indices of intestinal inflammation are measured.

(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab or infliximab.

A patient who commenced treatment with adalimumab for severe refractory Crohn disease prior to 9 November 2007 or infliximab prior to 7 March 2007 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction.

A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab or infliximab will be authorised under this criterion.

Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab or infliximab will be assessed under the continuing treatment restriction.

'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

infliximab 100 mg injection, 1 x 100 mg vial

9613Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	788.53	Remicade [JC]

Interleukin inhibitors

■ ANAKINRA

Authority required (STREAMLINED)

4920

Moderate to severe cryopyrin associated periodic syndromes (CAPS)

Treatment criteria:

Must be treated by a rheumatologist or in consultation with a rheumatologist.

A diagnosis of CAPS must be documented in the patient's medical records.

Note

This drug is not PBS-subsidised for conditions other than CAPS.

anakinra 100 mg/0.67 mL injection, 28 x 0.67 mL syringes

10263E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	5	..	1696.76	Kineret [FK]

■ TOCILIZUMAB

Authority required

Initial 1 (new and recommencing patients after a break of more than 12 months)

Initial treatment by a rheumatologist, or under the supervision of a paediatric rheumatology treatment centre, of a patient under 18 years who:

(a) has been diagnosed with systemic juvenile idiopathic arthritis; AND

(b) has polyarticular course disease and either:

(i) failure to achieve an adequate response to the following treatment regimen (see (1) below for definition of failure to achieve an adequate response):

— oral or parenteral methotrexate at a dose of at least 15 mg per square metre weekly, alone or in combination with oral or intra-articular corticosteroids for a minimum of 3 months; or

(ii) severe intolerance of, or toxicity due to, methotrexate (see (2) below for definition of severe intolerance and toxicity); OR

(c) has refractory systemic symptoms, demonstrated by:

— an inability to decrease and maintain the dose of prednisolone (or equivalent) below 0.5 mg per kg per day following a minimum of 2 months of therapy; AND

(d) has not received PBS-subsidised treatment with tocilizumab for this condition in the previous 12 months.

(1) The following criteria indicate failure to achieve an adequate response to prior methotrexate therapy and must be demonstrated in all patients at the time of the initial application:

(a) in a patient with polyarticular course disease:

(i) an active joint count of at least 20 active (swollen and tender) joints; OR

(ii) at least 4 active joints from the following list:

— elbow, wrist, knee and/or ankle (assessed as swollen and tender); AND/OR

— shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

(b) in a patient with refractory systemic symptoms:

(i) an active joint count of at least 2 active joints; AND

(ii) persistent fever greater than 38 degrees Celsius for at least 5 out of 14 consecutive days; AND/OR

(iii) a C-reactive protein (CRP) level and platelet count above the upper limits of normal (ULN).

(2) Severe intolerance to methotrexate is defined as intractable nausea and vomiting and general malaise unresponsive to manoeuvres, including reducing or omitting concomitant NSAIDs on the day of methotrexate administration, use of folic acid supplementation, or administering the dose of methotrexate in 2 divided doses over 24 hours.

Toxicity to methotrexate is defined as evidence of hepatotoxicity with repeated elevations of transaminases, bone marrow suppression temporally related to methotrexate use, pneumonia, or serious sepsis.

If treatment with methotrexate alone or in combination with other treatments is contraindicated according to the relevant TGA-approved Product Information, please provide details at time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, please provide details of this toxicity at the time of application.

The baseline measurements of joint count, fever and/or CRP level and platelet count must be performed preferably whilst on treatment, but no longer than 4 weeks following cessation of the most recent prior treatment.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline must be provided for all subsequent continuing treatment applications.

The authority application must be made in writing and must include:

- (1) completed authority prescription form(s); and
- (2) a completed Systemic Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the date of assessment of severe active systemic juvenile idiopathic arthritis;
 - (ii) details of prior treatment including dose and duration of treatment;
 - (iii) pathology reports detailing CRP and platelet count where appropriate; and
- (3) a signed patient or authorised guardian acknowledgement form.

The most recent systemic juvenile idiopathic arthritis assessment must be no more than 1 month old at the time of application.

A maximum of 16 weeks of treatment will be authorised under this restriction.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for two infusions (one month supply). A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

Where fewer than 3 repeats are requested at the time of initial application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 4 weeks from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to respond to 2 courses of treatment in a treatment cycle they will not be eligible to receive further PBS-subsidised tocilizumab therapy in that treatment cycle. A patient may re-trial tocilizumab after a minimum of 12 months have elapsed between the date the last PBS-subsidised treatment was stopped and the date of the first application under a new treatment cycle

Authority required

Initial 2 (retrial or recommencement of treatment after a break of less than 12 months)

Initial PBS-subsidised treatment by a rheumatologist, or under the supervision of a paediatric rheumatology treatment centre, of a patient who:

- (a) has a documented history of systemic juvenile idiopathic arthritis; AND
- (b) has received PBS-subsidised treatment with tocilizumab for this condition in the previous 12 months; AND
- (c) has not failed PBS-subsidised therapy with tocilizumab for this condition more than once in the current treatment cycle.

The authority application must be made in writing and must include:

- (1) completed authority prescription form(s); and
- (2) a completed Systemic Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) pathology reports detailing CRP and platelet count where appropriate.

Applications for a patient who has received PBS-subsidised treatment with tocilizumab in this treatment cycle and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised tocilizumab treatment, within the timeframes specified below.

A maximum of 16 weeks of treatment will be authorised under this restriction.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for two infusions (one month supply). A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

Where fewer than 3 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment with tocilizumab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

An assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criteria. Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with tocilizumab.

Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to that course of tocilizumab.

If a patient fails to respond to 2 courses of treatment they will not be eligible to receive further PBS-subsidised tocilizumab therapy in this treatment cycle. A patient may re-trial tocilizumab after a minimum of 12 months have elapsed between the date the last PBS-subsidised treatment was stopped and the date of the first application under a new treatment cycle

Authority required

Initial 3 ('grandfather' patients)

Initial treatment by a rheumatologist, or under the supervision of a paediatric rheumatology treatment centre, of a patient who:

- (a) has a documented history of systemic juvenile idiopathic arthritis; and
- (b) was receiving treatment with tocilizumab prior 1 November 2011; and
- (c) has demonstrated a response as specified in the criteria for continuing PBS-subsidised treatment with tocilizumab; and

(d) is receiving treatment with tocilizumab at the time of application.

To ensure consistency in determining response, the same indices of disease severity used to establish the baseline must be provided for all subsequent continuing treatment applications.

The authority application must be made in writing and must include:

- (1) completed authority prescription form(s); and
- (2) a completed Systemic Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) pathology reports detailing CRP and platelet count where appropriate; and
 - (3) a signed patient or authorised guardian acknowledgement form.

The most recent systemic juvenile idiopathic arthritis assessment must be no more than 1 month old at the time of application.

The baseline systemic juvenile idiopathic arthritis assessment must be provided and must be from immediately prior to commencing treatment with tocilizumab. (See NOTE (3) above for definition of baseline measurements to determine response.)

An assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criteria.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with tocilizumab.

Patients are eligible to receive continuing tocilizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for two infusions (one months supply). A separate authority prescription form must be completed for each strength requested. Up to a maximum of 5 repeats will be authorised.

Where fewer than 5 repeats are initially requested with the authority prescription, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

A patient may only qualify for PBS-subsidised treatment under this restriction once

Authority required

Continuing treatment

Continuing treatment with tocilizumab, by a rheumatologist or under the supervision of a paediatric rheumatology treatment centre, of a patient who:

- (a) has a documented history of systemic juvenile idiopathic arthritis; AND
- (b) has demonstrated an adequate response to treatment with tocilizumab.

An adequate response to treatment is defined as:

- (a) in a patient with polyarticular course disease:

- (i) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

- (ii) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

— elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

— shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

- (b) in a patient with refractory systemic symptoms:

- (i) absence of fever greater than 38 degrees Celsius in the preceding seven days; AND/OR

- (ii) a reduction in the CRP level and platelet count by at least 30% from baseline; AND/OR

- (iii) a reduction in the dose of corticosteroid by at least 30% from baseline.

The authority application must be made in writing and must include:

- (1) completed authority prescription form(s); and
- (2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) baseline and current pathology reports detailing CRP and platelet count where appropriate.

The most recent systemic juvenile idiopathic arthritis assessment must be no more than 1 month old at the time of application.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under the Initial treatment restriction, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be provided to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Patients are eligible to receive continuing tocilizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for two infusions (one month supply). A separate authority prescription form must be completed for each strength requested. Up to a maximum of 5 repeats will be authorised.

Where fewer than 5 repeats are requested at the time of initial application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

If a patient fails to respond to 2 courses of treatment they will not be eligible to receive further PBS-subsidised tocilizumab therapy in this treatment cycle. A patient may re-trial tocilizumab after a minimum of 12 months have elapsed between the date the last PBS-subsidised treatment was stopped and the date of the first application under a new treatment cycle

Note

Any queries concerning the arrangements to prescribe tocilizumab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Further prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe tocilizumab should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying anti-rheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

PBS-subsidised abatacept, golimumab, infliximab and rituximab must be used in combination with methotrexate at a dose of at least 7.5 mg weekly. Where a patient cannot tolerate 7.5 mg of methotrexate weekly, they are eligible to receive PBS-subsidised adalimumab, certolizumab pegol, etanercept and tocilizumab.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

- a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,
- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and
- once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact Medicare Australia on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or
- (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
- (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to Medicare Australia within 4 weeks.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a

patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to Medicare Australia 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and Medicare Australia will assess response according to these revised baseline measurements.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

TREATMENT OF PATIENTS WITH SEVERE ACTIVE SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of tocilizumab for a patient who has severe active systemic juvenile idiopathic arthritis (sJIA).

From 1 May 2012, a patient receiving PBS-subsidised tocilizumab therapy is considered to be in a treatment cycle. Under these arrangements, within a single treatment cycle, a patient may:

- continue to receive long-term treatment with PBS-subsidised tocilizumab while they continue to show a response to therapy, and
- fail to respond, or to sustain a response, to PBS-subsidised tocilizumab twice.

Once a patient has either failed or ceased to respond to 2 courses of treatment, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised tocilizumab therapy before they are eligible to receive further PBS-subsidised tocilizumab therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised tocilizumab treatment was stopped to the date of the first application for initial treatment with tocilizumab under the new treatment cycle.

A patient who was receiving PBS-subsidised tocilizumab treatment immediately prior to 1 May 2012 is considered to be in their first cycle as of 1 May 2012. A patient who has had a break in tocilizumab treatment of at least 12 months immediately prior to making a new application, on or after 1 May 2012, will commence a new treatment cycle.

A patient who has failed their first course of tocilizumab in a treatment cycle and who has a break in therapy of less than 12 months may commence a second course of treatment within the same treatment cycle.

A patient who has failed their first course of tocilizumab in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.

(1) How to prescribe PBS-subsidised tocilizumab therapy after 1 May 2012.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised tocilizumab treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
- (ii) a patient wishes to re-commence treatment with tocilizumab following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or
- (iii) a patient has received the first course of PBS-subsidised (initial or continuing) tocilizumab therapy in a treatment cycle and is deemed to have failed to respond or sustain a response and the treating physician wishes to trial a second course (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab for that course.

For second and subsequent courses of PBS-subsidised tocilizumab, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with tocilizumab, a patient may qualify to receive up to 24 weeks of continuing treatment with tocilizumab providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing tocilizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted tocilizumab supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

(2) Treatment cycle.

Once initial treatment with PBS-subsidised tocilizumab is approved, a patient deemed to have failed to respond to the first course of treatment may have a second course without having to requalify with respect to the indices of disease severity (joint count, fever and/or CRP level and platelet count) or the prior therapy requirements, except if the patient has had a break in therapy of more than 12 months.

To ensure a patient receives the maximum treatment opportunities allowed under these arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

(3) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated based on the relevant baseline measurements of the joint count, fever and/or CRP level and platelet count submitted with the first authority application for tocilizumab.

Where a patient is deemed to have failed to respond or to sustain a response to the first course of therapy in a treatment cycle, prescribers may provide new baseline measurements for the second course of treatment within that cycle. Medicare Australia will assess response according to these revised baseline measurements. If new baseline measurements are not submitted with the initial application for the second course of treatment, then those submitted with the first course will be used by Medicare Australia to assess response to the second course.

(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised tocilizumab therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.

(5) Patients 'grandfathered' onto PBS-subsidised treatment with tocilizumab.

A patient who commenced treatment with tocilizumab for severe active systemic juvenile idiopathic arthritis prior to 1 November 2011 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction.

A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment

with tocilizumab will be authorised under this criterion.

Following completion of the initial PBS-subsidised course, further applications for treatment with tocilizumab will be assessed under the continuing treatment restriction.

'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must qualify for initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 12 month break in PBS-subsidised therapy' above for further details.

(6) Withdrawal of treatment after sustained remission.

Withdrawal of treatment with tocilizumab should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to Medicare Australia at the time treatment is ceased.

Special Pricing Arrangements apply.

tocilizumab 200 mg/10 mL injection, 1 x 10 mL vial

1423X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	492.65	Actemra [RO]

tocilizumab 400 mg/20 mL injection, 1 x 20 mL vial

1464C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	978.54	Actemra [RO]

tocilizumab 80 mg/4 mL injection, 1 x 4 mL vial

1419Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	201.12	Actemra [RO]

■ TOCILIZUMAB

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months)

Clinical criteria:

Patient must have severe active juvenile idiopathic arthritis, **AND**

Patient must have received no prior PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition; OR

Patient must not have received PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in the previous 12 months, **AND**

Patient must have demonstrated severe intolerance of, or toxicity due to, methotrexate; OR

Patient must have demonstrated failure to achieve an adequate response to 1 or more of the following treatment regimens: (i) oral or parenteral methotrexate at a dose of at least 20 mg per square metre weekly, alone or in combination with oral or intra-articular corticosteroids, for a minimum of 3 months; or (ii) oral methotrexate at a dose of at least 10 mg per square metre weekly together with at least 1 other disease modifying anti-rheumatic drug (DMARD), alone or in combination with corticosteroids, for a minimum of 3 months, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be under 18 years of age and a parent or authorised guardian must have signed a patient acknowledgement.

Treatment criteria:

Must be treated by a paediatric rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

Severe intolerance to methotrexate is defined as intractable nausea and vomiting and general malaise unresponsive to manoeuvres, including reducing or omitting concomitant non-steroidal anti-inflammatory drugs (NSAIDs) on the day of methotrexate administration, use of folic acid supplementation, or administering the dose of methotrexate in 2 divided doses over 24 hours.

Toxicity due to methotrexate is defined as evidence of hepatotoxicity with repeated elevations of transaminases, bone marrow suppression temporally related to methotrexate use, pneumonitis, or serious sepsis.

If treatment with methotrexate alone or in combination with another DMARD is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

(a) an active joint count of at least 20 active (swollen and tender) joints; OR

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count assessment must be performed preferably whilst still on DMARD treatment, but no longer than 4 weeks following cessation of the most recent prior treatment.

The authority application must be made in writing and must include:

- (1) completed authority prescription form(s); and
- (2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form; and
- (3) an acknowledgement signed by a parent or authorised guardian.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle. A patient may re-trial tocilizumab after a minimum of 12 months have elapsed between the date the last PBS-subsidised bDMARD was stopped and the date of the first application under a new treatment cycle.

Note

Use of alternative DMARDs in children is dependent on approval by the Therapeutic Goods Administration as age restrictions may apply.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (change or recommencement of treatment after break of less than 12 months)

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**

Patient must have received prior PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in this treatment cycle, **AND**

Patient must not have failed PBS-subsidised therapy with tocilizumab for this condition in the current treatment cycle, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be under 18 years of age.

Treatment criteria:

Must be treated by a paediatric rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

The authority application must be made in writing and must include:

- (1) completed authority prescription form(s); and
- (2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with tocilizumab in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised tocilizumab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to respond to PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

An adequate response to treatment is defined as:

- (a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or
- (b) a reduction in the number of the following active joints, from at least 4, by at least 50%:
 - (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - (ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months) or Initial 2 (change or recommencement of treatment after break of less than 12 months) – balance of supply.

Clinical criteria:

Patient must have received insufficient tocilizumab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 12 months) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient tocilizumab therapy under the Initial 2 (change or recommencement of treatment after break of less than 12 months) restriction to complete 16 weeks treatment, **AND**
The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a paediatric rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Note

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**

Patient must have demonstrated an adequate response to treatment with tocilizumab, **AND**

Patient must have received tocilizumab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Determination of whether a response has been demonstrated to initial and subsequent courses of treatment will be based on the baseline measurement of joint count submitted with the initial treatment application.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with tocilizumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with tocilizumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.

From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:

(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and

(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.

(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.
(5) Withdrawal of treatment after sustained remission.

Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing Treatment – balance of supply

Clinical criteria:

Patient must have received insufficient tocilizumab therapy under the Continuing Treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

tocilizumab 200 mg/10 mL injection, 1 x 10 mL vial

10079L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	492.65	Actemra [RO]

tocilizumab 400 mg/20 mL injection, 1 x 20 mL vial

10060L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	978.54	Actemra [RO]

tocilizumab 80 mg/4 mL injection, 1 x 4 mL vial

10068X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	201.12	Actemra [RO]

■ TOCILIZUMAB

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**

Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months; OR

Patient must have received no PBS-subsidised bDMARD treatment for at least 5 years if they failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) in their last treatment cycle, **AND**

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be

tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDs which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

If methotrexate is contraindicated according to the TGA-approved Product Information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialed, their doses and duration of treatment, and all relevant contraindications and/or intolerances.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance and dose for each DMARD must be provided in the authority application.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle. A patient may re-trial tocilizumab after a minimum of 5 years have elapsed between the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle and the date of the first application under a new treatment cycle.

Note

The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:

(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose; (b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;

(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (change or recommencement of treatment after break of less than 24 months)

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**

Patient must have received prior PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in this treatment cycle, **AND**

Patient must not have failed PBS-subsidised therapy with tocilizumab for this condition in the current treatment cycle, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with tocilizumab in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised tocilizumab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to respond to PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) an active joint count of fewer than 10 active (swollen and tender) joints; or

(b) a reduction in the active (swollen and tender) joint count by at least 50% from baseline; or

(c) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply

Clinical criteria:

Patient must have received insufficient tocilizumab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient tocilizumab therapy under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**

Patient must have demonstrated an adequate response to treatment with tocilizumab, **AND**

Patient must have received tocilizumab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**
Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

- (a) an active joint count of fewer than 10 active (swollen and tender) joints; or
- (b) a reduction in the active (swollen and tender) joint count by at least 50% from baseline; or
- (c) a reduction in the number of the following active joints, from at least 4, by at least 50%:
 - (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - (ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

- (1) completed authority prescription form(s); and
- (2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with tocilizumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with tocilizumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH A HISTORY OF JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient over 18 years who has a history of juvenile idiopathic arthritis with onset prior to the age of 18 years. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.

From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:

- (i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
- (ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 5 year break in PBS-subsidised bDMARD therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in

their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 24 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle. A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 24 months may commence a further course of treatment within the same treatment cycle. A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 24 months must commence a new treatment cycle. The length of the break in therapy is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

A patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count and ESR/CRP) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.

(4) Re-commencement of treatment after a 24 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 24 months, must requalify for treatment under the Initial 1 treatment restriction.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing Treatment – balance of supply

Clinical criteria:

Patient must have received insufficient tocilizumab therapy under the Continuing Treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

tocilizumab 200 mg/10 mL injection, 1 x 10 mL vial

10071C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	492.65	Actemra [RO]

tocilizumab 400 mg/20 mL injection, 1 x 20 mL vial

10078K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	978.54	Actemra [RO]

tocilizumab 80 mg/4 mL injection, 1 x 4 mL vial

10073E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	201.12	Actemra [RO]

■ **TOCILIZUMAB**

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Clinical criteria:

Patient must have severe active rheumatoid arthritis, **AND**

Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**

Patient must not have failed previous PBS-subsidised treatment with tocilizumab for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDs which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

If methotrexate is contraindicated according to the TGA-approved product information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance including severity to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances including severity.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance including severity and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

- (1) completed authority prescription form(s); and
- (2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and
- (3) a signed patient acknowledgement.

At the time of the authority application, medical practitioners should request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for a single infusion at a dose of 8 mg per kg. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

If a patient fails to demonstrate a response to treatment with tocilizumab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

- (a) a total active joint count of at least 20 active (swollen and tender) joints; or
- (b) at least 4 active joints from the following list of major joints:
 - (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - (ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note

The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:

- (a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
- (b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;

- (c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months).

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

The authority application must be made in writing and must include:

- (a) completed authority prescription form(s); and
- (b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners should request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for a single infusion at a dose of 8 mg per kg. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with tocilizumab and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised tocilizumab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to demonstrate a response to a treatment with tocilizumab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

If a patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

- (a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or
- (b) a reduction in the number of the following active joints, from at least 4, by at least 50%:
 - (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - (ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note

Special Pricing Arrangements apply.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or commencement of treatment after break of less than 24 months) – balance of supply.

Clinical criteria:

Patient must have received insufficient tocilizumab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient tocilizumab therapy under the Initial 2 (change or commencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment.

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have demonstrated an adequate response to treatment with tocilizumab, **AND**

Patient must have received tocilizumab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners should request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for a single infusion at a dose of 8 mg per kg. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with tocilizumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with tocilizumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to demonstrate a response to treatment with tocilizumab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

- a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,

- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and

- once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or

- (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
- (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the

baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply.

Clinical criteria:

Patient must have received insufficient tocilizumab therapy under the Continuing Treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

tocilizumab 200 mg/10 mL injection, 1 x 10 mL vial

9672C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	492.65	Actemra [RO]

tocilizumab 400 mg/20 mL injection, 1 x 20 mL vial

9673D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	978.54	Actemra [RO]

tocilizumab 80 mg/4 mL injection, 1 x 4 mL vial

9671B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	201.12	Actemra [RO]

Calcineurin inhibitors

■ CYCLOSPORIN

Caution

Careful monitoring of patients is mandatory.

Authority required

For use by organ or tissue transplant recipients

cyclosporin 50 mg/mL injection, 10 x 1 mL ampoules

6109M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	64.86	Sandimmun [NV]

■ CYCLOSPORIN

Caution

Careful monitoring of patients is mandatory.

Authority required

Management of rejection in patients following organ or tissue transplantation, under the supervision and direction of a transplant unit. Management includes initiation, stabilisation and review of therapy as required

Authority required

Management (which includes initiation, stabilisation and review of therapy) by dermatologists or clinical immunologists of patients with severe atopic dermatitis for whom other systemic therapies are ineffective or inappropriate

Authority required

Management (which includes initiation, stabilisation and review of therapy) by dermatologists of patients with severe psoriasis for whom other systemic therapies are ineffective or inappropriate and in whom the disease has caused significant interference with quality of life

Authority required

Management (which includes initiation, stabilisation and review of therapy) by nephrologists of patients with nephrotic syndrome in patients in whom steroids and cytostatic drugs have failed or are not tolerated or are considered inappropriate and in whom renal function is unimpaired

Authority required

Management (which includes initiation, stabilisation and review of therapy) by rheumatologists or clinical immunologists of patients with severe active rheumatoid arthritis for whom classical slow-acting anti-rheumatic agents (including methotrexate) are ineffective or inappropriate

cyclosporin 10 mg capsule, 60

6232B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*85.16	Neoral 10 [NV]

cyclosporin 100 mg capsule, 30

6354K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	4	5	..	*683.88	^a Cyclosporin Sandoz [SZ]	^a Neoral 100 [NV]

cyclosporin 100 mg/mL oral liquid, 50 mL

6125J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	4	5	..	*1309.92	Neoral [NV]

cyclosporin 25 mg capsule, 30

6352H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	4	5	..	*166.48	^a Cyclosporin Sandoz [SZ]	^a Neoral 25 [NV]

cyclosporin 50 mg capsule, 30

6353J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	4	5	..	*339.08	^a Cyclosporin Sandoz [SZ]	^a Neoral 50 [NV]

■ TACROLIMUS
Caution

Careful monitoring of patients is mandatory.

Authority required

Management of rejection in patients following organ or tissue transplantation, under the supervision and direction of a transplant unit. Management includes initiation, stabilisation and review of therapy as required

tacrolimus 1 mg capsule, 100

6216E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*617.82	^a Pharmacor Tacrolimus 1 [CR] ^a Tacrolimus Sandoz [SZ]	^a Prograf [LL]

tacrolimus 1 mg capsule: modified release, 60 capsules

9682N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*373.38	Prograf XL [LL]

tacrolimus 5 mg capsule, 50

6217F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*1514.92	^a Pharmacor Tacrolimus 5 [CR] ^a Tacrolimus Sandoz [SZ]	^a Prograf [LL]

tacrolimus 5 mg capsule: modified release, 30 capsules

9683P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*923.38	Prograf XL [LL]

tacrolimus 500 microgram capsule, 100

6328C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*312.30	^a Pharmacor Tacrolimus 0.5 [CR] ^a Tacrolimus Sandoz [SZ]	^a Prograf [LL]

tacrolimus 500 microgram capsule: modified release, 30 capsules

9681M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*98.90	Prograf XL [LL]

Other immunosuppressants
■ LENALIDOMIDE
Authority required

Myelodysplastic syndrome

Treatment Phase: Initial treatment

Clinical criteria:

The treatment must be limited to a maximum duration of 16 weeks, **AND**

Patient must be classified as Low risk or Intermediate-1 according to the International Prognostic Scoring System (IPSS), **AND**

Patient must have a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities, **AND**

Patient must be red blood cell transfusion dependent.

Classification of a patient as Low risk requires a score of 0 on the IPSS, achieved with the following combination: less than 5% marrow blasts with good karyotypic status (normal, -Y alone, -5q alone, -20q alone), and 0/1 cytopenias.

Classification of a patient as Intermediate-1 requires a score of 0.5 to 1 on the IPSS, achieved with the following possible combinations:

1. 5%-10% marrow blasts with good karyotypic status (normal, -Y alone, -5q alone, -20q alone), and 0/1 cytopenias; OR
2. less than 5% marrow blasts with intermediate karyotypic status (other abnormalities), and 0/1 cytopenias; OR
3. less than 5% marrow blasts with good karyotypic status (normal, -Y alone, -5q alone, -20q alone), and 2/3 cytopenias; OR
4. less than 5% marrow blasts with intermediate karyotypic status (other abnormalities), and 2/3 cytopenias; OR
5. 5%-10% marrow blasts with intermediate karyotypic status (other abnormalities), and 0/1 cytopenias; OR
6. 5%-10% marrow blasts with good karyotypic status (normal, -Y alone, -5q alone, -20q alone), and 2/3 cytopenias; OR
7. less than 5% marrow blasts with poor karyotypic status (complex, greater than 3 abnormalities), and 0/1 cytopenias.

Classification of a patient as red blood cell transfusion dependent requires that:

(i) the patient has been transfused within the last 8 weeks; and

(ii) the patient has received at least 8 units of red blood cell in the last 6 months prior to commencing PBS-subsidised therapy with lenalidomide; and would be expected to continue this requirement without lenalidomide treatment.

Patients receiving lenalidomide under the PBS listing must be registered in the i-access risk management program.

The authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Myelodysplastic Syndrome Lenalidomide Authority Application - Supporting Information Form; and
- (c) a copy of the bone marrow biopsy report demonstrating that the patient has myelodysplastic syndrome; and
- (d) a copy of the full blood examination report; and
- (e) a copy of the pathology report detailing the cytogenetics demonstrating Low risk or Intermediate-1 disease according to the IPSS (note: using Fluorescence in Situ Hybridization (FISH) to demonstrate MDS -5q is acceptable); and
- (f) details of transfusion requirements including: (i) the date of most recent transfusion and the number of red blood cell units transfused; and (ii) the total number of red cell units transfused in the 4 and 6 months preceding the date of this application; and
- (g) a signed patient acknowledgement form.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Myelodysplastic syndrome

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must be classified as Low risk or Intermediate-1 according to the International Prognostic Scoring System (IPSS), **AND**

Patient must have a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities, **AND**

Patient must have received PBS-subsidised initial therapy with lenalidomide for myelodysplastic syndrome, **AND**

Patient must have achieved and maintained transfusion independence; or least a 50% reduction in red blood cell unit transfusion requirements compared with the four month period prior to commencing initial PBS-subsidised therapy with lenalidomide, **AND**

Patient must not have progressive disease.

Patients receiving lenalidomide under the PBS listing must be registered in the i-access risk management program. The first authority application for continuing supply must be made in writing. Subsequent authority applications for continuing supply may be made by telephone.

The following evidence of response must be provided at each application:

- (i) a haemoglobin level taken within the last 4 weeks; and
- (ii) the date of the last transfusion; and
- (iii) a statement of the number of units of red cells transfused in the 4 months immediately preceding this application; and
- (iv) a statement confirming that the patient has not progressed to acute myeloid leukaemia.

Note

Written applications for authority to prescribe should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

Subsequent authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Special Pricing Arrangements apply.

lenalidomide 10 mg capsule, 21

2796E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	3	..	5690.09	Revlimid [CJ]

lenalidomide 5 mg capsule, 21

2798G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	3	..	5439.14	Revlimid [CJ]

■ LENALIDOMIDE

Authority required

Multiple myeloma

Treatment Phase: Initial PBS-subsidised treatment

Clinical criteria:

The condition must be confirmed by a histological diagnosis, **AND**

The treatment must be as monotherapy; OR

The treatment must be in combination with dexamethasone, **AND**

Patient must have progressive disease after at least one prior therapy, **AND**

Patient must have undergone or be ineligible for a primary stem cell transplant, **AND**

Patient must have experienced treatment failure after a trial of at least four (4) weeks of thalidomide at a dose of at least 100 mg daily or have failed to achieve at least a minimal response after eight (8) or more weeks of thalidomide-based therapy for progressive disease, **AND**

Patient must not be receiving concomitant PBS-subsidised bortezomib.

Progressive disease is defined as at least 1 of the following:

- (a) at least a 25% increase and an absolute increase of at least 5 g per L in serum M protein (monoclonal protein); or
- (b) at least a 25% increase in 24-hour urinary light chain M protein excretion, and an absolute increase of at least 200 mg per 24 hours; or
- (c) in oligo-secretory and non-secretory myeloma patients only, at least a 50% increase of the difference between involved free light chain and uninvolved free light chain; or
- (d) at least a 25% relative increase and at least a 10% absolute increase in plasma cells in a bone marrow aspirate or on biopsy; or
- (e) an increase in the size or number of lytic bone lesions (not including compression fractures); or
- (f) at least a 25% increase in the size of an existing or the development of a new soft tissue plasmacytoma (determined by clinical examination or diagnostic imaging); or
- (g) development of hypercalcaemia (corrected serum calcium greater than 2.65 mmol per L not attributable to any other cause).

Oligo-secretory and non-secretory patients are defined as having active disease with less than 10 g per L serum M protein.

Thalidomide treatment failure is defined as:

- (1) confirmed disease progression during thalidomide treatment or within 6 months of discontinuing thalidomide treatment; or
- (2) severe intolerance or toxicity unresponsive to clinically appropriate dose adjustment.

Severe intolerance due to thalidomide is defined as unacceptable somnolence or sedation interfering with activities of daily living.

Toxicity from thalidomide is defined as peripheral neuropathy (Grade 2 or greater, interfering with function), drug-related seizures, serious Grade 3 or 4 drug-related dermatological reactions, such as Stevens-Johnson Syndrome, or other Grade 3 or 4 toxicity.

Failure to achieve at least a minimal response after 8 or more weeks of thalidomide-based therapy for progressive disease is defined as:

- (1) less than a 25% reduction in serum or urine M protein; or
 (2) in oligo-secretory and non-secretory myeloma patients only, less than a 25% reduction in the difference between involved and uninvolved serum free light chain levels.
- If the dosing requirement for thalidomide cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

- (1) a completed authority prescription form; and
 (2) a completed Multiple Myeloma lenalidomide Authority Application - Supporting Information Form, which includes details of the histological diagnosis of multiple myeloma, prior treatments including name(s) of drug(s) and date of most recent treatment cycle and record of prior stem cell transplant or ineligibility for prior stem cell transplant; details of thalidomide treatment failure; details of the basis of the diagnosis of progressive disease or failure to respond; and nomination of which disease activity parameters will be used to assess response; and
 (3) duration of thalidomide and daily dose prescribed; and
 (4) a signed patient acknowledgment.

To enable confirmation of eligibility for treatment, current diagnostic reports of at least one of the following must be provided:

- (a) the level of serum monoclonal protein; or
 (b) Bence-Jones proteinuria - the results of 24-hour urinary light chain M protein excretion; or
 (c) the serum level of free kappa and lambda light chains; or
 (d) bone marrow aspirate or trephine; or
 (e) if present, the size and location of lytic bone lesions (not including compression fractures); or
 (f) if present, the size and location of all soft tissue plasmacytomas by clinical or radiographic examination i.e. MRI or CT-scan; or
 (g) if present, the level of hypercalcaemia, corrected for albumin concentration.

As these parameters will be used to determine response, results for either (a) or (b) or (c) should be provided for all patients. Where the patient has oligo-secretory or non-secretory multiple myeloma, either (c) or (d) or if relevant (e), (f) or (g) should be provided. Where the prescriber plans to assess response in patients with oligo-secretory or non-secretory multiple myeloma with free light chain assays, evidence of the oligo-secretory or non-secretory nature of the multiple myeloma (current serum M protein less than 10 g per L) must be provided.

Patients receiving lenalidomide under the PBS listing must be registered in the i-access risk management program.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
 Prior Written Approval of Complex Drugs
 Reply Paid 9826
 GPO Box 9826

HOBART TAS 7001

Authority required

Multiple myeloma

Treatment Phase: Continuing PBS-subsidised treatment

Clinical criteria:

Patient must have previously received an authority prescription for lenalidomide, **AND**

Patient must not have progressive disease, **AND**

The treatment must be as monotherapy; OR

The treatment must be in combination with dexamethasone.

Progressive disease is defined as at least 1 of the following:

- (a) at least a 25% increase and an absolute increase of at least 5 g per L in serum M protein (monoclonal protein); or
 (b) at least a 25% increase in 24-hour urinary light chain M protein excretion, and an absolute increase of at least 200 mg per 24 hours; or
 (c) in oligo-secretory and non-secretory myeloma patients only, at least a 50% increase of the difference between involved free light chain and uninvolved free light chain; or
 (d) at least a 25% relative increase and at least a 10% absolute increase in plasma cells in a bone marrow aspirate or on biopsy; or
 (e) an increase in the size or number of lytic bone lesions (not including compression fractures); or
 (f) at least a 25% increase in the size of an existing or the development of a new soft tissue plasmacytoma (determined by clinical examination or diagnostic imaging); or
 (g) development of hypercalcaemia (corrected serum calcium greater than 2.65 mmol per L not attributable to any other cause).

Patients receiving lenalidomide under the PBS listing must be registered in the i-access risk management program.

Note

Authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authority to prescribe should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001
Special Pricing Arrangements apply.

lenalidomide 10 mg capsule, 21

9643M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	5690.09	Revlimid [CJ]

lenalidomide 15 mg capsule, 21

9644N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	6628.37	Revlimid [CJ]

lenalidomide 25 mg capsule, 21

9645P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	6980.96	Revlimid [CJ]

lenalidomide 5 mg capsule, 21

9642L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	5439.14	Revlimid [CJ]

■ RITUXIMAB

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (patient recommencing treatment after a break of more than 24 months)

Clinical criteria:

Patient must have severe active rheumatoid arthritis, **AND**

Patient must have failed to respond to at least 1 PBS-subsidised tumour necrosis factor (TNF) alfa antagonist, **AND**

Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**

Patient must not have failed previous PBS-subsidised treatment with rituximab for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDs which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**

Patient must not receive more than 2 infusions of rituximab under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction 'TNF' alfa antagonist means adalimumab, certolizumab pegol, etanercept, golimumab and infliximab.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab

If methotrexate is contraindicated according to the TGA-approved product information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance including severity to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances including severity.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance including severity and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

- (1) completed authority prescription form(s); and
- (2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and
- (3) a signed patient acknowledgement.

Assessment of a patient's response to an initial course of treatment must be made at least 12 weeks after the first infusion so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services within 4 weeks of the date it was conducted. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with rituximab.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction.

If a patient who fails to demonstrate a response to treatment with rituximab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

A patient who fails to demonstrate a response to rituximab treatment and who qualifies to trial an alternate bDMARD according to the interchangeability arrangements for bDMARDs for the treatment of severe rheumatoid arthritis, may do so without having to have a 22 week treatment-free period.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

- (a) a total active joint count of at least 20 active (swollen and tender) joints; or
 - (b) at least 4 active joints from the following list of major joints:
 - (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - (ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).
- The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response

Note

The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:

- (a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
- (b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;

- (c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months).

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have failed to respond to at least 1 PBS-subsidised tumour necrosis factor (TNF) alfa antagonist, **AND**

Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**

Patient must not receive more than 2 infusions of rituximab under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction 'TNF' alfa antagonist means adalimumab, certolizumab pegol, etanercept, golimumab and infliximab.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab

The authority application must be made in writing and must include:

- (a) completed authority prescription form(s); and
- (b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has received PBS-subsidised treatment with rituximab and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised rituximab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised rituximab treatment was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response at least 12 weeks after the first infusion. This assessment must be submitted no later than 4 weeks from the date of the assessment.

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent provided they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The demonstration of response must be submitted within 4 weeks of assessment.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with rituximab.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction.

If a patient fails to demonstrate a response to treatment with rituximab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

If a patient fails to demonstrate a response to a treatment with rituximab and who qualify to trial an alternate bDMARD according to the interchangeability arrangements for bDMARDs for the treatment of severe rheumatoid arthritis, may do so without having to have a 22 week treatment-free period.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

- (a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or
- (b) a reduction in the number of the following active joints, from at least 4, by at least 50%:
 - (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - (ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have demonstrated an adequate response to treatment with this drug, **AND**

Patient must have received this drug as the most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition, **AND**

Patient must not receive more than 2 infusions of rituximab under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

The authority application must be made in writing and must include:

- (a) completed authority prescription form(s); and
- (b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent provided they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The demonstration of response must be submitted within 4 weeks of assessment.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with rituximab.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction.

If a patient fails to demonstrate a response to treatment with rituximab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

- (a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or
- (b) a reduction in the number of the following active joints, from at least 4, by at least 50%:
 - (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note

Special Pricing Arrangements apply.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

- a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,
- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and
- once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or
- (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
- (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD.

However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

rituximab 500 mg/50 mL injection, 1 x 50 mL vial

9611W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	2079.67	Mabthera [RO]

■ THALIDOMIDE

Caution

Thalidomide is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and for 1 month after cessation of treatment.

Authority required

Multiple myeloma

Note

Patients receiving thalidomide under the PBS listing must be registered in the i-access risk management program.

thalidomide 100 mg capsule, 28

9684Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	..	..	*1726.76	Thalomid [CJ]

thalidomide 50 mg capsule, 28

6469L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	4	..	..	*1726.76	Thalomid [CJ]

MUSCULO-SKELETAL SYSTEM
MUSCLE RELAXANTS
MUSCLE RELAXANTS, CENTRALLY ACTING AGENTS
Other centrally acting agents
BACLOFEN
Authority required

Severe chronic spasticity, where oral antispastic agents have failed or have caused unacceptable side effects, in patients with chronic spasticity of cerebral origin

Authority required

Severe chronic spasticity, where oral antispastic agents have failed or have caused unacceptable side effects, in patients with chronic spasticity due to multiple sclerosis

Authority required

Severe chronic spasticity, where oral antispastic agents have failed or have caused unacceptable side effects, in patients with chronic spasticity due to spinal cord injury

Authority required

Severe chronic spasticity, where oral antispastic agents have failed or have caused unacceptable side effects, in patients with chronic spasticity due to spinal cord disease

baclofen 10 mg/5 mL injection: intrathecal, 1 x 5 mL ampoule

6284R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	10	..	..	*1530.46	Lioresal Intrathecal [NV]

DRUGS FOR TREATMENT OF BONE DISEASES
DRUGS AFFECTING BONE STRUCTURE AND MINERALIZATION
Bisphosphonates
IBANDRONIC ACID
Authority required

Bone metastases from breast cancer

ibandronic acid 6 mg/6 mL injection, 1 x 6 mL vial

9619G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	11	..	361.77	Bondronat [RO]

PAMIDRONATE DISODIUM
Authority required

Hypercalcaemia of malignancy

Clinical criteria:

Patient must have a malignancy refractory to anti-neoplastic therapy.

pamidronate disodium 15 mg/5 mL injection, 1 x 5 mL vial

6286W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	4	2	..	*79.40	Pamisol [HH]

pamidronate disodium 60 mg/10 mL injection, 1 x 10 mL vial

6288Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	2	..	79.41	Pamisol [HH]

PAMIDRONATE DISODIUM
Authority required

Hypercalcaemia of malignancy

Clinical criteria:

Patient must have a malignancy refractory to anti-neoplastic therapy.

Note

Pharmaceutical benefits that have the form disodium pamidronate powder for I.V. infusion 30 mg (after reconstitution) and pharmaceutical benefits that have the form disodium pamidronate concentrated injection 30 mg are equivalent for the purposes of substitution.

pamidronate disodium 30 mg injection [2 x 30 mg vials] (&) inert substance diluent [2 x 10 mL ampoules], 1 pack

6279L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	2	..	79.42	^a Aredia 30 mg [NV]

pamidronate disodium 30 mg/10 mL injection, 1 x 10 mL vial

6287X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	2	..	*79.42	^a Pamisol [HH]

■ PAMIDRONATE DISODIUM**Authority required**

Hypercalcaemia of malignancy

Clinical criteria:

Patient must have a malignancy refractory to anti-neoplastic therapy.

Authority required

Multiple myeloma

Authority required

Bone metastases

Clinical criteria:

The condition must be due to breast cancer.

Note

Pharmaceutical benefits that have the form disodium pamidronate powder for I.V. infusion 90 mg (after reconstitution) and pharmaceutical benefits that have the form disodium pamidronate concentrated injection 90 mg are equivalent for the purposes of substitution.

pamidronate disodium 90 mg injection [1 x 90 mg vial] (&) inert substance diluent [1 x 10 mL ampoule], 1 pack

6223M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	11	..	113.86	^a Aredia 90 mg [NV]

pamidronate disodium 90 mg/10 mL injection, 1 x 10 mL vial

6289B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	11	..	113.86	^a Pamisol [HH]

■ ZOLEDRONIC ACID**Authority required**

Multiple myeloma

Authority required

Bone metastases from breast cancer

Authority required

Bone metastases from castration-resistant prostate cancer

Authority required

Treatment of hypercalcaemia of malignancy refractory to anti-neoplastic therapy

Note

Special Pricing Arrangements apply.

zoledronic acid 4 mg/5 mL injection, 1 x 5 mL vial

6371H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	11	..	474.76	Zometa [NV]

■ NERVOUS SYSTEM**■ ANTI-PARKINSON DRUGS****DOPAMINERGIC AGENTS**

Dopa and dopa derivatives

■ LEVODOPA + CARBIDOPA ANHYDROUS**Authority required**

Management of advanced Parkinson disease in a patient with severe disabling motor fluctuations not adequately controlled by oral therapy.

Treatment must be commenced in a hospital-based movement disorder clinic

Note

Patients should have adequate cognitive function to manage administration with a portable continuous infusion pump.

A positive clinical response to Duodopa administered via a temporary nasoduodenal tube should be confirmed before a permanent percutaneous endoscopic gastrostomy (PEG) tube is inserted.

levodopa 20 mg/mL + carbidopa monohydrate 5 mg/mL gel: intestinal, 7 x 100 mL bags

9744W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	8	5	..	*11582.76	Duodopa [VE]

Dopamine agonists

■ APOMORPHINE

Authority required

Parkinson disease

Clinical criteria:

Patient must have experienced severely disabling motor fluctuations which have not responded to other therapy.

apomorphine hydrochloride 10 mg/mL injection, 5 x 1 mL ampoules

10235Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	72	5	..	*3643.48	Apomine [HH]

apomorphine hydrochloride 20 mg/2 mL injection, 5 x 2 mL ampoules

9607P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	72	5	..	*7243.48	Apomine [HH]

apomorphine hydrochloride 50 mg/10 mL injection: subcutaneous infusion, 5 x 10 mL syringes

9647R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	36	5	..	*7054.12	Apomine PFS [HH]

apomorphine hydrochloride 50 mg/5 mL injection, 5 x 5 mL ampoules

9640J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	36	5	..	*9050.32	Apomine [HH]

■ PSYCHOLEPTICS

ANTIPSYCHOTICS

Diazepines, oxazepines, thiazepines and oxepines

■ CLOZAPINE

Authority required

Schizophrenia

Clinical criteria:

Patient must be non-responsive to other neuroleptic agents; OR

Patient must be intolerant of other neuroleptic agents.

A medical practitioner should request a quantity sufficient for up to one month's supply. Up to 5 repeats will be authorised.

Note

Patients receiving clozapine under the PBS listing must be registered in a clozapine patient monitoring program; Novartis Clozaril Patient Monitoring System (eCPMS) or Clopineconnect.

clozapine 100 mg tablet, 100

6102E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	..	..	*258.84	^a Clopine 100 [HH]	^a Clozaril 100 [NV]

clozapine 200 mg tablet, 100

6418T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	..	..	*510.92	Clopine 200 [HH]

clozapine 25 mg tablet, 100

6101D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	..	..	*75.40	^a Clopine 25 [HH]	^a Clozaril 25 [NV]

clozapine 50 mg tablet, 100

6417R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	..	..	*141.22	Clopine 50 [HH]

clozapine 50 mg/mL oral liquid, 100 mL

9632Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	147.16	Clopine Suspension [HH]

■ RESPIRATORY SYSTEM

■ DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES

OTHER SYSTEMIC DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES

Other systemic drugs for obstructive airway diseases

■ OMALIZUMAB

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Initial treatment

Clinical criteria:

Patient must be under the care of the same physician for at least 12 months, **AND**

Patient must have a diagnosis of asthma confirmed and documented by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma, defined by the following standard clinical features: (i) forced expiratory volume (FEV1) reversibility greater than or equal to 12% and greater than or equal to 200 mL at baseline within 30 minutes after administration of salbutamol (200 to 400 micrograms), or (ii) airway hyperresponsiveness defined as a greater than 20% decline in FEV1 during a direct bronchial provocation test or greater than 15% decline during an indirect bronchial provocation test, or (iii) peak expiratory flow (PEF) variability of greater than 15% between the two highest and two lowest peak expiratory flow rates during 14 days, **AND**

Patient must have a duration of asthma of at least 1 year, **AND**

Patient must have forced expiratory volume (FEV1) less than or equal to 80% predicted, documented on 3 or more occasions in the previous 12 months, **AND**

Patient must have past or current evidence of atopy, documented by skin prick testing or RAST, **AND**

Patient must have total serum human immunoglobulin E greater than or equal to 76 IU/mL, **AND**

Patient must have signed a patient acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment, **AND**

Patient must have failed to achieve adequate control with optimised asthma therapy, despite formal assessment of and adherence to correct inhaler technique, which has been documented, **AND**

Patient must not receive more than 28 weeks of treatment under this restriction.

Population criteria:

Patient must be aged 12 years or older.

Treatment criteria:

Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

Optimised asthma therapy includes:

(i) adherence to maximal inhaled therapy, including high dose inhaled corticosteroid (budesonide 1600 micrograms per day or fluticasone propionate 1000 micrograms per day or equivalent), plus long-acting beta-2 agonist therapy (at least salmeterol 50 micrograms bd or formoterol 12 micrograms bd) for at least 12 months, unless contraindicated or not tolerated, **AND**

(ii) treatment with oral corticosteroids, either daily oral corticosteroids for at least 6 weeks, OR a cumulative dose of oral corticosteroids of at least 500 mg prednisolone equivalent in the previous 12 months, unless contraindicated or not tolerated.

If the requirement for treatment with optimised asthma therapy cannot be met because of contraindications according to the relevant TGA-approved Product Information and/or intolerances of a severity necessitating permanent treatment withdrawal, details of the contraindication and/or intolerance must be provided in the authority application.

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

The following initiation criteria indicate failure to achieve adequate control and must be demonstrated in all patients at the time of the application:

(a) an Asthma Control Questionnaire (ACQ-5) score of at least 2.0, as assessed in the previous month, **AND**

(b) while receiving optimised asthma therapy in the past 12 months, experienced at least 1 admission to hospital for a severe asthma exacerbation, OR 1 severe asthma exacerbation, requiring documented use of systemic corticosteroids (oral corticosteroids initiated or increased for at least 3 days, or parenteral corticosteroids) prescribed/supervised by a physician. The Asthma Control Questionnaire (5 item version) assessment of the patient's response to this initial course of treatment, and the assessment of oral corticosteroid dose, must be made at around 22 to 26 weeks after the first dose so that there is adequate time for a response to be demonstrated and for the application for continuing therapy to be processed.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted within 4 weeks of the date of assessment, and no later than 2 weeks prior to the patient completing their current treatment course, to avoid an interruption to supply. Where a response assessment is not undertaken and submitted within this timeframe, the patient will be deemed to have failed to respond to treatment with omalizumab.

A patient who fails to respond to a course of PBS-subsidised omalizumab for the treatment of uncontrolled severe allergic asthma will not be eligible to receive further PBS-subsidised treatment with omalizumab for this condition within 6 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate maximum quantity and number of repeats to provide for an initial course of omalizumab consisting of the recommended number of doses for the baseline IgE level and body weight of the patient (refer to the TGA-approved Product Information) to be administered every 2 or 4 weeks.

The authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Allergic Asthma PBS Authority Application - Supporting Information Form, which includes the following:
 - (i) details of prior optimised asthma drug therapy (dosage, date of commencement and duration of therapy); and
 - (ii) details of severe exacerbation/s experienced in the past 12 months while receiving optimised asthma therapy (date and treatment); and
 - (iii) the signed patient acknowledgement; and
 - (c) the IgE pathology report; and
 - (d) a completed Asthma Control Questionnaire (ACQ-5) calculation sheet including the date of assessment of the patient's symptoms.

Note

The Department of Human Services website (www.humanservices.gov.au) has details of the accepted toxicities, including severity, which will be accepted for the purposes of exempting a patient from the requirement of treatment with optimised asthma therapy.

It is recommended that an application for continuing treatment is submitted at the time of the 22 to 26 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised omalizumab treatment.

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Initial treatment - balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Initial treatment restriction to complete 28 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 28 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

Note

Authority approval for sufficient therapy to complete a maximum of 28 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 28 weeks of treatment should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe allergic asthma, **AND**

Patient must have demonstrated or sustained an adequate response to treatment with this drug, **AND**

Patient must not receive more than 24 weeks of treatment under this restriction.

Treatment criteria:

Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

An adequate response to omalizumab treatment is defined as:

- (a) a reduction in the Asthma Control Questionnaire (ACQ-5) score of at least 0.5 from baseline, OR
- (b) maintenance oral corticosteroid dose reduced by at least 25% from baseline, and no deterioration in ACQ-5 score from baseline.

All applications for continuing treatment with omalizumab must include a measurement of response to the prior course of therapy. The Asthma Control Questionnaire (5 item version) assessment of the patient's response to the prior course of treatment, and the assessment of oral corticosteroid dose, must be made at around 18 to 22 weeks after the first dose so that there is adequate time for a response to be demonstrated and for the application for continuing therapy to be processed.

The first assessment should, where possible, be completed by the same physician who initiated treatment with omalizumab. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted within 4 weeks of

the date of assessment, and no later than 2 weeks prior to the patient completing their current treatment course, to avoid an interruption to supply. Where a response assessment is not undertaken and submitted within this timeframe, the patient will be deemed to have failed to respond to treatment with omalizumab.

A patient who fails to respond to a course of PBS-subsidised omalizumab for the treatment of uncontrolled severe allergic asthma will not be eligible to receive further PBS-subsidised treatment with omalizumab for this condition within 6 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate maximum quantity and number of repeats to provide for a continuing course of omalizumab consisting of the recommended number of doses for the baseline IgE level and body weight of the patient (refer to the TGA-approved Product Information), sufficient for 24 weeks of therapy.

The authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Allergic Asthma PBS Authority Application - Supporting Information Form which includes details of maintenance oral corticosteroid dose; and
- (c) a completed Asthma Control Questionnaire (ACQ-5) calculation sheet including the date of assessment of the patient's symptoms.

Note

If the same physician cannot assess the patient please call the Department of Human Services on 1800 700 270.

For copies of the ACQ please contact Novartis Medical Information on 1800 671 203 or medinfo.phauno@novartis.com

It is recommended that an application for continuing treatment is submitted at the time of the 18 to 22 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised omalizumab treatment.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT AND ADOLESCENT PATIENTS WITH UNCONTROLLED SEVERE ALLERGIC ASTHMA

Patients are eligible to commence an 'omalizumab treatment cycle' (initial treatment course with or without continuing treatment course/s) if they satisfy the eligibility criteria as detailed under the initial treatment restriction.

Once a patient has either failed to achieve or maintain a response to omalizumab, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 6 month break in PBS-subsidised omalizumab therapy before they are eligible to commence the next cycle. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised omalizumab treatment is stopped to the date of the first application for initial treatment with omalizumab under the new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised omalizumab therapy:

(a) Initial treatment:

Applications for initial treatment should be made where a patient has received no prior PBS-subsidised omalizumab treatment in this treatment cycle and wishes to commence such therapy.

(b) Continuing treatment:

Following the completion of the initial treatment course with omalizumab, a patient may qualify to receive up to a further 24 weeks of continuing treatment with omalizumab providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing omalizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.

(2) Baseline measurements to determine response:

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Asthma Control Questionnaire (ACQ; 5 item version) and oral corticosteroid dose, submitted with the Initial authority application for omalizumab. However, prescribers may provide new baseline measurements when a new Initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.

(3) Re-commencement of treatment after a 6 month break in PBS-subsidised therapy:

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised omalizumab therapy of at least 6 months, must re-qualify for initial treatment with respect to the indices of disease severity (oral corticosteroid dose, Asthma Control Questionnaire (ACQ-5) score, and relevant exacerbation history). Patients must have received optimised standard therapy, at adequate doses and for the minimum period specified, immediately prior to the time the new baseline assessments are performed.

(4) Monitoring of patients:

Anaphylaxis and anaphylactoid reactions have been reported following first or subsequent administration of omalizumab (see Product Information). Patients should be monitored post-injection, and medications for the treatment of anaphylactic reactions should be available for immediate use following administration of omalizumab. Patients should be informed that such reactions are possible and prompt medical attention should be sought if allergic reactions occur.

Formal assessment and correction of inhaler technique should be performed in accordance with the National Asthma Council (NAC) Information Paper for Health Professionals on Inhaler Technique (available at www.humanservices.gov.au or

www.nationalasthma.org.au); the assessment and adherence to correct technique should be documented in the patient's medical records. Patients can obtain support with inhaler technique through their local Asthma Foundation (1800 645 130).

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Continuing treatment - balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Special Pricing Arrangements apply.

omalizumab 150 mg/mL injection, 1 x 1 mL syringe

10122R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	433.16	Xolair [NV]

omalizumab 75 mg/0.5 mL injection, 1 x 0.5 mL syringe

10110D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	219.96	Xolair [NV]

■ COUGH AND COLD PREPARATIONS

EXPECTORANTS, EXCL. COMBINATIONS WITH COUGH SUPPRESSANTS

Mucolytics

■ DORNASE ALFA

Authority required

Cystic fibrosis

Clinical criteria:

Patient must have a forced vital capacity (FVC) greater than 40% predicted for age, gender and weight, **AND**

Patient must have evidence of chronic suppurative lung disease (cough and sputum most days of the week, or greater than 3 respiratory tract infections of more than 2 weeks' duration in any 12 months, or objective evidence of obstructive airways disease).

Population criteria:

Patient must be 5 years of age or older.

Patient must be assessed at a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. The prescribing of dornase alfa therapy under the HSD program is limited to such physicians. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be by a specialist physician or paediatrician in consultation with such a unit.

The measurement of lung function is to be conducted by independent (other than the treating doctor) experienced personnel at an established lung function testing laboratory, unless this is not possible because of geographical isolation.

Prior to dornase alfa therapy, a baseline measurement of forced expiratory volume in 1 second (FEV1) must be undertaken during a stable period of the disease.

Initial therapy is limited to 3 months treatment with dornase alfa at a dose of 2.5 mg daily.

FEV1 measurement (single test under conditions as above) and a global assessment of the patient involving the patient, the patient's family (in the case of paediatric patients), the treating physician(s) and an additional independent member of the cystic fibrosis treatment team must be undertaken and documented following 3 months of initial therapy.

To be eligible for continued PBS-subsidised treatment with dornase alfa following 3 months of initial treatment:

(1) the patient must demonstrate no deterioration in FEV1 compared to baseline; **AND**

(2) the patient or the patient's family (in the case of paediatric patients) must report improvement in the patient's airway clearance; **AND**

(3) the treating physician(s) must report a benefit in the clinical status of the patient.

Further reassessments involving the patient, the patient's family (in the case of paediatric patients), the treating physician(s) and an additional independent member of the cystic fibrosis treatment team must be undertaken and documented at six-monthly intervals to establish that all agree that dornase alfa treatment is continuing to produce worthwhile benefits. Dornase alfa therapy should cease if there is not general agreement of benefit as there is always the possibility of harm from unnecessary use.

Other aspects of treatment, such as physiotherapy, must be continued.

Where there is documented evidence that a patient already receiving dornase alfa therapy would have met the criteria for subsidy, then the patient is eligible to continue treatment under the HSD program. Where such evidence is not available, patients will need to satisfy the initiation and continuation criteria as for new patients. (Four weeks is considered a suitable wash-out period.)

Authority required

Cystic fibrosis

Clinical criteria:

Patient must have a severe clinical course with frequent respiratory exacerbations or chronic respiratory symptoms (including chronic or recurrent cough, wheeze or tachypnoea) requiring hospital admissions more frequently than 3 times per year; OR

Patient must have significant bronchiectasis on chest high resolution computed tomography scan; OR

Patient must have severe cystic fibrosis bronchiolitis with persistent wheeze non-responsive to conventional medicines; OR

Patient must have severe physiological deficit measure by forced oscillation technique or multiple breath nitrogen washout and failure to respond to conventional therapy.

Population criteria:

Patient must be less than 5 years of age.

Patient must be assessed at a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. The prescribing of dornase alfa therapy under the HSD program is limited to such physicians. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be by a specialist physician or paediatrician in consultation with such a unit.

Following an initial 6 months therapy, a comprehensive assessment must be undertaken and documented involving the patient, the patient's family, the treating physician and an additional independent member of the cystic fibrosis treatment team to establish agreement that dornase alfa treatment is continuing to produce worthwhile benefit. Treatment with dornase alfa should cease if there is not agreement of benefit, as there is always the possibility of harm from unnecessary use. Further reassessments must be undertaken and documented at six-monthly intervals.

Authority required

Cystic fibrosis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have initiated treatment with dornase alfa at an age of less than 5 years, **AND**

Patient must have undergone a comprehensive assessment, involving the patient's family, the treating physician and an additional independent member of the cystic fibrosis treatment team which documents agreement that dornase alfa treatment is continuing to produce worthwhile benefit.

Population criteria:

Patient must be 5 years of age or older.

Further reassessments must be undertaken and documented at six-monthly intervals. Treatment with dornase alfa should cease if there is not agreement of benefit as there is always the possibility of harm from unnecessary use.

Authority required

Cystic fibrosis

Clinical criteria:

Patient must have initiated treatment with dornase alfa prior to 1 November 2009, **AND**

Patient must have undergone a comprehensive assessment, involving the patient's family, the treating physician and an additional independent member of the cystic fibrosis treatment team which documents agreement that dornase alfa treatment is continuing to produce worthwhile benefit.

Population criteria:

Patient must be less than 5 years of age.

Further reassessments must be undertaken and documented at six-monthly intervals. Treatment with dornase alfa should cease if there is not agreement of benefit as there is always the possibility of harm from unnecessary use.

Note

Dornase alfa is not PBS-subsidised for use in combination with PBS-subsidised mannitol.

It is highly desirable that all patients be included in the national cystic fibrosis patient database.

dornase alfa 2.5 mg/2.5 mL inhalation: solution, 30 x 2.5 mL ampoules

6120D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2406.76	Pulmozyme [RO]

▪ **MANNITOL**

Authority required

Cystic fibrosis

Clinical criteria:

Patient must have been assessed for bronchial hyperresponsiveness as per the TGA approved Product Information mannitol initiation dose assessment, prior to mannitol therapy. If the patient has a negative hyperresponsiveness test they may be eligible for PBS subsidised treatment with mannitol, **AND**

Patient must have a forced expiratory volume in 1 second (FEV1) greater than 30% predicted for age, gender and height, **AND**

Patient must be intolerant or inadequately responsive to dornase alfa, **AND**

Patient must have evidence of chronic suppurative lung disease (cough and sputum most days of the week, or greater than 3 respiratory tract infections of more than 2 weeks' duration in any 12 months, or objective evidence of obstructive airways disease).

Population criteria:

Patient must be 6 years of age or older.

Patient must be assessed at a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. The prescribing of mannitol therapy under the HSD program is limited to such physicians. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be by a specialist physician or paediatrician in consultation with such a unit.

The measurement of lung function is to be conducted by independent (other than the treating doctor) experienced personnel at an established lung function testing laboratory, unless this is not possible because of geographical isolation.

Prior to mannitol therapy, a baseline measurement of FEV1 must be undertaken during a stable period of the disease.

Initial therapy is limited to 3 months treatment with mannitol at a dose of 400 mg twice daily.

FEV1 measurement (single test under conditions as above) and a global assessment of the patient involving the patient, the patient's family (in the case of paediatric patients), the treating physician(s) and an additional independent member of the cystic fibrosis treatment team must be undertaken and documented following 3 months of initial therapy.

To be eligible for continued PBS-subsidised treatment with mannitol following 3 months of initial treatment:

(1) the patient must demonstrate no deterioration in FEV1 compared to baseline; **AND**

(2) the patient or the patient's family (in the case of paediatric patients) must report improvement in the patient's airway clearance; **AND**

(3) the treating physician(s) must report a benefit in the clinical status of the patient.

Further reassessments involving the patient, the patient's family (in the case of paediatric patients), the treating physician(s) and an additional independent member of the cystic fibrosis treatment team must be undertaken and documented at six-monthly intervals to establish that all agree that mannitol treatment is continuing to produce worthwhile benefits. Mannitol therapy should cease if there is not general agreement of benefit as there is always the possibility of harm from unnecessary use.

Other aspects of treatment, such as physiotherapy, must be continued.

Where there is documented evidence that a patient already receiving mannitol therapy would have met the criteria for subsidy then the patient is eligible to continue treatment under the HSD program. Where such evidence is not available, patients will need to satisfy the initiation and continuation criteria as for new patients. (Four weeks is considered a suitable wash-out period.)

Authority required

Cystic fibrosis

Clinical criteria:

Patient must have initiated treatment with mannitol prior to 1 August 2012, **AND**

Patient must have undergone a comprehensive assessment involving the patient's family, the treating physician and an additional independent member of the cystic fibrosis team, which documents agreement that mannitol treatment is continuing to produce a worthwhile benefit.

Population criteria:

Patient must be 6 years of age or older.

Further reassessments are to be undertaken and documented every 6 months. Treatment with mannitol should cease if there is not agreement of benefit as there is always the possibility of harm from unnecessary use.

Note

Mannitol is not PBS-subsidised for use in combination with PBS-subsidised dornase alfa.

It is highly desirable that all patients be included in the national cystic fibrosis patient database.

MANNITOL Pack containing 280 capsules containing powder for inhalation 40 mg and 2 inhalers, 1

2008Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	4	5	..	*1782.76	bronchitol [XA]

■ **OTHER RESPIRATORY SYSTEM PRODUCTS**

OTHER RESPIRATORY SYSTEM PRODUCTS

Other respiratory system products

■ **IVACAFTOR**

Authority required

Cystic fibrosis

Treatment Phase: Initial treatment – New patients

Clinical criteria:

Patient must be assessed through a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be in consultation with such a unit, **AND**

Patient must have G551D mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene on at least 1 allele; OR

Patient must have other gating (class III) mutation in the CFTR gene on at least 1 allele, **AND**

Patient must not receive more than 24 weeks of treatment under this restriction, **AND**

The treatment must be given concomitantly with standard therapy for this condition.

Population criteria:

Patient must be 6 years of age or older.

Patients receiving PBS-subsidised ivacaftor must be registered in the Australian Cystic Fibrosis Database Registry.

Treatment must not be given to a patient who has an acute upper or lower respiratory infection, pulmonary exacerbation, or changes in therapy (including antibiotics) for pulmonary disease in the last 4 weeks prior to commencing this drug.

Dosage of ivacaftor must not exceed the dose of 150 mg twice a week, if the patient is concomitantly receiving one of the following strong CYP3A4 drugs inhibitors: boceprevir, clarithromycin, conivaptan, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, mibefradil, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin, voriconazole.

Where a patient is concomitantly receiving a strong CYP3A4 inhibitor, a single supply of 56 tablets of ivacaftor will last for 28 weeks.

Dosage of ivacaftor must not exceed the dose of 150 mg daily, if the patient is concomitantly receiving one of the following moderate CYP3A4 inhibitors: amprenavir, aprepitant, atazanavir, darunavir/ritonavir, diltiazem, erythromycin, fluconazole, fosamprenavir, imatinib, verapamil.

Where a patient is concomitantly receiving a moderate CYP3A4 inhibitor, a single supply of 56 tablets of ivacaftor will last for 8 weeks.

Ivacaftor is not PBS-subsidised for this condition as a sole therapy.

Ivacaftor is not PBS-subsidised for this condition in a patient who is currently receiving one of the following CYP3A4 inducers:

Strong CYP3A4 inducers: avasimibe, carbamazepine, phenobarbital, phenytoin, rifabutin, rifampicin, St. John's wort

Moderate CYP3A4 inducers: bosentan, efavirenz, etravirine, modafinil, nafcillin

Weak CYP3A4 inducers: armodafinil, echinacea, pioglitazone, prednisone, rufinamide.

The authority application must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Cystic Fibrosis Ivacaftor Authority Application Supporting Information Form; and
- (3) a signed patient acknowledgement; or an acknowledgement signed by a parent or authorised guardian, if applicable; and
- (4) a copy of the pathology report detailing the molecular testing for G551D mutation or other gating (class III) mutation on the CFTR gene; and
- (5) the result of a FEV1 measurement performed within a month prior to the date of application. Note: FEV1, must be measured in an accredited pulmonary function laboratory, with documented no acute infective exacerbation at the time FEV1 is measured; and
- (6) evidence that the patient has either chronic sinopulmonary disease or gastrointestinal and nutritional abnormalities; and
- (7) a copy of a current medication history, including any CYP3A4 inhibitors and/or CYP3A4 inducers; and
- (8) a copy of a sweat chloride result; and
- (9) height and weight measurements at the time of application; and
- (10) a baseline measurement of the number of days of CF-related hospitalisation (including hospital-in-the home) in the previous 12 months.

Authority required

Cystic fibrosis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must be assessed through a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be in consultation with such a unit, **AND**

Patient must have received PBS-subsidised initial therapy with ivacaftor, given concomitantly with standard therapy, for this condition, **AND**

Patient must not receive more than 24 weeks of treatment under this restriction, **AND**

The treatment must be given concomitantly with standard therapy for this condition.

Population criteria:

Patient must be 6 years of age or older.

Patients receiving PBS-subsidised ivacaftor must be registered in the Australian Cystic Fibrosis Database Registry.

Treatment must not be given to a patient who has an acute upper or lower respiratory infection, pulmonary exacerbation, or changes in therapy (including antibiotics) for pulmonary disease in the last 4 weeks prior to commencing this drug.

Patients who have an acute infective exacerbation at the time of assessment for continuing therapy may receive an additional one month's supply in order to enable the assessment to be repeated following resolution of the exacerbation.

Dosage of ivacaftor must not exceed the dose of 150 mg twice a week, if the patient is concomitantly receiving one of the following strong CYP3A4 drugs inhibitors: boceprevir, clarithromycin, conivaptan, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, mibefradil, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin, voriconazole.

Where a patient is concomitantly receiving a strong CYP3A4 inhibitor, a single supply of 56 tablets of ivacaftor will last for 28 weeks.

Dosage of ivacaftor must not exceed the dose of 150 mg daily, if the patient is concomitantly receiving one of the following moderate CYP3A4 inhibitors: amprenavir, aprepitant, atazanavir, darunavir/ritonavir, diltiazem, erythromycin, fluconazole, fosamprenavir, imatinib, verapamil.

Where a patient is concomitantly receiving a moderate CYP3A4 inhibitor, a single supply of 56 tablets of ivacaftor will last for 8 weeks.

Ivacaftor is not PBS-subsidised for this condition as a sole therapy.

Ivacaftor is not PBS-subsidised for this condition in a patient who is currently receiving one of the following CYP3A4 inducers:

Strong CYP3A4 inducers: avasimibe, carbamazepine, phenobarbital, phenytoin, rifabutin, rifampicin, St. John's wort

Moderate CYP3A4 inducers: bosentan, efavirenz, etravirine, modafinil, nafcillin

Weak CYP3A4 inducers: armodafinil, echinacea, pioglitazone, prednisone, rufinamide.

The authority application must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Cystic Fibrosis Ivacaftor Authority Continuing Application Supporting Information Form; and
- (3) the result of a FEV1 measurement performed within one month prior to the date of application. Note: FEV1, must be measured in an accredited pulmonary function laboratory, with documented no acute infective exacerbation at the time FEV1 is measured; and
- (4) a copy of a current medication history, including any CYP3A4 inhibitors and/or CYP3A4 inducers; and
- (5) a recent sweat chloride result; and
- (6) height and weight measurements at the time of application; and
- (7) a measurement of number of days of CF-related hospitalisation (including hospital in the home) in the previous 6 months.

Authority required

Cystic fibrosis

Treatment Phase: Initial treatment - Grandfather patients

Clinical criteria:

Patient must be assessed through a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be in consultation with such a unit, **AND**

Patient must have G551D mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene on at least 1 allele; OR

Patient must have other gating (class III) mutation in the CFTR gene on at least 1 allele, **AND**

Patient must have received treatment with ivacaftor for this condition prior to 1 December 2014, **AND**

Patient must have received treatment with ivacaftor within the last 6 months at the time of application, **AND**

Patient must not receive more than 24 weeks of treatment under this restriction, **AND**

The treatment must be given concomitantly with standard therapy for this condition.

Population criteria:

Patient must be 6 years of age or older.

Patients receiving PBS-subsidised ivacaftor must be registered in the Australian Cystic Fibrosis Database Registry.

Treatment must not be given to a patient who has an acute upper or lower respiratory infection, pulmonary exacerbation, or changes in therapy (including antibiotics) for pulmonary disease in the last 4 weeks prior to commencing this drug.

Dosage of ivacaftor must not exceed the dose of 150 mg twice a week, if the patient is concomitantly receiving one of the following strong CYP3A4 drugs inhibitors: boceprevir, clarithromycin, conivaptan, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, mibefradil, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin, voriconazole.

Where a patient is concomitantly receiving a strong CYP3A4 inhibitor, a single supply of 56 tablets of ivacaftor will last for 28 weeks.

Dosage of ivacaftor must not exceed the dose of 150 mg daily, if the patient is concomitantly receiving one of the following moderate CYP3A4 inhibitors: amprenavir, aprepitant, atazanavir, darunavir/ritonavir, diltiazem, erythromycin, fluconazole, fosamprenavir, imatinib, verapamil.

Where a patient is concomitantly receiving a moderate CYP3A4 inhibitor, a single supply of 56 tablets of ivacaftor will last for 8 weeks.

Ivacaftor is not PBS-subsidised for this condition as a sole therapy.

Ivacaftor is not PBS-subsidised for this condition in a patient who is currently receiving one of the following CYP3A4 inducers:

Strong CYP3A4 inducers: avasimibe, carbamazepine, phenobarbital, phenytoin, rifabutin, rifampicin, St. John's wort

Moderate CYP3A4 inducers: bosentan, efavirenz, etravirine, modafinil, nafcillin

Weak CYP3A4 inducers: armodafinil, echinacea, pioglitazone, prednisone, rufinamide.

The authority application must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Cystic Fibrosis Ivacaftor Application Supporting Information Form; and
- (3) a signed patient acknowledgement; or an acknowledgement signed by a parent or authorised guardian, if applicable; and
- (4) a copy of the pathology report detailing the molecular testing for G551D mutation or other gating (class III) mutation on the CFTR gene performed prior to commencing treatment with ivacaftor; and
- (5) the result of a FEV1 measurement performed prior to commencing treatment with ivacaftor for this condition; and

- (6) the result of a FEV1 measurement performed within a month prior to date of application. Note: FEV1, must be measured in an accredited pulmonary function laboratory, with documented no acute infective exacerbation at the time FEV1 is measured; and
- (7) evidence that the patient had either chronic sinopulmonary disease or gastrointestinal and nutritional abnormalities prior to commencing treatment with ivacaftor for this condition; and
- (8) a copy of a current medication history, including any CYP3A4 inhibitors and/or CYP3A4 inducers; and
- (9) a copy of sweat chloride result performed prior to commencing treatment with ivacaftor for this condition; and
- (10) a recent sweat chloride result prior to commencing PBS-subsidised ivacaftor; and
- (11) height and weight measurements at the time of application; and
- (12) height and weight measurements performed immediately prior to commencement of ivacaftor; and
- (13) a baseline measurement of number of days of CF-related hospitalisation (including hospital-in-the home) in the 12 months prior to commencement of ivacaftor; and
- (14) a measurement of the number of days of CF-related hospitalisation (including hospital-in the home) in the 6 months prior to the date of application; and
- (15) dates of prior ivacaftor therapy.

Note

Special Pricing Arrangements apply.

No increase in the maximum number of repeats may be authorised.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

ivacaftor 150 mg tablet, 56

10175M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	5	..	22546.76	Kalydeco [VR]

VARIOUS

ALL OTHER THERAPEUTIC PRODUCTS

ALL OTHER THERAPEUTIC PRODUCTS

Iron chelating agents

DEFERASIROX

Authority required

Chronic iron overload in patients with disorders of erythropoiesis

Note

Special Pricing Arrangements apply.

deferasirox 125 mg tablet: dispersible, 28

6499C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	6	5	..	*1448.26	Exjade [NV]

deferasirox 250 mg tablet: dispersible, 28

6500D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	6	5	..	*2849.68	Exjade [NV]

deferasirox 500 mg tablet: dispersible, 28

9600G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	6	5	..	*5652.58	Exjade [NV]

DEFERIPRONE

Authority required

Iron overload in patients with thalassaemia major who are unable to take desferrioxamine therapy

Authority required

Iron overload in patients with thalassaemia major in whom desferrioxamine therapy has proven ineffective

deferiprone 100 mg/mL oral liquid, 250 mL

9638G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	5	5	..	*1173.16	Ferriprox [TX]

deferiprone 500 mg tablet, 100

6416Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	6	5	..	*2750.14	Ferriprox [TX]

■ DEFERRIOXAMINE**Authority required**

Disorders of erythropoiesis associated with treatment-related chronic iron overload

desferrioxamine mesylate 2 g injection, 1 x 2 g vial

6270B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	60	5	..	*1771.36	^a Hospira Pty Limited [HH]
			^B 17.40	*1788.76	^a Desferal 2 g [NV]

desferrioxamine mesylate 500 mg injection, 10 x 500 mg vials

6113R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	40	5	..	*2921.16	^a Hospira Pty Limited [HH]
			^B 238.40	*3159.56	^a Desferal 500 mg [NV]

Drugs for treatment of hyperkalemia and hyperphosphatemia**■ LANTHANUM****Authority required**

Hyperphosphataemia

Treatment Phase: Initiation and stabilisation

Clinical criteria:

The condition must not be adequately controlled by calcium, **AND**

Patient must have a serum phosphate of greater than 1.6 mmol per L at the commencement of therapy; OR

The condition must be where a serum calcium times phosphate product is greater than 4 at the commencement of therapy, **AND**

The treatment must not be used in combination with any other phosphate binding agents.

Treatment criteria:

Patient must be undergoing dialysis for chronic kidney disease.

LANTHANUM Tablet, chewable, 1000 mg (as carbonate hydrate), 90

9637F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*932.38	Fosrenol [ZI]

LANTHANUM Tablet, chewable, 500 mg (as carbonate hydrate), 90

9635D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*551.24	Fosrenol [ZI]

LANTHANUM Tablet, chewable, 750 mg (as carbonate hydrate), 90

9636E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*828.94	Fosrenol [ZI]

■ SEVELAMER**Authority required**

Hyperphosphataemia

Treatment Phase: Initiation and stabilisation

Clinical criteria:

The condition must not be adequately controlled by calcium, **AND**

Patient must have a serum phosphate of greater than 1.6 mmol per L at the commencement of therapy; OR

The condition must be where a serum calcium times phosphate product is greater than 4 at the commencement of therapy, **AND**

The treatment must not be used in combination with any other phosphate binding agents.

Treatment criteria:

Patient must be undergoing dialysis for chronic kidney disease.

sevelamer hydrochloride 800 mg tablet, 180

9620H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*651.56	Renagel [GZ]

▪ SUCROFERRIC OXYHYDROXIDE

Authority required

Hyperphosphataemia

Treatment Phase: Initiation and stabilisation

Clinical criteria:

The condition must not be adequately controlled by calcium, **AND**

Patient must have a serum phosphate of greater than 1.6 mmol per L at the commencement of therapy; OR

The condition must be where a serum calcium times phosphate product is greater than 4 at the commencement of therapy, **AND**

The treatment must not be used in combination with any other phosphate binding agents.

Treatment criteria:

Patient must be undergoing dialysis for chronic kidney disease.

iron (as sucroferric oxyhydroxide) 500 mg tablet: chewable, 90

10230K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*790.36	Velphoro [FN]

Highly Specialised Drugs Program (Public Hospital)

BLOOD AND BLOOD FORMING ORGANS	795
ANTIHEMORRHAGICS.....	795
VITAMIN K AND OTHER HEMOSTATICS	795
Other systemic hemostatics	795
ANTIANEMIC PREPARATIONS	798
OTHER ANTIANEMIC PREPARATIONS	798
Other antianemic preparations.....	798
CARDIOVASCULAR SYSTEM.....	802
ANTIHYPERTENSIVES	802
OTHER ANTIHYPERTENSIVES	802
Antihypertensives for pulmonary arterial hypertension	802
SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS.....	835
PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES	835
HYPOTHALAMIC HORMONES.....	835
Somatostatin and analogues	835
CALCIUM HOMEOSTASIS	837
ANTI-PARATHYROID AGENTS.....	837
Other anti-parathyroid agents	837
ANTIINFECTIVES FOR SYSTEMIC USE	838
ANTIBACTERIALS FOR SYSTEMIC USE	838
MACROLIDES, LINCOSAMIDES AND STREPTOGRAMINS.....	838
Macrolides	838
ANTIMYCOBACTERIALS	838
DRUGS FOR TREATMENT OF TUBERCULOSIS.....	838
Antibiotics	838
ANTIVIRALS FOR SYSTEMIC USE	839
DIRECT ACTING ANTIVIRALS	839
Nucleosides and nucleotides excl. reverse transcriptase inhibitors	839
Phosphonic acid derivatives	839
Protease inhibitors	840
Nucleoside and nucleotide reverse transcriptase inhibitors	845
Non-nucleoside reverse transcriptase inhibitors	850
Antivirals for treatment of HIV infections, combinations	852
Other antivirals.....	855
ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	856

ANTINEOPLASTIC AGENTS	856
ANTIMETABOLITES	856
Pyrimidine analogues	856
CYTOTOXIC ANTIBIOTICS AND RELATED SUBSTANCES	858
Anthracyclines and related substances	858
IMMUNOSTIMULANTS	858
IMMUNOSTIMULANTS	858
Colony stimulating factors	858
Interferons	862
Other immunostimulants	875
IMMUNOSUPPRESSANTS	876
IMMUNOSUPPRESSANTS	876
Selective immunosuppressants	876
Tumor necrosis factor alpha (TNF-) inhibitors	892
Interleukin inhibitors	939
Calcineurin inhibitors	959
Other immunosuppressants	961
MUSCULO-SKELETAL SYSTEM	969
MUSCLE RELAXANTS	969
MUSCLE RELAXANTS, CENTRALLY ACTING AGENTS	969
Other centrally acting agents	969
DRUGS FOR TREATMENT OF BONE DISEASES	969
DRUGS AFFECTING BONE STRUCTURE AND MINERALIZATION	969
Bisphosphonates	969
NERVOUS SYSTEM	971
ANTI-PARKINSON DRUGS	971
DOPAMINERGIC AGENTS	971
Dopa and dopa derivatives	971
Dopamine agonists	971
PSYCHOLEPTICS	971
ANTIPSYCHOTICS	971
Diazepines, oxazepines, thiazepines and oxepines	971
RESPIRATORY SYSTEM	972
DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES	972
OTHER SYSTEMIC DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES	972
Other systemic drugs for obstructive airway diseases	972
COUGH AND COLD PREPARATIONS	975
EXPECTORANTS, EXCL. COMBINATIONS WITH COUGH SUPPRESSANTS	975
Mucolytics	975
OTHER RESPIRATORY SYSTEM PRODUCTS	978
OTHER RESPIRATORY SYSTEM PRODUCTS	978
Other respiratory system products	978
VARIOUS	980
ALL OTHER THERAPEUTIC PRODUCTS	980
ALL OTHER THERAPEUTIC PRODUCTS	980
Iron chelating agents	980
Drugs for treatment of hyperkalemia and hyperphosphatemia	981

■ BLOOD AND BLOOD FORMING ORGANS

■ ANTIHEMORRHAGICS

VITAMIN K AND OTHER HEMOSTATICS

Other systemic hemostatics

■ ELTROMBOPAG

Authority required

Initial (new patients)

Initial treatment, as the sole PBS-subsidised thrombopoietin receptor agonist (TRA), of severe thrombocytopenia in an adult patient with severe chronic immune (idiopathic) thrombocytopenic purpura (ITP) who is:

(1) Splenectomised and:

(a) has had an inadequate response to, or is intolerant to, corticosteroid therapy post splenectomy; and

(b) has had an inadequate response to, or is intolerant to, immunoglobulin therapy post splenectomy;

OR

(2) Not splenectomised and:

(a) has had an inadequate response, or is intolerant to, corticosteroid therapy at a dose equivalent to 0.5-2 mg/kg/day of prednisone for at least 4-6 weeks; and

(b) has had an inadequate response, or is intolerant to, immunoglobulin therapy; and

(c) in whom splenectomy is contraindicated for medical reasons.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of initial application:

(a) a platelet count of less than or equal to 20,000 million per L;

OR

(b) a platelet count of 20-30,000 million per L, where the patient is experiencing significant bleeding or has a history of significant bleeding in this platelet range.

The authority application must be made in writing and must include:

(1) a completed authority prescription form,

(2) a signed patient acknowledgement,

(3) a completed Idiopathic Thrombocytopenic Purpura Initial PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)],

(4) a copy of a full blood count pathology report supporting the diagnosis of ITP, and

(5) where the application is sought on the basis of a medical contraindication to surgery, a signed and dated letter from the clinician making this assessment which includes the date upon which the patient was assessed for surgery and the clinical grounds upon which surgery is contraindicated.

The full blood count must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with eltrombopag will be authorised under this criterion

Authority required

Initial (grandfather patients)

Initial treatment, as the sole PBS-subsidised thrombopoietin receptor agonist (TRA), of severe thrombocytopenia in an adult patient with severe chronic immune (idiopathic) thrombocytopenic purpura (ITP) who was receiving treatment with eltrombopag prior to 1 November 2011 and in whom the criteria for initial treatment can be demonstrated to have been met at the time eltrombopag was commenced.

The authority application must be made in writing and must include:

(1) a completed authority prescription form,

(2) a signed patient acknowledgement,

(3) a completed Idiopathic Thrombocytopenic Purpura Initial PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)], and

(4) where the application is sought on the basis of a medical contraindication to surgery, a signed and dated letter from the clinician making this assessment which includes the date upon which the patient was assessed for surgery and the clinical grounds upon which surgery is contraindicated.

A maximum of 24 weeks of treatment with eltrombopag will be authorised under this criterion

Authority required

Continuing therapy or re-initiation after a break in therapy

First period of PBS-subsidised continuing treatment or re-initiation of interrupted PBS-subsidised treatment, as the sole PBS-subsidised thrombopoietin receptor agonist (TRA), of severe thrombocytopenia in an adult patient with chronic immune (idiopathic) thrombocytopenic purpura (ITP) who has displayed a sustained platelet response to treatment with eltrombopag during the initial period of PBS-subsidised treatment.

For the purposes of this restriction, a sustained platelet response is defined as:

(a) use of rescue medication (corticosteroids or immunoglobulins) on no more than one occasion during the initial period of PBS-subsidised eltrombopag,

AND either of the following:

(b) a platelet count greater than or equal to 50,000 million per L on at least four (4) occasions, each at least one week apart;

OR

(c) a platelet count greater than 30,000 million per L and which is double the baseline (pre-treatment) platelet count on at least four (4) occasions, each at least one week apart.

Applications for the first period of continuing PBS-subsidised treatment or re-initiation of interrupted treatment must be made in writing and must include:

- (1) a completed authority prescription form, and
- (2) a completed Idiopathic Thrombocytopenic Purpura Continuing PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)], and
- (3) copies of the platelet count pathology reports (unless previously provided for patients re-initiating therapy).

The most recent platelet count must be no more than one month old at the time of application.

A maximum of 24 weeks of treatment with eltrombopag will be authorised under this criterion.

Where fewer than 5 repeats are initially requested with the authority prescription, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be made by telephone

Authority required

Second and subsequent applications for continuing therapy

Continuing treatment, as the sole PBS-subsidised thrombopoietin receptor agonist (TRA), of severe thrombocytopenia in an adult patient with chronic immune (idiopathic) thrombocytopenic purpura (ITP) who has previously received PBS-subsidised therapy with eltrombopag and who continues to display a response to treatment with eltrombopag.

For the purposes of this restriction, a continuing response to treatment with eltrombopag is defined as:

- (a) use of rescue medication (corticosteroids or immunoglobulins) on no more than one occasion during the most recent 24 week period of PBS-subsidised treatment with eltrombopag,

AND either of the following:

- (b) a platelet count greater than or equal to 50,000 million per L

OR

- (c) a platelet count greater than 30,000 million per L and which is double the baseline platelet count.

Platelet counts must be no more than 1 month old at the time of application.

Authority applications for second and subsequent periods of continuing therapy may be made by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

Note

Eltrombopag is not PBS-subsidised as an alternative to splenectomy.

Any queries concerning the arrangements to prescribe eltrombopag may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authority to prescribe eltrombopag should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Further prescribing information is on the Medicare Australia website at www.medicareaustralia.gov.au.

Patients will be able to trial either eltrombopag and/or romiplostim within the initial 24 weeks treatment period. Patients who fail to demonstrate a response to treatment with either eltrombopag and/or romiplostim under the initial restriction will not be eligible to receive further PBS-subsidised treatment with either of these drugs.

No applications for increased repeats will be authorised.

No applications for increased repeats will be authorised.

eltrombopag 25 mg tablet, 28

5825N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	5	..	1512.00	Revolade [GK]

eltrombopag 50 mg tablet, 28

5826P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	5	..	3024.00	Revolade [GK]

■ ROMIPILOSTIM

Authority required

Initial (new patients)

Initial treatment, as the sole PBS-subsidised thrombopoietin receptor agonist (TRA), of severe thrombocytopenia in an adult patient with severe chronic immune (idiopathic) thrombocytopenic purpura (ITP) who is:

- (1) Splenectomised and:

- (a) has had an inadequate response to, or is intolerant to, corticosteroid therapy post splenectomy; and

- (b) has had an inadequate response to, or is intolerant to, immunoglobulin therapy post splenectomy;

OR

- (2) Not splenectomised and:

- (a) has had an inadequate response, or is intolerant to, corticosteroid therapy at a dose equivalent to 0.5-2 mg/kg/day of prednisone for at least 4-6 weeks; and

- (b) has had an inadequate response, or is intolerant to, immunoglobulin therapy; and

- (c) in whom splenectomy is contraindicated for medical reasons.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of initial application:

(a) a platelet count of less than or equal to 20,000 million per L;

OR

(b) a platelet count of 20-30,000 million per L, where the patient is experiencing significant bleeding or has a history of significant bleeding in this platelet range.

The authority application must be made in writing and must include:

- (1) a completed authority prescription form,
- (2) a signed patient acknowledgement,
- (3) a completed Idiopathic Thrombocytopenic Purpura Initial PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)],
- (4) a copy of a full blood count pathology report supporting the diagnosis of ITP, and
- (5) where the application is sought on the basis of a medical contraindication to surgery, a signed and dated letter from the clinician making this assessment which includes the date upon which the patient was assessed for surgery and the clinical grounds upon which surgery is contraindicated.

The full blood count must be no more than 1 month old at the time of application.

At the time of the written authority application, medical practitioners should request the appropriate quantity of vials of appropriate strength to provide sufficient drug for a single treatment at a dose of 1 microgram/kg. Up to 1 repeat may be requested with the initial written application.

Subsequently during the initial period of dose titration, authority applications for a single dose and up to 1 repeat may be made by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The dose (microgram/kg/week) must be provided at the time of application.

Once a patient's dose has been stable for a period of 4 weeks, authority approvals for sufficient vials of appropriate strength based on the weight of the patient and dose (microgram/kg/week) for up to 4 weeks of treatment and up to 4 repeats may be granted, as long as the total period of treatment authorised under this restriction does not exceed 24 weeks.

Authority approval will not be given for doses of higher than 10 micrograms/kg/week

Authority required

Initial (grandfather patients)

Initial PBS-subsidised treatment, as the sole PBS-subsidised thrombopoietin receptor agonist (TRA), of severe thrombocytopenia in an adult patient with severe chronic immune (idiopathic) thrombocytopenic purpura (ITP) who was receiving treatment with romiplostim prior to 1 April 2011 and in whom the criteria for initial treatment can be demonstrated to have been met at the time romiplostim was commenced.

The authority application must be made in writing and must include:

- (1) a completed authority prescription form,
- (2) a signed patient acknowledgement,
- (3) a completed Idiopathic Thrombocytopenic Purpura Initial PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)], and
- (4) where the application is sought on the basis of a medical contraindication to surgery, a signed and dated letter from the clinician making this assessment which includes the date upon which the patient was assessed for surgery and the clinical grounds upon which surgery is contraindicated.

For patients whose dose of romiplostim had been stable for at least 4 weeks at the time of the initial application for PBS-subsidy, the medical practitioner should request sufficient number of vials based on the weight of the patient and dose (microgram/kg/week) to provide up to 4 weeks of treatment. Up to a maximum of 5 repeats may be authorised.

Where the patient is in the titration phase of treatment with romiplostim, medical practitioners should request the appropriate quantity of vials of appropriate strength to provide sufficient drug for a single treatment at a dose of 1 microgram/kg. Up to 1 repeat may be requested with the initial written application.

Subsequently during the initial period of dose titration, authority applications for a single dose and up to 1 repeat may be made by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). The dose (microgram/kg/week) must be provided at the time of application.

Once a patient's dose has been stable for a period of 4 weeks, authority approvals for sufficient vials of appropriate strength based on the weight of the patient and dose (microgram/kg/week) for up to 4 weeks of treatment and up to 4 repeats may be granted, as long as the total period of treatment authorised under this restriction does not exceed 24 weeks.

Authority approval will not be given for doses of higher than 10 micrograms/kg/week

Authority required

Continuing therapy or re-initiation after a break in therapy

First period of PBS-subsidised continuing treatment or re-initiation of interrupted PBS-subsidised treatment, as the sole PBS-subsidised thrombopoietin receptor agonist (TRA), of severe thrombocytopenia in an adult patient with chronic immune (idiopathic) thrombocytopenic purpura (ITP) who has displayed a sustained platelet response to treatment with romiplostim during the initial period of PBS-subsidised treatment.

For the purposes of this restriction, a sustained platelet response is defined as:

(a) use of rescue medication (corticosteroids or immunoglobulins) on no more than one occasion during the initial period of PBS-subsidised romiplostim,

AND either of the following:

(b) a platelet count greater than or equal to 50,000 million per L on at least four (4) occasions, each at least one week apart;

OR

(c) a platelet count greater than 30,000 million per L and which is double the baseline (pre-treatment) platelet count on at least four (4) occasions, each at least one week apart.

Applications for the first period of continuing PBS-subsidised treatment or re-initiation of interrupted treatment must be made in writing and must include:

- (1) a completed authority prescription form, and

- (2) a completed Idiopathic Thrombocytopenic Purpura Continuing PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)], and
(3) copies of the platelet count pathology reports (unless previously provided for patients re-initiating therapy).
The most recent platelet count must be no more than one month old at the time of application.

The medical practitioner should request sufficient number of vials of appropriate strength based on the weight of the patient and dose (microgram/kg/week) to provide 4 weeks of treatment. Up to a maximum of 5 repeats may be authorised.

Where fewer than 5 repeats are initially requested with the authority prescription, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be made by telephone.

Authority approval will not be given for doses of higher than 10 micrograms/kg/week

Authority required

Second and subsequent applications for continuing therapy

Continuing treatment, as the sole PBS-subsidised thrombopoietin receptor agonist (TRA), of severe thrombocytopenia in an adult patient with chronic immune (idiopathic) thrombocytopenic purpura (ITP) who has previously received PBS-subsidised therapy with romiplostim and who continues to display a response to treatment with romiplostim.

For the purposes of this restriction, a continuing response to treatment with romiplostim is defined as:

(a) use of rescue medication (corticosteroids or immunoglobulins) on no more than one occasion during the most recent 24 week period of PBS-subsidised treatment with romiplostim,

AND either of the following:

(b) a platelet count greater than or equal to 50,000 million per L

OR

(c) a platelet count greater than 30,000 million per L and which is double the baseline platelet count.

Platelet counts must be no more than 1 month old at the time of application.

Authority applications for second and subsequent periods of continuing therapy may be made by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

The medical practitioner should request sufficient number of vials of appropriate strength based on the weight of the patient and dose (microgram/kg/week) to provide 4 weeks of treatment. Up to a maximum of 5 repeats may be authorised.

Authority approval will not be given for doses of higher than 10 micrograms/kg/week

Note

Romiplostim is not PBS-subsidised as an alternative to splenectomy.

Any queries concerning the arrangements to prescribe romiplostim may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authority to prescribe romiplostim should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Further prescribing information is on the Medicare Australia website at www.medicareaustralia.gov.au.

Patients will be able to trial either eltrombopag and/or romiplostim within the initial 24 weeks treatment period. Patients who fail to demonstrate a response to treatment with either eltrombopag and/or romiplostim under the initial restriction will not be eligible to receive further PBS-subsidised treatment with either of these drugs.

Special Pricing Arrangements apply.

romiplostim 250 microgram injection, 1 x 250 microgram vial

9696H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	977.50	Nplate [AN]

romiplostim 500 microgram injection, 1 x 500 microgram vial

9698K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	1955.00	Nplate [AN]

■ ANTIANEMIC PREPARATIONS

OTHER ANTIANEMIC PREPARATIONS

Other antianemic preparations

■ DARBEPOETIN ALFA

Authority required (STREAMLINED)

3334

Treatment of anaemia requiring transfusion, defined as a haemoglobin level of less than 100 g per L, where intrinsic renal disease, as assessed by a nephrologist, is the primary cause of the anaemia

darbepoetin alfa 10 microgram/0.4 mL injection, 4 x 0.4 mL syringes

5637Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*356.08	Aranesp [AN]

darbepoetin alfa 100 microgram/0.5 mL injection, 1 x 0.5 mL syringe

5649H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	8	5	..	*2620.48	Aranesp SureClick [AN]

darbepoetin alfa 100 microgram/0.5 mL injection, 4 x 0.5 mL syringes

5651K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2620.50	Aranesp [AN]

darbepoetin alfa 150 microgram/0.3 mL injection, 1 x 0.3 mL syringe

5650J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	8	5	..	*3904.48	Aranesp SureClick [AN]

darbepoetin alfa 150 microgram/0.3 mL injection, 4 x 0.3 mL syringes

5643B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3904.50	Aranesp [AN]

darbepoetin alfa 20 microgram/0.5 mL injection, 1 x 0.5 mL syringe

5645D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	8	5	..	*670.64	Aranesp SureClick [AN]

darbepoetin alfa 20 microgram/0.5 mL injection, 4 x 0.5 mL syringes

5638R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*670.62	Aranesp [AN]

darbepoetin alfa 30 microgram/0.3 mL injection, 4 x 0.3 mL syringes

5639T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*917.46	Aranesp [AN]

darbepoetin alfa 40 microgram/0.4 mL injection, 1 x 0.4 mL syringe

5646E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	8	5	..	*1113.60	Aranesp SureClick [AN]

darbepoetin alfa 40 microgram/0.4 mL injection, 4 x 0.4 mL syringes

5640W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1113.60	Aranesp [AN]

darbepoetin alfa 50 microgram/0.5 mL injection, 4 x 0.5 mL syringes

5641X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1376.78	Aranesp [AN]

darbepoetin alfa 60 microgram/0.3 mL injection, 1 x 0.3 mL syringe

5647F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	8	5	..	*1616.64	Aranesp SureClick [AN]

darbepoetin alfa 60 microgram/0.3 mL injection, 4 x 0.3 mL syringes

5642Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1616.66	Aranesp [AN]

darbepoetin alfa 80 microgram/0.4 mL injection, 1 x 0.4 mL syringe

5648G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	8	5	..	*2128.00	Aranesp SureClick [AN]

darbepoetin alfa 80 microgram/0.4 mL injection, 4 x 0.4 mL syringes

5644C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2128.00	Aranesp [AN]

▪ EPOETIN ALFA**Authority required (STREAMLINED)****3334**

Treatment of anaemia requiring transfusion, defined as a haemoglobin level of less than 100 g per L, where intrinsic renal disease, as assessed by a nephrologist, is the primary cause of the anaemia

epoetin alfa 10 000 international units/mL injection, 6 x 1 mL syringes

5722E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1970.30	Eprex 10000 [JC]

epoetin alfa 1000 international units/0.5 mL injection, 6 x 0.5 mL syringes

5714R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*279.30	Eprex 1000 [JC]

epoetin alfa 20 000 international units/0.5 mL injection, 6 x 0.5 mL syringes

5713Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3876.00	Eprex 20,000 [JC]

epoetin alfa 2000 international units/0.5 mL injection, 6 x 0.5 mL syringes

5719B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*516.80	Eprex 2000 [JC]

epoetin alfa 3000 international units/0.3 mL injection, 6 x 0.3 mL syringes

5720C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*666.90	Eprex 3000 [JC]

epoetin alfa 40 000 international units/mL injection, 1 x 1 mL syringe

5718Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1254.00	Eprex 40,000 [JC]

epoetin alfa 4000 international units/0.4 mL injection, 6 x 0.4 mL syringes

5721D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*849.30	Eprex 4000 [JC]

epoetin alfa 5000 international units/0.5 mL injection, 6 x 0.5 mL syringes

5715T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1057.34	Eprex 5000 [JC]

epoetin alfa 6000 international units/0.6 mL injection, 6 x 0.6 mL syringes

5716W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1255.14	Eprex 6000 [JC]

epoetin alfa 8000 international units/0.8 mL injection, 6 x 0.8 mL syringes

5717X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1627.92	Eprex 8000 [JC]

■ EPOETIN BETA**Authority required (STREAMLINED)****3334**

Treatment of anaemia requiring transfusion, defined as a haemoglobin level of less than 100 g per L, where intrinsic renal disease, as assessed by a nephrologist, is the primary cause of the anaemia

epoetin beta 10 000 international units/0.6 mL injection, 6 x 0.6 mL syringes

5729M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1970.30	NeoRecormon [RO]

epoetin beta 2000 international units/0.3 mL injection, 6 x 0.3 mL syringes

5724G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*516.80	NeoRecormon [RO]

epoetin beta 3000 international units/0.3 mL injection, 6 x 0.3 mL syringes

5725H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*666.90	NeoRecormon [RO]

epoetin beta 4000 international units/0.3 mL injection, 6 x 0.3 mL syringes

5726J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*849.30	NeoRecormon [RO]

epoetin beta 5000 international units/0.3 mL injection, 6 x 0.3 mL syringes

5727K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1057.36	NeoRecormon [RO]

epoetin beta 6000 international units/0.3 mL injection, 6 x 0.3 mL syringes

5728L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1255.14	NeoRecormon [RO]

▪ EPOETIN LAMBDA**Authority required (STREAMLINED)****3334**

Treatment of anaemia requiring transfusion, defined as a haemoglobin level of less than 100 g per L, where intrinsic renal disease, as assessed by a nephrologist, is the primary cause of the anaemia

Note

Epoetin lambda should only be administered by the intravenous route.

epoetin lambda 10 000 international units/mL injection, 6 x 1 mL syringes

9596C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1866.60	Novicrit [SZ]

epoetin lambda 1000 international units/0.5 mL injection, 6 x 0.5 mL syringes

9668W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*264.60	Novicrit [SZ]

epoetin lambda 2000 international units/mL injection, 6 x 1 mL syringes

9669X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*489.60	Novicrit [SZ]

epoetin lambda 3000 international units/0.3 mL injection, 6 x 0.3 mL syringes

9670Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*631.80	Novicrit [SZ]

epoetin lambda 4000 international units/0.4 mL injection, 6 x 0.4 mL syringes

9587N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*804.60	Novicrit [SZ]

epoetin lambda 5000 international units/0.5 mL injection, 6 x 0.5 mL syringes

9589Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1001.70	Novicrit [SZ]

epoetin lambda 6000 international units/0.6 mL injection, 6 x 0.6 mL syringes

9591T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1189.08	Novicrit [SZ]

epoetin lambda 8000 international units/0.8 mL injection, 6 x 0.8 mL syringes

9594Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1542.24	Novicrit [SZ]

▪ METHOXY POLYETHYLENE GLYCOL-EPOETIN BETA**Authority required (STREAMLINED)****3334**

Treatment of anaemia requiring transfusion, defined as a haemoglobin level of less than 100 g per L, where intrinsic renal disease, as assessed by a nephrologist, is the primary cause of the anaemia

methoxy polyethylene glycol-epoetin beta 100 microgram/0.3 mL injection, 1 x 0.3 mL syringe

5797D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1158.82	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 120 microgram/0.3 mL injection, 1 x 0.3 mL syringe

5798E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1341.64	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 200 microgram/0.3 mL injection, 1 x 0.3 mL syringe

5799F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1924.30	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 30 microgram/0.3 mL injection, 1 x 0.3 mL syringe

5794Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*369.18	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 360 microgram/0.6 mL injection, 1 x 0.6 mL syringe

5800G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3326.52	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 50 microgram/0.3 mL injection, 1 x 0.3 mL syringe

5795B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*615.30	Mircera [RO]

methoxy polyethylene glycol-epoetin beta 75 microgram/0.3 mL injection, 1 x 0.3 mL syringe

5796C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*896.02	Mircera [RO]

■ CARDIOVASCULAR SYSTEM

■ ANTIHYPERTENSIVES

OTHER ANTIHYPERTENSIVES

Antihypertensives for pulmonary arterial hypertension

■ AMBRISENTAN

Caution

This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**

Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**

Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR

Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**

Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the TGA-approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND** Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease, **AND** The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

- (i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR

Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and
- (3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents:

Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 7 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to

that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment.

Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 7 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note

Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or Continuing treatment (all patients) – balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Continuing treatment (all patients) restriction to complete a maximum of six months of treatment, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**

The treatment must provide no more than the balance of up to six months treatment available under the above restrictions.

Note

Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authorisation under this criterion should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Continuing treatment (all patients)

Clinical criteria:

Patient must have received approval for initial PBS-subsidised treatment with this agent, **AND**

Patient must have been assessed by a physician from a designated hospital to have achieved a response to their most recent course of treatment with this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments plus 6MWT;
- (2) RHC plus ECHO composite assessments;
- (3) RHC composite assessment plus 6MWT;
- (4) ECHO composite assessment plus 6MWT;
- (5) RHC composite assessment only;
- (6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with each written continuing treatment application (i.e., every 6 months), except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

The assessment of the patient's response to the first and subsequent 6 month courses of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Applications for continuing treatment with a PAH agent should be made prior to the completion of the 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

ambrisentan 10 mg tablet, 30

5608E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	2876.47	Volibris [GK]

ambrisentan 5 mg tablet, 30

5607D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	2876.47	Volibris [GK]

■ BOSENTAN

Caution

This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**

Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**

Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR

Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**

Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) two completed authority prescription forms; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

- (i) RHC composite assessment; and
- (ii) ECHO composite assessment; and
- (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

- (i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or
- (ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**

Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease; OR Patient must have WHO Functional Class III or IV pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology), **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) two completed authority prescription forms; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

- (i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or
- (ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) two completed authority prescription forms; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and
- (3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents:

Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 7 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment.

Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent.

For eligible patients, applications to swap between the 7 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note

Where the 62.5 mg tablet strength is required for the second authority prescription, please contact the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) for further advice.

The approved second authority prescription will be returned to the prescriber by the Department of Human Services two weeks after the date of the approval of the first authority prescription, to allow for the uninterrupted completion of the six months initial treatment course. The Department of Human Services will contact prescribers prior to dispatch of the second authority prescription to confirm the tablet strength required for the patient.

Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or Continuing treatment (all patients) – balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Continuing treatment (all patients) restriction to complete a maximum of six months of treatment, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**

The treatment must provide no more than the balance of up to six months treatment available under the above restrictions.

Note

Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authorisation under this criterion should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Continuing treatment (all patients)

Clinical criteria:

Patient must have received approval for initial PBS-subsidised treatment with this agent, **AND**

Patient must have been assessed by a physician from a designated hospital to have achieved a response to their most recent course of treatment with this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments plus 6MWT;
- (2) RHC plus ECHO composite assessments;
- (3) RHC composite assessment plus 6MWT;
- (4) ECHO composite assessment plus 6MWT;
- (5) RHC composite assessment only;
- (6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with each written continuing treatment application (i.e., every 6 months), except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

The assessment of the patient's response to the first and subsequent 6 month courses of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Applications for continuing treatment with a PAH agent should be made prior to the completion of the 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

bosentan 125 mg tablet, 60

5619R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	2876.47	Tracleer [AT]

■ BOSENTAN

Caution

This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND** Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**

Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR

Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**

Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) two completed authority prescription forms; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND** Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease; OR

Patient must have WHO Functional Class III or IV pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology), **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) two completed authority prescription forms; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

- (i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or
- (ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR

Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) two completed authority prescription forms; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and
- (3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

Approvals for the first authority prescription will be limited to 1 month of therapy with the 62.5 mg strength tablet, with the quantity approved based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information. No repeats will be authorised for this prescription.

The second authority prescription may be written for either the 62.5 mg tablet or the 125 mg tablet strengths. Approvals for the second authority prescription will be limited to 1 month of treatment, with the quantity approved based on the dosage recommendations in the TGA-approved Product Information, and a maximum of 4 repeats.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents:

Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 7 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment.

Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent.

For eligible patients, applications to swap between the 7 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note

Where the 62.5 mg tablet strength is required for the second authority prescription, please contact the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday) for further advice.

The approved second authority prescription will be returned to the prescriber by the Department of Human Services two weeks after the date of the approval of the first authority prescription, to allow for the uninterrupted completion of the six months initial treatment course. The Department of Human Services will contact prescribers prior to dispatch of the second authority prescription to confirm the tablet strength required for the patient.

Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or Continuing treatment (all patients) – balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Continuing treatment (all patients) restriction to complete a maximum of six months of treatment, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**

The treatment must provide no more than the balance of up to six months treatment available under the above restrictions.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Continuing treatment (all patients)

Clinical criteria:

Patient must have received approval for initial PBS-subsidised treatment with this agent, **AND**

Patient must have been assessed by a physician from a designated hospital to have achieved a response to their most recent course of treatment with this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments plus 6MWT;
- (2) RHC plus ECHO composite assessments;
- (3) RHC composite assessment plus 6MWT;
- (4) ECHO composite assessment plus 6MWT;
- (5) RHC composite assessment only;
- (6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with each written continuing treatment application (i.e., every 6 months), except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

The assessment of the patient's response to the first and subsequent 6 month courses of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Applications for continuing treatment with a PAH agent should be made prior to the completion of the 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Cessation of treatment (all patients)

Clinical criteria:

Patient must have received approval for initial PBS-subsidised treatment with this agent, **AND**

Patient must have not responded to prior PBS-subsidised therapy with this agent, **AND**

The treatment must be for the purpose of gradual dose reduction prior to ceasing therapy, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment. Treatment beyond 1 month will not be approved.

Note

Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authorisation under this criterion should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

bosentan 62.5 mg tablet, 60

5618Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	2876.47	Tracleer [AT]

■ EPOPROSTENOL

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**

Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

- (i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or
- (ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (change or re-commencement of therapy for all patients)

Clinical criteria:

Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR

Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and must have received prior treatment with a PBS-subsidised PAH agent other than this agent; OR

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and must have failed to respond to a prior PBS-subsidised PAH agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and
- (3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent; and
- (4) for WHO Functional Class III patients, where this is the first application for this agent, assessment details of the PBS-subsidised PAH agent they have failed to respond to.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents:

Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 7 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment.

Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 7 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note

Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients) or Initial 2 (change or re-commencement of therapy for all patients) or Continuing treatment (all patients) – balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 2 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Continuing treatment (all patients) restriction to complete a maximum of six months of treatment, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**

The treatment must provide no more than the balance of up to six months treatment available under the above restrictions.

Note

Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authorisation under this criterion should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Continuing treatment (all patients)

Clinical criteria:

Patient must have received approval for initial PBS-subsidised treatment with this agent, **AND**

Patient must have been assessed by a physician from a designated hospital to have achieved a response to their most recent course of treatment with this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

- (i) RHC composite assessment; and
- (ii) ECHO composite assessment; and
- (iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments plus 6MWT;
- (2) RHC plus ECHO composite assessments;
- (3) RHC composite assessment plus 6MWT;
- (4) ECHO composite assessment plus 6MWT;
- (5) RHC composite assessment only;
- (6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with each written continuing treatment application (i.e., every 6 months), except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application. The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

The assessment of the patient's response to the first and subsequent 6 month courses of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Applications for continuing treatment with a PAH agent should be made prior to the completion of the 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Pharmaceutical benefits that have the form epoprostenol sodium powder for I.V. infusion 1.5 mg (base) infusion administration set and pharmaceutical benefits that have the form epoprostenol 1.5 mg injection vial are equivalent for the purposes of substitution.

Pharmaceutical benefits that have the form epoprostenol sodium powder for I.V. infusion 500 micrograms (base) infusion administration set and pharmaceutical benefits that have the form epoprostenol 500 microgram injection vial are equivalent for the purposes of substitution.

EPOPROSTENOL SODIUM Powder for I.V. infusion 1.5 mg (base) infusion administration set, 1

5035B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	66.55	^a Flolan Kit [GK]

EPOPROSTENOL SODIUM Powder for I.V. infusion 500 micrograms (base) infusion administration set, 1

5030R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	33.28	^a Flolan Kit [GK]

epoprostenol 1.5 mg injection, 1 x 1.5 mg vial

10117L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	66.55	^a Veletri [AT]

epoprostenol 500 microgram injection, 1 x 500 microgram vial

10130E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	33.28	^a Veletri [AT]

■ ILOPROST

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with this agent, **AND**

Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III drug-induced PAH, **AND**

Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR
Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**

Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the TGA-approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND** Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III drug-induced PAH and a mean right atrial pressure greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR

Patient must have WHO Functional Class III drug-induced PAH with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease; OR

Patient must have WHO Functional Class IV drug-induced PAH, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments;

(2) RHC composite assessment plus 6MWT;

(3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

(1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease or drug-induced PAH and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR

Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and must have received prior treatment with a PBS-subsidised PAH agent other than this agent; OR

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and must have failed to respond to a prior PBS-subsidised PAH agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and
- (3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent; and
- (4) for WHO Functional Class III patients, where this is the first application for this agent, assessment details of the PBS-subsidised PAH agent they have failed to respond to.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents:

Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 7 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment.

Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent.

For eligible patients, applications to swap between the 7 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note

Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or Continuing treatment (all patients) – balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Continuing treatment (all patients) restriction to complete a maximum of six months of treatment, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**

The treatment must provide no more than the balance of up to six months treatment available under the above restrictions.

Note

Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authorisation under this criterion should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)
Treatment Phase: Continuing treatment (all patients)

Clinical criteria:

Patient must have received approval for initial PBS-subsidised treatment with this agent, **AND**

Patient must have been assessed by a physician from a designated hospital to have achieved a response to their most recent course of treatment with this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments plus 6MWT;
- (2) RHC plus ECHO composite assessments;
- (3) RHC composite assessment plus 6MWT;
- (4) ECHO composite assessment plus 6MWT;
- (5) RHC composite assessment only;
- (6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with each written continuing treatment application (i.e., every 6 months), except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

The assessment of the patient's response to the first and subsequent 6 month courses of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Applications for continuing treatment with a PAH agent should be made prior to the completion of the 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Special Pricing Arrangements apply.

iloprost 20 microgram/2 mL inhalation: solution, 30 x 2 mL ampoules

5751Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	1076.00	Ventavis [BN]

■ MACITENTAN

Caution

This is a category X drug and must not be given to pregnant women. Pregnancy must be avoided during treatment and for at least 3 months following cessation of therapy.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**

Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**

Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR

Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**

Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

- (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the TGA-approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND** Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class IV idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class IV pulmonary arterial hypertension secondary to connective tissue disease; OR

Patient must have WHO Functional Class III or IV pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology), **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR

Patient must have idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease or PAH associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and
- (3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents:

Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 7 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment.

Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent.

For eligible patients, applications to swap between the 7 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note

Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or Continuing treatment (all patients) – balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR
 Patient must have received insufficient therapy with this agent under the Continuing treatment (all patients) restriction to complete a maximum of six months of treatment, **AND**
 The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**
 The treatment must provide no more than the balance of up to six months treatment available under the above restrictions.

Note

Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authorisation under this criterion should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Continuing treatment (all patients)

Clinical criteria:

Patient must have received approval for initial PBS-subsidised treatment with this agent, **AND**

Patient must have been assessed by a physician from a designated hospital to have achieved a response to their most recent course of treatment with this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments plus 6MWT;
- (2) RHC plus ECHO composite assessments;
- (3) RHC composite assessment plus 6MWT;
- (4) ECHO composite assessment plus 6MWT;
- (5) RHC composite assessment only;
- (6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with each written continuing treatment application (i.e., every 6 months), except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

The assessment of the patient's response to the first and subsequent 6 month courses of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Applications for continuing treatment with a PAH agent should be made prior to the completion of the 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

macitentan 10mg tablet, 30

10136L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	2876.47	Opsumit [AT]

■ SILDENAFIL

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**

Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**

Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR

Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**

Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the TGA-approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND** Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;

(2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and

(3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents:

Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 7 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment.

Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent.

For eligible patients, applications to swap between the 7 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note

Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or Continuing treatment (all patients) – balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Continuing treatment (all patients) restriction to complete a maximum of six months of treatment, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**

The treatment must provide no more than the balance of up to six months treatment available under the above restrictions.

Note

Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authorisation under this criterion should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Continuing treatment (all patients)

Clinical criteria:

Patient must have received approval for initial PBS-subsidised treatment with this agent, **AND**

Patient must have been assessed by a physician from a designated hospital to have achieved a response to their most recent course of treatment with this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

(1) RHC plus ECHO composite assessments plus 6MWT;

(2) RHC plus ECHO composite assessments;

(3) RHC composite assessment plus 6MWT;

(4) ECHO composite assessment plus 6MWT;

(5) RHC composite assessment only;

(6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with each written continuing treatment application (i.e., every 6 months), except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

The assessment of the patient's response to the first and subsequent 6 month courses of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated. Applications for continuing treatment with a PAH agent should be made prior to the completion of the 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician. Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent. The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan. PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

sildenafil 20 mg tablet, 90

9547L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	..	..	754.68	^a APO-Sildenafil PHT [TX] ^a Sildenafil AN PHT 20 [EA] ^a Sildenafil Sandoz PHT 20 [SZ]	^a Revatio [PF] ^a SILDENAFIL-DRx [RZ]

■ TADALAFIL

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND**

Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease, **AND**

Patient must have a mean right atrial pressure of 8 mmHg or less as measured by right heart catheterisation (RHC); OR

Patient must have right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds, **AND**

Patient must have failed to respond to 6 or more weeks of appropriate vasodilator treatment unless intolerance or a contraindication to such treatment exists, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:

(i) RHC composite assessment; and

(ii) ECHO composite assessment; and

(iii) 6 Minute Walk Test (6MWT); and

(3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

(i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or

(ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Details of prior vasodilator treatment, including the dose and duration of treatment, must be provided at the time of application. Where the patient has an adverse event to a vasodilator or where vasodilator treatment is contraindicated, details of the nature of the adverse event or contraindication according to the Therapeutic Goods Administration (TGA) approved Product Information must also be provided with the application.

Response to prior vasodilator treatment is defined as follows:

For patients with 2 or more baseline tests, response to treatment is defined as 2 or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the TGA-approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 2 (new patients)

Clinical criteria:

Patient must not have received prior PBS-subsidised treatment with a pulmonary arterial hypertension (PAH) agent, **AND** Patient must have been assessed by a physician at a designated hospital, **AND**

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, and a mean right atrial pressure of greater than 8 mmHg, as measured by right heart catheterisation (RHC); OR

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH), or anorexigen-induced PAH or hereditary PAH, with right ventricular function assessed by echocardiography (ECHO) where a RHC cannot be performed on clinical grounds; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease and a mean right atrial pressure greater than 8 mmHg, as measured by RHC; OR

Patient must have WHO Functional Class III pulmonary arterial hypertension secondary to connective tissue disease with right ventricular function assessed by ECHO where a RHC cannot be performed on clinical grounds, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT); and
- (3) a signed patient acknowledgement.

Idiopathic pulmonary arterial hypertension, anorexigen-induced pulmonary arterial hypertension, hereditary pulmonary arterial hypertension, drug-induced pulmonary arterial hypertension, pulmonary arterial hypertension secondary to connective tissue disease including scleroderma, or pulmonary arterial hypertension associated with a congenital systemic-to-pulmonary shunt (including Eisenmenger's physiology) are defined as follows:

- (i) mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest and pulmonary artery wedge pressure (PAWP) less than 15 mmHg; or
- (ii) where a right heart catheter (RHC) cannot be performed on clinical grounds, right ventricular systolic pressure (RVSP), assessed by echocardiography (ECHO), greater than 40 mmHg, with normal left ventricular function.

Test requirements to establish baseline for initiation of treatment are as follows:

The first written application for PBS-subsidised treatment with the first PAH agent should be accompanied by the results of a right heart catheter (RHC) composite assessment plus an echocardiograph (ECHO) composite assessment, plus a 6 minute walk test (6MWT) to establish the patient's baseline measurements.

Where it is not possible to perform all 3 tests above on clinical grounds, the following list outlines the preferred test combination, in descending order, for the purposes of initiation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments;
- (2) RHC composite assessment plus 6MWT;
- (3) RHC composite assessment only.

In circumstances where a RHC cannot be performed on clinical grounds, applications may be submitted for consideration based on the results of the following test combinations, which are listed in descending order of preference:

- (1) ECHO composite assessment plus 6MWT;
- (2) ECHO composite assessment only.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and must wish to re-commence PBS-subsidised therapy with this agent after a break in therapy and must have demonstrated a response to their most recent course of PBS-subsidised treatment with this agent; OR

Patient must have WHO Functional Class III idiopathic pulmonary arterial hypertension (iPAH) or anorexigen-induced PAH or hereditary PAH or PAH secondary to connective tissue disease and whose most recent course of PBS-subsidised treatment was with a PAH agent other than this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form; and
- (3) the results of the patient's response to treatment with their last course of PBS-subsidised PAH agent.

Where fewer than 3 tests are able to be performed on clinical grounds, a patient specific reason outlining why the particular test(s) could not be conducted must be provided with the authority application.

The test results provided must not be more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats may be requested.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Swapping between PAH agents:

Patients can access PAH agents through the PBS according to the relevant restrictions. Once these patients are approved initial treatment with 1 of these 7 drugs, they may swap between PAH agents at any time without having to re-qualify for treatment with the alternate agent. This means that patients may commence treatment with the alternate agent, subject to that agent's restriction, irrespective of the severity of their disease at the time the application to swap therapy is submitted. It also means that no new baseline measurements will be necessary. New baselines may be submitted where the patient has failed to respond to their current treatment.

Eligible patients may only swap between PAH agents if they have not failed prior PBS-subsidised treatment with that agent. For eligible patients, applications to swap between the 7 PAH agents must be made under the relevant initial treatment restriction. Patients should be assessed for response to the treatment they are ceasing at the time the application to swap therapy is being made. Patients who fail to demonstrate a response or for whom no assessment results are submitted with the application to swap therapy may not re-commence PBS-subsidised treatment with the drug they are ceasing.

Note

Applications for patients who wish to swap to an alternate PAH agent should be accompanied by the previously approved authority prescription, or remaining repeats, for the treatment the patient is ceasing.

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Initial 1 or Initial 2 (new patients) or Initial 3 (change or re-commencement of therapy for all patients) or Continuing treatment (all patients) – balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this agent under the Initial 1 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 2 (new patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Initial 3 (change or re-commencement of therapy for all patients) restriction to complete a maximum of six months of treatment; OR

Patient must have received insufficient therapy with this agent under the Continuing treatment (all patients) restriction to complete a maximum of six months of treatment, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition, **AND**

The treatment must provide no more than the balance of up to six months treatment available under the above restrictions.

Note

Applications for authorisation under this criterion may be made by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authorisation under this criterion should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Pulmonary arterial hypertension (PAH)

Treatment Phase: Continuing treatment (all patients)

Clinical criteria:

Patient must have received approval for initial PBS-subsidised treatment with this agent, **AND**

Patient must have been assessed by a physician from a designated hospital to have achieved a response to their most recent course of treatment with this agent, **AND**

The treatment must be the sole PBS-subsidised PAH agent for this condition.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Pulmonary Arterial Hypertension PBS Authority Application - Supporting Information form which includes results from the three tests below, where available:
 - (i) RHC composite assessment; and
 - (ii) ECHO composite assessment; and
 - (iii) 6 Minute Walk Test (6MWT).

Test requirements to establish response to treatment for continuation of treatment are as follows:

The following list outlines the preferred test combination, in descending order, for the purposes of continuation of PBS-subsidised treatment:

- (1) RHC plus ECHO composite assessments plus 6MWT;
- (2) RHC plus ECHO composite assessments;
- (3) RHC composite assessment plus 6MWT;
- (4) ECHO composite assessment plus 6MWT;
- (5) RHC composite assessment only;
- (6) ECHO composite assessment only.

The results of the same tests as conducted at baseline should be provided with each written continuing treatment application (i.e., every 6 months), except for patients who were able to undergo all 3 tests at baseline, and whose subsequent ECHO and 6MWT results demonstrate disease stability or improvement, in which case RHC can be omitted. In all other patients, where the same test(s) conducted at baseline cannot be performed for assessment of response on clinical grounds, a patient specific reason why the test(s) could not be conducted must be provided with the application.

The test results provided with the application for continuing treatment must be no more than 2 months old at the time of application.

Response to a PAH agent is defined as follows:

For patients with two or more baseline tests, response to treatment is defined as two or more tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with a RHC composite assessment alone at baseline, response to treatment is defined as a RHC result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients with an ECHO composite assessment alone at baseline, response to treatment is defined as an ECHO result demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

For patients aged less than 18 years, response to treatment is defined as at least one of the baseline tests demonstrating stability or improvement of disease, as assessed by a physician from a designated hospital.

The maximum quantity authorised will be limited to provide sufficient supply for 1 month of treatment, based on the dosage recommendations in the Therapeutic Goods Administration (TGA) approved Product Information.

A maximum of 5 repeats will be authorised.

The assessment of the patient's response to the first and subsequent 6 month courses of treatment should be made following the preceding 5 months of treatment, in order to allow sufficient time for a response to be demonstrated.

Applications for continuing treatment with a PAH agent should be made prior to the completion of the 6 month treatment course to ensure continuity for those patients who respond to treatment, as assessed by the treating physician.

Patients who fail to demonstrate a response to PBS-subsidised treatment with this agent at the time where an assessment is required must cease PBS-subsidised therapy with this agent.

The term 'PAH agents' refers to bosentan monohydrate, iloprost trometamol, epoprostenol sodium, sildenafil citrate, ambrisentan, tadalafil, and macitentan.

PAH agents are not PBS-subsidised for patients with pulmonary hypertension secondary to interstitial lung disease associated with connective tissue disease, where the total lung capacity is less than 70% of predicted.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

tadalafil 20 mg tablet, 56

1308W

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
1	838.53	Adcirca [LY]

■ SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

■ PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES

HYPOTHALAMIC HORMONES

Somatostatin and analogues

■ LANREOTIDE

Authority required (STREAMLINED)

4567

Acromegaly

Clinical criteria:

The condition must be active, **AND**

Patient must have persistent elevation of mean growth hormone levels of greater than 2.5 micrograms per litre, **AND**

The treatment must be after failure of other therapy including dopamine agonists; OR

The treatment must be as interim treatment while awaiting the effects of radiotherapy and where treatment with dopamine agonists has failed; OR

The treatment must be in a patient who is unfit for or unwilling to undergo surgery and where radiotherapy is contraindicated, **AND**

The treatment must cease in a patient treated with radiotherapy if there is biochemical evidence of remission (normal IGF1) after lanreotide has been withdrawn for at least 4 weeks (6 weeks after the last dose), **AND**

The treatment must cease if IGF1 is not lower after 3 months of treatment.

In a patient treated with radiotherapy, lanreotide should be withdrawn every 2 years in the 10 years after radiotherapy for assessment of remission.

lanreotide 30 mg injection: modified release [1 x 30 mg vial] (&) inert substance diluent [1 x 2 mL ampoule], 1 pack

5776B

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
2	11	..	*1500.00	Somatuline LA [IS]

■ LANREOTIDE

Authority required (STREAMLINED)**4570**

Acromegaly

Clinical criteria:The condition must be active, **AND**Patient must have persistent elevation of mean growth hormone levels of greater than 2.5 micrograms per litre, **AND**

The treatment must be after failure of other therapy including dopamine agonists; OR

The treatment must be as interim treatment while awaiting the effects of radiotherapy and where treatment with dopamine agonists has failed; OR

The treatment must be in a patient who is unfit for or unwilling to undergo surgery and where radiotherapy is contraindicated, **AND**The treatment must cease in a patient treated with radiotherapy if there is biochemical evidence of remission (normal IGF1) after lanreotide has been withdrawn for at least 4 weeks (8 weeks after the last dose), **AND**

The treatment must cease if IGF1 is not lower after 3 months of treatment.

In a patient treated with radiotherapy, lanreotide should be withdrawn every 2 years in the 10 years after radiotherapy for assessment of remission.

Authority required (STREAMLINED)**4575**

Functional carcinoid tumour

Clinical criteria:The condition must be causing intractable symptoms, **AND**Patient must have experienced on average over 1 week, 3 or more episodes per day of diarrhoea and/or flushing, which persisted despite the use of anti-histamines, anti-serotonin agents and anti-diarrhoea agents, **AND**Patient must be one in whom surgery or antineoplastic therapy has failed or is inappropriate, **AND**

The treatment must cease if there is failure to produce a clinically significant reduction in the frequency and severity of symptoms after 3 months' therapy at a dose of 120 mg every 28 days.

Dosage and tolerance to the drug should be assessed regularly and the dosage should be titrated slowly downwards to determine the minimum effective dose.

lanreotide 120 mg injection, 1 syringe

5779E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*4480.00	Somatuline Autogel [IS]

lanreotide 60 mg injection, 1 syringe

5777C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2690.00	Somatuline Autogel [IS]

lanreotide 90 mg injection, 1 syringe

5778D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3580.00	Somatuline Autogel [IS]

■ OCTREOTIDE

Authority required (STREAMLINED)**3407**Active acromegaly in a patient with persistent elevation of mean growth hormone levels of greater than 2.5 micrograms per litre **AND**

(a) after failure of other therapy including dopamine agonists; or

(b) as interim treatment while awaiting the effects of radiotherapy and where treatment with dopamine agonists has failed; or

(c) if the patient is unfit for or unwilling to undergo surgery and where radiotherapy is contraindicated.

In a patient treated with radiotherapy, treatment must cease if there is biochemical evidence of remission (normal IGF1) after octreotide has been withdrawn for at least 4 weeks. Octreotide should be withdrawn every 2 years in the 10 years after radiotherapy for assessment of remission.

Treatment must cease if IGF1 is not lower after 3 months treatment at a dose of 100 micrograms 3 times daily

Authority required (STREAMLINED)**3408**

Functional carcinoid tumour or vasoactive intestinal peptide secreting tumour (VIPoma) causing intractable symptoms. The patient must have experienced on average over 1 week, 3 or more episodes per day of diarrhoea and/or flushing, which persisted despite the use of anti-histamines, anti-serotonin agents and anti-diarrhoea agents, and surgery or antineoplastic therapy must have failed or be inappropriate.

Treatment must cease if there is failure to produce a clinically significant reduction in the frequency and severity of symptoms after 2 months' therapy. Dosage and tolerance to the drug should be assessed regularly and the dosage should be titrated slowly downwards to determine the minimum effective dose

octreotide 100 microgram/mL injection, 5 x 1 mL ampoules

9509L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	18	11	..	*1236.42	^a Hospira Pty Limited [HH]	^a Octreotide MaxRx [GQ]

^a Octreotide (SUN) [ZF]^a Sandostatin 0.1 [NV]**octreotide 50 microgram/mL injection, 5 x 1 mL ampoules**

9508K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	18	11	..	*619.02	^a Hospira Pty Limited [HH] ^a Octreotide (SUN) [ZF]	^a Octreotide MaxRx [GQ] ^a Sandostatin 0.05 [NV]

octreotide 500 microgram/mL injection, 5 x 1 mL ampoules

9510M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	18	11	..	*6194.52	^a Hospira Pty Limited [HH] ^a Octreotide (SUN) [ZF]	^a Octreotide MaxRx [GQ] ^a Sandostatin 0.5 [NV]

■ OCTREOTIDE**Authority required (STREAMLINED)****4563**

Acromegaly

Clinical criteria:The condition must be controlled with octreotide immediate release injections, **AND**The treatment must cease in a patient treated with radiotherapy if there is biochemical evidence of remission (normal IGF1) after octreotide has been withdrawn for at least 4 weeks (8 weeks after the last dose), **AND**

The treatment must cease if IGF1 is not lower after 3 months of treatment.

In a patient treated with radiotherapy, octreotide should be withdrawn every 2 years in the 10 years after radiotherapy for assessment of remission

Authority required (STREAMLINED)**4561**

Functional carcinoid tumour

Clinical criteria:Patient must have achieved symptom control on octreotide immediate release injections, **AND**

The treatment must cease if there is failure to produce a clinically significant reduction in the frequency and severity of symptoms after 3 months' therapy at a dose of 30 mg every 28 days and having allowed adequate rescue therapy with octreotide immediate release injections.

Dosage and tolerance to the drug should be assessed regularly and the dosage should be titrated slowly downwards to determine the minimum effective dose.

Authority required (STREAMLINED)**4564**

Vasoactive intestinal peptide secreting tumour (VIPoma)

Clinical criteria:Patient must have achieved symptom control on octreotide immediate release injections, **AND**

The treatment must cease if there is failure to produce a clinically significant reduction in the frequency and severity of symptoms after 3 months' therapy at a dose of 30 mg every 28 days and having allowed adequate rescue therapy with octreotide immediate release injections.

Dosage and tolerance to the drug should be assessed regularly and the dosage should be titrated slowly downwards to determine the minimum effective dose.

octreotide 10 mg injection: modified release [1 x 10 mg vial] (&) inert substance diluent [1 x 2.5 mL syringe], 1 pack

9511N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2613.72	Sandostatin LAR [NV]

octreotide 20 mg injection: modified release [1 x 20 mg vial] (&) inert substance diluent [1 x 2.5 mL syringe], 1 pack

9512P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3479.62	Sandostatin LAR [NV]

octreotide 30 mg injection: modified release [1 x 30 mg vial] (&) inert substance diluent [1 x 2.5 mL syringe], 1 pack

9513Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*4354.92	Sandostatin LAR [NV]

■ CALCIUM HOMEOSTASIS**ANTI-PARATHYROID AGENTS***Other anti-parathyroid agents***■ CINACALCET****Authority required (STREAMLINED)****3323**

Management, including initiation and stabilisation, by a nephrologist, of a patient with chronic kidney disease on dialysis who has sustained secondary hyperparathyroidism with iPTH of at least 50 pmol per L, not responding to conventional therapy

Authority required (STREAMLINED)

3324

Management, including initiation and stabilisation, by a nephrologist, of a patient with chronic kidney disease on dialysis who has sustained secondary hyperparathyroidism with iPTH of at least 15 pmol per L and less than 50 pmol per L AND an (adjusted) serum calcium concentration at least 2.6 mmol per L, not responding to conventional treatment

Note

During the titration phase, intact PTH should be monitored 4 weekly (measured at least 12 hours post dose) and dose titrated until an appropriate iPTH concentration is achieved. During the titration phase, approval will be limited to sufficient supply for 4 weeks treatment at a time, with doses between 30 and 180 mg per day according to the patient's response and tolerability.

During the maintenance phase, approval will be limited to provide sufficient quantity for 4 weeks treatment up to a maximum of 6 months supply for doses between 30 and 180 mg per day according to the patient's response and tolerability. Intact PTH should be monitored quarterly (measured at least 12 hours post dose) and dose adjusted as necessary to maintain an appropriate iPTH concentration.

"Sustained" means the abnormality was detected on at least 2 blood samples collected over a period of 2 to 4 months. Special Pricing Arrangements apply.

cinacalcet 30 mg tablet, 28

5621W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*385.92	Sensipar [AN]

cinacalcet 60 mg tablet, 28

5622X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*771.84	Sensipar [AN]

cinacalcet 90 mg tablet, 28

5623Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1157.76	Sensipar [AN]

■ **ANTIINFECTIVES FOR SYSTEMIC USE**

■ **ANTIBACTERIALS FOR SYSTEMIC USE**

MACROLIDES, LINCOSAMIDES AND STREPTOGRAMINS

Macrolides

■ **AZITHROMYCIN**

Authority required (STREAMLINED)

3317

Prophylaxis against Mycobacterium avium complex infections in HIV-positive patients with CD4 cell counts of less than 75 per cubic millimetre

azithromycin 600 mg tablet, 8

5616N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*128.06	Zithromax [PF]

■ **CLARITHROMYCIN**

Authority required (STREAMLINED)

3325

Treatment of Mycobacterium avium complex infections

clarithromycin 250 mg tablet, 100

5625C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	2	..	20.00	Klacid [GO]

clarithromycin 500 mg tablet, 100

5624B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	2	..	39.93	Klacid [GO]

■ **ANTIMYCOBACTERIALS**

DRUGS FOR TREATMENT OF TUBERCULOSIS

Antibiotics

■ RIFABUTIN

Authority required (STREAMLINED)

3415

Treatment of Mycobacterium avium complex infections in HIV-positive patients

Authority required (STREAMLINED)

3317

Prophylaxis against Mycobacterium avium complex infections in HIV-positive patients with CD4 cell counts of less than 75 per cubic millimetre

rifabutin 150 mg capsule, 30

9541E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	4	5	..	*647.36	Mycobutin [PF]

■ ANTIVIRALS FOR SYSTEMIC USE

DIRECT ACTING ANTIVIRALS

Nucleosides and nucleotides excl. reverse transcriptase inhibitors

■ GANCICLOVIR

Authority required (STREAMLINED)

3379

Cytomegalovirus retinitis in severely immunocompromised patients

Authority required (STREAMLINED)

3380

Prophylaxis of cytomegalovirus disease in bone marrow transplant patients at risk of cytomegalovirus disease

Authority required (STREAMLINED)

3381

Prophylaxis of cytomegalovirus disease in solid organ transplant patients at risk of cytomegalovirus disease

ganciclovir 500 mg injection, 5 x 500 mg vials

5749N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	1	..	*560.00	Cymevene [RO]

■ VALACICLOVIR

Authority required (STREAMLINED)

3419

Prophylaxis of cytomegalovirus (CMV) infection and disease following renal transplantation in patients at risk of CMV disease

valaciclovir 500 mg tablet, 100

9568N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	5	2	..	*606.00	^a APO-Valaciclovir [TX] ^a Valtrex [AS]	^a Valaciclovir RBX [RA] ^a Zelitrex [UA]

■ VALGANCICLOVIR

Authority required (STREAMLINED)

3420

Cytomegalovirus retinitis in patients with acquired immunodeficiency syndrome

Authority required (STREAMLINED)

3421

Prophylaxis of cytomegalovirus infection and disease in solid organ transplant patients at risk of cytomegalovirus disease

valganciclovir 450 mg tablet, 60

9569P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*4491.60	Valcyte [RO]

valganciclovir 50 mg/mL oral liquid: powder for, 100 mL

9655E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	11	5	..	*4574.79	Valcyte [RO]

Phosphonic acid derivatives

■ FOSCARNET

Authority required (STREAMLINED)

3322

Treatment of cytomegalovirus retinitis in patients with AIDS

Authority required (STREAMLINED)

3378

Treatment of aciclovir-resistant herpes simplex virus infection in immunocompromised patients with HIV infection

FOSCARNET SODIUM I.V. infusion 24 mg per mL, 250 mL bottle, 6

5747L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	1	..	1177.50	Foscavir [IX]

Protease inhibitors■ **ATAZANAVIR****Authority required (STREAMLINED)****4512**

HIV infection

Treatment Phase: Initial

Clinical criteria:Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)**4454**

HIV infection

Treatment Phase: Continuing

Clinical criteria:Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

atazanavir 150 mg capsule, 60

5613K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1043.82	Reyataz [BQ]

atazanavir 200 mg capsule, 60

5614L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1391.76	Reyataz [BQ]

atazanavir 300 mg capsule, 30

5612J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1043.82	Reyataz [BQ]

■ **BOCEPREVIR****Authority required (STREAMLINED)****4182**

Chronic genotype 1 hepatitis C infection

Clinical criteria:Patient must have compensated liver disease, **AND**Patient must have received no more than one prior treatment with interferon alfa or peginterferon alfa for hepatitis C, **AND**The treatment must be in combination with peginterferon alfa and ribavirin, **AND**

The treatment must be limited to a maximum duration of 32 weeks in patients without hepatic cirrhosis who were partial responders or relapsers to the prior course of interferon based therapy for hepatitis C; OR

The treatment must be limited to a maximum duration of 44 weeks in patients without hepatic cirrhosis who were null responders to the prior course of interferon based therapy for hepatitis C; OR

The treatment must be limited to a maximum duration of 44 weeks for all patients with hepatic cirrhosis, **AND**The treatment must cease after the first 8 weeks of boceprevir treatment if plasma HCV RNA is detectable by an HCV RNA qualitative assay at treatment week 12, **AND**

The treatment must cease after the first 20 weeks of boceprevir treatment if plasma HCV RNA is detectable by an HCV RNA qualitative assay at treatment week 24.

Population criteria:Patient must be 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Chronic genotype 1 hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Patients who have received prior treatment with an NS3/4A protease inhibitor are not eligible to receive PBS-subsidised boceprevir, except where the patient has developed an intolerance to the other NS3/4A protease inhibitor of a severity necessitating permanent treatment withdrawal. Details of the intolerance must be documented in the patient's medical records.

For patients without hepatic cirrhosis who were partial responders or relapsers to the prior course of interferon based therapy, a maximum of 7 repeats may be prescribed.

For patients without hepatic cirrhosis who were null responders to the prior course of interferon based therapy, a maximum of 10 repeats may be prescribed.

For patients with hepatic cirrhosis, a maximum of 10 repeats may be prescribed.

Authority required (STREAMLINED)

4202

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**

The treatment must be in combination with peginterferon alfa and ribavirin, **AND**

The treatment must be limited to a maximum duration of 24 weeks in patients without hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 44 weeks in patients with hepatic cirrhosis, **AND**

The treatment must cease after the first 20 weeks of boceprevir treatment if plasma HCV RNA is detectable by an HCV RNA qualitative assay at treatment week 24.

Population criteria:

Patient must be 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic genotype 1 hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Patients who have received prior treatment with an NS3/4A protease inhibitor are not eligible to receive PBS-subsidised boceprevir, except where the patient has developed an intolerance to the other NS3/4A protease inhibitor of a severity necessitating permanent treatment withdrawal. Details of the intolerance must be documented in the patient's medical records.

For patients without hepatic cirrhosis, a maximum of 5 repeats may be prescribed.

For patients with hepatic cirrhosis, a maximum of 10 repeats may be prescribed.

Note

No increase in the maximum quantity or number of units may be authorised.

Treatment centres are required to have access to the following appropriate specialist facilities for the provision of clinical support services for hepatitis C:

- (a) a nurse educator/counsellor for patients; and
- (b) 24-hour access by patients to medical advice; and

- (c) an established liver clinic.

Boceprevir 200 mg capsule, 336 capsules

2433C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	10	..	3920.00	Victrelis [MK]

▪ **DARUNAVIR**

Authority required (STREAMLINED)

4313

Human immunodeficiency virus (HIV) infection

Clinical criteria:

The treatment must be in addition to optimised background therapy, **AND**

The treatment must be in combination with other antiretroviral agents, **AND**

The treatment must be co-administered with 100 mg ritonavir, **AND**

Patient must have experienced virological failure or clinical failure or genotypic resistance after at least one antiretroviral regimen, **AND**

Patient must not have demonstrated darunavir resistance associated mutations detected on resistance testing.

Virological failure is defined as a viral load greater than 400 copies per mL on two consecutive occasions, while clinical failure is linked to emerging signs and symptoms of progressing HIV infection or treatment-limiting toxicity.

darunavir 800 mg tablet, 30

2980W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1398.28	Prezista [JC]

▪ **DARUNAVIR**

Authority required (STREAMLINED)

3595

Treatment of HIV infection, in addition to optimised background therapy in combination with other antiretroviral agents, and co-administered with 100 mg ritonavir twice daily in an antiretroviral experienced patient who, after at least one antiretroviral regimen, has experienced virological failure or clinical failure or genotypic resistance.

Virological failure is defined as a viral load greater than 400 copies per mL on two consecutive occasions, while clinical failure is linked to emerging signs and symptoms of progressing HIV infection or treatment-limiting toxicity

darunavir 150 mg tablet, 240

5653M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	5	..	1048.71	Prezista [JC]

darunavir 600 mg tablet, 60

3392M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2097.42	Prezista [JC]

■ FOSAMPRENAVIR**Authority required (STREAMLINED)****4512**

HIV infection

Treatment Phase: Initial

Clinical criteria:Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)**4454**

HIV infection

Treatment Phase: Continuing

Clinical criteria:Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

fosamprenavir 50 mg/mL oral liquid, 225 mL

5745J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	8	5	..	*812.48	Telzir [VI]

fosamprenavir 700 mg tablet, 60

5746K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*758.32	Telzir [VI]

■ INDINAVIR**Authority required (STREAMLINED)****4512**

HIV infection

Treatment Phase: Initial

Clinical criteria:Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)**4454**

HIV infection

Treatment Phase: Continuing

Clinical criteria:Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

indinavir 400 mg capsule, 180

5752R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*910.00	Crixivan 400 mg [MK]

■ RITONAVIR**Authority required (STREAMLINED)****4512**

HIV infection

Treatment Phase: Initial

Clinical criteria:Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)**4454**

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**
The treatment must be in combination with other antiretroviral agents.

ritonavir 100 mg tablet, 30

9660K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	24	5	..	*982.80	Norvir [VE]

ritonavir 600 mg/7.5 mL oral liquid, 90 mL

9542F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	10	5	..	*910.00	Norvir [VE]

▪ SAQUINAVIR

Authority required (STREAMLINED)

4512

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

saquinavir 500 mg tablet, 120

9545J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1011.12	Invirase [RO]

▪ SIMEPREVIR

Authority required (STREAMLINED)

4758

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**

The treatment must be in combination with peginterferon alfa and ribavirin, **AND**

The treatment must be limited to a maximum duration of 12 weeks, **AND**

The treatment must cease if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is 25 IU/mL or greater.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic genotype 1 hepatitis C infection (repeatedly anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Patients who have received prior treatment with an NS3/4A protease inhibitor are not eligible to receive PBS-subsidised simeprevir, except where the patient has developed an intolerance to the other NS3/4A protease inhibitor of a severity necessitating permanent treatment withdrawal. Details of the intolerance must be documented in the patient's medical records.

Authority required (STREAMLINED)

4759

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must have received prior treatment with interferon alfa or peginterferon alfa for hepatitis C, **AND**

The treatment must be in combination with peginterferon alfa and ribavirin, **AND**

The treatment must be limited to a maximum duration of 12 weeks, **AND**

The treatment must cease if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is 25 IU/mL or greater.

Population criteria:

Patient must be 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic genotype 1 hepatitis C infection (repeatedly anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Patients who have received prior treatment with an NS3/4A protease inhibitor are not eligible to receive PBS-subsidised simeprevir, except where the patient has developed an intolerance to the other NS3/4A protease inhibitor of a severity necessitating permanent treatment withdrawal. Details of the intolerance must be documented in the patient's medical records.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Treatment centres are required to have access to the following appropriate specialist facilities for the provision of clinical support services for hepatitis C:

- (a) a nurse educator/counsellor for patients; and
- (b) 24-hour access by patients to medical advice; and

- (c) an established liver clinic.

simeprevir sodium 150 mg capsule, 7

10200W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	6	..	..	*14865.72	Olysio [JC]

▪ **TELAPREVR**

Authority required (STREAMLINED)

4186

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must not have received prior treatment with interferon alfa or peginterferon alfa for hepatitis C, **AND**

The treatment must be in combination with peginterferon alfa and ribavirin, **AND**

The treatment must be limited to a maximum duration of 12 weeks, **AND**

The treatment must cease if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than 1000 IU/mL.

Population criteria:

Patient must be 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic genotype 1 hepatitis C infection (repeatedly anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Patients who have received prior treatment with an NS3/4A protease inhibitor are not eligible to receive PBS-subsidised telaprevir, except where the patient has developed an intolerance to the other NS3/4A protease inhibitor of a severity necessitating permanent treatment withdrawal. Details of the intolerance must be documented in the patient's medical records.

Authority required (STREAMLINED)

4191

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must have received prior treatment with interferon alfa or peginterferon alfa for hepatitis C, **AND**

The treatment must be in combination with peginterferon alfa and ribavirin, **AND**

The treatment must be limited to a maximum duration of 12 weeks, **AND**

The treatment must cease if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than 1000 IU/mL.

Population criteria:

Patient must be 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic genotype 1 hepatitis C infection (repeatedly anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Patients who have received prior treatment with an NS3/4A protease inhibitor are not eligible to receive PBS-subsidised telaprevir, except where the patient has developed an intolerance to the other NS3/4A protease inhibitor of a severity

necessitating permanent treatment withdrawal. Details of the intolerance must be documented in the patient's medical records.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Treatment centres are required to have access to the following appropriate specialist facilities for the provision of clinical support services for hepatitis C:

- (a) a nurse educator/counsellor for patients; and
- (b) 24-hour access by patients to medical advice; and

- (c) an established liver clinic.

telaprevir 375 mg tablet, 42

2437G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	6	..	..	*14865.72	Incivo [JC]

▪ **TIPRANAVIR**

Authority required (STREAMLINED)

3601

Treatment of HIV infection, in addition to optimised background therapy in combination with other antiretroviral agents, and co-administered with 200 mg ritonavir twice daily in an antiretroviral experienced patient who, after each of at least three different antiretroviral regimens that have included one drug from at least 3 different antiretroviral classes, has experienced virological failure or clinical failure or genotypic resistance.

Virological failure is defined as a viral load greater than 400 copies per mL on two consecutive occasions, while clinical failure is linked to emerging signs and symptoms of progressing HIV infection or treatment-limiting toxicity

Note

Special Pricing Arrangements apply.

tipranavir 250 mg capsule, 120

9567M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2142.00	Aptivus [BY]

HSD (Public)

Nucleoside and nucleotide reverse transcriptase inhibitors

▪ **ABACAVIR**

Authority required (STREAMLINED)

4512

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

abacavir 20 mg/mL oral liquid, 240 mL

5602W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	8	5	..	*657.12	Ziagen [VI]

abacavir 300 mg tablet, 60

5601T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*564.00	Ziagen [VI]

▪ **ADEFOVIR DIPIVOXIL**

Authority required (STREAMLINED)

3973

Chronic hepatitis B in a patient without cirrhosis who has failed antihepadnaviral therapy and who satisfies all of the following criteria:

- (a) Repeatedly elevated serum ALT levels while on concurrent antihepadnaviral therapy of greater than or equal to 6 months duration in conjunction with documented chronic hepatitis B infection; or
- (b) Repeatedly elevated HBV DNA levels one log greater than the nadir value or failure to achieve a 1 log reduction in HBV DNA within 3 months, whilst on previous antihepadnaviral therapy except in patients with evidence of poor compliance

Authority required (STREAMLINED)**3974**

Chronic hepatitis B in a patient with cirrhosis who has failed antihepadnaviral therapy and who has detectable HBV DNA. Persons with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy

Note

Patients may receive treatment in combination with lamivudine but not with other PBS-subsidised antihepadnaviral therapy.

adefovir dipivoxil 10 mg tablet, 30

5606C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*1050.00	^a APO-Adefovir [TX]	^a Hepsera [GI]

■ DIDANOSINE**Authority required (STREAMLINED)****4512**

HIV infection

Treatment Phase: Initial

Clinical criteria:Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)**4454**

HIV infection

Treatment Phase: Continuing

Clinical criteria:Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

didanosine 125 mg capsule: enteric, 30

5663C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*280.86	Videx EC [BQ]

didanosine 200 mg capsule: enteric, 30

5664D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*326.80	Videx EC [BQ]

didanosine 250 mg capsule: enteric, 30

5665E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*408.48	Videx EC [BQ]

didanosine 400 mg capsule: enteric, 30

5666F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*653.58	Videx EC [BQ]

■ EMTRICITABINE**Authority required (STREAMLINED)****4512**

HIV infection

Treatment Phase: Initial

Clinical criteria:Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)**4454**

HIV infection

Treatment Phase: Continuing

Clinical criteria:Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

emtricitabine 200 mg capsule, 30

5709L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*564.00	Emtriva [GI]

■ ENTECAVIR

Authority required (STREAMLINED)

3961

Chronic hepatitis B in a patient without cirrhosis who satisfies all of the following criteria:

(1) Elevated HBV DNA levels - greater than 20,000 IU/mL (100,000 copies/mL) if HBeAg positive, or greater than 2,000 IU/mL (10,000 copies/mL) if HBeAg negative - in conjunction with documented chronic hepatitis B infection;

(2) Evidence of chronic liver injury as determined by:

(a) Confirmed elevated serum ALT; or

(b) Liver biopsy

Authority required (STREAMLINED)

3962

Chronic hepatitis B in a patient with cirrhosis who has detectable HBV DNA.

Persons with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy

Note

PBS-subsidised entecavir monohydrate must be used as monotherapy.

entecavir monohydrate 500 microgram tablet, 30

5711N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*768.60	Baraclude [BQ]

■ ENTECAVIR

Authority required (STREAMLINED)

3964

Chronic hepatitis B in a patient without cirrhosis who has failed lamivudine and who satisfies all of the following criteria:

(a) Repeatedly elevated serum ALT levels while on concurrent antihepadnaviral therapy of greater than or equal to 6 months duration in conjunction with documented chronic hepatitis B infection; or

(b) Repeatedly elevated HBV DNA levels one log greater than the nadir value or failure to achieve a 1 log reduction in HBV DNA within 3 months, whilst on previous antihepadnaviral therapy except in patients with evidence of poor compliance

Authority required (STREAMLINED)

3966

Chronic hepatitis B in a patient with cirrhosis who has failed lamivudine and who has detectable HBV DNA.

Persons with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy

Note

PBS-subsidised entecavir monohydrate must be used as monotherapy.

entecavir monohydrate 1 mg tablet, 30

5712P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1250.00	Baraclude [BQ]

■ LAMIVUDINE

Authority required (STREAMLINED)

3961

Chronic hepatitis B in a patient without cirrhosis who satisfies all of the following criteria:

(1) Elevated HBV DNA levels - greater than 20,000 IU/mL (100,000 copies/mL) if HBeAg positive, or greater than 2,000 IU/mL (10,000 copies/mL) if HBeAg negative - in conjunction with documented chronic hepatitis B infection;

(2) Evidence of chronic liver injury as determined by:

(a) Confirmed elevated serum ALT; or

(b) Liver biopsy

Authority required (STREAMLINED)

3962

Chronic hepatitis B in a patient with cirrhosis who has detectable HBV DNA.

Persons with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy

lamivudine 100 mg tablet, 28

5770Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*162.44	^a Zeffix [AS]	^a Zetlam [AF]

lamivudine 5 mg/mL oral liquid, 240 mL

5771R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	5	5	..	*226.25	Zeffix [AS]

■ LAMIVUDINE

Authority required (STREAMLINED)**4512**

HIV infection

Treatment Phase: Initial

Clinical criteria:Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)**4454**

HIV infection

Treatment Phase: Continuing

Clinical criteria:Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

lamivudine 10 mg/mL oral liquid, 240 mL

5773W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	8	5	..	*447.84	3TC [VI]

lamivudine 150 mg tablet, 60

5772T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*306.68	^a 3TC [VI] ^a Lamivudine RBX [RA]	^a Lamivudine Alphapharm [AF]

lamivudine 300 mg tablet, 30

5774X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*306.68	^a 3TC [VI] ^a Lamivudine RBX [RA]	^a Lamivudine Alphapharm [AF]

■ STAVUDINE

Authority required (STREAMLINED)**4512**

HIV infection

Treatment Phase: Initial

Clinical criteria:Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)**4454**

HIV infection

Treatment Phase: Continuing

Clinical criteria:Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

stavudine 20 mg capsule, 60

9553T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*560.00	Zerit [BQ]

stavudine 30 mg capsule, 60

9554W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*667.36	Zerit [BQ]

stavudine 40 mg capsule, 60

9556Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*889.80	Zerit [BQ]

■ TELBIVUDINE

Authority required (STREAMLINED)**3969**

Treatment, as sole PBS-subsidised therapy, in a patient with chronic hepatitis B without cirrhosis who is nucleoside analogue naive and satisfies all of the following criteria:

(1) Elevated HBV DNA levels - greater than 20,000 IU/mL (100,000 copies/mL) if HBeAg positive, or greater than 2,000 IU/mL (10,000 copies/mL) if HBeAg negative - in conjunction with documented hepatitis B infection;

(2) Evidence of chronic liver injury as determined by:

(a) Confirmed elevated serum ALT; or

(b) Liver biopsy

Authority required (STREAMLINED)

3970

Treatment, as sole PBS-subsidised therapy, in a patient with chronic hepatitis B with cirrhosis who is nucleoside analogue naive and who has detectable HBV DNA.

Persons with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy

telbivudine 600 mg tablet, 28

9562G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*501.76	Sebivo [NV]

▪ **TENOFOVIR**

Authority required (STREAMLINED)

4512

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4489

Chronic hepatitis B

Clinical criteria:

Patient must not have cirrhosis, **AND**

Patient must be nucleoside analogue naive, **AND**

Patient must have elevated HBV DNA levels greater than 20,000 IU/mL (100,000 copies/mL) if HBeAg positive, in conjunction with documented hepatitis B infection; OR

Patient must have elevated HBV DNA levels greater than 2,000 IU/mL (10,000 copies/mL) if HBeAg negative, in conjunction with documented hepatitis B infection, **AND**

Patient must have evidence of chronic liver injury determined by: (i) confirmed elevated serum ALT; or (ii) liver biopsy, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

Authority required (STREAMLINED)

4476

Chronic hepatitis B

Clinical criteria:

Patient must have cirrhosis, **AND**

Patient must be nucleoside analogue naive, **AND**

Patient must have detectable HBV DNA, **AND**

The treatment must be the sole PBS-subsidised therapy for this condition.

Persons with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy.

Authority required (STREAMLINED)

4490

Chronic hepatitis B

Clinical criteria:

Patient must not have cirrhosis, **AND**

Patient must have failed antihepadnaviral therapy, **AND**

Patient must have repeatedly elevated serum ALT levels while on concurrent antihepadnaviral therapy of greater than or equal to 6 months duration, in conjunction with documented chronic hepatitis B infection; OR

Patient must have repeatedly elevated HBV DNA levels one log greater than the nadir value or failure to achieve a 1 log reduction in HBV DNA within 3 months whilst on previous antihepadnaviral therapy, except in patients with evidence of poor compliance.

Authority required (STREAMLINED)

4510

Chronic hepatitis B

Clinical criteria:

Patient must have cirrhosis, **AND**

Patient must have failed antihepadnaviral therapy, **AND**

Patient must have detectable HBV DNA.

Persons with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy.

Note

Patients may receive treatment in combination with lamivudine but not with other PBS-subsidised antihepadnaviral therapy.

tenofovir disoproxil fumarate 300 mg tablet, 30

9563H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*966.20	Viread [GI]

■ ZIDOVUDINE

Authority required (STREAMLINED)

4512

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

zidovudine 100 mg capsule, 100

9651Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	4	5	..	*821.84	Retrovir [VI]

zidovudine 250 mg capsule, 40

9652B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	6	5	..	*1232.76	Retrovir [VI]

zidovudine 50 mg/5 mL oral liquid, 200 mL

9570Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	15	5	..	*673.20	Retrovir [VI]

Non-nucleoside reverse transcriptase inhibitors

■ EFAVIRENZ

Authority required (STREAMLINED)

4512

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

efavirenz 200 mg tablet, 90

5708K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*543.16	Stocrin [MK]

efavirenz 30 mg/mL oral liquid, 180 mL

5707J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	7	5	..	*570.29	Stocrin [MK]

efavirenz 600 mg tablet, 30

5706H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*543.16	Stocrin [MK]

■ ETRAVIRINE**Authority required (STREAMLINED)****3597**

Treatment of HIV infection, in addition to optimised background therapy in combination with other antiretroviral agents in an antiretroviral experienced patient who, after each of at least three different antiretroviral regimens that have included one drug from at least 3 different antiretroviral classes, has experienced virological failure or clinical failure or genotypic resistance.

Virological failure is defined as a viral load greater than 400 copies per mL on two consecutive occasions, while clinical failure is linked to emerging signs and symptoms of progressing HIV infection or treatment-limiting toxicity

etravirine 200 mg tablet, 60

5084N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1233.00	Intelence [JC]

■ NEVIRAPINE**Authority required (STREAMLINED)****4526**

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must have been stabilised on nevirapine immediate release, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)**4454**

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

nevirapine 400 mg tablet: modified release, 30 tablets

1132N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*396.18	Viramune XR [BY]

■ NEVIRAPINE**Authority required (STREAMLINED)****4512**

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)**4454**

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

nevirapine 10 mg/mL oral liquid, 240 mL

9507J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	10	5	..	*1350.00	Viramune [BY]

nevirapine 200 mg tablet, 60

9506H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*396.18	^a Nevipin [GN] ^a Nevirapine RBX [RA]	^a Nevirapine Alphapharm [AF] ^a Viramune [BY]

■ RILPIVIRINE**Authority required (STREAMLINED)****4512**

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

rilpivirine 25 mg tablet, 30

1173R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*543.16	Edurant [JC]

Antivirals for treatment of HIV infections, combinations

▪ **ABACAVIR + LAMIVUDINE**

Authority required (STREAMLINED)

4527

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Population criteria:

Patient must be aged 12 years or older, **AND**

Patient must weigh 40 kg or more.

Authority required (STREAMLINED)

4528

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

Population criteria:

Patient must be aged 12 years or older, **AND**

Patient must weigh 40 kg or more.

abacavir 600 mg + lamivudine 300 mg tablet, 30

5603X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*870.68	Kivexa [VI]

▪ **ABACAVIR + LAMIVUDINE + ZIDOVUDINE**

Authority required (STREAMLINED)

4495

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive.

Population criteria:

Patient must be aged 12 years or older, **AND**

Patient must weigh 40 kg or more.

Authority required (STREAMLINED)

4480

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection.

Population criteria:

Patient must be aged 12 years or older, **AND**

Patient must weigh 40 kg or more.

abacavir 300 mg + lamivudine 150 mg + zidovudine 300 mg tablet, 60

5604Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1357.28	Trizivir [VI]

▪ DOLUTEGRAVIR + ABACAVIR + LAMIVUDINE

Authority required (STREAMLINED)

4495

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive.

Population criteria:

Patient must be aged 12 years or older, **AND**

Patient must weigh 40 kg or more.

Authority required (STREAMLINED)

4480

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection.

Population criteria:

Patient must be aged 12 years or older, **AND**

Patient must weigh 40 kg or more.

dolutegravir 50 mg + abacavir 600 mg + lamivudine 300 mg tablet, 30

10247H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2073.36	Triumeq [VI]

▪ EMTRICITABINE + RILPIVIRINE + TENOFOVIR

Authority required (STREAMLINED)

4522

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive.

Authority required (STREAMLINED)

4470

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection.

emtricitabine 200 mg + rilpivirine 25 mg + tenofovir disoproxil fumarate 300 mg tablet, 30

1491L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2073.36	Eviplera [GI]

▪ LAMIVUDINE + ZIDOVUDINE

Authority required (STREAMLINED)

4512

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

lamivudine 150 mg + zidovudine 300 mg tablet, 60

5775Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*787.46	^a Combivir [VI]	^a Lamivudine 150 mg + Zidovudine 300 mg Alphapharm [AF]

▪ LOPINAVIR + RITONAVIR

Authority required (STREAMLINED)

4512

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

lopinavir 100 mg + ritonavir 25 mg tablet, 60

5790R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*342.50	Kaletra [VE]

lopinavir 200 mg + ritonavir 50 mg tablet, 120

5791T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1370.00	Kaletra [VE]

lopinavir 400 mg/5 mL + ritonavir 100 mg/5 mL oral liquid, 60 mL

5789Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	10	5	..	*1290.00	Kaletra [VE]

▪ **TENOFOVIR + EMTRICITABINE**

Authority required (STREAMLINED)

4512

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

tenofovir disoproxil fumarate 300 mg + emtricitabine 200 mg tablet, 30

9564J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1530.20	Truvada [GI]

▪ **TENOFOVIR + EMTRICITABINE + EFAVIRENZ**

Authority required (STREAMLINED)

4522

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive.

Authority required (STREAMLINED)

4470

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection.

tenofovir disoproxil fumarate 300 mg + emtricitabine 200 mg + efavirenz 600 mg tablet, 30

9565K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2073.36	Atripla [GI]

▪ **TENOFOVIR + EMTRICITABINE + ELVITEGRAVIR + COBICISTAT**

Authority required (STREAMLINED)

4522

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive.

Authority required (STREAMLINED)

4470

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection.

tenofovir disoproxil fumarate 300 mg + emtricitabine 200 mg + elvitegravir 150 mg + cobicistat 150 mg tablet, 30

10088Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2073.36	Stribild [GI]

Other antiretrovirals

▪ **DOLUTEGRAVIR**

Authority required (STREAMLINED)

4512

HIV infection

Treatment Phase: Initial

Clinical criteria:

Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)

4454

HIV infection

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

dolutegravir 50 mg tablet, 30

10065R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1331.10	Tivicay [VI]

▪ **ENFUVIRTIDE**

Authority required (STREAMLINED)

3597

Treatment of HIV infection, in addition to optimised background therapy in combination with other antiretroviral agents in an antiretroviral experienced patient who, after each of at least three different antiretroviral regimens that have included one drug from at least 3 different antiretroviral classes, has experienced virological failure or clinical failure or genotypic resistance.

Virological failure is defined as a viral load greater than 400 copies per mL on two consecutive occasions, while clinical failure is linked to emerging signs and symptoms of progressing HIV infection or treatment-limiting toxicity

enfuvirtide 90 mg injection [60 x 90 mg vials] (&) inert substance diluent [60 x 1.1 mL vials], 1 pack

5710M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*4426.00	Fuzeon [RO]

▪ **MARAVIROC**

Authority required (STREAMLINED)

3599

Treatment, in addition to optimised background therapy in combination with other antiretroviral agents, of an antiretroviral experienced patient infected with only CCR5-tropic HIV-1, who, after each of at least three different antiretroviral regimens that have included one drug from at least 3 different antiretroviral classes, has experienced virological failure or clinical failure or genotypic resistance. A tropism assay to determine CCR5 only strain status is required prior to initiation. Individuals with CXCR4 tropism demonstrated at any time point are not eligible.

Virological failure is defined as a viral load greater than 400 copies per mL on two consecutive occasions, while clinical failure is linked to emerging signs and symptoms of progressing HIV infection or treatment-limiting toxicity

maraviroc 150 mg tablet, 60

5792W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1835.40	Celsentri [VI]

maraviroc 300 mg tablet, 60

5793X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1835.40	Celsentri [VI]

■ RALTEGRAVIR

Authority required (STREAMLINED)**4512**

HIV infection

Treatment Phase: Initial

Clinical criteria:Patient must be antiretroviral treatment naive, **AND**

The treatment must be in combination with other antiretroviral agents.

Authority required (STREAMLINED)**4454**

HIV infection

Treatment Phase: Continuing

Clinical criteria:Patient must have previously received PBS-subsidised therapy for HIV infection, **AND**

The treatment must be in combination with other antiretroviral agents.

raltegravir 400 mg tablet, 60

9523F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1331.10	Isentress [MK]

■ RALTEGRAVIR

Authority required (STREAMLINED)**4275**

HIV infection

Treatment Phase: Initial

Clinical criteria:The treatment must be in combination with other antiretroviral agents, **AND**Patient must be antiretroviral experienced with at least 6 months therapy with 2 alternate classes of anti-retroviral therapy, **AND**

Patient must have a CD4 count of less than 500 per cubic millimetre; OR

Patient must have symptomatic HIV disease.

Population criteria:

Patient must be aged 2 years or older.

Authority required (STREAMLINED)**4274**

HIV infection

Treatment Phase: Continuing

Clinical criteria:The treatment must be in combination with other antiretroviral agents, **AND**Patient must be antiretroviral experienced with at least 6 months therapy with 2 alternate classes of anti-retroviral therapy, **AND**

Patient must have previously received PBS-subsidised therapy for HIV infection.

Population criteria:

Patient must be aged 2 years or older.

raltegravir 100 mg tablet: chewable, 60

2760G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	6	5	..	*2025.00	Isentress [MK]

raltegravir 25 mg tablet: chewable, 60

2736B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	6	5	..	*506.28	Isentress [MK]

■ ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

■ ANTINEOPLASTIC AGENTS

ANTIMETABOLITES

Pyrimidine analogues

■ AZACITIDINE

Authority required

Initial PBS-subsidised treatment of a patient with:

(1) Myelodysplastic syndrome classified as Intermediate-2 or high risk according to the International Prognostic Scoring System (IPSS); OR

(2) Chronic Myelomonocytic Leukaemia (10% to 29% marrow blasts without Myeloproliferative Disorder); OR

(3) Acute Myeloid Leukaemia with 20 to 30% marrow blasts and multi-lineage dysplasia, according to World Health Organisation (WHO) Classification.

Classification of a patient as Intermediate-2 requires a score of 1.5 to 2.0 on the IPSS, achieved with the possible combinations:

1. 11% to 30% marrow blasts with good karyotypic status (normal, -Y alone, del(5q) alone, del(20q) alone), and 0 to 1 cytopenias; OR
2. 11% to 20% marrow blasts with intermediate karyotypic status (other abnormalities), and 0 to 1 cytopenias; OR
3. 11% to 20% marrow blasts with good karyotypic status (normal, -Y alone, del(5q) alone, del(20q) alone), and 2 to 3 cytopenias; OR
4. 5% to 10% marrow blasts with poor karyotypic status (3 or more abnormalities or chromosome 7 anomalies), regardless of cytopenias; OR
5. 5% to 10% marrow blasts with intermediate karyotypic status (other abnormalities), and 2 to 3 cytopenias; OR
6. less than 5% marrow blasts with poor karyotypic status (3 or more abnormalities or chromosome 7 anomalies), and 2 to 3 cytopenias.

Classification of a patient as high risk requires a score of 2.5 or more on the IPSS, achieved with the possible combinations:

1. 21% to 30% marrow blasts with good karyotypic status (normal, -Y alone, del(5q) alone, del(20q) alone), and 2 to 3 cytopenias; OR
2. 21% to 30% marrow blasts with intermediate (other abnormalities) or poor karyotypic status (3 or more abnormalities or chromosome 7 anomalies), regardless of cytopenias; OR
3. 11% to 20% marrow blasts with poor karyotypic status (3 or more abnormalities or chromosome 7 anomalies), regardless of cytopenias; OR
4. 11% to 20% marrow blasts with intermediate karyotypic status (other abnormalities), and 2 to 3 cytopenias.

The first authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Azacitidine PBS Authority Application - Supporting Information Form; and
- (c) a copy of the bone marrow biopsy report demonstrating that the patient has myelodysplastic syndrome, chronic myelomonocytic leukaemia or acute myeloid leukaemia; and
- (d) a copy of the full blood examination report; and
- (e) for myelodysplastic syndrome, a copy of the pathology report detailing the cytogenetics demonstrating intermediate-2 or high risk disease according to the International Prognostic Scoring System (IPSS); and
- (f) a signed patient acknowledgment form.

No more than three cycles will be authorised

Note

Any queries concerning the arrangements to prescribe azacitidine may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe azacitidine should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

Special Pricing Arrangements apply.

azacitidine 100 mg injection, 1 x 100 mg vial

9597D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	14	2	..	*7700.00	Vidaza [CJ]

■ AZACITIDINE

Authority required

Continuing treatment of a patient with:

- (1) Myelodysplastic syndrome classified as Intermediate-2 or high risk according to the International Prognostic Scoring System (IPSS); OR
- (2) Chronic Myelomonocytic Leukaemia (10% to 29% marrow blasts without Myeloproliferative Disorder); OR
- (3) Acute Myeloid Leukaemia with 20 to 30% blasts and multi-lineage dysplasia, according to World Health Organisation (WHO) Classification;

who has previously been issued with an authority prescription for azacitidine and does not have progressive disease.

Authority applications for continuing treatment may be made by telephone on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Up to six cycles will be authorised

Note

Any queries concerning the arrangements to prescribe azacitidine may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe azacitidine should be forwarded to:
Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

Special Pricing Arrangements apply.

azacitidine 100 mg injection, 1 x 100 mg vial

9598E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	14	5	..	*7700.00	Vidaza [CJ]

CYTOTOXIC ANTIBIOTICS AND RELATED SUBSTANCES

Anthracyclines and related substances

■ DOXORUBICIN HYDROCHLORIDE-PEGYLATED LIPOSOMAL

Authority required (STREAMLINED)

3348

Treatment of AIDS-related Kaposi's sarcoma in patients with CD4 cell counts of less than 200 per cubic millimetre and extensive mucocutaneous involvement

Authority required (STREAMLINED)

3349

Treatment of AIDS-related Kaposi's sarcoma in patients with CD4 cell counts of less than 200 per cubic millimetre and extensive visceral involvement

doxorubicin hydrochloride-pegylated liposomal 20 mg/10 mL injection, 1 x 10 mL vial

5705G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	4	5	..	*2093.24	^a Caelyx [JC]	^a Liposomal Doxorubicin SUN [ZF]

■ IMMUNOSTIMULANTS

IMMUNOSTIMULANTS

Colony stimulating factors

■ FILGRASTIM

Authority required (STREAMLINED)

3357

For use in a patient undergoing induction and consolidation therapy for acute myeloid leukaemia

Authority required (STREAMLINED)

3358

Mobilisation of peripheral blood progenitor cells to facilitate harvest of such cells for autologous transplantation into a patient with a non-myeloid malignancy who has had myeloablative or myelosuppressive therapy

Authority required (STREAMLINED)

3359

Mobilisation of peripheral blood progenitor cells, in a normal volunteer, for use in allogeneic transplantation

Authority required (STREAMLINED)

3360

A patient receiving marrow-ablative chemotherapy and subsequent bone marrow transplantation

Authority required (STREAMLINED)

3361

A patient with a non-myeloid malignancy receiving marrow-ablative chemotherapy and subsequent autologous peripheral blood progenitor cell transplantation

Authority required (STREAMLINED)

3368

A patient with chronic cyclic neutropenia (absolute neutrophil count of less than 500 million cells per litre lasting for 3 days per cycle, measured over 3 separate cycles, and, either having experienced a life-threatening infectious episode requiring hospitalisation and treatment with intravenous antibiotics, or having recurrent clinically significant infections (a minimum of 3 in the previous 12 months))

Authority required (STREAMLINED)

3369

A patient with inoperable Stage III, IVa or IVb squamous cell carcinoma of the oral cavity, larynx, oropharynx or hypopharynx receiving neoadjuvant treatment with docetaxel in combination with cisplatin and fluorouracil who has had a prior episode of febrile neutropenia or prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required (STREAMLINED)

3362

A patient with breast cancer receiving standard dose adjuvant chemotherapy who has had a prior episode of febrile neutropenia or prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required (STREAMLINED)

3363

A patient receiving chemotherapy for B-cell chronic lymphocytic leukaemia with fludarabine and cyclophosphamide who has had a prior episode of febrile neutropenia or prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required (STREAMLINED)

3364

A patient receiving first-line chemotherapy for Hodgkin disease who has had a prior episode of febrile neutropenia or prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required (STREAMLINED)

3365

A patient receiving chemotherapy for myeloma who has had a prior episode of febrile neutropenia, and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required (STREAMLINED)

3366

A patient with severe congenital neutropenia (absolute neutrophil count of less than 100 million cells per litre measured on 3 occasions, with readings at least 2 weeks apart, and in whom a bone marrow examination has shown evidence of maturational arrest of the neutrophil lineage)

Authority required (STREAMLINED)

3367

A patient with severe chronic neutropenia (absolute neutrophil count of less than 1,000 million cells per litre measured on 3 occasions, with readings at least 2 weeks apart, or evidence of neutrophil dysfunction, and, either having experienced a life-threatening infectious episode requiring hospitalisation and treatment with intravenous antibiotics in the previous 12 months, or having recurrent clinically significant infections (a minimum of 3 in the previous 12 months))

Authority required (STREAMLINED)

3370

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in acute lymphoblastic leukaemia

Authority required (STREAMLINED)

3371

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in breast cancer (adjuvant chemotherapy with docetaxel in combination with an anthracycline and cyclophosphamide)

Authority required (STREAMLINED)

3372

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in germ cell tumours

Authority required (STREAMLINED)

3373

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in infants and children with CNS tumours

Authority required (STREAMLINED)

3374

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in neuroblastoma

Authority required (STREAMLINED)

3375

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in non-Hodgkin lymphoma (aggressive grades; or low grade receiving an anthracycline-containing regimen)

Authority required (STREAMLINED)

3376

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in relapsed Hodgkin disease

Authority required (STREAMLINED)

3377

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in sarcoma

Authority required (STREAMLINED)

3834

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in Hodgkin disease (first-line chemotherapy with escalated BEACOPP)

filgrastim 120 microgram/0.2 mL injection, 10 x 0.2 mL syringes

5829T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*853.28	Nivestim [HH]

filgrastim 300 microgram/0.5 mL injection, 10 x 0.5 mL syringes

1123D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*2133.18	TevaGrastim [AS]

filgrastim 300 microgram/0.5 mL injection, 10 x 0.5 mL syringes

5742F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*2133.18	Neupogen [AN]

filgrastim 300 microgram/0.5 mL injection, 10 x 0.5 mL syringes

9692D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*2133.18	Nivestim [HH]

filgrastim 300 microgram/0.5 mL injection, 5 x 0.5 mL syringes

2758E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	4	11	..	*2133.16	Zarzio [SZ]

filgrastim 300 microgram/mL injection, 10 x 1 mL vials

5741E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*2133.18	Neupogen [AN]

filgrastim 480 microgram/0.5 mL injection, 10 x 0.5 mL syringes

5744H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*3419.62	Neupogen [AN]

filgrastim 480 microgram/0.5 mL injection, 10 x 0.5 mL syringes

9694F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*3419.62	Nivestim [HH]

filgrastim 480 microgram/0.5 mL injection, 5 x 0.5 mL syringes

2783L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	4	11	..	*3419.60	Zarzio [SZ]

filgrastim 480 microgram/0.8 mL injection, 10 x 0.8 mL syringes

1126G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*3419.62	TevaGrastim [AS]

filgrastim 480 microgram/1.6 mL injection, 10 x 1.6 mL vials

5743G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*3419.62	Neupogen [AN]

■ **LENOGRASTIM****Authority required (STREAMLINED)****3395**

Patients with breast cancer receiving standard dose adjuvant chemotherapy who have had a prior episode of febrile neutropenia or prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required (STREAMLINED)**3396**

Patients receiving first-line chemotherapy for Hodgkin's disease who have had a prior episode of febrile neutropenia or prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required (STREAMLINED)**3392**

Mobilisation of peripheral blood progenitor cells to facilitate harvest of such cells for reinfusion into patients with non-myeloid malignancies who have had myeloablative or myelosuppressive therapy

Authority required (STREAMLINED)**3393**

Mobilisation of peripheral blood progenitor cells, in normal volunteers, for use in allogeneic transplantation to facilitate harvest of such cells in healthy donors

Authority required (STREAMLINED)**3394**

Patients with non-myeloid malignancies receiving marrow-ablative chemotherapy and subsequent peripheral blood progenitor cell or bone marrow transplantation

Authority required (STREAMLINED)**3397**

Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in acute lymphoblastic leukaemia

Authority required (STREAMLINED)**3398**

Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in Ewing's sarcoma

Authority required (STREAMLINED)**3399**

Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in germ cell tumours

Authority required (STREAMLINED)**3400**

Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in infants and children with CNS tumours

Authority required (STREAMLINED)**3401**

Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in neuroblastoma

Authority required (STREAMLINED)**3402**

Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in non-Hodgkin's lymphoma (intermediate or high grade)

Authority required (STREAMLINED)**3403**

Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in osteosarcoma

Authority required (STREAMLINED)**3404**

Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in relapsed Hodgkin's disease

Authority required (STREAMLINED)**3405**

Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in rhabdomyosarcoma

LENOGRASTIM Powder for injection 13,400,000 i.u. (105 micrograms) vial, 10

5787N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*1025.00	Granocyte 13 [HH]

LENOGRASTIM Powder for injection 33,600,000 i.u. (263 micrograms) vial, 10

5788P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*2567.20	Granocyte 34 [HH]

■ PEGFILGRASTIM**Authority required (STREAMLINED)****3357**

For use in a patient undergoing induction and consolidation therapy for acute myeloid leukaemia

Authority required (STREAMLINED)**3362**

A patient with breast cancer receiving standard dose adjuvant chemotherapy who has had a prior episode of febrile neutropenia or prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required (STREAMLINED)**3363**

A patient receiving chemotherapy for B-cell chronic lymphocytic leukaemia with fludarabine and cyclophosphamide who has had a prior episode of febrile neutropenia or prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required (STREAMLINED)**3364**

A patient receiving first-line chemotherapy for Hodgkin disease who has had a prior episode of febrile neutropenia or prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required (STREAMLINED)

3365

A patient receiving chemotherapy for myeloma who has had a prior episode of febrile neutropenia, and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required (STREAMLINED)

3369

A patient with inoperable Stage III, IVa or IVb squamous cell carcinoma of the oral cavity, larynx, oropharynx or hypopharynx receiving neoadjuvant treatment with docetaxel in combination with cisplatin and fluorouracil who has had a prior episode of febrile neutropenia or prolonged severe neutropenia (neutrophil count of less than 1,000 million cells per litre), and for whom there is clinical justification for wishing to continue therapy with the same drug combination, dosage and treatment schedule, and for whom a good response to treatment is anticipated providing chemotherapy can be delivered as planned

Authority required (STREAMLINED)

3370

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in acute lymphoblastic leukaemia

Authority required (STREAMLINED)

3371

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in breast cancer (adjuvant chemotherapy with docetaxel in combination with an anthracycline and cyclophosphamide)

Authority required (STREAMLINED)

3372

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in germ cell tumours

Authority required (STREAMLINED)

3373

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in infants and children with CNS tumours

Authority required (STREAMLINED)

3374

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in neuroblastoma

Authority required (STREAMLINED)

3375

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in non-Hodgkin lymphoma (aggressive grades; or low grade receiving an anthracycline-containing regimen)

Authority required (STREAMLINED)

3376

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in relapsed Hodgkin disease

Authority required (STREAMLINED)

3377

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in sarcoma

Authority required (STREAMLINED)

3834

A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in Hodgkin disease (first-line chemotherapy with escalated BEACOPP)

pegfilgrastim 6 mg/0.6 mL injection, 1 x 0.6 mL syringe

9514R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	11	..	1925.00	Neulasta [AN]

Interferons

▪ **INTERFERON ALFA-2A**

Caution

Treatment with interferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required (STREAMLINED)

3382

Use in the treatment of Philadelphia chromosome positive myelogenous leukaemia in the chronic phase

Authority required (STREAMLINED)

3961

Chronic hepatitis B in a patient without cirrhosis who satisfies all of the following criteria:

- (1) Elevated HBV DNA levels - greater than 20,000 IU/mL (100,000 copies/mL) if HBeAg positive, or greater than 2,000 IU/mL (10,000 copies/mL) if HBeAg negative - in conjunction with documented chronic hepatitis B infection;
- (2) Evidence of chronic liver injury as determined by:
- (a) Confirmed elevated serum ALT; or
- (b) Liver biopsy

Authority required (STREAMLINED)

3962

Chronic hepatitis B in a patient with cirrhosis who has detectable HBV DNA.

Persons with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy

interferon alfa-2a 3 million international units/0.5 mL injection, 1 x 0.5 mL syringe

5759D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	30	5	..	*894.00	Roferon-A [RO]

interferon alfa-2a 4.5 million international units/0.5 mL injection, 1 x 0.5 mL syringe

5760E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	30	5	..	*1341.00	Roferon-A [RO]

interferon alfa-2a 6 million international units/0.5 mL injection, 1 x 0.5 mL syringe

5761F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	30	5	..	*1787.40	Roferon-A [RO]

interferon alfa-2a 9 million international units/0.5 mL injection, 1 x 0.5 mL syringe

5762G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	30	5	..	*2681.40	Roferon-A [RO]

■ **INTERFERON ALFA-2B**

Caution

Treatment with interferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required (STREAMLINED)

3384

Adjunctive therapy of malignant melanoma following surgery in patients with nodal involvement

Authority required (STREAMLINED)

3382

Use in the treatment of Philadelphia chromosome positive myelogenous leukaemia in the chronic phase

Authority required (STREAMLINED)

3961

Chronic hepatitis B in a patient without cirrhosis who satisfies all of the following criteria:

- (1) Elevated HBV DNA levels - greater than 20,000 IU/mL (100,000 copies/mL) if HBeAg positive, or greater than 2,000 IU/mL (10,000 copies/mL) if HBeAg negative - in conjunction with documented chronic hepatitis B infection;
- (2) Evidence of chronic liver injury as determined by:
- (a) Confirmed elevated serum ALT; or
- (b) Liver biopsy

Authority required (STREAMLINED)

3962

Chronic hepatitis B in a patient with cirrhosis who has detectable HBV DNA.

Persons with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy

interferon alfa-2b 10 million international units/mL injection, 5 x 1 mL vials

5768N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	3	5	..	*1489.50	Intron A [MK]

interferon alfa-2b 18 million international units/1.2 mL injection, 1 x 1.2 mL cartridge

5763H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*357.48	Intron A Redipen [MK]

interferon alfa-2b 18 million international units/3 mL injection, 1 x 3 mL vial

5766L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	15	5	..	*2681.10	Intron A [MK]

interferon alfa-2b 25 million international units/2.5 mL injection, 1 x 2.5 mL vial

5767M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	15	5	..	*3723.75	Intron A [MK]

interferon alfa-2b 30 million international units/1.2 mL injection, 1 x 1.2 mL cartridge

5764J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*595.80	Intron A Redipen [MK]

interferon alfa-2b 60 million international units/1.2 mL injection, 1 x 1.2 mL cartridge

5765K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1191.60	Intron A Redipen [MK]

■ INTERFERON GAMMA-1B
Authority required (STREAMLINED)
3385

Treatment of chronic granulomatous disease in patients with frequent and severe infections despite adequate prophylaxis with antimicrobial agents

interferon gamma-1b 2 million international units (100 microgram/0.5 mL) injection, 6 x 0.5 mL vials

5769P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	11	..	*2721.80	Imukin [BY]

■ PEGINTERFERON ALFA-2A
Caution

Treatment with peginterferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Authority required (STREAMLINED)
3977

Treatment, as sole PBS-subsidised therapy, in a patient with chronic hepatitis B without cirrhosis who satisfies all of the following criteria:

- (1) Elevated HBV DNA levels - greater than 20,000 IU/mL (100,000 copies/mL) if HBeAg positive, or greater than 2,000 IU/mL (10,000 copies/mL) if HBeAg negative - in conjunction with documented chronic hepatitis B infection;
- (2) Evidence of chronic liver injury as determined by:
 - (a) Confirmed elevated serum ALT; or
 - (b) Liver biopsy;
- (3) Has received no prior peginterferon alfa therapy for the treatment of hepatitis B

Authority required (STREAMLINED)
3978

Treatment, as sole PBS-subsidised therapy, in a patient with chronic hepatitis B with cirrhosis who has detectable HBV DNA. Persons with Child's class B or C cirrhosis (ascites, variceal bleeding, encephalopathy, albumin less than 30 g per L, bilirubin greater than 30 micromoles per L) should have their treatment discussed with a transplant unit prior to initiating therapy.

Treatment is limited to 1 course of treatment for a duration of up to 48 weeks

Authority required (STREAMLINED)
3412

Treatment, managed by an accredited treatment centre, of chronic hepatitis C in patients 18 years or older who have compensated liver disease and who have received no prior interferon alfa or peginterferon alfa treatment for hepatitis C and have a contraindication to ribavirin, who satisfy all of the following criteria:

- (1) Documented chronic hepatitis C infection (repeatedly anti-HCV positive and HCV RNA positive);
- (2) Female patients of child-bearing age are not pregnant, not breast-feeding, and are using an effective form of contraception.

The treatment course is limited to up to 48 weeks.

Patients may only continue treatment after the first 12 weeks if the result of an HCV RNA quantitative assay (performed at the same laboratory using the same test) shows that the plasma HCV RNA has become undetectable or the viral load has decreased by at least a 2 log drop

Note

Treatment centres are required to have access to the following appropriate specialist facilities for the provision of clinical support services for hepatitis C:

- (a) a nurse educator/counsellor for patients; and
- (b) 24 hour access by patients to medical advice; and
- (c) an established liver clinic; and

- (d) facilities for safe liver biopsy.

peginterferon alfa-2a 135 microgram/0.5 mL injection, 4 x 0.5 mL syringes

9515T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2331.80	Pegasys [RO]

peginterferon alfa-2a 180 microgram/0.5 mL injection, 4 x 0.5 mL syringes

9516W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2700.46	Pegasys [RO]

■ PEGINTERFERON ALFA-2A (&) RIBAVIRIN**Caution**

Treatment with peginterferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Ribavirin is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and during the 6 months period after cessation of treatment.

Authority required (STREAMLINED)**4184**

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must have failed prior treatment with interferon based therapies (non-pegylated or pegylated), **AND**

Patient must have received no more than one prior treatment with interferon alfa or peginterferon alfa for hepatitis C if using peginterferon and ribavirin without an NS3 protease inhibitor, or, in triple combination therapy with boceprevir; OR

Patient must have received prior treatment with interferon alfa or peginterferon alfa for hepatitis C if using peginterferon and ribavirin in triple combination therapy with telaprevir; OR

Patient must have received prior treatment with interferon alfa or peginterferon alfa for hepatitis C if using peginterferon and ribavirin in triple combination therapy with simeprevir, **AND**

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with telaprevir who were prior treatment relapsers and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 4 and 12; OR

The treatment must be limited to a maximum duration of 36 weeks in patients using peginterferon and ribavirin in triple combination therapy with boceprevir who were prior treatment partial responders or relapsers and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 8 and 12; OR

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir who were prior treatment relapsers and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at week 4; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin without an NS3 protease inhibitor; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with boceprevir who: (i) were prior treatment null responders; or (ii) were prior treatment partial responders or relapsers and in whom plasma HCV RNA is detectable by an HCV RNA qualitative assay at week 8, and undetectable by an HCV RNA qualitative assay at week 12; or (iii) have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with telaprevir who: (i) were prior treatment partial or null responders; or (ii) were prior treatment relapsers and for whom the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is detectable but less than or equal to 1000 IU/mL; or (iii) have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir who: (i) were prior treatment partial or null responders; or (ii) were prior treatment relapsers and for whom the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is detectable but less than 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin without an NS3 protease inhibitor if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with boceprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with boceprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than 1000 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than or equal to 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic genotype 1 hepatitis C infection (repeatedly anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Authority required (STREAMLINED)
4197

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with telaprevir and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 4 and 12; OR

The treatment must be limited to a maximum duration of 28 weeks in patients using peginterferon and ribavirin in triple combination therapy with boceprevir and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 8 and 24; OR

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir and in whom plasma HCV RNA is undetectable by an HCV RNA quantitative assay at week 4; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin without an NS3 protease inhibitor; OR

The treatment must be limited to a maximum duration of 48 weeks in patients: (i) using peginterferon and ribavirin in triple combination therapy with boceprevir and in whom plasma HCV RNA is detectable by an HCV RNA qualitative assay at week 8, and undetectable by an HCV RNA qualitative assay at week 24; or (ii) using peginterferon and ribavirin in triple combination therapy with boceprevir who have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients: (i) using peginterferon and ribavirin in triple combination therapy with telaprevir and for whom the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is detectable but less than or equal to 1000 IU/mL; or (ii) using peginterferon and ribavirin in triple combination therapy with telaprevir who have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir and for whom the results of an HCV RNA qualitative assay at week 4 show that the plasma HCV RNA is detectable but less than 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin without an NS3 protease inhibitor unless the results of an HCV RNA quantitative assay at week 12 (performed at the same laboratory using the same test) show that plasma HCV RNA has become undetectable or the viral load has decreased by at least a 2 log drop, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with boceprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than 1000 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than or equal to 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

For patients using peginterferon and ribavirin without an NS3 protease inhibitor who are viral negative at week 12, an HCV RNA qualitative assay at week 24 is unnecessary.

Authority required (STREAMLINED)
4206

Chronic non-genotype 1 hepatitis C infection

Clinical criteria:

The treatment must be the sole PBS-subsidised treatment for hepatitis C, **AND**

Patient must have compensated liver disease, **AND**

The condition must be genotype 2, 3, 4, 5 or 6 hepatitis C, **AND**
 Patient must have failed prior treatment with interferon based therapies (non-pegylated or pegylated), **AND**
 Patient must have received no more than one prior treatment with interferon alfa or peginterferon alfa for hepatitis C, **AND**
 The treatment must be limited to a maximum duration of 48 weeks, **AND**
 The treatment must cease if HCV RNA is detectable by an HCV RNA qualitative assay at week 12.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

4187

Chronic non-genotype 1 hepatitis C infection

Clinical criteria:

The treatment must be the sole PBS-subsidised treatment for hepatitis C, **AND**

Patient must have compensated liver disease, **AND**

Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**

The condition must be genotype 2, 3, 4, 5 or 6 hepatitis C, **AND**

The treatment must be limited to a maximum duration of 24 weeks for patients with genotype 2 or 3 hepatitis C without hepatic cirrhosis or bridging fibrosis; OR

The treatment must be limited to a maximum duration of 48 weeks for patients with genotype 4, 5 or 6 hepatitis C; OR

The treatment must be limited to a maximum duration of 48 weeks for patients with genotype 2 or 3 hepatitis C with hepatic cirrhosis or bridging fibrosis, **AND**

The treatment must cease in patients with genotype 4, 5, or 6 hepatitis C unless the results of an HCV RNA quantitative assay at week 12 (performed at the same laboratory using the same test) shows that plasma HCV RNA has become undetectable or the viral load has decreased by at least a 2 log drop, **AND**

The treatment must cease in patients eligible for 48 weeks of treatment if HCV RNA is detectable by an HCV RNA qualitative assay at week 24.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

For patients with genotype 4, 5, or 6 who are viral negative at week 12, an HCV RNA qualitative assay at week 24 is unnecessary.

For patients with genotype 2 or 3 without cirrhosis, an HCV RNA assay at week 12 is unnecessary because of the high likelihood of early viral response by week 12.

For patients who are eligible for 24 weeks of treatment, a maximum of 2 repeats may be prescribed.

For patients who are eligible for 48 weeks of treatment, a maximum of 5 repeats may be prescribed.

Note

Treatment centres are required to have access to the following appropriate specialist facilities for the provision of clinical support services for hepatitis C:

- (a) a nurse educator/counsellor for patients; and
- (b) 24-hour access by patients to medical advice; and

- (c) an established liver clinic.

peginterferon alfa-2a 135 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [168 tablets], 1 pack

9524G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3072.84	Pegasys RBV [RO]

peginterferon alfa-2a 180 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [112 tablets], 1 pack

9525H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3085.28	Pegasys RBV [RO]

peginterferon alfa-2a 180 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [140 tablets], 1 pack

9526J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3245.82	Pegasys RBV [RO]

peginterferon alfa-2a 180 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [168 tablets], 1 pack

9527K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3406.36	Pegasys RBV [RO]

■ PEGINTERFERON ALFA-2B (&) RIBAVIRIN**Caution**

Treatment with peginterferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Ribavirin is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and during the 6 months period after cessation of treatment.

Authority required (STREAMLINED)**4184**

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must have failed prior treatment with interferon based therapies (non-pegylated or pegylated), **AND**

Patient must have received no more than one prior treatment with interferon alfa or peginterferon alfa for hepatitis C if using peginterferon and ribavirin without an NS3 protease inhibitor, or, in triple combination therapy with boceprevir; OR

Patient must have received prior treatment with interferon alfa or peginterferon alfa for hepatitis C if using peginterferon and ribavirin in triple combination therapy with telaprevir; OR

Patient must have received prior treatment with interferon alfa or peginterferon alfa for hepatitis C if using peginterferon and ribavirin in triple combination therapy with simeprevir, **AND**

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with telaprevir who were prior treatment relapsers and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 4 and 12; OR

The treatment must be limited to a maximum duration of 36 weeks in patients using peginterferon and ribavirin in triple combination therapy with boceprevir who were prior treatment partial responders or relapsers and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 8 and 12; OR

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir who were prior treatment relapsers and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at week 4; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin without an NS3 protease inhibitor; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with boceprevir who: (i) were prior treatment null responders; or (ii) were prior treatment partial responders or relapsers and in whom plasma HCV RNA is detectable by an HCV RNA qualitative assay at week 8, and undetectable by an HCV RNA qualitative assay at week 12; or (iii) have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with telaprevir who: (i) were prior treatment partial or null responders; or (ii) were prior treatment relapsers and for whom the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is detectable but less than or equal to 1000 IU/mL; or (iii) have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir who: (i) were prior treatment partial or null responders; or (ii) were prior treatment relapsers and for whom the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is detectable but less than 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin without an NS3 protease inhibitor if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with boceprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with boceprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than 1000 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than or equal to 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic genotype 1 hepatitis C infection (repeatedly anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Authority required (STREAMLINED)

4197

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with telaprevir and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 4 and 12; OR

The treatment must be limited to a maximum duration of 28 weeks in patients using peginterferon and ribavirin in triple combination therapy with boceprevir and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 8 and 24; OR

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir and in whom plasma HCV RNA is undetectable by an HCV RNA quantitative assay at week 4; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin without an NS3 protease inhibitor; OR

The treatment must be limited to a maximum duration of 48 weeks in patients: (i) using peginterferon and ribavirin in triple combination therapy with boceprevir and in whom plasma HCV RNA is detectable by an HCV RNA qualitative assay at week 8, and undetectable by an HCV RNA qualitative assay at week 24; or (ii) using peginterferon and ribavirin in triple combination therapy with boceprevir who have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients: (i) using peginterferon and ribavirin in triple combination therapy with telaprevir and for whom the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is detectable but less than or equal to 1000 IU/mL; or (ii) using peginterferon and ribavirin in triple combination therapy with telaprevir who have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir and for whom the results of an HCV RNA qualitative assay at week 4 show that the plasma HCV RNA is detectable but less than 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin without an NS3 protease inhibitor unless the results of an HCV RNA quantitative assay at week 12 (performed at the same laboratory using the same test) show that plasma HCV RNA has become undetectable or the viral load has decreased by at least a 2 log drop, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with boceprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than 1000 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than or equal to 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

For patients using peginterferon and ribavirin without an NS3 protease inhibitor who are viral negative at week 12, an HCV RNA qualitative assay at week 24 is unnecessary.

Authority required (STREAMLINED)

4206

Chronic non-genotype 1 hepatitis C infection

Clinical criteria:

The treatment must be the sole PBS-subsidised treatment for hepatitis C, **AND**
Patient must have compensated liver disease, **AND**
The condition must be genotype 2, 3, 4, 5 or 6 hepatitis C, **AND**
Patient must have failed prior treatment with interferon based therapies (non-pegylated or pegylated), **AND**
Patient must have received no more than one prior treatment with interferon alfa or peginterferon alfa for hepatitis C, **AND**
The treatment must be limited to a maximum duration of 48 weeks, **AND**
The treatment must cease if HCV RNA is detectable by an HCV RNA qualitative assay at week 12.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)
4187

Chronic non-genotype 1 hepatitis C infection

Clinical criteria:

The treatment must be the sole PBS-subsidised treatment for hepatitis C, **AND**

Patient must have compensated liver disease, **AND**

Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**

The condition must be genotype 2, 3, 4, 5 or 6 hepatitis C, **AND**

The treatment must be limited to a maximum duration of 24 weeks for patients with genotype 2 or 3 hepatitis C without hepatic cirrhosis or bridging fibrosis; OR

The treatment must be limited to a maximum duration of 48 weeks for patients with genotype 4, 5 or 6 hepatitis C; OR

The treatment must be limited to a maximum duration of 48 weeks for patients with genotype 2 or 3 hepatitis C with hepatic cirrhosis or bridging fibrosis, **AND**

The treatment must cease in patients with genotype 4, 5, or 6 hepatitis C unless the results of an HCV RNA quantitative assay at week 12 (performed at the same laboratory using the same test) shows that plasma HCV RNA has become undetectable or the viral load has decreased by at least a 2 log drop, **AND**

The treatment must cease in patients eligible for 48 weeks of treatment if HCV RNA is detectable by an HCV RNA qualitative assay at week 24.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

For patients with genotype 4, 5, or 6 who are viral negative at week 12, an HCV RNA qualitative assay at week 24 is unnecessary.

For patients with genotype 2 or 3 without cirrhosis, an HCV RNA assay at week 12 is unnecessary because of the high likelihood of early viral response by week 12.

For patients who are eligible for 24 weeks of treatment, a maximum of 2 repeats may be prescribed.

For patients who are eligible for 48 weeks of treatment, a maximum of 5 repeats may be prescribed.

Note

Treatment centres are required to have access to the following appropriate specialist facilities for the provision of clinical support services for hepatitis C:

- (a) a nurse educator/counsellor for patients; and
- (b) 24-hour access by patients to medical advice; and

- (c) an established liver clinic.

peginterferon alfa-2b 120 microgram injection [4 x 120 microgram cartridges] (&) ribavirin 200 mg capsule [140 capsules] (&) inert substance diluent [4 x 0.5 mL cartridges], 1 pack

9536X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3491.58	Pegatron [MK]

peginterferon alfa-2b 150 microgram injection [4 x 150 microgram cartridges] (&) ribavirin 200 mg capsule [140 capsules] (&) inert substance diluent [4 x 0.5 mL cartridges], 1 pack

9538B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*4079.52	Pegatron [MK]

peginterferon alfa-2b 150 microgram injection [4 x 150 microgram cartridges] (&) ribavirin 200 mg capsule [168 capsules] (&) inert substance diluent [4 x 0.5 mL cartridges], 1 pack

9539C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*4079.52	Pegatron [MK]

peginterferon alfa-2b 150 microgram injection [4 x 150 microgram cartridges] (&) ribavirin 200 mg capsule [196 capsules] (&) inert substance diluent [4 x 0.5 mL cartridges], 1 pack

9540D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*4364.48	Pegatron [MK]

peginterferon alfa-2b 80 microgram injection [4 x 80 microgram cartridges] (&) ribavirin 200 mg capsule [140 capsules] (&) inert substance diluent [4 x 0.5 mL cartridges], 1 pack

9531P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2707.66	Pegatron [MK]

■ PEGINTERFERON ALFA-2B (&) RIBAVIRIN

Caution

Treatment with peginterferon alfa has been associated with depression and suicide in some patients. Patients with a history of suicidal ideation or depressive illness should be warned of the risks. Psychiatric status during therapy should be monitored.

Ribavirin is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and during the 6 months period after cessation of treatment.

Authority required (STREAMLINED)

4189

Chronic genotype 1 hepatitis C infection

Clinical criteria:

The treatment must be the sole PBS-subsidised treatment for hepatitis C, **AND**

Patient must have compensated liver disease, **AND**

Patient must have failed prior treatment with interferon based therapies (non-pegylated or pegylated), **AND**

Patient must have received no more than one prior treatment with interferon alfa or peginterferon alfa for hepatitis C, **AND**

The treatment must be limited to a maximum duration of 48 weeks, **AND**

The treatment must cease if HCV RNA is detectable by an HCV RNA qualitative assay at week 12.

Population criteria:

Patient must weigh at least 27 kg, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic genotype 1 hepatitis C infection (repeatedly anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Authority required (STREAMLINED)

4198

Chronic genotype 1 hepatitis C infection

Clinical criteria:

The treatment must be the sole PBS-subsidised treatment for hepatitis C, **AND**

Patient must have compensated liver disease, **AND**

Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**

The treatment must be limited to a maximum duration of 48 weeks, **AND**

The treatment must cease unless the results of an HCV RNA quantitative assay at week 12 (performed at the same laboratory using the same test) show that plasma HCV RNA has become undetectable or the viral load has decreased by at least a 2 log drop.

Population criteria:

Patient must weigh at least 27 kg, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

For patients who are viral negative at week 12, an HCV RNA qualitative assay at week 24 is unnecessary.

Authority required (STREAMLINED)

4199

Chronic non-genotype 1 hepatitis C infection

Clinical criteria:

The treatment must be the sole PBS-subsidised treatment for hepatitis C, **AND**

Patient must have compensated liver disease, **AND**

The condition must be genotype 2, 3, 4, 5 or 6 hepatitis C, **AND**

Patient must have failed prior treatment with interferon based therapies (non-pegylated or pegylated), **AND**

Patient must have received no more than one prior treatment with interferon alfa or peginterferon alfa for hepatitis C, **AND**

The treatment must be limited to a maximum duration of 48 weeks, **AND**

The treatment must cease if HCV RNA is detectable by an HCV RNA qualitative assay at week 12.

Population criteria:

Patient must weigh at least 27 kg, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Authority required (STREAMLINED)**4192**

Chronic non-genotype 1 hepatitis C infection

Clinical criteria:

The treatment must be the sole PBS-subsidised treatment for hepatitis C, **AND**

Patient must have compensated liver disease, **AND**

Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**

The condition must be genotype 2, 3, 4, 5 or 6 hepatitis C, **AND**

The treatment must be limited to a maximum duration of 24 weeks for patients with genotype 2 or 3 hepatitis C without hepatic cirrhosis or bridging fibrosis; OR

The treatment must be limited to a maximum duration of 48 weeks for patients with genotype 4, 5 or 6 hepatitis C; OR

The treatment must be limited to a maximum duration of 48 weeks for patients with genotype 2 or 3 hepatitis C with hepatic cirrhosis or bridging fibrosis, **AND**

The treatment must cease in patients with genotype 4, 5, or 6 hepatitis C unless the results of an HCV RNA quantitative assay at week 12 (performed at the same laboratory using the same test) shows that plasma HCV RNA has become undetectable or the viral load has decreased by at least a 2 log drop, **AND**

The treatment must cease in patients eligible for 48 weeks of treatment if HCV RNA is detectable by an HCV RNA qualitative assay at week 24.

Population criteria:

Patient must weigh at least 27 kg, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

For patients with genotype 4, 5, or 6 who are viral negative at week 12, an HCV RNA qualitative assay at week 24 is unnecessary.

For patients with genotype 2 or 3 without cirrhosis, an HCV RNA assay at week 12 is unnecessary because of the high likelihood of early viral response by week 12.

For patients who are eligible for 24 weeks of treatment, a maximum of 2 repeats may be prescribed.

For patients who are eligible for 48 weeks of treatment, a maximum of 5 repeats may be prescribed.

Authority required (STREAMLINED)**4184**

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must have failed prior treatment with interferon based therapies (non-pegylated or pegylated), **AND**

Patient must have received no more than one prior treatment with interferon alfa or peginterferon alfa for hepatitis C if using peginterferon and ribavirin without an NS3 protease inhibitor, or, in triple combination therapy with boceprevir; OR

Patient must have received prior treatment with interferon alfa or peginterferon alfa for hepatitis C if using peginterferon and ribavirin in triple combination therapy with telaprevir; OR

Patient must have received prior treatment with interferon alfa or peginterferon alfa for hepatitis C if using peginterferon and ribavirin in triple combination therapy with simeprevir, **AND**

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with telaprevir who were prior treatment relapsers and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 4 and 12; OR

The treatment must be limited to a maximum duration of 36 weeks in patients using peginterferon and ribavirin in triple combination therapy with boceprevir who were prior treatment partial responders or relapsers and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 8 and 12; OR

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir who were prior treatment relapsers and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at week 4; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin without an NS3 protease inhibitor; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with boceprevir who: (i) were prior treatment null responders; or (ii) were prior treatment partial responders or relapsers and in whom plasma HCV RNA is detectable by an HCV RNA qualitative assay at week 8, and undetectable by an HCV RNA qualitative assay at week 12; or (iii) have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with telaprevir who: (i) were prior treatment partial or null responders; or (ii) were prior treatment relapsers and for whom the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is detectable but less than or equal to 1000 IU/mL; or (iii) have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir who: (i) were prior treatment partial or null responders; or (ii) were prior treatment relapsers and for whom the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is detectable but less than 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin without an NS3 protease inhibitor if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with boceprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with boceprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than 1000 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than or equal to 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic genotype 1 hepatitis C infection (repeatedly anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Authority required (STREAMLINED)

4197

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease, **AND**

Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with telaprevir and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 4 and 12; OR

The treatment must be limited to a maximum duration of 28 weeks in patients using peginterferon and ribavirin in triple combination therapy with boceprevir and in whom plasma HCV RNA is undetectable by an HCV RNA qualitative assay at weeks 8 and 24; OR

The treatment must be limited to a maximum duration of 24 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir and in whom plasma HCV RNA is undetectable by an HCV RNA quantitative assay at week 4; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin without an NS3 protease inhibitor; OR

The treatment must be limited to a maximum duration of 48 weeks in patients: (i) using peginterferon and ribavirin in triple combination therapy with boceprevir and in whom plasma HCV RNA is detectable by an HCV RNA qualitative assay at week 8, and undetectable by an HCV RNA qualitative assay at week 24; or (ii) using peginterferon and ribavirin in triple combination therapy with boceprevir who have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients: (i) using peginterferon and ribavirin in triple combination therapy with telaprevir and for whom the results of an HCV RNA quantitative assay at week 4 show that the

plasma HCV RNA is detectable but less than or equal to 1000 IU/mL; or (ii) using peginterferon and ribavirin in triple combination therapy with telaprevir who have hepatic cirrhosis; OR

The treatment must be limited to a maximum duration of 48 weeks in patients using peginterferon and ribavirin in triple combination therapy with simeprevir and for whom the results of an HCV RNA qualitative assay at week 4 show that the plasma HCV RNA is detectable but less than 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin without an NS3 protease inhibitor unless the results of an HCV RNA quantitative assay at week 12 (performed at the same laboratory using the same test) show that plasma HCV RNA has become undetectable or the viral load has decreased by at least a 2 log drop, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with boceprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than 1000 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with telaprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if the results of an HCV RNA quantitative assay at week 4 show that the plasma HCV RNA is greater than or equal to 25 IU/mL, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 12, **AND**

The treatment must cease in patients using peginterferon and ribavirin in combination with simeprevir if HCV RNA is detectable by an HCV RNA qualitative assay at week 24.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

For patients using peginterferon and ribavirin without an NS3 protease inhibitor who are viral negative at week 12, an HCV RNA qualitative assay at week 24 is unnecessary.

Authority required (STREAMLINED)

4206

Chronic non-genotype 1 hepatitis C infection

Clinical criteria:

The treatment must be the sole PBS-subsidised treatment for hepatitis C, **AND**

Patient must have compensated liver disease, **AND**

The condition must be genotype 2, 3, 4, 5 or 6 hepatitis C, **AND**

Patient must have failed prior treatment with interferon based therapies (non-pegylated or pegylated), **AND**

Patient must have received no more than one prior treatment with interferon alfa or peginterferon alfa for hepatitis C, **AND**

The treatment must be limited to a maximum duration of 48 weeks, **AND**

The treatment must cease if HCV RNA is detectable by an HCV RNA qualitative assay at week 12.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

Note

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

Authority required (STREAMLINED)

4187

Chronic non-genotype 1 hepatitis C infection

Clinical criteria:

The treatment must be the sole PBS-subsidised treatment for hepatitis C, **AND**

Patient must have compensated liver disease, **AND**

Patient must not have received prior interferon alfa or peginterferon alfa treatment for hepatitis C, **AND**

The condition must be genotype 2, 3, 4, 5 or 6 hepatitis C, **AND**

The treatment must be limited to a maximum duration of 24 weeks for patients with genotype 2 or 3 hepatitis C without hepatic cirrhosis or bridging fibrosis; OR

The treatment must be limited to a maximum duration of 48 weeks for patients with genotype 4, 5 or 6 hepatitis C; OR

The treatment must be limited to a maximum duration of 48 weeks for patients with genotype 2 or 3 hepatitis C with hepatic cirrhosis or bridging fibrosis, **AND**

The treatment must cease in patients with genotype 4, 5, or 6 hepatitis C unless the results of an HCV RNA quantitative assay at week 12 (performed at the same laboratory using the same test) shows that plasma HCV RNA has become undetectable or the viral load has decreased by at least a 2 log drop, **AND**

The treatment must cease in patients eligible for 48 weeks of treatment if HCV RNA is detectable by an HCV RNA qualitative assay at week 24.

Population criteria:

Patient must be aged 18 years or older, **AND**

Patient must not be pregnant or breastfeeding. Female partners of male patients must not be pregnant. Patients and their partners must each be using an effective form of contraception if of child-bearing age.

Treatment criteria:

Must be treated in an accredited treatment centre.

Evidence of chronic hepatitis C infection (repeated anti-HCV positive and HCV RNA positive) must be documented in the patient's medical records.

For patients with genotype 4, 5, or 6 who are viral negative at week 12, an HCV RNA qualitative assay at week 24 is unnecessary.

For patients with genotype 2 or 3 without cirrhosis, an HCV RNA assay at week 12 is unnecessary because of the high likelihood of early viral response by week 12.

For patients who are eligible for 24 weeks of treatment, a maximum of 2 repeats may be prescribed.

For patients who are eligible for 48 weeks of treatment, a maximum of 5 repeats may be prescribed.

Note

Treatment centres are required to have access to the following appropriate specialist facilities for the provision of clinical support services for hepatitis C:

- (a) a nurse educator/counsellor for patients; and
- (b) 24-hour access by patients to medical advice; and

- (c) an established liver clinic.

peginterferon alfa-2b 100 microgram injection [4 x 100 microgram cartridges] (&) ribavirin 200 mg capsule [112 capsules] (&) inert substance diluent [4 x 0.5 mL cartridges], 1 pack

9534T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*3099.62	Pegatron [MK]

peginterferon alfa-2b 50 microgram injection [4 x 50 microgram cartridges] (&) ribavirin 200 mg capsule [112 capsules] (&) inert substance diluent [4 x 0.5 mL cartridges], 1 pack

9529M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2119.74	Pegatron [MK]

peginterferon alfa-2b 80 microgram injection [4 x 80 microgram cartridges] (&) ribavirin 200 mg capsule [84 capsules] (&) inert substance diluent [4 x 0.5 mL cartridges], 1 pack

9530N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2422.72	Pegatron [MK]

Other immunostimulants

▪ **PLERIXAFOR**

Authority required (STREAMLINED)

4549

Mobilisation of haematopoietic stem cells

Clinical criteria:

The treatment must be in combination with granulocyte-colony stimulating factor (G-CSF), **AND**

Patient must have lymphoma; OR

Patient must have multiple myeloma, **AND**

Patient must require autologous stem cell transplantation, **AND**

Patient must have failed previous stem cell collection; OR

Patient must be undergoing chemotherapy plus G-CSF mobilisation and their peripheral blood CD34+ count is less than 10,000 per millilitre or less than 10 million per litre on the day of planned collection; OR

Patient must be undergoing chemotherapy plus G-CSF mobilisation and the first apheresis has yielded less than 1 million CD34+ cells/kg.

Evidence that the patient meets the PBS restriction criteria must be recorded in the patient's medical records.

Note

Applications for increased maximum quantities will only be authorised for patients with body weight greater than 100 kg.

plerixafor 24 mg/1.2 mL injection: subcutaneous infusion, 1 x 1.2 mL vial

10083Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	1	..	6991.00	Mozobil [GZ]

■ IMMUNOSUPPRESSANTS

IMMUNOSUPPRESSANTS

Selective immunosuppressants

■ ABATACEPT

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Clinical criteria:

Patient must have severe active rheumatoid arthritis, **AND**

Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**

Patient must not have failed previous PBS-subsidised treatment with this drug for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDs which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

If methotrexate is contraindicated according to the TGA-approved Product Information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and
- (3) a signed patient acknowledgement.

At the time of authority application, medical practitioners should request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for a single infusion. Up to a maximum of 4 repeats will be authorised.

Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted no later than 1 month from the date of completion of this initial course of treatment.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) a total active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note

The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:

(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose; (b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;

(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Special Pricing Arrangements apply.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months).

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for a single infusion. Up to a maximum of 4 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with this drug and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised treatment with this drug was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to a treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

A patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

- (a) an active joint count of fewer than 10 active (swollen and tender) joints; or
- (b) a reduction in the active (swollen and tender) joint count by at least 50% from baseline; or
- (c) a reduction in the number of the following active joints, from at least 4, by at least 50%:
 - (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - (ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alpha antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

- a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,
- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and
- once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or
- (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
- (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity

of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply.

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment.

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have demonstrated an adequate response to treatment with this drug, **AND**

Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners should request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for a single infusion. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

If a patient fails to demonstrate a response to treatment with this drug under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alpha antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

- a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,
- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and
- once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or
- (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
- (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply.

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

abatacept 250 mg injection, 1 x 250 mg vial

5605B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	504.43	Orencia [BQ]

▪ **ALEMTUZUMAB**

Authority required (STREAMLINED)

4829

Multiple sclerosis

Treatment Phase: Continuing

Clinical criteria:

Patient must have previously been issued with an authority prescription for this drug, **AND**

Patient must not show continuing progression of disability while on treatment with this drug, **AND**

Patient must not receive more than one PBS-subsidised treatment per year, **AND**

The treatment must be as monotherapy, **AND**

Patient must have demonstrated compliance with, and an ability to tolerate this therapy.

Treatment criteria:

Must be treated by a neurologist.

Note

Neurologists prescribing PBS-subsidised alemtuzumab must be registered with the Lemtrada monitoring program.

Special Pricing Arrangements apply.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

alemtuzumab 12 mg/1.2 mL injection, 1 x 1.2 mL vial

10232M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	3	..	..	*34182.00	Lemtrada [GZ]

▪ **ALEMTUZUMAB**

Authority required (STREAMLINED)

4834

Multiple sclerosis

Treatment Phase: Initial

Clinical criteria:

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by magnetic resonance imaging of the brain and/or spinal cord; OR

The condition must be diagnosed as clinically definite relapsing-remitting multiple sclerosis by accompanying written certification provided by a radiologist that a magnetic resonance imaging scan is contraindicated because of the risk of physical (not psychological) injury to the patient, **AND**

The treatment must be as monotherapy, **AND**

Patient must have experienced at least 2 documented attacks of neurological dysfunction, believed to be due to the multiple sclerosis, in the preceding 2 years, **AND**

Patient must be ambulatory (without assistance or support).

Treatment criteria:

Must be treated by a neurologist.

Where applicable, the date of the magnetic resonance imaging scan must be provided with the authority application.

Note

Neurologists prescribing PBS-subsidised alemtuzumab must be registered with the Lemtrada monitoring program.

Special Pricing Arrangements apply.

No increase in the maximum quantity or number of units may be authorised.

No increase in the maximum number of repeats may be authorised.

alemtuzumab 12 mg/1.2 mL injection, 1 x 1.2 mL vial

10228H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	5	..	..	*56970.00	Lemtrada [GZ]

▪ **ECULIZUMAB**

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Initial treatment 1 – New patient – Balance of Supply

Clinical criteria:

Patient must have received PBS-subsidised initial supply of eculizumab for this condition, **AND**

Patient must have ADAMTS-13 activity of greater than or equal to 10% on a blood sample, **AND**

Patient must not receive more than 20 weeks supply under this restriction.

Treatment criteria:

Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

ADAMTS-13 activity result must have been submitted to the Department of Human Services. In the case that a sample for ADAMTS-13 activity taken prior to plasma exchange or infusion was not available at the time of application for Initial Treatment 1 New Patient, ADAMTS-13 activity must have been measured 1-2 weeks following the last plasma exchange or infusion, and must have been submitted to the Department of Human Services within 27 days of commencement of eculizumab. The date and time that the sample for the ADAMTS-13 assay was collected, and the dates and times of the last, if any, plasma exchange or infusion that was undertaken in the two weeks prior to collection of the ADAMTS-13 assay must also have been provided to Department of Human Services.

Note

Serial haematological results (every 3 months while the patient is receiving treatment) must be provided with every subsequent application for treatment. This will assist DHS in the consideration of the patient's eligibility for further PBS subsidised treatment

At the time of authority application, medical practitioners must request the appropriate number of vials to provide sufficient drug for 4 weeks and up to 4 repeats, according to the specified dosage in the approved Product Information (PI).

Applications for treatment with eculizumab where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

eculizumab 300 mg/30 mL injection, 1 x 30 mL vial

10190H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	4	..	5937.50	Soliris [XI]

■ ECULIZUMAB

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Initial treatment 1 – New patient

Clinical criteria:

Patient must have active and progressing thrombotic microangiopathy (TMA), **AND**

Patient must have ADAMTS-13 activity of greater than or equal to 10% on a blood sample taken prior to plasma exchange or infusion; or, if ADAMTS-13 activity was not collected prior to plasma exchange or infusion, patient must have platelet counts of greater than $30 \times 10^9/L$ and a serum creatinine of greater than $150 \mu\text{mol/L}$, **AND**

Patient must have a confirmed negative STEC (Shiga toxin-producing E.Coli) result if the patient has had diarrhoea in the preceding 14 days, **AND**

Patient must have clinical features of active organ damage or impairment, **AND**

Patient must not receive more than 4 weeks of treatment under this restriction.

Treatment criteria:

Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

Evidence of active and progressing TMA is defined by the following:

(1) a platelet count of less than $150 \times 10^9/L$; and evidence of two of the following:

- (i) presence of schistocytes on blood film;
- (ii) low or absent haptoglobin;
- (iii) lactate dehydrogenase (LDH) above normal range;

OR

(2) tissue biopsy confirming TMA in patients who don't have evidence of platelet consumption and haemolysis; **AND**

(3) evidence of at least one of the following clinical features of active TMA-related organ damage or impairment is defined as below:

(a) kidney impairment as demonstrated by one of the following:

(i) a decline in estimated Glomerular Filtration Rate (eGFR) of greater than 20% in a patient who has pre-existing kidney impairment; and/or

(ii) a serum creatinine (sCr) of greater than the upper limit of normal (ULN) in a patient who has no history of pre-existing kidney impairment; or

(iii) a sCr of greater than the age-appropriate ULN in paediatric patients; or

(iv) a renal biopsy

(b) onset of TMA-related neurological impairment;

(c) onset of TMA-related cardiac impairment;

(d) onset of TMA-related gastrointestinal impairment;

(e) onset of TMA-related pulmonary impairment

The authority application must be in writing and must include:

- (1) A completed authority prescription form; and
- (2) A completed aHUS eculizumab Authority Application Supporting Information Form- Initial PBS-subsidised eculizumab treatment; and
- (3) A signed patient acknowledgement or an acknowledgement signed by a parent or authorised guardian, if applicable; and
- (4) A copy of a current Certificate of vaccination; and
- (5) A measurement of body weight at the time of application; and
- (6) The result of ADAMTS-13 activity on a blood sample taken prior to plasma exchange or infusion; the date and time that the sample for the ADAMTS-13 assay was collected, and the dates and times of any plasma exchanges or infusions that were undertaken in the two weeks prior to collection of the ADAMTS-13 assay; and
- (7) In the case that a sample for ADAMTS-13 assay was not collected prior to plasma exchange or infusion, measurement of ADAMTS-13 activity must be taken 1-2 weeks following the last plasma exchange or infusion. The ADAMTS-13 result must be submitted to the Department of Human Services within 27 days of commencement of eculizumab treatment in order for the patient to be considered as eligible for further PBS-subsidised eculizumab treatment, under Initial treatment 1-balance of supply; and
- (8) A confirmed negative STEC result if the patient has had diarrhoea in the preceding 14 days; and
- (9) Evidence of active and progressing TMA, including pathology results where relevant. Evidence of the onset of TMA-related neurological, cardiac, gastrointestinal or pulmonary impairment requires a supporting statement with clinical evidence in patient records. All tests must have been performed within one month of application; and
- (10) For all patients, a recent measurement of eGFR, platelets and two of either LDH, haptoglobin or schistocytes of no more than 1 week old at the time of application.

Note

Serial haematological results (every 3 months while the patient is receiving treatment) must be provided with every subsequent application for treatment. This will assist DHS in the consideration of the patient's eligibility for further PBS subsidised treatment

At the time of authority application, medical practitioners must request the appropriate number of vials to provide sufficient drug for four weeks of treatment, according to the specified dosage in the approved Product Information (PI)

Applications for treatment with eculizumab where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

WARNING: Eculizumab increases the risk of meningococcal infections (septicaemia and/or meningitis)

> Vaccinate patients with a meningococcal vaccine at least 2 weeks prior to receiving the first dose of eculizumab; revaccinate according to current medical guidelines for vaccine use

> Patients less than 2 years of age and those who are treated with eculizumab less than 2 weeks after receiving a meningococcal vaccine must receive treatment with appropriate prophylactic antibiotics until 2 weeks after vaccination. Monitor patients

for early signs of meningococcal infections, evaluate immediately if infection is suspected, and treat with antibiotics if necessary.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

eculizumab 300 mg/30 mL injection, 1 x 30 mL vial

10191J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	5937.50	Soliris [XI]

■ ECULIZUMAB

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Continuing treatment – New patient

Clinical criteria:

Patient must have received 24 weeks therapy under the initial restriction with PBS subsidised eculizumab for this condition, **AND**

Patient must have demonstrated on-going treatment response of PBS-subsidised eculizumab treatment for this condition, **AND**

Patient must not have experienced treatment failure with eculizumab including PBS-subsidised eculizumab for this condition, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Treatment criteria:

Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

A treatment response is defined as:

- (1) Normalisation of haematology as demonstrated by at least 2 of the following: platelet count, haptoglobin, and LDH; **AND**

(2) One of the following:

- a) An increase in eGFR of > 25% from baseline, where the baseline is the eGFR measurement immediately prior to commencing treatment with eculizumab or
- b) an eGFR within +/- 25% from baseline; or
- c) an avoidance of dialysis-dependence but worsening of kidney function with a reduction in eGFR 25% from baseline.

PBS-subsidised treatment with eculizumab will not be permitted if a patient has experienced treatment failure .

A treatment failure is defined as a patient who is:

- (1) dialysis-dependent at the time of application and has failed to demonstrate significant resolution of extra-renal complications if originally presented; or
- (2) on dialysis and has been on dialysis for 4 months of the previous 6 months while receiving PBS-subsidised eculizumab and has failed to demonstrate significant resolution of extra-renal complications if originally presented.

Serial haematological results (every 3 months while the patient is receiving treatment) must be provided.

The authority application must be in writing and must include:

- (1) A completed authority prescription form; and
- (2) A completed aHUS eculizumab Authority Application Supporting Information Form for Continuing treatment; and
- (3) A copy of a current Certificate of vaccination; and
- (4) A measurement of body weight at the time of application; and
- (5) Evidence that the patient has had a treatment response including haematological results of no more than 1 week old at the time of application (platelet count, haptoglobin and LDH); and an eGFR level of no more than 1 week old at the time of application ; and
- (6) Evidence that the patient has not experienced treatment failure, including a supporting statement with clinical evidence that the patient does not require dialysis, unless the indication for continuing eculizumab is severe extra-renal complications that have significantly improved; and
- (7) If the indication for continuing eculizumab is severe extra-renal complications, then a supporting statement with clinical evidence that any initial extra-renal complications of TMA have significantly improved is required.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Continuing treatment – beyond initial 48 weeks of treatment

Clinical criteria:

Patient must have received 48 weeks of treatment under Initial treatment-New patient, Initial treatment-Balance of supply and Continuing treatment-New patient with PBS-subsidised eculizumab for this condition, **AND**

Patient must have demonstrated on-going treatment response with PBS-subsidised eculizumab for this condition, **AND** Patient must not have ever experienced treatment failure with eculizumab including PBS-subsidised eculizumab for this condition, **AND**

Patient must have a TMA-related cardiomyopathy as evidenced by left ventricular ejection fraction < 40%; OR

Patient must have severe TMA-related neurological impairment; OR

Patient must have severe TMA-related gastrointestinal impairment; OR

Patient must have severe TMA-related pulmonary impairment; OR

Patient must have grade 4 or 5 chronic kidney disease (eGFR of less than 30 ml/min), **AND**

Patient must not receive more than 24 weeks of treatment under this restriction.

Treatment criteria:

Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

A treatment response is defined as:

- (1) Normalisation of haematology as demonstrated by at least 2 of the following: platelet count, haptoglobin, and LDH; AND
- (2) One of the following:

a) An increase in eGFR of > 25% from baseline, where the baseline is the eGFR measurement immediately prior to commencing treatment with eculizumab or

b) an eGFR within +/- 25% from baseline; or

c) an avoidance of dialysis-dependence but worsening of kidney function with a reduction in eGFR 25% from baseline.

PBS-subsidised treatment with eculizumab will not be permitted if a patient has experienced treatment failure . A treatment failure is defined as a patient who is:

- (1) dialysis-dependent at the time of application and has failed to demonstrate significant resolution of extra-renal complications if originally presented; or
- (2) on dialysis and has been on dialysis for 4 months of the previous 6 months while receiving PBS-subsidised eculizumab and has failed to demonstrate significant resolution of extra-renal complications if originally presented.

Serial haematological results (every 3 months while the patient is receiving treatment) must be provided with every subsequent application for treatment. This will assist DHS in the consideration of the patient s eligibility for further PBS subsidised treatment.

The authority application must be in writing and must include:

- (1) A completed authority prescription form; and
- (2) A completed aHUS eculizumab Authority Application Supporting Information Form for Continuing treatment; and
- (3) A copy of a current Certificate of vaccination; and
- (4) A measurement of body weight at the time of application; and
- (5) A supporting statement with clinical evidence of severe TMA-related cardiomyopathy (including current LVEF result), neurological impairment, gastrointestinal impairment or pulmonary impairment; and

(6) Evidence that the patient has had a treatment response including haematological results of no more than 1 month old at the time of application (platelet count, haptoglobin and LDH); and an eGFR level of no more than 1 month old at the time of application; and

(7) Evidence that the patient has not experienced treatment failure, including a supporting statement with clinical evidence that the patient does not require dialysis, unless the indication for continuing eculizumab is severe extra-renal complications that have significantly improved; and

(8) If the indication for continuing eculizumab is severe extra-renal complications, then a supporting statement with clinical evidence that any initial extra-renal complications of TMA have significantly improved is required.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Initial treatment 2 – Recommencement of treatment after an initial 48-week period

Clinical criteria:

Patient must have demonstrated treatment response to previous 48 weeks of treatment with PBS-subsidised eculizumab for this condition, **AND**

Patient must not have ever experienced treatment failure with eculizumab including PBS-subsidised eculizumab for this condition, **AND**

Patient must have the following clinical conditions: (i) either significant haemolysis as measured by low/absent haptoglobin; or presence of schistocytes on the blood film; or lactate dehydrogenase (LDH) above normal; **AND** (ii) either platelet consumption as measured by either 25% decline from patient baseline or thrombocytopenia (platelet count $<150 \times 10^9/L$); **OR** (iii) TMA-related organ impairment including on recent biopsy, **AND**

Patient must not receive more than 24 weeks of treatment under this restriction.

Treatment criteria:

Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

A treatment response is defined as:

(1) Normalisation of haematology as demonstrated by at least 2 of the following: platelet count, haptoglobin, and LDH; **AND**

(2) One of the following:

a) An increase in eGFR of $> 25\%$ from baseline, where the baseline is the eGFR measurement immediately prior to commencing treatment with eculizumab or

b) an eGFR within $\pm 25\%$ from baseline; or

c) an avoidance of dialysis-dependence but worsening of kidney function with a reduction in eGFR 25% from baseline.

PBS-subsidised treatment with eculizumab will not be permitted if a patient has experienced treatment failure. A treatment failure is defined as a patient who is:

(1) dialysis-dependent at the time of application and has failed to demonstrate significant resolution of extra-renal complications if originally presented; or

(2) on dialysis and has been on dialysis for 4 months of the previous 6 months while receiving PBS-subsidised eculizumab and has failed to demonstrate significant resolution of extra-renal complications if originally presented.

Serial haematological results (every 3 months while the patient is receiving treatment) must be provided with every subsequent application for treatment. This will assist DHS in the consideration of the patient's eligibility for further PBS subsidised treatment.

The authority application must be in writing and must include:

(1) A completed authority prescription form(s); and

(2) A completed aHUS eculizumab Authority Application Supporting Information Form for Initial treatment 2- Recommencement of treatment after an initial 48-week period; and

(3) A signed patient acknowledgement or an acknowledgement signed by a parent or authorised guardian, if applicable; and

(4) A copy of a current Certificate of vaccination; and

(5) A measurement of body weight at the time of application, and

(6) A supporting statement with clinical evidence of TMA-related organ damage including current (within one week of application) haematological results (platelet count, haptoglobin and LDH), eGFR level, and, if applicable, on recent biopsy;

(7) Evidence that the patient has had a treatment response to their previous treatment with eculizumab; and

(8) Evidence that the patient has not experienced treatment failure, including a supporting statement with clinical evidence that the patient does not require dialysis, unless the indication for continuing eculizumab is severe extra-renal complications that have significantly improved; and

(9) If the indication for continuing eculizumab is severe extra-renal complications, then a supporting statement with clinical evidence that any initial extra-renal complications of TMA have significantly improved is required.

Note

A raise in LDH alone is not a sufficient reason to re-commence eculizumab, but thrombocytopenia with one marker of haemolysis (such as raised LDH, presence of schistocytes, or low/absence of haptoglobin) is an accepted reason to consider re-commencement of eculizumab treatment.

Kidney transplantation/dialysis is not a contraindication to recommencement of eculizumab treatment.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Continuing treatment – following recommencement of treatment after an initial 48-week period

Clinical criteria:

Patient must have received Initial treatment 2-recommencement of treatment after an initial 48-week period with PBS-subsidised eculizumab for this condition, **AND**

Patient must have demonstrated ongoing treatment response to the previous 24 weeks of PBS-subsidised eculizumab for this condition, **AND**

Patient must not have experienced treatment failure with eculizumab including PBS-subsidised eculizumab for this condition, **AND**

Patient must not receive more than 24 weeks of treatment under this restriction.

Treatment criteria:

Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

A treatment response is defined as:

(1) Normalisation of haematology as demonstrated by at least 2 of the following: platelet count, haptoglobin, and LDH; **AND**

(2) One of the following:

a) An increase in eGFR of > 25% from baseline, where the baseline is the eGFR measurement immediately prior to commencing treatment with eculizumab or

b) an eGFR within +/- 25% from baseline; or

c) an avoidance of dialysis-dependence but worsening of kidney function with a reduction in eGFR 25% from baseline.

PBS-subsidised treatment with eculizumab will not be permitted if a patient has experienced treatment failure. A treatment failure is defined as a patient who is:

(1) dialysis-dependent at the time of application and has failed to demonstrate significant resolution of extra-renal complications if originally presented; or

(2) on dialysis and has been on dialysis for 4 months of the previous 6 months while receiving PBS-subsidised eculizumab and has failed to demonstrate significant resolution of extra-renal complications if originally presented.

Serial haematological results (every 3 months while the patient is receiving treatment) must be provided with every subsequent application for treatment. This will assist DHS in the consideration of the patient's eligibility for further PBS subsidised treatment.

The authority application must be in writing and must include:

(1) A completed authority prescription form; and

(2) A completed aHUS eculizumab Authority Application Supporting Information Form for Continuing treatment; and

(3) A copy of a current Certificate of vaccination; and

(4) A measurement of body weight at the time of application; and

(5) Evidence that the patient has had a treatment response including haematological results of no more than 1 week old at the time of application (platelet count, haptoglobin and LDH); and an eGFR level of no more than 1 week old at the time of application; and

(6) Evidence that the patient has not experienced treatment failure, including a supporting statement with clinical evidence that the patient does not require dialysis, unless the indication for continuing eculizumab is severe extra-renal complications that have significantly improved; and

(7) If the indication for continuing eculizumab is severe extra-renal complications, then a supporting statement with clinical evidence that any initial extra-renal complications of TMA have significantly improved is required.

Note

At the time of authority application, medical practitioners must request the appropriate number of vials to provide sufficient drug for 4 weeks and up to 5 repeats, according to the specified dosage in the approved Product Information (PI).

Applications for treatment with eculizumab where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

Authority required

Atypical haemolytic uraemic syndrome (aHUS)

Treatment Phase: Initial 3 - Grandfather eculizumab patients

Clinical criteria:

Patient must have had documented history of active and progressing thrombotic microangiopathy (TMA), **AND**

Patient must have had documented an ADAMTS-13 activity level consistent with a diagnosis of aHUS, **AND**

Patient must have received treatment with eculizumab for this condition prior to 1 December 2014, **AND**

Patient must have received treatment with eculizumab within the last 6 months at the time of application, **AND**

Patient must have demonstrated on-going treatment response as specified in the Continuing treatment New Patient criteria for PBS-subsidised treatment with eculizumab for this condition, if the patient has received adequate therapy in order to demonstrate response, **AND**

Patient must not have experienced treatment failure with eculizumab for this condition as specified in the Continuing treatment New Patient criteria for PBS-subsidised treatment with eculizumab for this condition, **AND**

Patient must have clinical features of active organ damage or impairment at the time of a diagnosis of aHUS episode that required treatment with eculizumab, **AND**

Patient must not receive more than 24 weeks of treatment under this restriction.

Treatment criteria:

Must be treated by a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist, or, must be in consultation with a paediatric nephrologist, a nephrologist, a paediatric haematologist or a haematologist.

Evidence of active and progressing TMA is defined by the following:

(1) a platelet count of less than $150 \times 10^9/L$; and evidence of two of the following:

(i) presence of schistocytes on blood film;

(ii) low or absent haptoglobin;

(iii) lactate dehydrogenase (LDH) above normal range;

OR

(2) tissue biopsy confirming TMA in patients who don't have evidence of platelet consumption and haemolysis; **AND**

(3) evidence of at least one of the following clinical features of active TMA-related organ damage or impairment is defined as below:

(a) kidney impairment as demonstrated by one of the following:

(i) a decline in estimated Glomerular Filtration Rate (eGFR) of greater than 20% in a patient who has pre-existing kidney impairment; and/or

(ii) a serum creatinine (sCr) of greater than the upper limit of normal (ULN) in a patient who has no history of pre-existing kidney impairment; or

(iii) a sCr of greater than the age-appropriate ULN in paediatric patients ; or

(iv) a renal biopsy

(b) onset of TMA-related neurological impairment;

(c) onset of TMA-related cardiac impairment;

(d) onset of TMA-related gastrointestinal impairment;

(e) onset of TMA-related pulmonary impairment

A treatment response is defined as:

(1) Normalisation of haematology as demonstrated by at least 2 of the following: platelet count, haptoglobin, and LDH; AND

(2) One of the following:

a) An increase in eGFR of > 25% from baseline, where the baseline is the eGFR measurement immediately prior to commencing treatment with eculizumab or

b) an eGFR within +/- 25% from baseline; or

c) an avoidance of dialysis-dependence but worsening of kidney function with a reduction in eGFR 25% from baseline.

PBS-subsidised treatment with eculizumab will not be permitted if a patient has experienced treatment failure . A treatment failure is defined as a patient who is:

(1) dialysis-dependent at the time of application and has failed to demonstrate significant resolution of extra-renal complications if originally presented; or

(2) on dialysis and has been on dialysis for 4 months of the previous 6 months while receiving PBS-subsidised eculizumab and has failed to demonstrate significant resolution of extra-renal complications if originally presented.

The authority application must be in writing and must include:

(1) A completed authority prescription form; and

(2) A completed aHUS eculizumab Authority Application Supporting Information Form for initial PBS-subsidised eculizumab treatment; and

(3) A signed patient acknowledgement or an acknowledgement signed by a parent or authorised guardian, if applicable; and

(4) A copy of a current Certificate of vaccination; and

(5) A measurement of body weight at the time of application; and

(6) The result of ADAMTS-13 activity on a blood sample at the time this condition was diagnosed; and

(7) Evidence that the patient has previously received treatment with eculizumab for this condition within the last 6 months at the time of application; and

(8) Evidence that the patient has had a treatment response including haematological results of no more than 1 week old at the time of application (platelet count, haptoglobin and LDH); and an eGFR level of no more than 1 week old at the time of application ; or clinical reasons to justify the commencing of treatment with PBS-subsidised eculizumab; and

(9) Evidence that the patient has not experienced treatment failure, including a supporting statement with clinical evidence that the patient does not require dialysis, unless the indication for continuing eculizumab is severe extra-renal complications that have significantly improved; and

(10) A confirmed negative STEC (Shiga toxin-producing E.Coli) result if available at the time of diagnosis; or evidence that the diagnosis was not associated with an infection; and

(11) Where available in the week prior to commencing eculizumab results demonstrating:

(a) a platelet count of less than $150 \times 10^9/L$; and evidence of two of the following:

(i) presence of schistocytes on blood film;

(ii) low or absent haptoglobin;

(iii) lactate dehydrogenase (LDH) above normal range;

OR

(b) tissue biopsy confirming TMA in patients who don t have evidence of platelet consumption and haemolysis; AND

(c) evidence of at least one of the following clinical features of active TMA-related organ damage or impairment is defined as below:

(a) kidney impairment as demonstrated by one of the following:

(i) a decline in estimated Glomerular Filtration Rate (eGFR) of greater than 20% in a patient who has pre-existing kidney impairment; and/or

(ii) a serum creatinine (sCr) of greater than the upper limit of normal (ULN) in a patient who has no history of pre-existing kidney impairment; or

(iii) a sCr of greater than the age-appropriate ULN in paediatric patients ; or

(iv) a renal biopsy

(b) onset of TMA-related neurological impairment;

(c) onset of TMA-related cardiac impairment;

(d) onset of TMA-related gastrointestinal impairment;

(e) onset of TMA-related pulmonary impairment ; and

(12) Where available within one month prior to commencement of eculizumab, evidence of active and progressing TMA, including pathology results where relevant. Evidence of the onset of TMA-related neurological, cardiac, gastrointestinal or pulmonary impairment requires a supporting statement with clinical evidence in patient records.

Serial haematological results (every 3 months while the patient is receiving treatment) must be provided with every subsequent application for treatment. This will assist DHS in the consideration of the patient's eligibility for further PBS subsidised treatment.

Note

WARNING: Eculizumab increases the risk of meningococcal infections (septicaemia and/or meningitis)

> Vaccinate patients with a meningococcal vaccine at least 2 weeks prior to receiving the first dose of eculizumab; revaccinate according to current medical guidelines for vaccine use

> Patients less than 2 years of age and those who are treated with eculizumab less than 2 weeks after receiving a meningococcal vaccine must receive treatment with appropriate prophylactic antibiotics until 2 weeks after vaccination. Monitor patients

for early signs of meningococcal infections, evaluate immediately if infection is suspected, and treat with antibiotics if necessary.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

eculizumab 300 mg/30 mL injection, 1 x 30 mL vial

10183Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	5	..	5937.50	Soliris [XI]

■ EVEROLIMUS

Caution

Careful monitoring of patients is mandatory.

Authority required (STREAMLINED)

3355

Management of rejection, under the supervision and direction of a transplant unit, in patients receiving this drug for prophylaxis of renal allograft rejection. Management includes initiation, stabilisation and review of therapy as required

Authority required (STREAMLINED)

3356

Management of rejection, under the supervision and direction of a transplant unit, in patients receiving this drug for prophylaxis of cardiac allograft rejection. Management includes initiation, stabilisation and review of therapy as required

everolimus 1 mg tablet, 60

5737Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	4	5	..	*3844.80	Certican [NV]

everolimus 250 microgram tablet, 60

5738B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*480.60	Certican [NV]

everolimus 500 microgram tablet, 60

5739C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*961.20	Certican [NV]

everolimus 750 microgram tablet, 60

5740D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	4	5	..	*2883.60	Certican [NV]

■ MYCOPHENOLATE

Caution

Careful monitoring of patients is mandatory.

Authority required (STREAMLINED)

3355

Management of rejection, under the supervision and direction of a transplant unit, in patients receiving this drug for prophylaxis of renal allograft rejection. Management includes initiation, stabilisation and review of therapy as required

Authority required (STREAMLINED)

3356

Management of rejection, under the supervision and direction of a transplant unit, in patients receiving this drug for prophylaxis of cardiac allograft rejection. Management includes initiation, stabilisation and review of therapy as required

mycophenolate mofetil 1 g/5 mL oral liquid: powder for, 165 mL

9500B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*489.02	CellCept [RO]

mycophenolate mofetil 500 mg tablet, 50

9502D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	6	5	..	*544.02	^a APO-Mycophenolate [TX] ^a Ceptolate [AF] ^a Pharmacor Mycophenolate 500 [CR]	^a CellCept [RO] ^a Mycophenolate Sandoz [SZ]

■ MYCOPHENOLATE**Caution**

Careful monitoring of patients is mandatory.

Authority required (STREAMLINED)**4084**

Prophylaxis of renal allograft rejection

Treatment Phase: Management

Clinical criteria:

The treatment must be under the supervision and direction of a transplant unit.

Authority required (STREAMLINED)**4095**

WHO Class III, IV or V lupus nephritis

Treatment Phase: Management

Clinical criteria:

The condition must be proven by biopsy.

Treatment criteria:

Must be treated by a nephrologist or in consultation with a nephrologist.

The name of the consulting nephrologist must be included in the patient medical records.

Note

Management includes initiation, stabilisation and review of therapy as required.

mycophenolate 180 mg tablet: enteric, 120 tablets

9503E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*217.62	Myfortic [NV]

mycophenolate 360 mg tablet: enteric, 120 tablets

9504F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*435.22	Myfortic [NV]

■ MYCOPHENOLATE**Caution**

Careful monitoring of patients is mandatory.

Authority required (STREAMLINED)**3355**

Management of rejection, under the supervision and direction of a transplant unit, in patients receiving this drug for prophylaxis of renal allograft rejection. Management includes initiation, stabilisation and review of therapy as required

Authority required (STREAMLINED)**3356**

Management of rejection, under the supervision and direction of a transplant unit, in patients receiving this drug for prophylaxis of cardiac allograft rejection. Management includes initiation, stabilisation and review of therapy as required

Note

For item codes 9501C and 1839T, pharmaceutical benefits that have the form capsule 250 mg are equivalent for the purposes of substitution.

mycophenolate Capsule 250 mg, 50

1839T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	12	5	..	*544.08	^a Ceptolate [AF]

mycophenolate mofetil 250 mg capsule, 100

9501C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	6	5	..	*544.08	^a APO-Mycophenolate [TX] ^a Mycophenolate Sandoz [SZ]	^a CellCept [RO] ^a Pharmacor Mycophenolate 250 [CR]

■ NATALIZUMAB**Caution**

Progressive multifocal leukoencephalopathy has been reported with this drug.

Authority required (STREAMLINED)

3425

Treatment, as monotherapy, by a neurologist, of clinically definite relapsing-remitting multiple sclerosis in an ambulatory (without assistance or support) patient 18 years of age or older, who has experienced at least 2 documented attacks of neurological dysfunction, believed to be due to multiple sclerosis, in the preceding 2 years.

The diagnosis must be confirmed by magnetic resonance imaging of the brain and/or spinal cord and the date of the scan included in the patient's medical notes, unless written certification provided by a radiologist that an MRI scan is contraindicated because of the risk of physical (not psychological) injury to the patient is included in the patient's medical notes.

Natalizumab must be ceased if there is continuing progression of disability while on treatment with natalizumab. For continued treatment the patient must demonstrate compliance with, and an ability to tolerate, natalizumab

Note

Neurologists prescribing natalizumab under the PBS listing must be registered with the Tysabri Australian Prescribing Program.

Special Pricing Arrangements apply.

natalizumab 300 mg/15 mL injection, 1 x 15 mL vial

9505G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	5	..	1568.04	Tysabri [BD]

▪ **SIROLIMUS**

Caution

Careful monitoring of patients is mandatory.

Authority required (STREAMLINED)

3355

Management of rejection, under the supervision and direction of a transplant unit, in patients receiving this drug for prophylaxis of renal allograft rejection. Management includes initiation, stabilisation and review of therapy as required

sirolimus 1 mg tablet, 100

9549N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*1446.66	Rapamune [PF]

sirolimus 1 mg/mL oral liquid, 60 mL

9550P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*936.00	Rapamune [PF]

sirolimus 2 mg tablet, 100

9548M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2893.34	Rapamune [PF]

sirolimus 500 microgram tablet, 100

9747B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*723.34	Rapamune [PF]

Tumor necrosis factor alpha (TNF-) inhibitors

▪ **ADALIMUMAB**

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months)

Clinical criteria:

Patient must have severe active juvenile idiopathic arthritis, **AND**

Patient must have received no prior PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition; OR

Patient must not have received PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in the previous 12 months, **AND**

Patient must have demonstrated severe intolerance of, or toxicity due to, methotrexate; OR

Patient must have demonstrated failure to achieve an adequate response to 1 or more of the following treatment regimens: (i) oral or parenteral methotrexate at a dose of at least 20 mg per square metre weekly, alone or in combination with oral or intra-articular corticosteroids, for a minimum of 3 months; or (ii) oral methotrexate at a dose of at least 10 mg per square metre weekly together with at least 1 other disease modifying anti-rheumatic drug (DMARD), alone or in combination with corticosteroids, for a minimum of 3 months, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be under 18 years of age and a parent or authorised guardian must have signed a patient acknowledgement.

Treatment criteria:

Must be treated by a paediatric rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

Severe intolerance to methotrexate is defined as intractable nausea and vomiting and general malaise unresponsive to manoeuvres, including reducing or omitting concomitant non-steroidal anti-inflammatory drugs (NSAIDs) on the day of methotrexate administration, use of folic acid supplementation, or administering the dose of methotrexate in 2 divided doses over 24 hours.

Toxicity due to methotrexate is defined as evidence of hepatotoxicity with repeated elevations of transaminases, bone marrow suppression temporally related to methotrexate use, pneumonitis, or serious sepsis.

If treatment with methotrexate alone or in combination with another DMARD is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

(a) an active joint count of at least 20 active (swollen and tender) joints; OR

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count assessment must be performed preferably whilst still on DMARD treatment, but no longer than 4 weeks following cessation of the most recent prior treatment.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form; and

(3) an acknowledgement signed by a parent or authorised guardian.

At the time of authority application, medical practitioners must request the appropriate number of injections of appropriate strength, based on the weight of the patient, to provide sufficient for two doses. Up to a maximum of 3 repeats will be authorised.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle. A patient may re-trial adalimumab after a minimum of 12 months have elapsed between the date the last PBS-subsidised bDMARD was stopped and the date of the first application under a new treatment cycle.

Note

Use of alternative DMARDs in children is dependent on approval by the Therapeutic Goods Administration as age restrictions may apply.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (change or recommencement of treatment after break of less than 12 months)

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**

Patient must have received prior PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in this treatment cycle, **AND**

Patient must not have failed PBS-subsidised therapy with adalimumab for this condition in the current treatment cycle, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be under 18 years of age.

Treatment criteria:

Must be treated by a paediatric rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of injections of appropriate strength, based on the weight of the patient, to provide sufficient for two doses. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with adalimumab in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised adalimumab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised adalimumab treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised adalimumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

If a patient fails to respond to PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months) or Initial 2 (change or recommencement of treatment after break of less than 12 months) – balance of supply

Clinical criteria:

Patient must have received insufficient adalimumab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 12 months) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient adalimumab therapy under the Initial 2 (change or recommencement of treatment after break of less than 12 months) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a paediatric rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Note

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**

Patient must have demonstrated an adequate response to treatment with adalimumab, **AND**

Patient must have received adalimumab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Determination of whether a response has been demonstrated to initial and subsequent courses of treatment will be based on the baseline measurement of joint count submitted with the initial treatment application.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of injections of appropriate strength, based on the weight of the patient, to provide sufficient for two doses. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with adalimumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with adalimumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with adalimumab.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.

From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:

(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and

(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.

(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.

(5) Withdrawal of treatment after sustained remission.

Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment – balance of supply

Clinical criteria:

Patient must have received insufficient adalimumab therapy under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

adalimumab 20 mg/0.4 mL injection, 2 x 0.4 mL syringes

9661L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	1630.00	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges

9663N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	1630.00	Humira [VE]

adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes

9662M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	1630.00	Humira [VE]

■ ETANERCEPT

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months)

Clinical criteria:

Patient must have severe active juvenile idiopathic arthritis, **AND**

Patient must have received no prior PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition; OR

Patient must not have received PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in the previous 12 months, **AND**

Patient must have demonstrated severe intolerance of, or toxicity due to, methotrexate; OR

Patient must have demonstrated failure to achieve an adequate response to 1 or more of the following treatment regimens: (i) oral or parenteral methotrexate at a dose of at least 20 mg per square metre weekly, alone or in combination with oral or intra-articular corticosteroids, for a minimum of 3 months; or (ii) oral methotrexate at a dose of at least 10 mg per square metre weekly together with at least 1 other disease modifying anti-rheumatic drug (DMARD), alone or in combination with corticosteroids, for a minimum of 3 months, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be under 18 years of age and a parent or authorised guardian must have signed a patient acknowledgement.

Treatment criteria:

Must be treated by a paediatric rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

Severe intolerance to methotrexate is defined as intractable nausea and vomiting and general malaise unresponsive to manoeuvres, including reducing or omitting concomitant non-steroidal anti-inflammatory drugs (NSAIDs) on the day of methotrexate administration, use of folic acid supplementation, or administering the dose of methotrexate in 2 divided doses over 24 hours.

Toxicity due to methotrexate is defined as evidence of hepatotoxicity with repeated elevations of transaminases, bone marrow suppression temporally related to methotrexate use, pneumonitis, or serious sepsis.

If treatment with methotrexate alone or in combination with another DMARD is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

(a) an active joint count of at least 20 active (swollen and tender) joints; OR

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count assessment must be performed preferably whilst still on DMARD treatment, but no longer than 4 weeks following cessation of the most recent prior treatment.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form; and

(3) an acknowledgement signed by a parent or authorised guardian.

At the time of authority application, medical practitioners must request the appropriate number of injections to provide sufficient for four weeks of treatment. Up to a maximum of 3 repeats will be authorised.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle. A patient may re-trial etanercept after a minimum of 12 months have elapsed between the date the last PBS-subsidised bDMARD was stopped and the date of the first application under a new treatment cycle.

Note

Use of alternative DMARDs in children is dependent on approval by the Therapeutic Goods Administration as age restrictions may apply.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (change or recommencement of treatment after break of less than 12 months)

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**

Patient must have received prior PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in this treatment cycle, **AND**

Patient must not have failed PBS-subsidised therapy with etanercept for this condition in the current treatment cycle, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be under 18 years of age.

Treatment criteria:

Must be treated by a paediatric rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of injections to provide sufficient for four weeks of treatment. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with etanercept in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised etanercept treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised etanercept treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised etanercept treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept.

If a patient fails to respond to PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months) or Initial 2 (change or recommencement of treatment after break of less than 12 months) – balance of supply

Clinical criteria:

Patient must have received insufficient etanercept therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 12 months) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient etanercept therapy under the Initial 2 (change or recommencement of treatment after break of less than 12 months) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a paediatric rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Note

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**

Patient must have demonstrated an adequate response to treatment with etanercept, **AND**

Patient must have received etanercept as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Determination of whether a response has been demonstrated to initial and subsequent courses of treatment will be based on the baseline measurement of joint count submitted with the initial treatment application.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of injections to provide sufficient for four weeks of treatment. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with etanercept must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with etanercept, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with etanercept.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.

From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:

(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and

(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.

(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.

(5) Withdrawal of treatment after sustained remission.

Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment – balance of supply

Clinical criteria:

Patient must have received insufficient etanercept therapy under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1

5735W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	1630.01	Enbrel [PF]

ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1

5733R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	1630.01	Enbrel [PF]

etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack

5734T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	815.00	Enbrel [PF]

■ INFLIXIMAB**Authority required (STREAMLINED)****4524**

Acute severe ulcerative colitis

Clinical criteria:

Patient must have received an infusion of infliximab for the treatment of this condition as a hospital inpatient no more than two weeks prior to the date of the authority application, **AND**

Patient must be an adult aged 18 years or older, and prior to initiation of infliximab treatment in hospital must have been experiencing six or more bloody stools per day, plus at least one of the following: (i) Temperature greater than 37.8 degrees Celsius; (ii) Pulse rate greater than 90 beats per minute; (iii) Haemoglobin less than 105 g/L; (iv) Erythrocyte sedimentation rate greater than 30 mm/h; OR

Patient must be a child aged 6 to 17 years inclusive, and prior to initiation of infliximab treatment in hospital must have had a Paediatric Ulcerative Colitis Activity Index (PUCAI) greater than or equal to 65, with the diagnosis confirmed by a gastroenterologist, or a consultant physician as specified below, **AND**

Patient must have failed to achieve an adequate response to at least 72 hours treatment with intravenous corticosteroids prior to initiation of infliximab treatment in hospital.

Population criteria:

Patient must be 6 years of age or older.

Treatment criteria:

Must be treated by a gastroenterologist; OR

Must be treated by a consultant physician [internal medicine specialising in gastroenterology, or general medicine specialising in gastroenterology].

For adults aged 18 years or older, failure to achieve an adequate response to intravenous corticosteroid treatment is defined by the Oxford criteria where:

(i) If assessed on day 3, patients pass 8 or more stools per day or 3 or more stools per day with a C-reactive protein (CRP) greater than 45 mg/L

(ii) If assessed on day 7, patients pass 3 or more stools per day with visible blood.

For children aged 6 to 17 years, failure to achieve an adequate response to intravenous corticosteroids means a PUCAI score greater than 45 at 72 hours.

At the time of authority application, prescribers should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg.

Before administering infliximab to a child aged 6 to 17 years, the treating clinician must have consulted with a paediatric gastroenterologist or with an institution experienced in performance of paediatric colectomy. The name of the specialist or institution must be included in the patient's medical records.

Evidence that the patient meets the PBS restriction criteria must be recorded in the patient's medical records.

Note

No increase in the maximum number of repeats may be authorised.

infliximab 100 mg injection, 1 x 100 mg vial

10067W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	5	1	..	*3758.50	Remicade [JC]

■ INFLIXIMAB**Authority required**

Initial treatment of Crohn disease in a paediatric patient.

Initial PBS-subsidised treatment by a gastroenterologist, paediatrician or consultant physician as specified in the NOTE below, of a patient aged 6 to 17 years inclusive with moderate to severe refractory Crohn disease who satisfies the following criteria:

- (a) has confirmed Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or consultant physician as specified in the NOTE below; and
- (b) whose parent or authorised guardian has signed a patient acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and
- (c) has failed to achieve an adequate response to 2 of the following 3 conventional prior therapies including:

- (i) a tapered course of steroids, starting at a dose of at least 1 mg per kg or 40 mg (whichever is the lesser) prednisolone (or equivalent), over a 6 week period;
- (ii) an 8 week course of enteral nutrition;
- (iii) immunosuppressive therapy including:
 - azathioprine at a dose of at least 2 mg per kg daily for 3 or more months; or
 - 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months; or
 - methotrexate at a dose of at least 10 mg per square metre weekly for 3 or more months.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of the accepted toxicities including severity can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criterion indicates failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

- (a) severity of disease activity which results in a Paediatric Crohn Disease Activity Index (PCDAI) Score greater than or equal to 30 as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.
- (b) The most recent PCDAI assessment must be no more than 1 month old at the time of application.

All tests and assessments should be performed preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed current Paediatric Crohn Disease Activity Index (PCDAI) calculation sheet including the date of assessment of the patient's condition; and
 - (ii) details of previous systemic drug therapy [dosage, date of commencement and duration of therapy], or dates of enteral nutrition; and
 - (iii) the signed patient acknowledgement.

A maximum quantity and number of repeats to provide for an initial course of infliximab consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete the 3 doses of infliximab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

A PCDAI assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

Authority required

Continuing treatment of Crohn disease in a patient initiated on PBS-subsidised treatment as a paediatric patient.

Continuing PBS-subsidised treatment with infliximab by a gastroenterologist, paediatrician, consultant physician as specified in the NOTE below or other consultant physician in consultation with a gastroenterologist, of a patient who:

- (a) has a documented history of moderate to severe refractory Crohn disease; and
- (b) has demonstrated or sustained an adequate response to treatment with infliximab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to infliximab treatment is defined as a reduction in Paediatric Crohn Disease Activity Index (PCDAI) Score by at least 15 points as compared to baseline AND a total PCDAI score of 30 points or less.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed Paediatric Crohn Disease Activity Index (PCDAI) calculation sheet along with the date of the assessment of the patient's condition.

The PCDAI assessment must be no more than 1 month old at the time of application.

If the application is the first application for continuing treatment with infliximab, a PCDAI assessment of the patient's response must be made up to 12 weeks after the first dose so that there is adequate time for a response to be demonstrated.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

Patients who fail to demonstrate or sustain a response to treatment with infliximab for Crohn disease as specified in the criteria for continuing treatment with infliximab, will not be eligible to receive PBS-subsidised treatment with this drug within 12 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

Authority required

Initial PBS-subsidised treatment of Crohn disease in a paediatric patient who has previously received non-PBS-subsidised therapy with infliximab.

Initial PBS-subsidised supply for continuing treatment with infliximab by a gastroenterologist, paediatrician, consultant physician as specified in the NOTE below or other consultant physician in consultation with a gastroenterologist, of a patient aged 6 to 17 years inclusive who:

(a) has a documented history of moderate to severe refractory Crohn disease and was receiving treatment with infliximab prior to 4 July 2007; and

(b) had a Paediatric Crohn Disease Activity Index (PCDAI) Score of greater than 30 prior to commencing treatment with infliximab. Where a baseline CDAI assessment is not available, please call Medicare Australia on 1800 700 270 to discuss; and

(c) whose parent or authorised guardian has signed a patient acknowledgement indicating that they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and

(d) has demonstrated or sustained an adequate response to treatment with infliximab. For advice please contact Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to infliximab treatment is defined as a reduction in Paediatric Crohn Disease Activity Index (PCDAI) Score by at least 15 points as compared to baseline AND a total PCDAI score of 30 points or less.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the completed current and baseline Paediatric Crohn Disease Activity Index (PCDAI) calculation sheet along with the date of the assessment of the patient's condition; and

(ii) the signed patient acknowledgement.

The current PCDAI assessment must be no more than 1 month old at the time of application. The baseline PCDAI assessment must be from immediately prior to commencing treatment with infliximab.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

Patients who fail to demonstrate or sustain a response to treatment with infliximab for Crohn disease as specified in the criteria for continuing treatment with infliximab, will not be eligible to recommence PBS-subsidised treatment with this drug within 12 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Patients may qualify for PBS-subsidised treatment under this restriction once only

Note

Any queries concerning the arrangements to prescribe infliximab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe infliximab should be forwarded to:

Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

infliximab 100 mg injection, 1 x 100 mg vial

5755X

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
1	751.70	Remicade [JC]

■ INFLIXIMAB**Authority required**

Initial 1

Initial treatment of complex refractory FISTULISING CROHN DISEASE.

Initial PBS-subsidised treatment with infliximab by a gastroenterologist or a consultant physician as specified in the NOTE below, of a patient with complex refractory fistulising Crohn disease who:

(a) has confirmed Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or a consultant physician as specified in the NOTE below; and

(b) has an externally draining enterocutaneous or rectovaginal fistula; and

(c) has signed a patient acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

Authority applications must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) a completed current Fistula Assessment Form including the date of assessment of the patient's condition; and

(ii) a signed patient acknowledgement.

The most recent fistula assessment must be no more than 1 month old at the time of application.

A maximum quantity and number of repeats to provide for an initial course of infliximab consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6 will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete 3 doses of infliximab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

An assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (up to 6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

Authority required

Initial 2

Change or re-commencement of treatment of complex refractory FISTULISING CROHN DISEASE.

Initial PBS-subsidised treatment with infliximab of complex refractory fistulising Crohn disease by a gastroenterologist or a consultant physician as specified in the NOTE below, of a patient with complex refractory fistulising Crohn disease who:

(a) has a documented history of complex refractory fistulising Crohn disease; and

(b) in this treatment cycle, has received prior PBS-subsidised treatment with adalimumab or infliximab for a draining enterocutaneous or rectovaginal fistula; and

(c) has not failed PBS-subsidised therapy with infliximab for this condition more than once in the current treatment cycle.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of TNF-alfa antagonist therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised TNF-alfa antagonist treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of TNF-alfa antagonist treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of TNF-alfa antagonist.

Authority applications must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) a completed current Fistula Assessment Form including the date of assessment of the patient's condition; and

(ii) details of prior TNF-alfa antagonist treatment including details of date and duration of treatment.

The most recent fistula assessment must be no more than 1 month old at the time of application.

A maximum quantity and number of repeats to provide for an initial course of infliximab consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete 3 doses of infliximab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

An assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (up to 6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

Authority required

Initial 3 (grandfather)

Initial PBS-subsidised treatment of complex refractory FISTULISING CROHN DISEASE in a patient who has previously received non-PBS-subsidised therapy with infliximab.

Initial PBS-subsidised supply for continuing treatment with infliximab by a gastroenterologist, a consultant physician as specified in the NOTE below, or other consultant physician in consultation with a gastroenterologist of a patient who satisfies the following criteria:

- (a) has a documented history of complex refractory fistulising Crohn disease and was receiving treatment with infliximab prior to 1 March 2010; and
- (b) had a draining enterocutaneous or rectovaginal fistula(e) prior to commencing treatment with infliximab; and
- (c) has signed a patient acknowledgement indicating that they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and
- (d) is receiving treatment with infliximab at the time of application; and
- (e) has demonstrated or sustained an adequate response to treatment with infliximab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to infliximab treatment is defined as:

- (a) a decrease from baseline in the number of open draining fistulae of greater than or equal to 50%; and/or
- (b) a marked reduction in drainage of all fistula(e) from baseline, together with less pain and induration as reported by the patient.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) a completed current and baseline Fistula Assessment form including the date of assessment of the patient's condition; and
 - (ii) a signed patient acknowledgement.

The current fistula assessment must be no more than 1 month old at the time of application.

The baseline fistula assessment must be from immediately prior to commencing treatment with infliximab.

An assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criteria.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Patients may qualify for PBS-subsidised treatment under this restriction once only

Authority required

Continuing treatment of complex refractory FISTULISING CROHN DISEASE.

Continuing PBS-subsidised treatment with infliximab by a gastroenterologist, a consultant physician as specified in the NOTE below or other consultant physician in consultation with a gastroenterologist, of a patient who:

- (a) has a documented history of complex refractory fistulising Crohn disease; and
- (b) has demonstrated or sustained an adequate response to treatment with infliximab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response is defined as:

- (a) a decrease from baseline in the number of open draining fistulae of greater than or equal to 50%; and/or

(b) a marked reduction in drainage of all fistula(e) from baseline, together with less pain and induration as reported by the patient.

Authority applications must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Fistulising Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes a completed Fistula Assessment form including the date of the assessment of the patient's condition.

The fistula assessment must be no more than 1 month old at the time of application.

If the application is the first application for continuing treatment with infliximab, an assessment of the patient's response must be made up to 12 weeks after the first dose so that there is adequate time for a response to be demonstrated.

An assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criteria.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

Note

Any queries concerning the arrangements to prescribe infliximab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe infliximab should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF COMPLEX REFRACTORY FISTULISING CROHN DISEASE

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab and infliximab for patients with complex refractory fistulising Crohn disease. Where the term 'tumour necrosis factor (TNF) alfa antagonist' appears in the following NOTES and restrictions, it refers to adalimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any 1 time.

From 1 April 2011, under the PBS, all patients will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.

A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 April 2011 is considered to be in their first cycle as of 1 April 2011.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised TNF-alfa antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alfa antagonist under the new treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised TNF-alfa antagonist therapy after 1 April 2011.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised TNF-alfa antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient has received prior PBS-subsidised (initial or continuing) TNF-alfa antagonist therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iii) a patient wishes to re-commence treatment with a specific TNF-alfa antagonist following a break in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab and 14 weeks of therapy for infliximab.

From 1 April 2011, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose)

for infliximab, and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Adalimumab only: Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific TNF-alfa antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing TNF-alfa antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF-alfa antagonist supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised TNF-alfa antagonist is approved, a patient may swap if eligible to the alternate TNF-alfa antagonist within the same treatment cycle.

A patient may trial the alternate TNF-alfa antagonist at any time, regardless of whether they are receiving therapy (initial or continuing) with a TNF-alfa antagonist at the time of the application. However, they cannot swap to a particular TNF-alfa antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to the alternate TNF-alfa antagonist should be accompanied by the approved authority prescription or remaining repeats for the TNF-alfa antagonist the patient is ceasing.

(3) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated based on the baseline measurements submitted with the first authority application for a TNF-alfa antagonist. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and Medicare Australia will assess response according to these revised baseline measurements.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF-alfa antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity.

(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab or infliximab.

A patient who commenced treatment with adalimumab for complex refractory fistulising Crohn disease prior to 4 November 2010 or infliximab prior to 1 March 2010 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction.

A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab or infliximab will be authorised under this criterion.

Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab or infliximab will be assessed under the continuing treatment restriction.

'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

infliximab 100 mg injection, 1 x 100 mg vial

9654D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	751.70	Remicade [JC]

■ INFLIXIMAB

Authority required

Initial treatment [Initial 1, Whole body (New patients — No prior biological agent)]

Initial treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over who:

- (a) have severe chronic plaque psoriasis where lesions have been present for at least 6 months from the time of initial diagnosis; and
- (b) have not received any prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle; and
- (c) have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (whole body); and
- (d) have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments:
 - (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or
 - (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or

(iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or

(iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks.

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity to necessitate permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of acceptable toxicities including severity, associated with phototherapy, methotrexate, cyclosporin and acitretin, can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criterion indicates failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

(a) A current Psoriasis Area and Severity Index (PASI) score of greater than 15, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]]; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

A maximum of 22 weeks of treatment with infliximab will be authorised under this restriction.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats will be authorised.

Where fewer than 3 repeats are requested at the time of the initial application, authority approvals for sufficient repeats to complete a maximum of 22 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period beyond 22 weeks.

A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

Authority required

Initial or re-Treatment [Initial 2, Whole body (Received prior biological agent under PBS)]

Treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over who:

(a) have a documented history of severe chronic plaque psoriasis; and

(b) have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle; and

(c) have not failed PBS-subsidised therapy with infliximab for the treatment of this condition in the current Treatment Cycle.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets including the dates of assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]]; and

(ii) details of prior biological treatment, including dosage, date and duration of treatment.

Applications for patients who have demonstrated a response to PBS-subsidised infliximab treatment within this Treatment Cycle and who wish to re-commence infliximab treatment within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised infliximab treatment has been submitted to Medicare Australia within 1 month of cessation of treatment.

A maximum of 22 weeks of treatment with infliximab will be authorised under this restriction.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats will be authorised.

Where fewer than 3 repeats are requested at the time of the initial application, authority approvals for sufficient repeats to complete a maximum of 22 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be

granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period beyond 22 weeks.

A PASI assessment of the patient's response to this course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle

Authority required

Continuing treatment (Whole body)

Continuing PBS-subsidised treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over:

- (a) who have a documented history of severe chronic plaque psoriasis; and
- (b) whose most recent course of PBS-subsidised biological treatment for this condition in this Treatment Cycle was with infliximab; and
- (c) who have demonstrated an adequate response to their most recent course of treatment with infliximab.

An adequate response to treatment is defined as:

A Psoriasis Area and Severity Index (PASI) score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-biological treatment baseline value for this Treatment Cycle.

This assessment must be provided to Medicare Australia no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with infliximab, the assessment of response must be after a minimum of 12 weeks of treatment with an initial course.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet along with the date of the assessment of the patient's condition.

The most recent PASI assessment must be no more than 1 month old at the time of application.

Approval will be based on the PASI assessment of response to the most recent course of treatment with infliximab.

A maximum of 24 weeks of treatment with infliximab will be authorised under this restriction.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for continuing authority applications, or for treatment that would otherwise extend the treatment period beyond 24 weeks.

A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for further continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle

Authority required

Initial treatment [Initial 1, Face, hand, foot (New patients — No prior biological agent)]

Initial treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over who:

- (a) have severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis; and
- (b) have not received any prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle; and
- (c) have signed a patient and prescriber acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment (face, hand, foot); and

(d) have failed to achieve an adequate response, as demonstrated by a Psoriasis Area and Severity Index (PASI) assessment, to at least 3 of the following 4 treatments:

- (i) phototherapy (UVB or PUVA) for 3 treatments per week for at least 6 weeks; and/or
- (ii) methotrexate at a dose of at least 10 mg weekly for at least 6 weeks; and/or
- (iii) cyclosporin at a dose of at least 2 mg per kg per day for at least 6 weeks; and/or
- (iv) acitretin at a dose of at least 0.4 mg per kg per day for at least 6 weeks.

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, or where phototherapy is contraindicated, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity to necessitate permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of acceptable toxicities including severity, associated with phototherapy, methotrexate, cyclosporin and acitretin, can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criterion indicates failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

(a) Chronic plaque psoriasis classified as severe due to a plaque or plaques on the face, palm of a hand or sole of a foot where:

(i) at least 2 of the 3 Psoriasis Area and Severity Index (PASI) symptom subscores for erythema, thickness and scaling are rated as severe or very severe, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment; or

(ii) the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed, preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

(b) A PASI assessment must be completed for each prior treatment course, preferably whilst still on treatment, but no longer than 1 month following cessation of each course of treatment.

(c) The most recent PASI assessment must be no more than 1 month old at the time of application.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the completed current and previous Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]]; and

(ii) details of previous phototherapy and systemic drug therapy [dosage (where applicable), date of commencement and duration of therapy]; and

(iii) the signed patient and prescriber acknowledgements.

A maximum of 22 weeks of treatment with infliximab will be authorised under this restriction.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats will be authorised.

Where fewer than 3 repeats are requested at the time of the initial application, authority approvals for sufficient repeats to complete a maximum of 22 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period beyond 22 weeks.

A PASI assessment of the patient's response to this initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment.

The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline

Authority required

Initial or re-Treatment [Initial 2, Face, hand, foot (Received prior biological agent under PBS)]

Treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over who:

- (a) have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot; and
- (b) have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle; and
- (c) have not failed PBS-subsidised therapy with infliximab for the treatment of this condition in the current Treatment Cycle.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the completed current Psoriasis Area and Severity Index (PASI) calculation sheets and face, hand, foot area diagrams including the dates of assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]]; and

(ii) details of prior biological treatment, including dosage, date and duration of treatment.

Applications for patients who have demonstrated a response to PBS-subsidised infliximab treatment within this Treatment Cycle and who wish to re-commence infliximab treatment within the same Cycle following a break in therapy, will only be approved where evidence of the patient's response to their most recent course of PBS-subsidised infliximab treatment has been submitted to Medicare Australia within 1 month of cessation of treatment.

A maximum of 22 weeks of treatment with infliximab will be authorised under this restriction.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats will be authorised.

Where fewer than 3 repeats are requested at the time of the initial application, authority approvals for sufficient repeats to complete a maximum of 22 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period beyond 22 weeks.

A PASI assessment of the patient's response to this course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment.

The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.

Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle

Authority required

Continuing treatment (Face, hand, foot)

Continuing PBS-subsidised treatment as systemic monotherapy (other than methotrexate) by a dermatologist for adults 18 years and over:

- (a) who have a documented history of severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot; and
- (b) whose most recent course of PBS-subsidised biological treatment for this condition in this Treatment Cycle was with infliximab; and
- (c) who have demonstrated an adequate response to treatment with infliximab.

An adequate response to infliximab treatment is defined as the plaque or plaques assessed prior to biological treatment showing:

- (i) a reduction in the Psoriasis Area and Severity Index (PASI) symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the pre-biological treatment baseline values; or
- (ii) a reduction by 75% or more in the skin area affected, or sustained at this level, as compared to the pre-biological treatment baseline value.

This assessment must be provided to Medicare Australia no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with infliximab, the assessment of response must be after a minimum of 12 weeks of treatment with an initial course.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Chronic Plaque Psoriasis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed Psoriasis Area and Severity Index (PASI) calculation sheet and face, hand, foot area diagrams along with the date of the assessment of the patient's condition [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)].

The most recent PASI assessment must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with infliximab will be authorised under this restriction.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for continuing authority applications, or for treatment that would otherwise extend the treatment period beyond 24 weeks.

A PASI assessment of the patient's response must be conducted within 4 weeks prior to completion of this course of treatment. This assessment, which will be used to determine eligibility for further continuing treatment must be submitted to Medicare Australia no later than 1 month from the date of completion of this course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

It is recommended that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment.

The PASI assessment for continuing treatment must be performed on the same affected area assessed at baseline. Patients who fail to demonstrate a response to treatment with 3 biological agents are deemed to have completed this Treatment Cycle and must cease PBS-subsidised therapy. These patients may re-commence a new Biological Treatment Cycle after a minimum of 5 years has elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle

Note

Any queries concerning the arrangements to prescribe infliximab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe infliximab should be forwarded to:
Medicare Australia
Prior Written Approval of Specialised Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE CHRONIC PLAQUE PSORIASIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, etanercept, infliximab and ustekinumab, for adult patients with severe chronic plaque psoriasis. Therefore, where the term 'biological agents' appears in the following NOTES and restrictions, it only refers to adalimumab, etanercept, infliximab and ustekinumab.

From 1 March 2010, all patients will be able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial adalimumab, etanercept, infliximab or ustekinumab without having to meet the initial treatment criteria, that is they will not need to experience a disease flare when swapping to an alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

A patient who received PBS-subsidised biological agent treatment for chronic plaque psoriasis prior to 1 March 2010 is considered to be in their first Cycle as of 1 March 2010.

Patients are eligible for PBS-subsidised treatment with only 1 biological agent at any 1 time.

Within the same Treatment Cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for a PBS-subsidised biological agent, they must change to an alternate agent if they wish to continue PBS-subsidised biological treatment. A patient who, prior to 1 March 2010, was authorised to receive PBS-subsidised initial treatment for chronic plaque psoriasis with the same agent twice, is exempt from this condition in respect of applications approved prior to 1 March 2010.

Patients must be assessed for response to each course of continuing treatment according to the criteria included in the relevant continuing treatment restriction.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a Treatment Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological agent therapy before they are eligible to commence the next Cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised biological agent treatment in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Treatment Cycle.

Patients for whom a break in PBS-subsidised therapy of less than 5 years duration has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle.

There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe chronic plaque psoriasis after 1 March 2010.

There are separate restrictions for both the initial and continuing treatment for psoriasis affecting the whole body, versus psoriasis affecting the face, hands and feet.

(1) Application for approval for initial treatment.

Applications for a course of initial treatment should be made in the following situations:

- (i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); or
- (ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under '(4) Swapping therapy' below]; or
- (iii) patients who wish to re-commence treatment following a break in PBS-subsidised therapy with that agent (Initial 2).

All applications for initial treatment will be limited to provide for a maximum of 16 weeks of treatment in the case of adalimumab and etanercept, 22 weeks of treatment in the case of infliximab and 28 weeks of treatment in the case of ustekinumab.

(2) Assessment of response to initial treatment.

When prescribing initial treatment with a biological agent, a PASI assessment must be conducted after at least 12 weeks of treatment. This assessment must be submitted to Medicare Australia within 1 month of the completion of this initial treatment course. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

The PASI assessment for continuing treatment must be performed on the same affected area as assessed at baseline.

(3) Application for continuing treatment.

Following the completion of an initial treatment course of a biological agent to which an adequate response has been demonstrated, patients may qualify to receive up to 24 weeks of continuing treatment with that biological agent. Patients are eligible to continue to receive continuous treatment with 24 week courses providing they continue to sustain a response.

For second and subsequent courses of PBS-subsidised treatment with adalimumab, etanercept, infliximab or ustekinumab it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Where a response assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to sustain a response to treatment with that biological agent. In circumstances where it is not possible to submit a response assessment within these timeframes, please call Medicare Australia on 1800 700 270 to discuss.

(4) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate agent within the same Treatment Cycle without having to requalify with respect to disease severity (i.e. a PASI score of greater than 15), or prior treatment requirements.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

Patients may trial an alternate biological agent at any time, regardless of whether they are receiving therapy with a biological agent at the time of the application or not. However, they cannot swap to a particular agent if they have failed to respond to treatment with that particular agent within the same Cycle.

Patients who commenced treatment with adalimumab prior to 1 June 2009 or ustekinumab prior to 1 March 2010 access these interchangeability arrangements in the same way as patients who have not.

To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the approved authority prescription or remaining repeats for the agent being ceased.

(5) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated, based on the baseline PASI assessment submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment authority is submitted within a Treatment Cycle and subsequent response will be assessed according to this revised PASI score.

To ensure consistency in determining response, the same body area assessed at the baseline PASI assessment must be assessed for demonstration of response to treatment for the purposes of all continuing treatment applications.

(6) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

Patients who wish to trial a second or subsequent Biological Treatment Cycle, following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment according to the criteria of the relevant restriction and index of disease severity. Patients must have had at least 1 prior treatment, as listed in the criteria, for a minimum of 6 weeks, and must have a PASI assessment conducted preferably whilst still on treatment, but no later than 1 month following cessation of treatment. The PASI assessment must be no older than 1 month at the time of application.

No applications for increased repeats will be authorised.

infliximab 100 mg injection, 1 x 100 mg vial

5758C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	751.70	Remicade [JC]

■ INFLIXIMAB

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Initial treatment (new patient)

Clinical criteria:

Patient must have failed to achieve an adequate response to a 5-aminosalicylate oral preparation in a standard dose for induction of remission for 3 or more months or have intolerance necessitating permanent treatment withdrawal, **AND** Patient must have failed to achieve an adequate response to azathioprine at a dose of at least 2 mg per kg daily for 3 or more months or have intolerance necessitating permanent treatment withdrawal; OR

Patient must have failed to achieve an adequate response to 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months or have intolerance necessitating permanent treatment withdrawal; OR

Patient must have failed to achieve an adequate response to a tapered course of oral steroids, starting at a dose of at least 40 mg (for a child, 1 to 2 mg/kg up to 40 mg) prednisolone (or equivalent), over a 6 week period or have intolerance necessitating permanent treatment withdrawal, **AND**

Patient must have a Mayo clinic score greater than or equal to 6 if an adult patient; OR

Patient must have a partial Mayo clinic score greater than or equal to 6, provided the rectal bleeding and stool frequency subscores are both greater than or equal to 2 (endoscopy subscore is not required for a partial Mayo clinic score); OR

Patient must have a Paediatric Ulcerative Colitis Activity Index (PUCAI) Score greater than or equal to 30 if aged 6 to 17 years.

Population criteria:

Patient must be 6 years of age or older.

Treatment criteria:

Must be treated by a gastroenterologist (code 87) or a consultant physician [internal medicine specialising in

gastroenterology (code 81)] or a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR

Must be treated by a paediatrician or specialist paediatric gastroenterologist if aged between 6 to 17 years.

Applications for authorisation of initial treatment must be in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Ulcerative Colitis PBS Authority Application - Supporting Information Form which includes the following:
 - (i) the completed current Mayo clinic or partial Mayo clinic or Paediatric Ulcerative Colitis Activity Index (PUCAI) calculation sheet including the date of assessment of the patient's condition; and
 - (ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and
 - (iii) the signed patient acknowledgement.

A maximum quantity and number of repeats to provide for an initial course of this drug consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

All tests and assessments should be performed preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment. The most recent Mayo clinic, partial Mayo clinic or PUCAI score must be no more than 1 month old at the time of application.

Patients who fail to achieve a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1, or a PUCAI score less than 10 within the first 12 weeks of receiving this drug for ulcerative colitis, or have failed to maintain a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1, or have failed to maintain a PUCAI score less than 10 (if aged 6 to 17 years) with continuing treatment with this drug, will not be eligible to receive further PBS-subsidised treatment with this drug.

A partial Mayo clinic or PUCAI assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

The patient or guardian (required if patient aged 6 to 17 years) must have signed a patient acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application. If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application.

Patients may qualify for PBS-subsidised treatment under this restriction once only.

Note

Details of the toxicities, including severity, which will be accepted for the purposes of administering this restriction can be found on the Department of Human Services website at www.humanservices.gov.au

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Initial PBS-subsidised treatment of moderate to severe ulcerative colitis in a patient who has previously received non-PBS-subsidised therapy with this drug (grandfather)

Clinical criteria:

Patient must have been receiving treatment with this drug prior to 1 December 2014, **AND**

Patient must have had a Mayo clinic score greater than or equal to 6 prior to commencing treatment with this drug; OR

Patient must have had a partial Mayo clinic score greater than or equal to 6, provided the rectal bleeding and stool frequency subscores were both greater than or equal to 2 (endoscopy subscore is not required for a partial Mayo score) prior to commencing treatment with this drug; OR

Patient must have had a Paediatric Ulcerative Colitis Activity Index (PUCAI) Score greater than or equal to 30 prior to commencing treatment with this drug; OR

Patient must have a documented history of moderate to severe refractory ulcerative colitis prior to having commenced treatment with this drug where a Mayo clinic, partial Mayo clinic or PUCAI baseline assessment is not available, **AND** Patient must have demonstrated or sustained an adequate response to treatment by having a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1 while receiving treatment with this drug; OR

Patient must have demonstrated or sustained an adequate response to treatment by having a Paediatric Ulcerative Colitis Activity Index (PUCAI) score less than 10 while receiving treatment with this drug if aged 6 to 17 years.

Population criteria:

Patient must be 6 years of age or older.

Treatment criteria:

Must be treated by a gastroenterologist (code 87) or a consultant physician [internal medicine specialising in gastroenterology (code 81)] or a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR Must be treated by a paediatrician or specialist paediatric gastroenterologist if aged between 6 to 17 years.

Applications for authorisation of initial treatment must be in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Ulcerative Colitis PBS Authority Application - Supporting Information Form which includes the following:
 - (i) the completed current and baseline Mayo clinic or partial Mayo clinic or Paediatric Ulcerative Colitis Activity Index (PUCAI) calculation sheet including the date of assessment of the patient's condition and
 - (ii) the date of commencement of this drug and
 - (iii) the signed patient acknowledgement.

The current Mayo clinic or partial Mayo clinic or PUCAI assessment must be no more than 1 month old at the time of application. The baseline assessment must be from immediately prior to commencing treatment with this drug.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to be sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

The patient or guardian (required if patient aged 6 to 17 years) must have signed a patient acknowledgement indicating they understand and acknowledge that the PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment.

Patients may qualify for PBS-subsidised treatment under this restriction once only. For continuing PBS-subsidised treatment, a Grandfathered patient must qualify under the Continuing treatment criteria.

Note

Where a baseline assessment is not available, please call the Department of Human Services on 1800 700 270 to discuss (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Initial treatment (new patient) restriction to complete the 3 doses (i.e. the initial infusion regimen at weeks 0, 2 and 6 weeks); OR

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks of treatment; OR

Patient must have received insufficient therapy with this drug to complete 24 weeks of treatment under the Initial PBS-subsidised treatment restriction for patients who had previously received non-PBS subsidised treatment (Grandfathered patient), **AND**

The treatment must provide no more than the balance of up to 3 doses (new patients) or 2 repeats (Continuing patients or Grandfathered patients).

Population criteria:

Patient must be 6 years of age or older.

Treatment criteria:

Must be treated by a gastroenterologist (code 87) or a consultant physician [internal medicine specialising in gastroenterology (code 81)] or a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR

Must be treated by a paediatrician or specialist paediatric gastroenterologist if aged between 6 to 17 years.

Note

Authority approval for sufficient therapy to complete a maximum of 3 initial doses or 2 repeats may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authority approval for sufficient therapy to complete a maximum of 3 initial doses or 2 repeats should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Moderate to severe ulcerative colitis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have previously been issued with an authority prescription for this drug for this condition, **AND**

Patient must have demonstrated or sustained an adequate response to treatment by having a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1 while receiving treatment with this drug; OR

Patient must have demonstrated or sustained an adequate response to treatment by having a Paediatric Ulcerative Colitis Activity Index (PUCAI) score less than 10 while receiving treatment with this drug if aged 6 to 17 years.

Treatment criteria:

Must be treated by a gastroenterologist (code 87) or a consultant physician [internal medicine specialising in gastroenterology (code 81)] or a consultant physician [general medicine specialising in gastroenterology (code 82)]; OR

Must be treated by a paediatrician or specialist paediatric gastroenterologist if aged between 6 to 17 years.

Patients who have failed to maintain a partial Mayo clinic score less than or equal to 2, with no subscore greater than 1, or, patients who have failed to maintain a PUCAI score less than 10 (if aged 6 to 17 years) with continuing treatment with this drug, will not be eligible to receive further PBS-subsidised treatment with this drug.

Patients are eligible to receive continuing treatment with this drug in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

Special Pricing Arrangements apply.

infliximab 100 mg injection, 1 x 100 mg vial

10196P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	751.70	Remicade [JC]

■ INFLIXIMAB

Authority required

Active ankylosing spondylitis

Treatment Phase: Initial 1 (new patients)

Clinical criteria:

The condition must be radiographically (plain X-ray) confirmed Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis, **AND**

Patient must not have received any PBS-subsidised treatment with either adalimumab, certolizumab pegol, etanercept, golimumab or infliximab in this treatment cycle, **AND**

Patient must have at least 2 of the following: (i) low back pain and stiffness for 3 or more months that is relieved by exercise but not by rest; or (ii) limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by a score of at least 1 on each of the lumbar flexion and lumbar side flexion measurements of the Bath Ankylosing Spondylitis Metrology Index (BASMI); or (iii) limitation of chest expansion relative to normal values for age and gender, **AND**

Patient must have failed to achieve an adequate response following treatment with at least 2 non-steroidal anti-inflammatory drugs (NSAIDs), whilst completing an appropriate exercise program, for a total period of 3 months.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

The application must include details of the NSAIDs trialled, their doses and duration of treatment.

If the NSAID dose is less than the maximum recommended dose in the relevant TGA-approved Product Information, the application must include the reason a higher dose cannot be used.

If treatment with NSAIDs is contraindicated according to the relevant TGA-approved Product Information, the application must provide details of the contraindication.

If intolerance to NSAID treatment develops during the relevant period of use which is of a severity to necessitate permanent treatment withdrawal, the application must provide details of the nature and severity of this intolerance.

The following criteria indicate failure to achieve an adequate response and must be demonstrated at the time of the initial application:

- (a) a Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 4 on a 0-10 scale; AND
- (b) an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 10 mg per L.

The BASDAI must be determined at the completion of the 3 month NSAID and exercise trial, but prior to ceasing NSAID treatment. The BASDAI must be no more than 1 month old at the time of initial application.

Both ESR and CRP measures should be provided with the initial treatment application and both must be no more than 1 month old. If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reason this criterion cannot be satisfied.

The authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form which must include the following:
 - (i) a copy of the radiological report confirming Grade II bilateral sacroiliitis or Grade III unilateral sacroiliitis; and
 - (ii) a completed BASDAI Assessment Form; and

- (iii) a completed Exercise Program Self Certification Form included in the supporting information form; and
- (iv) a signed patient acknowledgment.

The assessment of the patient's response to the initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted no later than 4 weeks from the cessation of that treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

A maximum of 18 weeks of treatment with this drug will be approved under this criterion.

At the time of authority application, the doctor should request the appropriate number of vials, based on the weight of the patient, to provide for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats will be authorised.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) was approved in this cycle and the date of the first application under a new cycle.

Note

Details of the toxicities, including severity, which will be accepted for the purposes of administering this restriction can be found on the Department of Human Services website at www.humanservices.gov.au

For details on the appropriate minimum exercise program that will be accepted for the purposes of administering this restriction, please refer to the Department of Human Services website at www.humanservices.gov.au

Authority required

Ankylosing spondylitis

Treatment Phase: Initial 2 (change or recommencement for all patients)

Clinical criteria:

Patient must have a documented history of active ankylosing spondylitis, **AND**

Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition in this treatment cycle, **AND**

Patient must not have failed PBS-subsidised therapy with this drug for this condition in the current treatment cycle, **AND**

Patient must be eligible to receive further bDMARD therapy.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

Where the most recent course of PBS-subsidised bDMARD treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised bDMARD therapy or, under this restriction, for patients who have received previous PBS-subsidised bDMARD therapy) the patient must have been assessed for response to that course following a minimum of 12 weeks of treatment. These assessments must be provided to the Department of Human Services no later than 4 weeks from the date the course was ceased. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, patients must have been assessed for response, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

The authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

A maximum of 18 weeks of treatment with this drug will be approved under this criterion.

At the time of authority application, the doctor should request the appropriate number of vials, based on the weight of the patient, to provide for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats will be authorised.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Authority required

Ankylosing spondylitis

Treatment Phase: Initial treatment – Initial 1 (new patients) or Initial 2 (change or recommencement for all patients) – balance of supply

Clinical criteria:

Patient must have active, or a documented history of active, ankylosing spondylitis, **AND**

Patient must have received insufficient therapy with this drug under the Initial 1 (new patients) restriction to complete 18 weeks treatment; **OR**

Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement for all patients) restriction to complete 18 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 18 weeks treatment available under the above restrictions.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

Note

Authority approval for sufficient therapy to complete a maximum of 18 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 18 weeks of treatment should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of active ankylosing spondylitis, **AND**

Patient must have received this drug as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**

Patient must have demonstrated an adequate response to treatment with this drug.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

An adequate response is defined as an improvement from baseline of at least 2 of the BASDAI and 1 of the following:

- (a) an ESR measurement no greater than 25 mm per hour; or
- (b) a CRP measurement no greater than 10 mg per L; or
- (c) an ESR or CRP measurement reduced by at least 20% from baseline.

Where only 1 acute phase reactant measurement is supplied in the first application for PBS-subsidised treatment, that same marker must be measured and supplied in all subsequent continuing treatment applications.

The authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Ankylosing Spondylitis PBS Authority Application - Supporting Information Form.

All measurements provided must be no more than 1 month old at the time of application.

A maximum of 24 weeks of treatment with this drug will be authorised under this criterion.

At the time of authority application, the doctor should request the appropriate number of vials, based on the weight of the patient, to provide for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats will be authorised.

All applications for continuing treatment with this drug must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment following an initial treatment course it must be made following a minimum of 12 weeks of treatment with this drug. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this treatment cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised bDMARD was approved in this cycle and the date of the first application under a new cycle.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, certolizumab pegol, etanercept, golimumab and infliximab for adult patients with active ankylosing spondylitis.

Where the term 'bDMARD' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 5 bDMARDs at any 1 time.

From 1 March 2007, under the PBS, all patients will be able to commence a treatment cycle where they may trial PBS-subsidised bDMARDs without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a bDMARD while they continue to show a response to therapy.

A patient who received PBS-subsidised bDMARD treatment prior to 1 March 2007 is considered to be in their first cycle as of 1 March 2007.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once. A patient who, prior to 1 March 2007, was authorised to receive PBS-subsidised initial treatment for ankylosing spondylitis with the same agent twice, is exempt from this condition in respect of applications approved prior to 1 March 2007.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised bDMARD therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised bDMARD treatment in the most recent cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 bDMARDs in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
- (ii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iii) a patient wishes to re-commence treatment with a specific bDMARD following a break in PBS-subsidised therapy with that agent (Initial 2).

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the BASDAI), or the prior NSAID therapy and exercise program requirements.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the BASDAI, ESR and/or CRP submitted with the first authority application for a bDMARD.

However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to these revised baseline measurements.

For a new patient, the BASDAI used to determine the baseline must be measured while the patient is receiving NSAID therapy and completing their exercise program.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with at least 1 NSAID, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the BASDAI, ESR and/or CRP levels are measured.

Authority required

Ankylosing spondylitis

Treatment Phase: Continuing treatment – balance of supply

Clinical criteria:

Patient must have a documented history of active ankylosing spondylitis, **AND**

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

infliximab 100 mg injection, 1 x 100 mg vial

5753T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	751.70	Remicade [JC]

■ **INFLIXIMAB**

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Clinical criteria:

Patient must have severe active rheumatoid arthritis, **AND**

Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**

Patient must have not failed previous PBS-subsidised treatment with infliximab for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDs which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**

Patient must not receive more than 22 weeks of treatment under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

If methotrexate is contraindicated according to the TGA-approved product information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance including severity to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances including severity.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance including severity and dose for each DMARD must be provided in the authority application including severity.

The authority application must be made in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and
- (3) a signed patient acknowledgement.

At the time of authority application, medical practitioners should request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for a single infusion at a dose of 3 mg per kg. Up to a maximum of 3 repeats will be authorised.

Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted no later than 1 month from the date of completion of this initial course of treatment.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

Applications for a patient who has received PBS-subsidised treatment with infliximab and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised infliximab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised infliximab treatment was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised infliximab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

If a patient fails to demonstrate a response to treatment with infliximab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

- (a) a total active joint count of at least 20 active (swollen and tender) joints; or
 - (b) at least 4 active joints from the following list of major joints:
 - (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - (ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).
- The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note

The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:

- (a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
- (b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;

- (c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Special Pricing Arrangements apply.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months).

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**

Patient must not receive more than 22 weeks of treatment under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners should request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for single infusion at a dose of 3 mg per kg. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with infliximab and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised infliximab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised infliximab treatment was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised infliximab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

If a patient fails to demonstrate a response to a treatment with infliximab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

A patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply.

Clinical criteria:

Patient must have received insufficient infliximab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 22 weeks treatment; OR

Patient must have received insufficient infliximab therapy under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 22 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 22 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 22 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 22 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment.

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have demonstrated an adequate response to treatment with infliximab, **AND**

Patient must have received infliximab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners should request the appropriate number of vials to provide sufficient drug, based on the weight of the patient, for single infusion at a dose of 3 mg per kg. Up to a maximum of 2 repeats will be authorised.

All applications for continuing treatment with infliximab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with infliximab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

If a patient fails to demonstrate a response to treatment with infliximab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,

a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and

once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF- α antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements. To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply.

Clinical criteria:

Patient must have received insufficient infliximab therapy under the Continuing Treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

infliximab 100 mg injection, 1 x 100 mg vial

5757B

Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
1	751.70	Remicade [JC]

▪ INFLIXIMAB

Authority required

Initial 1 (new patients)

Initial treatment of Crohn disease in a patient assessed by CDAI.

Initial PBS-subsidised treatment with infliximab by a gastroenterologist or a consultant physician as specified in the NOTE below, of a patient with severe refractory Crohn disease who satisfies the following criteria:

(a) has confirmed Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or a consultant physician as specified in the NOTE below; and

(b) has signed a patient acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and

(c) has failed to achieve an adequate response to prior systemic therapy including:

(i) a tapered course of steroids, starting at a dose of at least 40 mg prednisolone (or equivalent), over a 6 week period; and

(ii) immunosuppressive therapy including:

- azathioprine at a dose of at least 2 mg per kg daily for 3 or more months; or
- 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months; or
- methotrexate at a dose of at least 15 mg weekly for 3 or more months.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of the accepted toxicities including severity can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criterion indicates failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

(a) have a severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 300 as assessed.

All tests and assessments should be performed preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

The most recent CDAI assessment must be no more than 1 month old at the time of application.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed current Crohn Disease Activity Index (CDAI) calculation sheet including the date of assessment of the patient's condition; and
 - (ii) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and
 - (iii) the signed patient acknowledgement.

A maximum quantity and number of repeats to provide for an initial course of infliximab consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete the 3 doses of infliximab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

A CDAI assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

Authority required

Initial 2

Change or re-commencement of treatment of Crohn disease in a patient assessed by CDAI.

Initial PBS-subsidised treatment with infliximab by a gastroenterologist or a consultant physician as specified in the NOTE below of a patient who:

- (a) has a documented history of severe refractory Crohn disease; and
- (b) in this treatment cycle, has received prior PBS-subsidised treatment with infliximab or adalimumab for this condition; and
- (c) has not failed PBS-subsidised therapy with infliximab for this condition more than once in the current treatment cycle.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of TNF-alfa antagonist therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised TNF-alfa antagonist treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of TNF-alfa antagonist treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of TNF-alfa antagonist.

Authority applications must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed current Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition; and
 - (ii) details of prior TNF alfa antagonist treatment including details of date and duration of treatment.

A maximum quantity and number of repeats to provide for an initial course of infliximab consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete the 3 doses of infliximab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

A CDAI assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

Authority required

Continuing treatment of Crohn disease in a patient assessed by CDAI.

Continuing PBS-subsidised treatment with infliximab by a gastroenterologist, a consultant physician as specified in the NOTE below or other consultant physician in consultation with a gastroenterologist, of a patient who:

- (a) has a documented history of severe refractory Crohn disease; and
- (b) has demonstrated or sustained an adequate response to treatment with infliximab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to infliximab treatment is defined as a reduction in Crohn Disease Activity Index (CDAI) Score to a level no greater than 150.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition.

The CDAI assessment must be no more than 1 month old at the time of application.

If the application is the first application for continuing treatment with infliximab, a CDAI assessment of the patient's response must be made up to 12 weeks after the first dose so that there is adequate time for a response to be demonstrated.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

Authority required

Initial 1

Initial treatment of Crohn disease in a patient with short gut syndrome or an ostomy patient.

Initial PBS-subsidised treatment with infliximab by a gastroenterologist, or consultant physician as specified in the NOTE below of a patient who satisfies the following criteria:

- (a) has confirmed Crohn disease defined by standard clinical, endoscopic and/or imaging features, including histological evidence with the diagnosis confirmed by a gastroenterologist or consultant physician as specified in the NOTE below; and
- (b) has diagnostic imaging or surgical evidence of short gut syndrome or has an ileostomy or colostomy; and
- (c) has evidence of intestinal inflammation; and
- (d) has signed a patient acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and
- (e) has failed to achieve an adequate response to prior systemic drug therapy including:
 - (i) a tapered course of steroids, starting at a dose of at least 40 mg prednisolone (or equivalent), over a 6 week period; and
 - (ii) immunosuppressive therapy including:
 - azathioprine at a dose of at least 2 mg per kg daily for 3 or more months; or
 - 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months; or
 - methotrexate at a dose of at least 15 mg weekly for 3 or more months.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of the accepted toxicities including severity can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

(a) have evidence of intestinal inflammation, including:

(i) blood: higher than normal platelet count, or, an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour, or, a C-reactive protein (CRP) level greater than 15 mg per L; AND/OR

(ii) faeces: higher than normal lactoferrin or calprotectin level; AND/OR

(iii) diagnostic imaging: demonstration of increased uptake of intravenous contrast with thickening of the bowel wall or mesenteric lymphadenopathy or fat streaking in the mesentery;

AND/OR

(b) be assessed clinically as being in a high faecal output state;

AND/OR

(c) be assessed clinically as requiring surgery or total parenteral nutrition (TPN) as the next therapeutic option, in the absence of infliximab.

All tests and assessments should be performed preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

Any one of the baseline criteria may be used to determine response to an initial course of treatment and eligibility for continued therapy, according to the criteria included in the continuing treatment restriction. However, the same criterion must be used for any subsequent determination of response to treatment, for the purpose of eligibility for continuing PBS-subsidised therapy.

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and

(ii) reports and dates of the pathology or diagnostic imaging test(s) nominated as the response criterion, if relevant; and

(iii) date of the most recent clinical assessment; and

(iv) the signed patient acknowledgement.

All assessments, pathology tests and diagnostic imaging studies must be made within 1 month of the date of application.

A maximum quantity and number of repeats to provide for an initial course of infliximab consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete the 3 doses of infliximab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

The assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

Authority required

Initial 2

Change or re-commencement of treatment of Crohn disease in a patient with short gut syndrome, an ostomy patient or a patient with extensive small intestine disease.

Initial PBS-subsidised treatment with infliximab by a gastroenterologist or a consultant physician as specified in the NOTE below of a patient who:

(a) has a documented history of severe refractory Crohn disease; and

(b) in this treatment cycle, has received prior PBS-subsidised treatment with infliximab or adalimumab for this condition; and

(c) has not failed PBS-subsidised therapy with infliximab for this condition more than once in the current treatment cycle.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

To demonstrate a response to treatment the application must be accompanied by the results of the most recent course of TNF-alfa antagonist therapy within the timeframes specified in the relevant restriction.

Where the most recent course of PBS-subsidised TNF-alfa antagonist treatment was approved under an initial treatment restriction, the patient must have been assessed for response to that course following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

If the response assessment to the previous course of TNF-alfa antagonist treatment is not submitted as detailed above, the patient will be deemed to have failed therapy with that particular course of TNF-alfa antagonist.

Authority applications must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

- (i) reports and dates of the pathology or diagnostic imaging test(s) nominated as the response criteria, if relevant; and
 - (ii) details of prior TNF alfa antagonist treatment including details of date and duration of treatment.
- A maximum quantity and number of repeats to provide for an initial course of infliximab consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of therapy so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

Authority required

Continuing treatment of Crohn disease in a patient with short gut syndrome or an ostomy patient.

Continuing PBS-subsidised treatment with infliximab by a gastroenterologist, a consultant physician as specified in the NOTE below or other consultant physician in consultation with a gastroenterologist, of a patient who:

- (a) has a documented history of severe refractory Crohn disease with intestinal inflammation and with short gut syndrome or with an ileostomy or colostomy; and
- (b) has demonstrated or sustained an adequate response to treatment with infliximab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to infliximab treatment is defined as:

- (a) improvement of intestinal inflammation as demonstrated by:

- (i) blood: normalisation of the platelet count, or an erythrocyte sedimentation rate (ESR) level no greater than 25 mm per hour, or a C-reactive protein (CRP) level no greater than 15 mg per L; AND/OR

- (ii) faeces: normalisation of lactoferrin or calprotectin level; AND/OR

- (iii) evidence of mucosal healing, as demonstrated by diagnostic imaging findings, compared to the baseline assessment; or

- (b) reversal of high faecal output state; or

- (c) avoidance of the need for surgery or total parenteral nutrition (TPN).

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription; and

- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

- (i) the reports and dates of the pathology or diagnostic imaging test(s) used to assess response to therapy or the date of clinical assessment.

The patient's assessment must be no more than 1 month old at the time of application.

If the application is the first application for continuing treatment with infliximab, an assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

Authority required

Initial 1

Initial treatment of Crohn disease in a patient with extensive small intestine disease.

Initial PBS-subsidised treatment with infliximab by a gastroenterologist or a consultant physician as specified in the NOTE below, of a patient with severe refractory Crohn disease who satisfies the following criteria:

- (a) has confirmed Crohn disease, defined by standard clinical, endoscopic and/or imaging features, including histological evidence, with the diagnosis confirmed by a gastroenterologist or consultant physician as specified in the NOTE below; and
- (b) has extensive small intestinal disease with radiological evidence of intestinal inflammation affecting more than 50 cm of the small intestine; and

- (c) has signed a patient acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and

- (d) has failed to achieve an adequate response to prior systemic therapy including:
- (i) a tapered course of steroids, starting at a dose of at least 40 mg prednisolone (or equivalent), over a 6 week period; and
 - (ii) immunosuppressive therapy including:
 - azathioprine at a dose of at least 2 mg per kg daily for 3 or more months; or
 - 6-mercaptopurine at a dose of at least 1 mg per kg daily for 3 or more months; or
 - methotrexate at a dose of at least 15 mg weekly for 3 or more months.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, please provide details at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, please provide details of the degree of this toxicity at the time of application. Details of the accepted toxicities including severity can be found on the Medicare Australia website (www.medicareaustralia.gov.au).

The following initiation criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the application:

- (a) have severity of disease activity which results in a Crohn Disease Activity Index (CDAI) Score greater than or equal to 220;

AND/OR

- (b) have evidence of active intestinal inflammation, including:

- (i) blood: higher than normal platelet count, or, an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour, or, a C-reactive protein (CRP) level greater than 15 mg per L; AND/OR

- (ii) faeces: higher than normal lactoferrin or calprotectin level; AND/OR

- (iii) diagnostic imaging: demonstration of increased uptake of intravenous contrast with thickening of the bowel wall or mesenteric lymphadenopathy or fat streaking in the mesentery;

AND/OR

- (c) be assessed clinically as being in a high faecal output state;

AND/OR

- (d) be assessed clinically as requiring surgery or total parenteral nutrition (TPN) as the next therapeutic option, in the absence of infliximab.

All tests and assessments should be performed preferably whilst still on treatment, but no longer than 1 month following cessation of the most recent prior treatment.

Any one of the baseline criteria may be used to determine response to an initial course of treatment and eligibility for continued therapy, according to the criteria included in the continuing treatment restriction. However, the same criterion must be used for any subsequent determination of response to treatment, for the purpose of eligibility for continuing PBS-subsidised therapy.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and

- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

- (i) details of prior systemic drug therapy [dosage, date of commencement and duration of therapy]; and

- (ii) (1) reports and dates of the pathology or diagnostic imaging test(s) nominated as the response criterion, if relevant; or (2) the completed current Crohn Disease Activity Index (CDAI) calculation sheet including the dates of assessment of the patient's condition, if relevant; and

- (iii) date of the most recent clinical assessment; and

- (iv) the signed patient acknowledgement.

All assessments, pathology tests and diagnostic imaging studies must be made within 1 month of the date of application.

A maximum quantity and number of repeats to provide for an initial course of infliximab consisting of 3 doses at 5 mg per kg body weight per dose to be administered at weeks 0, 2 and 6, will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete the 3 doses of infliximab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday). Under no circumstances will telephone approvals be granted for initial authority applications, or for treatment that would otherwise extend the initial treatment period.

The assessment of the patient's response to this initial course of treatment must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 1 month from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with infliximab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 12 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised infliximab treatment

Authority required

Continuing treatment of Crohn disease in a patient with extensive small intestine disease.

Continuing PBS-subsidised treatment with infliximab by a gastroenterologist, or consultant physician as specified in the NOTE below or other consultant physician in consultation with a gastroenterologist, of a patient who:

- (a) has a documented history of severe refractory Crohn disease with extensive intestinal inflammation affecting more than 50 cm of the small intestine; and

- (b) has demonstrated or sustained an adequate response to treatment with infliximab.

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)]. An adequate response to infliximab treatment is defined as:

- (a) a reduction in Crohn Disease Activity Index (CDAI) Score to no greater than 150; or
- (b) improvement of intestinal inflammation as demonstrated by:
 - (i) blood: normalisation of the platelet count, or an erythrocyte sedimentation rate (ESR) level no greater than 25 mm per hour, or a C-reactive protein (CRP) level no greater than 15 mg per L; AND/OR
 - (ii) faeces: normalisation of lactoferrin or calprotectin level; AND/OR
 - (iii) evidence of mucosal healing, as demonstrated by diagnostic imaging findings, compared to the baseline assessment; or
- (c) reversal of high faecal output state; or
- (d) avoidance of the need for surgery or total parenteral nutrition (TPN).

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition; or
 - (ii) the reports and dates of the pathology test or diagnostic imaging test(s) used to assess response to therapy; or
 - (iii) the date of clinical assessment.

All assessments must be no more than 1 month old at the time of application.

If the application is the first application for continuing treatment with infliximab, an assessment of the patient's response must be made up to 12 weeks after the first dose (6 weeks following the third dose) so that there is adequate time for a response to be demonstrated.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday)

Authority required

Initial 3 (grandfather)

Initial PBS-subsidised treatment of Crohn disease in a patient assessed by CDAI who has previously received non-PBS-subsidised therapy with infliximab.

Initial PBS-subsidised supply for continuing treatment with infliximab by a gastroenterologist, a consultant physician as specified in the NOTE below, or other consultant physician in consultation with a gastroenterologist of a patient who:

- (a) has a documented history of severe refractory Crohn disease and was receiving treatment with infliximab prior to 7 March 2007; and
- (b) had a Crohn Disease Activity Index (CDAI) Score of greater than or equal to 300 prior to commencing treatment with infliximab. Where a baseline CDAI assessment is not available, please call Medicare Australia on 1800 700 270 to discuss; and
- (c) has signed a patient acknowledgement indicating that they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and
- (d) has demonstrated or sustained an adequate response to treatment with infliximab. For advice please contact Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

An adequate response to infliximab treatment is defined as a reduction in Crohn Disease Activity Index (CDAI) Score to no greater than 150.

Applications for authorisation must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:
 - (i) the completed current and baseline Crohn Disease Activity Index (CDAI) Score calculation sheet including the date of the assessment of the patient's condition; and
 - (ii) the signed patient acknowledgement.

The current CDAI assessment must be no more than 1 month old at the time of application. The baseline CDAI assessment must be from immediately prior to commencing treatment with infliximab.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Patients may qualify for PBS-subsidised treatment under this restriction once only

Authority required

Initial 3

Initial PBS-subsidised treatment of Crohn disease in a patient with short gut syndrome, an ostomy patient, or a patient with extensive small intestine disease, who has previously received non-PBS-subsidised therapy with infliximab.

Initial PBS-subsidised supply for continuing treatment with infliximab by a gastroenterologist, a consultant physician as specified in the NOTE below, or other consultant physician in consultation with a gastroenterologist, of a patient who:

(a) has a documented history of severe refractory Crohn disease and was receiving treatment with infliximab prior to 7 March 2007; and

(b) (1) has a history of extensive small intestinal disease with radiological evidence of intestinal inflammation affecting more than 50 cm of the small intestine; or

(2) has diagnostic imaging or surgical evidence of short gut syndrome or has an ileostomy or colostomy with a documented history of intestinal inflammation; and

(c) has signed a patient acknowledgement indicating that they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criterion for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment; and

(d) has demonstrated or sustained an adequate response to treatment with infliximab according to the criteria included in the relevant continuation restriction. For advice please contact Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

NOTE: Prescribers must be gastroenterologists (code 87), consultant physicians [internal medicine specialising in gastroenterology (code 81)] or consultant physicians [general medicine specialising in gastroenterology (code 82)].

The same criteria used to determine an inadequate response to prior treatment at baseline must be used to determine response to treatment and eligibility for continuing therapy, according to the criteria included in the continuing treatment restriction.

An adequate response to infliximab treatment is defined as:

(a) a reduction in Crohn Disease Activity Index (CDAI) Score to no greater than 150; or

(b) improvement of intestinal inflammation as demonstrated by:

(i) blood: normalisation of the platelet count, or an erythrocyte sedimentation rate (ESR) level no greater than 25 mm per hour, or a C-reactive protein (CRP) level no greater than 15 mg per L; AND/OR

(ii) faeces: normalisation of lactoferrin or calprotectin level; AND/OR

(iii) evidence of mucosal healing, as demonstrated by diagnostic imaging findings, compared to the baseline assessment; or

(c) reversal of high faecal output state; or

(d) avoidance of the need for surgery or total parenteral nutrition (TPN).

Applications for authorisation must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Crohn Disease PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) (1) the completed current and baseline Crohn Disease Activity Index (CDAI) Score calculation sheet, where relevant, including the date of the assessment of the patient's condition; or

(2) the reports and dates of the current and baseline pathology or diagnostic imaging test(s) in order to assess response to therapy; or

(3) the date of clinical assessment(s); and

(ii) the signed patient acknowledgement.

The patient's assessment must be no more than 1 month old at the time of application. The baseline CDAI assessments must be from immediately prior to commencing treatment with infliximab. Where a baseline assessment is not available, please call Medicare Australia on 1800 700 270 to discuss.

The assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criterion.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with infliximab.

Patients are eligible to receive continuing infliximab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of the authority application, medical practitioners should request the appropriate number of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats will be authorised. No applications for increased repeats will be authorised.

Where fewer than 2 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Patients may qualify for PBS-subsidised treatment under this restriction once only

Note

Any queries concerning the arrangements to prescribe infliximab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe infliximab should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE REFRACTORY CROHN DISEASE

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab and infliximab for adult patients with severe refractory Crohn disease. Where the term 'tumour necrosis factor (TNF) alfa antagonist' appears in the following NOTES and restrictions, it refers to adalimumab and infliximab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 2 TNF-alfa antagonists at any 1 time.

From 1 August 2008, under the PBS, all patients will be able to commence a treatment cycle where they may trial each PBS-subsidised TNF-alfa antagonist without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single treatment cycle, a patient may continue to receive long-term treatment with a TNF-alfa antagonist while they continue to show a response to therapy.

A patient who received PBS-subsidised TNF-alfa antagonist treatment prior to 1 August 2008 is considered to be in their first cycle as of 1 August 2008.

Within the same treatment cycle, a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised TNF-alfa antagonist more than twice.

Once a patient has either failed or ceased to respond to treatment 3 times, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 5-year break in PBS-subsidised TNF-alfa antagonist therapy before they are eligible to commence the next cycle. The 5-year break is measured from the date of the last approval for PBS-subsidised TNF-alfa antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alfa antagonist under the new treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of less than 5 years, may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alfa antagonists in a treatment cycle and who has a break in therapy of more than 5 years, may commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised TNF-alfa antagonist therapy after 1 August 2008.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised TNF-alfa antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient has received prior PBS-subsidised (initial or continuing) TNF-alfa antagonist therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iii) a patient wishes to re-commence treatment with a specific TNF-alfa antagonist following a break in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy for adalimumab and 14 weeks of therapy for infliximab.

From 1 August 2008, a patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy for adalimumab and up to 12 weeks after the first dose (6 weeks following the third dose) for infliximab, and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

For second and subsequent courses of PBS-subsidised TNF-alfa antagonist treatment, it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Adalimumab only: Two completed authority prescriptions must be submitted with every initial application for adalimumab. One prescription must be for the induction pack containing a quantity of 6 doses of 40 mg and no repeats. The second prescription must be written for 2 doses of 40 mg and 2 repeats.

(b) Continuing treatment. Following the completion of an initial treatment course with a specific TNF-alfa antagonist, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing TNF-alfa antagonist treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted TNF-alfa antagonist supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that TNF-alfa antagonist.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised TNF-alfa antagonist is approved, a patient may swap if eligible to the alternate TNF-alfa antagonist within the same treatment cycle without having to requalify with respect to the indices of disease severity (i.e. Crohn Disease Activity Index (CDAI) Score, evidence of intestinal inflammation), or the prior

corticosteroid therapy and immunosuppressive therapy.

A patient may trial the alternate TNF-alfa antagonist at any time, regardless of whether they are receiving therapy (initial or continuing) with a TNF-alfa antagonist at the time of the application. However, they cannot swap to a particular TNF-alfa antagonist if they have failed to respond to prior treatment with that drug two times within the same treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to the alternate TNF-alfa antagonist should be accompanied by the approved authority prescription or remaining repeats for the TNF-alfa antagonist the patient is ceasing.

(3) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated based on the baseline measurements of the CDAI or evidence of intestinal inflammation submitted with the first authority application for a TNF-alfa antagonist. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted within a treatment cycle and Medicare Australia will assess response according to these revised baseline measurements.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

(4) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised TNF-alfa antagonist therapy of at least 5 years, must requalify for initial treatment with respect to the indices of disease severity. Patients must have received treatment with a corticosteroid and at least 1 immunosuppressive agent, at an adequate dose, for a minimum of 3 consecutive months immediately prior to the time the CDAI score or the indices of intestinal inflammation are measured.

(5) Patients 'grandfathered' onto PBS-subsidised treatment with adalimumab or infliximab.

A patient who commenced treatment with adalimumab for severe refractory Crohn disease prior to 9 November 2007 or infliximab prior to 7 March 2007 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction.

A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with adalimumab or infliximab will be authorised under this criterion.

Following completion of the initial PBS-subsidised course, further applications for treatment with adalimumab or infliximab will be assessed under the continuing treatment restriction.

'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must requalify for initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' above for further details.

infliximab 100 mg injection, 1 x 100 mg vial

5754W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	751.70	Remicade [JC]

■ INFLIXIMAB

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more)

Clinical criteria:

Patient must have severe active psoriatic arthritis, **AND**

Patient must have received no prior PBS-subsidised treatment with a biological agent for this condition; **OR**

Patient must have received no PBS-subsidised treatment with a biological agent for at least 5 years if they have previously received PBS-subsidised treatment with a biological agent for this condition, **AND**

Patient must have failed to achieve an adequate response to methotrexate at a dose of at least 20 mg weekly for a minimum period of 3 months, **AND**

Patient must have failed to achieve an adequate response to sulfasalazine at a dose of at least 2 g per day for a minimum period of 3 months; **OR**

Patient must have failed to achieve an adequate response to leflunomide at a dose of up to 20 mg daily for a minimum period of 3 months, **AND**

Patient must not receive more than 22 weeks of treatment under this restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist; **OR**

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab or infliximab.

Where treatment with methotrexate, sulfasalazine or leflunomide is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

Where intolerance to treatment with methotrexate, sulfasalazine or leflunomide developed during the relevant period of use, which was of a severity to necessitate permanent treatment withdrawal, details of the degree of this toxicity must be provided at the time of application.

The following initiation criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; and

either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list of major joints:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats may be authorised.

Note

Details of the toxicities, including severity, which will be accepted as a reason for exempting a patient from the requirement for 3 months treatment with methotrexate and 3 months treatment with sulfasalazine or leflunomide can be found on the Department of Human Services website (www.humanservices.gov.au)

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment – Initial 2 (change or recommencement of treatment)

Clinical criteria:

Patient must have a documented history of severe active psoriatic arthritis, **AND**

Patient must have received prior PBS-subsidised treatment with a biological agent for this condition in this Treatment Cycle, **AND**

Patient must not have already failed, or ceased to respond to, PBS-subsidised treatment with 3 biological agents within this Treatment Cycle, **AND**

Patient must not have failed, or ceased to respond to, PBS-subsidised treatment with this drug during the current Treatment Cycle, **AND**

Patient must not receive more than 22 weeks of treatment under this restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab or infliximab.

The authority application must be made in writing and must include:

(1) a completed authority prescription form; and

(2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 3 repeats may be authorised.

Applications for a patient who has previously received PBS-subsidised treatment with this drug within this Treatment Cycle and who wishes to recommence therapy with this drug within this same Cycle, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised treatment with this drug.

Where the most recent course of PBS-subsidised treatment was approved under either of the initial treatment restrictions (i.e. for patients with no prior PBS-subsidised biological therapy or, under this restriction, for patients who have received previous PBS-subsidised biological therapy), the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must have been submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised treatment with this drug was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment was not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

- (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note

The assessment of the patient's response to this initial course of treatment must be made following a minimum of 12 weeks of treatment and submitted to the Department of Human Services no later than 4 weeks from the cessation of the treatment course. If the response assessment is not submitted within these timeframes, the patient will be deemed to have failed this course of treatment.

Authority required

Severe psoriatic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) or Initial 2 (change or recommencement of treatment) - balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Initial 1 (new patient or patient recommencing treatment after a break of 5 years or more) restriction to complete 22 weeks treatment; OR

Patient must have received insufficient therapy with this drug under the Initial 2 (change or recommencement of treatment) restriction to complete 22 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 22 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 22 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 22 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active psoriatic arthritis, **AND**

Patient must have received this drug as their most recent course of PBS-subsidised treatment with a biological agent for this condition in the current Treatment Cycle, **AND**

Patient must demonstrate, at the time of application, an adequate response to treatment with this drug, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

Patient must be an adult.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

For the purposes of this restriction 'biological agent' means adalimumab, certolizumab pegol, etanercept, golimumab or infliximab.

An adequate response to treatment is defined as:

an erythrocyte sedimentation rate (ESR) no greater than 25 mm per hour or a C-reactive protein (CRP) level no greater than 15 mg per L or either marker reduced by at least 20% from baseline; and

either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications.

All applications for continuing treatment with this drug must include a measurement of response to the most recent course of PBS-subsidised therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with this drug, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Where a response assessment is not submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with this drug.

The authority application must be made in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Psoriatic Arthritis PBS Authority Application - Supporting Information Form.

At the time of the authority application, medical practitioners should request the appropriate quantity of vials, based on the weight of the patient, to provide sufficient for a single infusion at a dose of 5 mg per kg. Up to a maximum of 2 repeats may be authorised.

Note

Patients who fail to demonstrate a response to treatment with this drug under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug in this Treatment Cycle. Patients may re-trial this drug after a minimum of 5 years have elapsed between the date the last prescription for a PBS-subsidised biological agent was approved in this Cycle and the date of the first application under the new Cycle.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE PSORIATIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological agents adalimumab, certolizumab pegol, etanercept, golimumab and infliximab for adult patients with severe active psoriatic arthritis.

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological agents at any 1 time.

Where the term 'biological agents' appears in notes and restrictions, it refers to adalimumab, certolizumab pegol, etanercept, golimumab and infliximab only.

Patients receiving PBS-subsidised treatment for psoriatic arthritis are able to commence a 'Biological Treatment Cycle' (Cycle), where they may trial biological agents without having to experience a disease flare when swapping to the alternate agent. Under these interchangeability arrangements, within a single Cycle, patients may receive long-term treatment with a biological agent as long as they sustain a response to therapy.

Following demonstration of response to initial treatment, these biological agents are available under the PBS for continuing treatment as set out in the continuing treatment restriction for each agent.

Once patients have either failed or ceased to sustain a response to treatment 3 times, they are deemed to have completed a single Cycle and they must have, at a minimum, a 5-year break in PBS-subsidised biological therapy before they are eligible to commence another Cycle [further details are under '(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy' below].

The duration of the break in therapy will be measured from the date the last approval for PBS-subsidised treatment was granted in the most recent Cycle to the date of the first application for initial treatment with a biological agent under the new Cycle.

Within the same Cycle, patients are not allowed to fail, or cease to respond to, the same PBS-subsidised biological agent more than once. Therefore once a patient fails to meet the response criteria for any biological agent, they must change to an alternate agent which they have not previously failed, if they wish to continue PBS-subsidised biological treatment.

Patients for whom a break in PBS-subsidised therapy of less than 5 years has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, may commence a further course of treatment within that Cycle.

Patients for whom a break in PBS-subsidised therapy of 5 years or more has occurred, and, who have failed therapy fewer than 3 times within a particular treatment Cycle, as defined in the relevant restriction, are eligible to commence a new Cycle. There is no limit to the number of Biological Treatment Cycles a patient may undertake in their lifetime.

How to prescribe biological agents for the treatment of severe active psoriatic arthritis.

(1) Initial treatment.

Applications for initial treatment should be made where:

- (i) patients have received no prior PBS-subsidised biological treatment and wish to commence such therapy (Initial 1); and
- (ii) patients have received prior PBS-subsidised biological therapy and wish to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; and
- (iii) patients wish to re-commence treatment with a specific biological agent following a break in PBS-subsidised therapy with that specific agent (Initial 2).

All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of therapy for adalimumab, etanercept and golimumab, 18 to 20 weeks of therapy for certolizumab pegol (depending upon the dosing regimen), and 22 weeks of therapy for infliximab. It is recommended that patients be reviewed in the month prior to completing their course of initial treatment to ensure uninterrupted biological agent supply.

Patients must be assessed for response to any course of PBS-subsidised initial treatment following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

Grandfather patients - certolizumab pegol only.

For patients who commenced treatment with certolizumab pegol for psoriatic arthritis prior to 1 April 2015, applications for initial PBS-subsidised treatment as continuing therapy may be made under the relevant initial treatment restriction (Initial 3). These patients access the PBS interchangeability arrangements in the same way as new patients who have not been treated with any biological agent prior to PBS listing of that agent.

Applications for initial PBS-subsidised treatment for grandfather patients will provide for a maximum of 24 weeks of treatment for all agents. Approval will be based on the criteria included in the relevant restriction.

(2) Continuing treatment.

Following the completion of an initial treatment course with a specific biological agent, patients may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

Patients are eligible to receive continuing biological treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

Patients must be assessed for response to a course of continuing therapy, and the assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased. Where a response assessment is not submitted within these timeframes, patients will be deemed to have failed to respond to treatment with that biological agent.

(3) Swapping therapy.

Once an authority for initial treatment with the first PBS-subsidised biological agent is approved, patients may swap to an alternate biological agent without having to re-qualify with respect to either the indices of disease severity (i.e. erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) level, and active joint count) or the prior non-biological therapy requirements.

Patients may swap to an alternate biological agent at any time, regardless of whether they are receiving therapy (initial or continuing) with a biological agent at the time of the application or not.

Within a Treatment Cycle patients may alternate between therapy with any biological agent of their choice (1 at a time) providing:

- (i) they have not received PBS-subsidised treatment with that particular biological agent previously; or
- (ii) they have demonstrated an adequate response to that particular biological agent if they have previously trialled it on the PBS; and
- (iii) they have not previously failed to respond to treatment 3 times in this Treatment Cycle.

To ensure patients receive the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, applications for patients who wish to swap to an alternate biological agent should be accompanied by the approved authority prescription or remaining repeats for the biological agent the patient is ceasing.

(4) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the indices of disease severity submitted with the first authority application for a biological agent. However, prescribers may provide new baseline measurements any time that an initial treatment application is submitted within a treatment Cycle and these revised baseline measurements will be used to assess response.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. 20 or more active joints), response will be determined according to a reduction in the total number of active joints.

(5) Re-commencement of treatment after a 5-year break in PBS-subsidised therapy.

Patients who wish to trial a second or subsequent treatment Cycle following a break in PBS-subsidised biological therapy of at least 5 years, must requalify for initial treatment with respect to both the indices of disease severity. Patients must have received treatment with methotrexate and sulfasalazine or leflunomide, at an adequate dose, for a minimum of 3 months at the time the ESR or CRP levels and the active joint counts are measured.

Authority required

Severe psoriatic arthritis

Treatment Phase: Continuing treatment - balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of psoriatic arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

infliximab 100 mg injection, 1 x 100 mg vial

5756Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	751.70	Remicade [JC]

Interleukin inhibitors**■ ANAKINRA****Authority required (STREAMLINED)****4920**

Moderate to severe cryopyrin associated periodic syndromes (CAPS)

Treatment criteria:

Must be treated by a rheumatologist or in consultation with a rheumatologist.

A diagnosis of CAPS must be documented in the patient's medical records.

Note

This drug is not PBS-subsidised for conditions other than CAPS.

anakinra 100 mg/0.67 mL injection, 28 x 0.67 mL syringes

10264F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	5	..	1650.00	Kineret [FK]

■ TOCILIZUMAB**Authority required**

Initial 1 (new and recommencing patients after a break of more than 12 months)

Initial treatment by a rheumatologist, or under the supervision of a paediatric rheumatology treatment centre, of a patient under 18 years who:

(a) has been diagnosed with systemic juvenile idiopathic arthritis; AND

(b) has polyarticular course disease and either:

(i) failure to achieve an adequate response to the following treatment regimen (see (1) below for definition of failure to achieve an adequate response):

— oral or parenteral methotrexate at a dose of at least 15 mg per square metre weekly, alone or in combination with oral or intra-articular corticosteroids for a minimum of 3 months; or

(ii) severe intolerance of, or toxicity due to, methotrexate (see (2) below for definition of severe intolerance and toxicity); OR

(c) has refractory systemic symptoms, demonstrated by:

— an inability to decrease and maintain the dose of prednisolone (or equivalent) below 0.5 mg per kg per day following a minimum of 2 months of therapy; AND

(d) has not received PBS-subsidised treatment with tocilizumab for this condition in the previous 12 months.

(1) The following criteria indicate failure to achieve an adequate response to prior methotrexate therapy and must be demonstrated in all patients at the time of the initial application:

(a) in a patient with polyarticular course disease:

(i) an active joint count of at least 20 active (swollen and tender) joints; OR

(ii) at least 4 active joints from the following list:

— elbow, wrist, knee and/or ankle (assessed as swollen and tender); AND/OR

— shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

(b) in a patient with refractory systemic symptoms:

(i) an active joint count of at least 2 active joints; AND

(ii) persistent fever greater than 38 degrees Celsius for at least 5 out of 14 consecutive days; AND/OR

(iii) a C-reactive protein (CRP) level and platelet count above the upper limits of normal (ULN).

(2) Severe intolerance to methotrexate is defined as intractable nausea and vomiting and general malaise unresponsive to manoeuvres, including reducing or omitting concomitant NSAIDs on the day of methotrexate administration, use of folic acid supplementation, or administering the dose of methotrexate in 2 divided doses over 24 hours.

Toxicity to methotrexate is defined as evidence of hepatotoxicity with repeated elevations of transaminases, bone marrow suppression temporally related to methotrexate use, pneumonia, or serious sepsis.

If treatment with methotrexate alone or in combination with other treatments is contraindicated according to the relevant TGA-approved Product Information, please provide details at time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, please provide details of this toxicity at the time of application.

The baseline measurements of joint count, fever and/or CRP level and platelet count must be performed preferably whilst on treatment, but no longer than 4 weeks following cessation of the most recent prior treatment.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline must be provided for all subsequent continuing treatment applications.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Systemic Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

(i) the date of assessment of severe active systemic juvenile idiopathic arthritis;

- (ii) details of prior treatment including dose and duration of treatment;
- (iii) pathology reports detailing CRP and platelet count where appropriate; and
- (3) a signed patient or authorised guardian acknowledgement form.

The most recent systemic juvenile idiopathic arthritis assessment must be no more than 1 month old at the time of application.

A maximum of 16 weeks of treatment will be authorised under this restriction.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for two infusions (one month supply). A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

Where fewer than 3 repeats are requested at the time of initial application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Assessment of a patient's response to an initial course of treatment must be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia no later than 4 weeks from the date of completion of this initial course of treatment. Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to respond to 2 courses of treatment in a treatment cycle they will not be eligible to receive further PBS-subsidised tocilizumab therapy in that treatment cycle. A patient may re-trial tocilizumab after a minimum of 12 months have elapsed between the date the last PBS-subsidised treatment was stopped and the date of the first application under a new treatment cycle.

Authority required

Initial 2 (retrial or recommencement of treatment after a break of less than 12 months)

Initial PBS-subsidised treatment by a rheumatologist, or under the supervision of a paediatric rheumatology treatment centre, of a patient who:

- (a) has a documented history of systemic juvenile idiopathic arthritis; AND
- (b) has received PBS-subsidised treatment with tocilizumab for this condition in the previous 12 months; AND
- (c) has not failed PBS-subsidised therapy with tocilizumab for this condition more than once in the current treatment cycle.

The authority application must be made in writing and must include:

- (1) completed authority prescription form(s); and
- (2) a completed Systemic Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

- (i) pathology reports detailing CRP and platelet count where appropriate.

Applications for a patient who has received PBS-subsidised treatment with tocilizumab in this treatment cycle and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised tocilizumab treatment, within the timeframes specified below.

A maximum of 16 weeks of treatment will be authorised under this restriction.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for two infusions (one month supply). A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

Where fewer than 3 repeats are requested at the time of the application, authority approvals for sufficient repeats to complete a maximum of 16 weeks of treatment with tocilizumab may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

An assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criteria. Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with tocilizumab.

Where a response assessment is not undertaken and submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to that course of tocilizumab.

If a patient fails to respond to 2 courses of treatment they will not be eligible to receive further PBS-subsidised tocilizumab therapy in this treatment cycle. A patient may re-trial tocilizumab after a minimum of 12 months have elapsed between the date the last PBS-subsidised treatment was stopped and the date of the first application under a new treatment cycle.

Authority required

Initial 3 ('grandfather' patients)

Initial treatment by a rheumatologist, or under the supervision of a paediatric rheumatology treatment centre, of a patient who:

- (a) has a documented history of systemic juvenile idiopathic arthritis; and
- (b) was receiving treatment with tocilizumab prior 1 November 2011; and
- (c) has demonstrated a response as specified in the criteria for continuing PBS-subsidised treatment with tocilizumab; and
- (d) is receiving treatment with tocilizumab at the time of application.

To ensure consistency in determining response, the same indices of disease severity used to establish the baseline must be provided for all subsequent continuing treatment applications.

The authority application must be made in writing and must include:

- (1) completed authority prescription form(s); and
- (2) a completed Systemic Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

- (i) pathology reports detailing CRP and platelet count where appropriate; and
- (3) a signed patient or authorised guardian acknowledgement form.

The most recent systemic juvenile idiopathic arthritis assessment must be no more than 1 month old at the time of application.

The baseline systemic juvenile idiopathic arthritis assessment must be provided and must be from immediately prior to commencing treatment with tocilizumab. (See NOTE (3) above for definition of baseline measurements to determine response.)

An assessment of the patient's response to a continuing course of therapy must be made within the 4 weeks prior to completion of that course and posted to Medicare Australia no less than 2 weeks prior to the date the next dose is scheduled, in order to ensure continuity of treatment for those patients who meet the continuation criteria.

Where an assessment is not submitted to Medicare Australia within these timeframes, patients will be deemed to have failed to respond, or to have failed to sustain a response, to treatment with tocilizumab.

Patients are eligible to receive continuing tocilizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for two infusions (one months supply). A separate authority prescription form must be completed for each strength requested. Up to a maximum of 5 repeats will be authorised.

Where fewer than 5 repeats are initially requested with the authority prescription, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

A patient may only qualify for PBS-subsidised treatment under this restriction once

Authority required

Continuing treatment

Continuing treatment with tocilizumab, by a rheumatologist or under the supervision of a paediatric rheumatology treatment centre, of a patient who:

- (a) has a documented history of systemic juvenile idiopathic arthritis; AND
- (b) has demonstrated an adequate response to treatment with tocilizumab.

An adequate response to treatment is defined as:

- (a) in a patient with polyarticular course disease:

- (i) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

- (ii) a reduction in the number of the following major active joints, from at least 4, by at least 50%:

— elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

— shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

- (b) in a patient with refractory systemic symptoms:

- (i) absence of fever greater than 38 degrees Celsius in the preceding seven days; AND/OR

- (ii) a reduction in the CRP level and platelet count by at least 30% from baseline; AND/OR

- (iii) a reduction in the dose of corticosteroid by at least 30% from baseline.

The authority application must be made in writing and must include:

- (1) completed authority prescription form(s); and

- (2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)] which includes the following:

- (i) baseline and current pathology reports detailing CRP and platelet count where appropriate.

The most recent systemic juvenile idiopathic arthritis assessment must be no more than 1 month old at the time of application.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under the Initial treatment restriction, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be provided to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Patients are eligible to receive continuing tocilizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for two infusions (one month supply). A separate authority prescription form must be completed for each strength requested. Up to a maximum of 5 repeats will be authorised.

Where fewer than 5 repeats are requested at the time of initial application, authority approvals for sufficient repeats to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

If a patient fails to respond to 2 courses of treatment they will not be eligible to receive further PBS-subsidised tocilizumab therapy in this treatment cycle. A patient may re-trial tocilizumab after a minimum of 12 months have elapsed between the date the last PBS-subsidised treatment was stopped and the date of the first application under a new treatment cycle

Note

Any queries concerning the arrangements to prescribe tocilizumab may be directed to Medicare Australia on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Further prescribing information (including Authority Application Forms) is available on the Medicare Australia website at www.medicareaustralia.gov.au.

Written applications for authority to prescribe tocilizumab should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying anti-rheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alpha antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

PBS-subsidised abatacept, golimumab, infliximab and rituximab must be used in combination with methotrexate at a dose of at least 7.5 mg weekly. Where a patient cannot tolerate 7.5 mg of methotrexate weekly, they are eligible to receive PBS-subsidised adalimumab, certolizumab pegol, etanercept and tocilizumab.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alpha antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

— a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,

— a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and

— once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alpha antagonists prior to 1 August 2010 please contact Medicare Australia on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to Medicare Australia within 4 weeks.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to Medicare Australia 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF- α antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and Medicare Australia will assess response according to these revised baseline measurements.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

TREATMENT OF PATIENTS WITH SEVERE ACTIVE SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of tocilizumab for a patient who has severe active systemic juvenile idiopathic arthritis (sJIA).

From 1 May 2012, a patient receiving PBS-subsidised tocilizumab therapy is considered to be in a treatment cycle. Under these arrangements, within a single treatment cycle, a patient may:

- continue to receive long-term treatment with PBS-subsidised tocilizumab while they continue to show a response to therapy, and
- fail to respond, or to sustain a response, to PBS-subsidised tocilizumab twice.

Once a patient has either failed or ceased to respond to 2 courses of treatment, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised tocilizumab therapy before

they are eligible to receive further PBS-subsidised tocilizumab therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised tocilizumab treatment was stopped to the date of the first application for initial treatment with tocilizumab under the new treatment cycle.

A patient who was receiving PBS-subsidised tocilizumab treatment immediately prior to 1 May 2012 is considered to be in their first cycle as of 1 May 2012. A patient who has had a break in tocilizumab treatment of at least 12 months immediately prior to making a new application, on or after 1 May 2012, will commence a new treatment cycle.

A patient who has failed their first course of tocilizumab in a treatment cycle and who has a break in therapy of less than 12 months may commence a second course of treatment within the same treatment cycle.

A patient who has failed their first course of tocilizumab in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.

(1) How to prescribe PBS-subsidised tocilizumab therapy after 1 May 2012.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised tocilizumab treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to re-commence treatment with tocilizumab following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or

(iii) a patient has received the first course of PBS-subsidised (initial or continuing) tocilizumab therapy in a treatment cycle and is deemed to have failed to respond or sustain a response and the treating physician wishes to trial a second course (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab for that course.

For second and subsequent courses of PBS-subsidised tocilizumab, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to Medicare Australia no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with tocilizumab, a patient may qualify to receive up to 24 weeks of continuing treatment with tocilizumab providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing tocilizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted tocilizumab supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to Medicare Australia no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

(2) Treatment cycle.

Once initial treatment with PBS-subsidised tocilizumab is approved, a patient deemed to have failed to respond to the first course of treatment may have a second course without having to requalify with respect to the indices of disease severity (joint count, fever and/or CRP level and platelet count) or the prior therapy requirements, except if the patient has had a break in therapy of more than 12 months.

To ensure a patient receives the maximum treatment opportunities allowed under these arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

(3) Baseline measurements to determine response.

Medicare Australia will determine whether a response to treatment has been demonstrated based on the relevant baseline measurements of the joint count, fever and/or CRP level and platelet count submitted with the first authority application for tocilizumab.

Where a patient is deemed to have failed to respond or to sustain a response to the first course of therapy in a treatment cycle, prescribers may provide new baseline measurements for the second course of treatment within that cycle. Medicare Australia will assess response according to these revised baseline measurements. If new baseline measurements are not submitted with the initial application for the second course of treatment, then those submitted with the first course will be used by Medicare Australia to assess response to the second course.

(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised tocilizumab therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.

(5) Patients 'grandfathered' onto PBS-subsidised treatment with tocilizumab.

A patient who commenced treatment with tocilizumab for severe active systemic juvenile idiopathic arthritis prior to 1 November 2011 and who continues to receive treatment at the time of application, may qualify for treatment under the initial 'grandfather' treatment restriction.

A patient may only qualify for PBS-subsidised treatment under this criterion once. A maximum of 24 weeks of treatment with tocilizumab will be authorised under this criterion.

Following completion of the initial PBS-subsidised course, further applications for treatment with tocilizumab will be assessed under the continuing treatment restriction.

'Grandfather' arrangements will only apply for the first treatment cycle. For the second and subsequent cycles, a 'grandfather' patient must qualify for initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 12 month break in PBS-subsidised therapy' above for further details.

(6) Withdrawal of treatment after sustained remission.

Withdrawal of treatment with tocilizumab should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to Medicare Australia at the time treatment is ceased.

Special Pricing Arrangements apply.

tocilizumab 200 mg/10 mL injection, 1 x 10 mL vial

1481Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	467.20	Actemra [RO]

tocilizumab 400 mg/20 mL injection, 1 x 20 mL vial

1482B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	934.40	Actemra [RO]

tocilizumab 80 mg/4 mL injection, 1 x 4 mL vial

1476Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	186.88	Actemra [RO]

■ TOCILIZUMAB

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months)

Clinical criteria:

Patient must have severe active juvenile idiopathic arthritis, **AND**

Patient must have received no prior PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition; OR

Patient must not have received PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in the previous 12 months, **AND**

Patient must have demonstrated severe intolerance of, or toxicity due to, methotrexate; OR

Patient must have demonstrated failure to achieve an adequate response to 1 or more of the following treatment regimens:

(i) oral or parenteral methotrexate at a dose of at least 20 mg per square metre weekly, alone or in combination with oral or intra-articular corticosteroids, for a minimum of 3 months; or (ii) oral methotrexate at a dose of at least 10 mg per square metre weekly together with at least 1 other disease modifying anti-rheumatic drug (DMARD), alone or in combination with corticosteroids, for a minimum of 3 months, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be under 18 years of age and a parent or authorised guardian must have signed a patient acknowledgement.

Treatment criteria:

Must be treated by a paediatric rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

Severe intolerance to methotrexate is defined as intractable nausea and vomiting and general malaise unresponsive to manoeuvres, including reducing or omitting concomitant non-steroidal anti-inflammatory drugs (NSAIDs) on the day of methotrexate administration, use of folic acid supplementation, or administering the dose of methotrexate in 2 divided doses over 24 hours.

Toxicity due to methotrexate is defined as evidence of hepatotoxicity with repeated elevations of transaminases, bone marrow suppression temporally related to methotrexate use, pneumonitis, or serious sepsis.

If treatment with methotrexate alone or in combination with another DMARD is contraindicated according to the relevant TGA-approved Product Information, details must be provided at the time of application.

If intolerance to treatment develops during the relevant period of use, which is of a severity necessitating permanent treatment withdrawal, details of this toxicity must be provided at the time of application.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

(a) an active joint count of at least 20 active (swollen and tender) joints; OR

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count assessment must be performed preferably whilst still on DMARD treatment, but no longer than 4 weeks following cessation of the most recent prior treatment.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form; and

(3) an acknowledgement signed by a parent or authorised guardian.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle. A patient may re-trial tocilizumab after a minimum of 12 months have elapsed between the date the last PBS-subsidised bDMARD was stopped and the date of the first application under a new treatment cycle.

Note

Use of alternative DMARDs in children is dependent on approval by the Therapeutic Goods Administration as age restrictions may apply.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (change or recommencement of treatment after break of less than 12 months)

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**

Patient must have received prior PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in this treatment cycle, **AND**

Patient must not have failed PBS-subsidised therapy with tocilizumab for this condition in the current treatment cycle, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be under 18 years of age.

Treatment criteria:

Must be treated by a paediatric rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with tocilizumab in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised tocilizumab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to respond to PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 12 months) or Initial 2 (change or recommencement of treatment after break of less than 12 months) – balance of supply.

Clinical criteria:

Patient must have received insufficient tocilizumab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 12 months) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient tocilizumab therapy under the Initial 2 (change or recommencement of treatment after break of less than 12 months) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a paediatric rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Note

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis, **AND**

Patient must have demonstrated an adequate response to treatment with tocilizumab, **AND**

Patient must have received tocilizumab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

An adequate response to treatment is defined as:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Determination of whether a response has been demonstrated to initial and subsequent courses of treatment will be based on the baseline measurement of joint count submitted with the initial treatment application.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with tocilizumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with tocilizumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

TREATMENT OF PATIENTS WITH SEVERE ACTIVE JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient who has severe active juvenile idiopathic arthritis. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.

From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability

arrangements, within a single treatment cycle, a patient may:

- (i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and
- (ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 12 month break in PBS-subsidised biological therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 12 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 12 months may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 12 months must commence a new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or
- (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 12 months (Initial 1); or
- (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 12 months in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 12 months.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.

(4) Re-commencement of treatment after a 12 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 12 months, must requalify for treatment under the Initial 1 treatment restriction.

(5) Withdrawal of treatment after sustained remission.

Withdrawal of treatment with bDMARDs should be considered in a patient who has achieved and sustained complete remission of disease for 12 months. A demonstration of response to the current treatment should be submitted to the Department of Human Services at the time treatment is ceased.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing Treatment – balance of supply

Clinical criteria:

Patient must have received insufficient tocilizumab therapy under the Continuing Treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Patient must be undergoing treatment under the supervision of a paediatric rheumatology treatment centre.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

tocilizumab 200 mg/10 mL injection, 1 x 10 mL vial

10056G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	467.20	Actemra [RO]

tocilizumab 400 mg/20 mL injection, 1 x 20 mL vial

10064Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	934.40	Actemra [RO]

tocilizumab 80 mg/4 mL injection, 1 x 4 mL vial

10077J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	186.88	Actemra [RO]

■ TOCILIZUMAB**Authority required**

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**

Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months; OR

Patient must have received no PBS-subsidised bDMARD treatment for at least 5 years if they failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) in their last treatment cycle, **AND**

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDs which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

If methotrexate is contraindicated according to the TGA-approved Product Information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialed, their doses and duration of treatment, and all relevant contraindications and/or intolerances.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance and dose for each DMARD must be provided in the authority application.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

(a) an active joint count of at least 20 active (swollen and tender) joints; or

(b) at least 4 active joints from the following list:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form; and

(3) a signed patient acknowledgement.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle. A patient may re-trial tocilizumab after a minimum of 5 years have elapsed between the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle and the date of the first application under a new treatment cycle.

Note

The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:

(a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose; (b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;

(c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 2 (change or recommencement of treatment after break of less than 24 months)

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**

Patient must have received prior PBS-subsidised treatment with adalimumab, etanercept or tocilizumab for this condition in this treatment cycle, **AND**

Patient must not have failed PBS-subsidised therapy with tocilizumab for this condition in the current treatment cycle, **AND** Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with tocilizumab in this treatment cycle and who wishes to recommence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised tocilizumab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under either of the Initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to respond to PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) an active joint count of fewer than 10 active (swollen and tender) joints; or

(b) a reduction in the active (swollen and tender) joint count by at least 50% from baseline; or

(c) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or commencement of treatment after break of less than 24 months) – balance of supply

Clinical criteria:

Patient must have received insufficient tocilizumab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient tocilizumab therapy under the Initial 2 (change or commencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active juvenile idiopathic arthritis with onset prior to the age of 18 years, **AND**

Patient must have demonstrated an adequate response to treatment with tocilizumab, **AND**

Patient must have received tocilizumab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment in this treatment cycle, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction 'biological disease modifying anti-rheumatic drug' and 'bDMARD' mean adalimumab, etanercept or tocilizumab.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) an active joint count of fewer than 10 active (swollen and tender) joints; or

(b) a reduction in the active (swollen and tender) joint count by at least 50% from baseline; or

(c) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder, cervical spine and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

(2) a completed Juvenile Idiopathic Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners must request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for one infusion. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with tocilizumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with tocilizumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to respond to PBS-subsidised bDMARD treatment 3 times (once with each agent) they will not be eligible to receive further PBS-subsidised bDMARD therapy in this treatment cycle.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH A HISTORY OF JUVENILE IDIOPATHIC ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of adalimumab, etanercept and tocilizumab for a patient over 18 years who has a history of juvenile idiopathic arthritis with onset prior to the age of 18 years. Where the term bDMARD appears in notes and restrictions, it refers to adalimumab, etanercept and tocilizumab only.

A patient is eligible for PBS-subsidised treatment with only 1 of the 3 bDMARDs at any one time.

From 1 April 2014, a patient receiving PBS-subsidised bDMARD therapy is considered to be in a treatment cycle where they may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements, within a single treatment cycle, a patient may:

(i) continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy; and

(ii) fail to respond or to sustain a response to each PBS-subsidised bDMARD once only.

Once a patient has either failed or ceased to respond to PBS-subsidised bDMARD treatment 3 times, they are deemed to have completed a single treatment cycle and they must have, at a minimum, a 5 year break in PBS-subsidised bDMARD therapy before they are eligible to receive further PBS-subsidised bDMARD therapy. The length of a treatment break is measured from the date of the last approval for PBS-subsidised bDMARD therapy in the last treatment cycle to the date of the first application for initial treatment with a bDMARD under the new treatment cycle.

A patient who was receiving PBS-subsidised bDMARD treatment immediately prior to 1 April 2014 is considered to be in their first cycle as of 1 April 2014. A patient who has had a break in bDMARD treatment of at least 24 months immediately prior to making a new application, on or after 1 April 2014, will commence a new treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of less than 24 months may commence a further course of treatment within the same treatment cycle.

A patient who has failed fewer than 3 trials of a bDMARD in a treatment cycle and who has a break in therapy of more than 24 months must commence a new treatment cycle. The length of the break in therapy is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment was stopped to the date of the first application for initial treatment

with a bDMARD under the new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 April 2014.

(a) Initial treatment.

Applications for initial treatment should be made where:

(i) a patient has received no prior PBS-subsidised bDMARD treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

(ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or

(iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or

(iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial treatment authorisations will be limited to provide for a maximum of 16 weeks of therapy.

A patient must be assessed for response to any course of initial PBS-subsidised treatment following a minimum of 12 weeks of therapy, and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD, it is recommended that a patient is reviewed in the 4 weeks prior to completing their current course of treatment and that an application is posted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD, a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment.

A patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (joint count and ESR/CRP) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug within the current treatment cycle.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count submitted with the first authority application for a bDMARD. However, prescribers may provide a new baseline measurement any time that an initial treatment authority application is submitted within a treatment cycle and the Department of Human Services will assess response according to the revised baseline measurement.

(4) Re-commencement of treatment after a 24 month break in PBS-subsidised therapy.

A patient who wishes to start a second or subsequent treatment cycle following a break in PBS-subsidised bDMARD therapy of at least 24 months, must requalify for treatment under the Initial 1 treatment restriction.

Authority required

Severe active juvenile idiopathic arthritis

Treatment Phase: Continuing Treatment – balance of supply

Clinical criteria:

Patient must have received insufficient tocilizumab therapy under the Continuing Treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

tocilizumab 200 mg/10 mL injection, 1 x 10 mL vial

10058J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	467.20	Actemra [RO]

tocilizumab 400 mg/20 mL injection, 1 x 20 mL vial

10072D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	934.40	Actemra [RO]

tocilizumab 80 mg/4 mL injection, 1 x 4 mL vial

10081N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	186.88	Actemra [RO]

■ TOCILIZUMAB

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months)

Clinical criteria:

Patient must have severe active rheumatoid arthritis, **AND**

Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**

Patient must not have failed previous PBS-subsidised treatment with tocilizumab for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDs which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

If methotrexate is contraindicated according to the TGA-approved product information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance including severity to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances including severity.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance including severity and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

(1) completed authority prescription form(s); and

- (2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and
 (3) a signed patient acknowledgement.

At the time of the authority application, medical practitioners should request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for a single infusion at a dose of 8 mg per kg. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

If a patient fails to demonstrate a response to treatment with tocilizumab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

- (a) a total active joint count of at least 20 active (swollen and tender) joints; or
- (b) at least 4 active joints from the following list of major joints:
 - (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - (ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response.

Note

The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:

- (a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
- (b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;

- (c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months).

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**

Patient must not receive more than 16 weeks of treatment under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

The authority application must be made in writing and must include:

- (a) completed authority prescription form(s); and
- (b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners should request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for a single infusion at a dose of 8 mg per kg. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 3 repeats will be authorised.

Applications for a patient who has received PBS-subsidised treatment with tocilizumab and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised tocilizumab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response following a minimum of 12 weeks of therapy. This assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where the most recent course of PBS-subsidised tocilizumab treatment was approved under the continuing treatment criteria, the patient must have been assessed for response, and the assessment must be submitted no later than 4 weeks from the date that course was ceased.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to demonstrate a response to a treatment with tocilizumab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

If a patient who has demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note

Special Pricing Arrangements apply.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (new patient or patient recommencing treatment after a break of more than 24 months) or Initial 2 (change or recommencement of treatment after break of less than 24 months) – balance of supply.

Clinical criteria:

Patient must have received insufficient tocilizumab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more than 24 months) restriction to complete 16 weeks treatment; OR

Patient must have received insufficient tocilizumab therapy under the Initial 2 (change or recommencement of treatment after break of less than 24 months) restriction to complete 16 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 16 weeks treatment available under the above restrictions.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment.

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have demonstrated an adequate response to treatment with tocilizumab, **AND**

Patient must have received tocilizumab as their most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment, **AND**

Patient must not receive more than 24 weeks of treatment per continuing treatment course authorised under this restriction.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP level is provided with the initial application, the same marker will be used to determine response.

The authority application must be made in writing and must include:

- (1) completed authority prescription form(s); and
- (2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

At the time of authority application, medical practitioners should request the appropriate number of vials of appropriate strength to provide sufficient drug, based on the weight of the patient, for a single infusion at a dose of 8 mg per kg. A separate authority prescription form must be completed for each strength requested. Up to a maximum of 5 repeats will be authorised.

All applications for continuing treatment with tocilizumab must include a measurement of response to the prior course of therapy. This assessment must be submitted no later than 4 weeks from the cessation of that treatment course. If the application is the first application for continuing treatment with tocilizumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with tocilizumab.

If a patient fails to demonstrate a response to treatment with tocilizumab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alpha antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alpha antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

- a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,
- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and
- once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alpha antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or
- (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
- (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing

regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

the Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major

joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing Treatment – balance of supply.

Clinical criteria:

Patient must have received insufficient tocilizumab therapy under the Continuing Treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

tocilizumab 200 mg/10 mL injection, 1 x 10 mL vial

9658H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	467.20	Actemra [RO]

tocilizumab 400 mg/20 mL injection, 1 x 20 mL vial

9659J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	934.40	Actemra [RO]

tocilizumab 80 mg/4 mL injection, 1 x 4 mL vial

9657G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	186.88	Actemra [RO]

Calcineurin inhibitors

▪ **CYCLOSPORIN**

Caution

Careful monitoring of patients is mandatory.

Authority required (STREAMLINED)

3333

For use by organ or tissue transplant recipients

cyclosporin 50 mg/mL injection, 10 x 1 mL ampoules

5631J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	54.10	Sandimmun [NV]

▪ **CYCLOSPORIN**

Caution

Careful monitoring of patients is mandatory.

Authority required (STREAMLINED)

3328

Management of rejection in patients following organ or tissue transplantation, under the supervision and direction of a transplant unit. Management includes initiation, stabilisation and review of therapy as required

Authority required (STREAMLINED)

3329

Management (which includes initiation, stabilisation and review of therapy) by dermatologists or clinical immunologists of patients with severe atopic dermatitis for whom other systemic therapies are ineffective or inappropriate

Authority required (STREAMLINED)

3330

Management (which includes initiation, stabilisation and review of therapy) by dermatologists of patients with severe psoriasis for whom other systemic therapies are ineffective or inappropriate and in whom the disease has caused significant interference with quality of life

Authority required (STREAMLINED)

3331

Management (which includes initiation, stabilisation and review of therapy) by nephrologists of patients with nephrotic syndrome in patients in whom steroids and cytostatic drugs have failed or are not tolerated or are considered inappropriate and in whom renal function is unimpaired

Authority required (STREAMLINED)

3332

Management (which includes initiation, stabilisation and review of therapy) by rheumatologists or clinical immunologists of patients with severe active rheumatoid arthritis for whom classical slow-acting anti-rheumatic agents (including methotrexate) are ineffective or inappropriate

cyclosporin 10 mg capsule, 60

5632K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	
	2	5	..	*74.40	Neoral 10 [NV]	

cyclosporin 100 mg capsule, 30

5636P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	4	5	..	*651.08	^a Cyclosporin Sandoz [SZ]	^a Neoral 100 [NV]

cyclosporin 100 mg/mL oral liquid, 50 mL

5633L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	
	4	5	..	*1263.16	Neoral [NV]	

cyclosporin 25 mg capsule, 30

5634M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	4	5	..	*153.56	^a Cyclosporin Sandoz [SZ]	^a Neoral 25 [NV]

cyclosporin 50 mg capsule, 30

5635N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	4	5	..	*319.52	^a Cyclosporin Sandoz [SZ]	^a Neoral 50 [NV]

■ **TACROLIMUS**

Caution

Careful monitoring of patients is mandatory.

Authority required (STREAMLINED)

3328

Management of rejection in patients following organ or tissue transplantation, under the supervision and direction of a transplant unit. Management includes initiation, stabilisation and review of therapy as required

tacrolimus 1 mg capsule, 100

9560E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*587.56	^a Pharmacor Tacrolimus 1 [CR] ^a Tacrolimus Sandoz [SZ]	^a Prograf [LL]

tacrolimus 1 mg capsule: modified release, 60 capsules

9665Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	
	2	5	..	*352.52	Prograf XL [LL]	

tacrolimus 5 mg capsule, 50

9561F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*1468.16	^a Pharmacor Tacrolimus 5 [CR] ^a Tacrolimus Sandoz [SZ]	^a Prograf [LL]

tacrolimus 5 mg capsule: modified release, 30 capsules

9666R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	
	2	5	..	*881.36	Prograf XL [LL]	

tacrolimus 500 microgram capsule, 100

9558C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	5	..	*293.78	^a Pharmacor Tacrolimus 0.5 [CR] ^a Tacrolimus Sandoz [SZ]	^a Prograf [LL]

tacrolimus 500 microgram capsule: modified release, 30 capsules

9664P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*88.14	Prograf XL [LL]

Other immunosuppressants**■ LENALIDOMIDE****Authority required**

Myelodysplastic syndrome

Treatment Phase: Initial treatment

Clinical criteria:The treatment must be limited to a maximum duration of 16 weeks, **AND**Patient must be classified as Low risk or Intermediate-1 according to the International Prognostic Scoring System (IPSS), **AND**Patient must have a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities, **AND**

Patient must be red blood cell transfusion dependent.

Classification of a patient as Low risk requires a score of 0 on the IPSS, achieved with the following combination: less than 5% marrow blasts with good karyotypic status (normal, -Y alone, -5q alone, -20q alone), and 0/1 cytopenias.

Classification of a patient as Intermediate-1 requires a score of 0.5 to 1 on the IPSS, achieved with the following possible combinations:

1. 5%-10% marrow blasts with good karyotypic status (normal, -Y alone, -5q alone, -20q alone), and 0/1 cytopenias; OR
2. less than 5% marrow blasts with intermediate karyotypic status (other abnormalities), and 0/1 cytopenias; OR
3. less than 5% marrow blasts with good karyotypic status (normal, -Y alone, -5q alone, -20q alone), and 2/3 cytopenias; OR
4. less than 5% marrow blasts with intermediate karyotypic status (other abnormalities), and 2/3 cytopenias; OR
5. 5%-10% marrow blasts with intermediate karyotypic status (other abnormalities), and 0/1 cytopenias; OR
6. 5%-10% marrow blasts with good karyotypic status (normal, -Y alone, -5q alone, -20q alone), and 2/3 cytopenias; OR
7. less than 5% marrow blasts with poor karyotypic status (complex, greater than 3 abnormalities), and 0/1 cytopenias.

Classification of a patient as red blood cell transfusion dependent requires that:

(i) the patient has been transfused within the last 8 weeks; and

(ii) the patient has received at least 8 units of red blood cell in the last 6 months prior to commencing PBS-subsidised therapy with lenalidomide; and would be expected to continue this requirement without lenalidomide treatment.

Patients receiving lenalidomide under the PBS listing must be registered in the i-access risk management program.

The authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Myelodysplastic Syndrome Lenalidomide Authority Application - Supporting Information Form; and
- (c) a copy of the bone marrow biopsy report demonstrating that the patient has myelodysplastic syndrome; and
- (d) a copy of the full blood examination report; and
- (e) a copy of the pathology report detailing the cytogenetics demonstrating Low risk or Intermediate-1 disease according to the IPSS (note: using Fluorescence in Situ Hybridization (FISH) to demonstrate MDS -5q is acceptable); and
- (f) details of transfusion requirements including: (i) the date of most recent transfusion and the number of red blood cell units transfused; and (ii) the total number of red cell units transfused in the 4 and 6 months preceding the date of this application; and
- (g) a signed patient acknowledgement form.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Authority required

Myelodysplastic syndrome

Treatment Phase: Continuing treatment

Clinical criteria:Patient must be classified as Low risk or Intermediate-1 according to the International Prognostic Scoring System (IPSS), **AND**Patient must have a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities, **AND**Patient must have received PBS-subsidised initial therapy with lenalidomide for myelodysplastic syndrome, **AND**Patient must have achieved and maintained transfusion independence; or least a 50% reduction in red blood cell unit transfusion requirements compared with the four month period prior to commencing initial PBS-subsidised therapy with lenalidomide, **AND**

Patient must not have progressive disease.

Patients receiving lenalidomide under the PBS listing must be registered in the i-access risk management program. The first authority application for continuing supply must be made in writing. Subsequent authority applications for continuing supply may be made by telephone.

The following evidence of response must be provided at each application:

- (i) a haemoglobin level taken within the last 4 weeks; and
- (ii) the date of the last transfusion; and
- (iii) a statement of the number of units of red cells transfused in the 4 months immediately preceding this application; and
- (iv) a statement confirming that the patient has not progressed to acute myeloid leukaemia.

Note

Written applications for authority to prescribe should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

Subsequent authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Special Pricing Arrangements apply.

lenalidomide 10 mg capsule, 21

2802L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	3	..	5643.33	Revlimid [CJ]

lenalidomide 5 mg capsule, 21

2799H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	3	..	5392.38	Revlimid [CJ]

■ LENALIDOMIDE

Authority required

Multiple myeloma

Treatment Phase: Initial PBS-subsidised treatment

Clinical criteria:

The condition must be confirmed by a histological diagnosis, **AND**

The treatment must be as monotherapy; OR

The treatment must be in combination with dexamethasone, **AND**

Patient must have progressive disease after at least one prior therapy, **AND**

Patient must have undergone or be ineligible for a primary stem cell transplant, **AND**

Patient must have experienced treatment failure after a trial of at least four (4) weeks of thalidomide at a dose of at least 100 mg daily or have failed to achieve at least a minimal response after eight (8) or more weeks of thalidomide-based therapy for progressive disease, **AND**

Patient must not be receiving concomitant PBS-subsidised bortezomib.

Progressive disease is defined as at least 1 of the following:

- (a) at least a 25% increase and an absolute increase of at least 5 g per L in serum M protein (monoclonal protein); or
- (b) at least a 25% increase in 24-hour urinary light chain M protein excretion, and an absolute increase of at least 200 mg per 24 hours; or
- (c) in oligo-secretory and non-secretory myeloma patients only, at least a 50% increase of the difference between involved free light chain and uninvolved free light chain; or
- (d) at least a 25% relative increase and at least a 10% absolute increase in plasma cells in a bone marrow aspirate or on biopsy; or
- (e) an increase in the size or number of lytic bone lesions (not including compression fractures); or
- (f) at least a 25% increase in the size of an existing or the development of a new soft tissue plasmacytoma (determined by clinical examination or diagnostic imaging); or
- (g) development of hypercalcaemia (corrected serum calcium greater than 2.65 mmol per L not attributable to any other cause).

Oligo-secretory and non-secretory patients are defined as having active disease with less than 10 g per L serum M protein.

Thalidomide treatment failure is defined as:

- (1) confirmed disease progression during thalidomide treatment or within 6 months of discontinuing thalidomide treatment; or
- (2) severe intolerance or toxicity unresponsive to clinically appropriate dose adjustment.

Severe intolerance due to thalidomide is defined as unacceptable somnolence or sedation interfering with activities of daily living.

Toxicity from thalidomide is defined as peripheral neuropathy (Grade 2 or greater, interfering with function), drug-related seizures, serious Grade 3 or 4 drug-related dermatological reactions, such as Stevens-Johnson Syndrome, or other Grade 3 or 4 toxicity.

Failure to achieve at least a minimal response after 8 or more weeks of thalidomide-based therapy for progressive disease is defined as:

- (1) less than a 25% reduction in serum or urine M protein; or
- (2) in oligo-secretory and non-secretory myeloma patients only, less than a 25% reduction in the difference between involved and uninvolved serum free light chain levels.

If the dosing requirement for thalidomide cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be made in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Multiple Myeloma lenalidomide Authority Application - Supporting Information Form, which includes details of the histological diagnosis of multiple myeloma, prior treatments including name(s) of drug(s) and date of most recent treatment cycle and record of prior stem cell transplant or ineligibility for prior stem cell transplant; details of thalidomide treatment failure; details of the basis of the diagnosis of progressive disease or failure to respond; and nomination of which disease activity parameters will be used to assess response; and
- (3) duration of thalidomide and daily dose prescribed; and
- (4) a signed patient acknowledgment.

To enable confirmation of eligibility for treatment, current diagnostic reports of at least one of the following must be provided:

- (a) the level of serum monoclonal protein; or
- (b) Bence-Jones proteinuria - the results of 24-hour urinary light chain M protein excretion; or
- (c) the serum level of free kappa and lambda light chains; or
- (d) bone marrow aspirate or trephine; or
- (e) if present, the size and location of lytic bone lesions (not including compression fractures); or
- (f) if present, the size and location of all soft tissue plasmacytomas by clinical or radiographic examination i.e. MRI or CT-scan; or
- (g) if present, the level of hypercalcaemia, corrected for albumin concentration.

As these parameters will be used to determine response, results for either (a) or (b) or (c) should be provided for all patients. Where the patient has oligo-secretory or non-secretory multiple myeloma, either (c) or (d) or if relevant (e), (f) or (g) should be provided. Where the prescriber plans to assess response in patients with oligo-secretory or non-secretory multiple myeloma with free light chain assays, evidence of the oligo-secretory or non-secretory nature of the multiple myeloma (current serum M protein less than 10 g per L) must be provided.

Patients receiving lenalidomide under the PBS listing must be registered in the i-access risk management program.

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

Authority required

Multiple myeloma

Treatment Phase: Continuing PBS-subsidised treatment

Clinical criteria:

Patient must have previously received an authority prescription for lenalidomide, **AND**

Patient must not have progressive disease, **AND**

The treatment must be as monotherapy; OR

The treatment must be in combination with dexamethasone.

Progressive disease is defined as at least 1 of the following:

- (a) at least a 25% increase and an absolute increase of at least 5 g per L in serum M protein (monoclonal protein); or
- (b) at least a 25% increase in 24-hour urinary light chain M protein excretion, and an absolute increase of at least 200 mg per 24 hours; or
- (c) in oligo-secretory and non-secretory myeloma patients only, at least a 50% increase of the difference between involved free light chain and uninvolved free light chain; or
- (d) at least a 25% relative increase and at least a 10% absolute increase in plasma cells in a bone marrow aspirate or on biopsy; or
- (e) an increase in the size or number of lytic bone lesions (not including compression fractures); or
- (f) at least a 25% increase in the size of an existing or the development of a new soft tissue plasmacytoma (determined by clinical examination or diagnostic imaging); or
- (g) development of hypercalcaemia (corrected serum calcium greater than 2.65 mmol per L not attributable to any other cause).

Patients receiving lenalidomide under the PBS listing must be registered in the i-access risk management program.

Note

Authority applications for continuing treatment may be made by telephone to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written applications for authority to prescribe should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001
Special Pricing Arrangements apply.

lenalidomide 10 mg capsule, 21

5784K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	5643.33	Revlimid [CJ]

lenalidomide 15 mg capsule, 21

5785L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	6581.61	Revlimid [CJ]

lenalidomide 25 mg capsule, 21

5786M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	6934.20	Revlimid [CJ]

lenalidomide 5 mg capsule, 21

5783J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	5392.38	Revlimid [CJ]

■ RITUXIMAB**Authority required**

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 1 (patient recommencing treatment after a break of more than 24 months)

Clinical criteria:

Patient must have severe active rheumatoid arthritis, **AND**

Patient must have failed to respond to at least 1 PBS-subsidised tumour necrosis factor (TNF) alfa antagonist, **AND**

Patient must have received no PBS-subsidised treatment with a biological disease modifying anti-rheumatic drug (bDMARD) for this condition in the previous 24 months, **AND**

Patient must not have failed previous PBS-subsidised treatment with rituximab for this condition, and have not already failed, or ceased to respond to, PBS-subsidised bDMARD treatment for this condition 5 times, **AND**

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with disease modifying anti-rheumatic drugs (DMARDs) which must include at least 3 months continuous treatment with each of at least 2 DMARDs, one of which must be methotrexate at a dose of at least 20 mg weekly and one of which must be: (i) hydroxychloroquine at a dose of at least 200 mg daily; or (ii) leflunomide at a dose of at least 10 mg daily; or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if methotrexate is contraindicated according to the Therapeutic Goods Administration (TGA)-approved Product Information or cannot be tolerated at a 20 mg weekly dose, must include at least 3 months continuous treatment with each of at least 2 of the following DMARDs: (i) hydroxychloroquine at a dose of at least 200 mg daily; and/or (ii) leflunomide at a dose of at least 10 mg daily; and/or (iii) sulfasalazine at a dose of at least 2 g daily; OR

Patient must have failed, in the 24 months immediately prior to the date of the application, to achieve an adequate response to a trial of at least 6 months of intensive treatment with DMARDs which, if 3 or more of methotrexate, hydroxychloroquine, leflunomide and sulfasalazine are contraindicated according to the relevant TGA-approved Product Information or cannot be tolerated at the doses specified above, must include at least 3 months continuous treatment with each of at least 2 DMARDs, with one or more of the following DMARDs being used in place of the DMARDs which are contraindicated or not tolerated: (i) azathioprine at a dose of at least 1 mg/kg per day; and/or (ii) cyclosporin at a dose of at least 2 mg/kg/day; and/or (iii) sodium aurothiomalate at a dose of 50 mg weekly, **AND**

Patient must not receive more than 2 infusions of rituximab under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction 'TNF' alfa antagonist means adalimumab, certolizumab pegol, etanercept, golimumab and infliximab.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab

If methotrexate is contraindicated according to the TGA-approved product information or cannot be tolerated at a 20 mg weekly dose, the application must include details of the contraindication or intolerance including severity to methotrexate. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances including severity.

The requirement to trial at least 2 DMARDs for periods of at least 3 months each can be met using single agents sequentially or by using one or more combinations of DMARDs.

If the requirement to trial 6 months of intensive DMARD therapy with at least 2 DMARDs cannot be met because of contraindications and/or intolerances of a severity necessitating permanent treatment withdrawal to all of the DMARDs specified above, details of the contraindication or intolerance including severity and dose for each DMARD must be provided in the authority application.

The authority application must be made in writing and must include:

- (1) completed authority prescription form(s); and
- (2) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form; and
- (3) a signed patient acknowledgement.

Assessment of a patient's response to an initial course of treatment must be made at least 12 weeks after the first infusion so that there is adequate time for a response to be demonstrated. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to the Department of Human Services within 4 weeks of the date it was conducted. Where a response assessment is not undertaken and submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with rituximab.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction.

If a patient who fails to demonstrate a response to treatment with rituximab under this restriction they will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

A patient who fails to demonstrate a response to rituximab treatment and who qualifies to trial an alternate bDMARD according to the interchangeability arrangements for bDMARDs for the treatment of severe rheumatoid arthritis, may do so without having to have a 22 week treatment-free period.

The following criteria indicate failure to achieve an adequate response and must be demonstrated in all patients at the time of the initial application:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L; AND either

- (a) a total active joint count of at least 20 active (swollen and tender) joints; or
 - (b) at least 4 active joints from the following list of major joints:
 - (i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - (ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).
- The joint count and ESR and/or CRP must be determined at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy. All measures must be no more than one month old at the time of initial application.

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

Where the baseline joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints. If only an ESR or CRP is provided with the initial application, the same marker will be used to determine response

Note

The Department of Human Services website (www.humanservices.gov.au) has details of the toxicities, including severity, which will be accepted for the following purposes:

- (a) exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose;
- (b) substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial;

- (c) exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy.

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Initial treatment - Initial 2 (change or re-commencement of treatment after break of less than 24 months).

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have failed to respond to at least 1 PBS-subsidised tumour necrosis factor (TNF) alfa antagonist, **AND**

Patient must have received prior PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition and are eligible to receive further bDMARD therapy, **AND**

Patient must not receive more than 2 infusions of rituximab under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction 'TNF' alfa antagonist means adalimumab, certolizumab pegol, etanercept, golimumab and infliximab.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab

The authority application must be made in writing and must include:

(a) completed authority prescription form(s); and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

Applications for a patient who has received PBS-subsidised treatment with rituximab and who wishes to re-commence therapy with this drug, must be accompanied by evidence of a response to the patient's most recent course of PBS-subsidised rituximab treatment, within the timeframes specified below.

Where the most recent course of PBS-subsidised rituximab treatment was approved under either of the initial 1 or 2 treatment restrictions, the patient must have been assessed for response at least 12 weeks after the first infusion. This assessment must be submitted no later than 4 weeks from the date of the assessment.

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent provided they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The demonstration of response must be submitted within 4 weeks of assessment.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with rituximab.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction.

If a patient fails to demonstrate a response to treatment with rituximab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

If a patient fails to demonstrate a response to a treatment with rituximab and who qualify to trial an alternate bDMARD according to the interchangeability arrangements for bDMARDs for the treatment of severe rheumatoid arthritis, may do so without having to have a 22 week treatment-free period.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Authority required

Severe active rheumatoid arthritis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe active rheumatoid arthritis, **AND**

Patient must have demonstrated an adequate response to treatment with this drug, **AND**

Patient must have received this drug as the most recent course of PBS-subsidised biological disease modifying anti-rheumatic drug (bDMARD) treatment for this condition, **AND**

Patient must not receive more than 2 infusions of rituximab under this restriction, **AND**

The treatment must be given concomitantly with methotrexate at a dose of at least 7.5 mg weekly.

Population criteria:

Patient must be aged 18 years or older.

Treatment criteria:

Must be treated by a rheumatologist; OR

Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.

For the purposes of this restriction bDMARD means abatacept, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab or tocilizumab.

The authority application must be made in writing and must include:

(a) completed authority prescription form(s); and

(b) a completed Rheumatoid Arthritis PBS Authority Application - Supporting Information Form.

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent provided they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The demonstration of response must be submitted within 4 weeks of assessment.

Where a response assessment is not undertaken and submitted within these timeframes, the patient will be deemed to have failed to respond to treatment with rituximab.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction.

If a patient fails to demonstrate a response to treatment with rituximab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition.

An adequate response to treatment is defined as:

an ESR no greater than 25 mm per hour or a CRP level no greater than 15 mg per L or either marker reduced by at least 20% from baseline;

AND either of the following:

(a) a reduction in the total active (swollen and tender) joint count by at least 50% from baseline, where baseline is at least 20 active joints; or

(b) a reduction in the number of the following active joints, from at least 4, by at least 50%:

(i) elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

(ii) shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).

Note

Special Pricing Arrangements apply.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

The following information applies to the prescribing under the Pharmaceutical Benefits Scheme (PBS) of the biological disease modifying antirheumatic drugs (bDMARDs) for adults with severe active rheumatoid arthritis. Where the term bDMARD appears in the following notes and restrictions it refers to the tumour necrosis factor (TNF) alfa antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), the chimeric anti-CD20 monoclonal antibody (rituximab), the interleukin-6 inhibitor (tocilizumab) and the T-cell co-stimulation modulator (abatacept).

Patients are eligible for PBS-subsidised treatment with only 1 of the above biological disease modifying anti-rheumatic drugs at any 1 time.

In order to be eligible to receive PBS-subsidised treatment with rituximab, a patient must have already failed to demonstrate a response to at least 1 course of treatment with a PBS-subsidised TNF-alfa antagonist.

A patient receiving PBS-subsidised bDMARD therapy may swap to an alternate bDMARD without having to experience a disease flare. Under these interchangeability arrangements:

- a patient may continue to receive long-term treatment with a PBS-subsidised bDMARD while they continue to show a response to therapy,
- a patient cannot trial and fail, or cease to respond to, the same PBS-subsidised bDMARD more than once, and
- once a patient has either failed or ceased to respond to treatment 5 times, they will not be eligible to receive further PBS-subsidised bDMARDs for the treatment of rheumatoid arthritis.

For patients who have failed PBS-subsidised treatment with 2 or 3 TNF-alfa antagonists prior to 1 August 2010 please contact the Department of Human Services on 1800 700 270.

A patient whose most recent course of PBS-subsidised therapy was with rituximab and whose response to this treatment is sustained for more than 12 months, may apply for a further course of rituximab under the Continuing treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has a break in therapy of less than 24 months may commence a further course of treatment with a bDMARD without having to requalify under the Initial 1 treatment restriction. A patient who has failed fewer than 5 bDMARDs and who has had a break in therapy of longer than 24 months must requalify for treatment under the Initial 1 treatment restriction.

The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised bDMARD treatment is stopped to the date of the new application for treatment with a bDMARD.

(1) How to prescribe PBS-subsidised bDMARD therapy after 1 August 2010.

(a) Initial treatment.

Applications for initial treatment should be made where:

- (i) a patient has received no prior PBS-subsidised bDMARD treatment and wishes to commence such therapy, excluding rituximab (Initial 1); or
- (ii) a patient wishes to re-commence treatment with a bDMARD following a break in PBS-subsidised therapy of more than 24 months (Initial 1); or
- (iii) a patient has received prior PBS-subsidised (initial or continuing) bDMARD therapy and wishes to trial an alternate agent (Initial 2) [further details are under 'Swapping therapy' below]; or
- (iv) a patient wishes to re-commence treatment with a specific bDMARD following a break of less than 24 months in PBS-subsidised therapy with that agent (Initial 2).

Initial applications for new or re-commencing patients (Initial 1) must include a joint count and ESR and/or CRP measured at the completion of the 6-month intensive DMARD trial, but prior to ceasing DMARD therapy.

Initial treatment authorisations will be limited to provide a maximum of 16 weeks of therapy for abatacept, adalimumab, etanercept, golimumab and tocilizumab, 18 to 20 weeks of therapy with certolizumab pegol (depending upon the dosing regimen), 22 weeks of therapy for infliximab and 2 infusions of rituximab.

A patient must be assessed for response to any course of initial PBS-subsidised treatment (excluding rituximab) following a minimum of 12 weeks of therapy and this assessment must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients must be assessed following a minimum of 12 weeks after the first infusion, and this assessment must be submitted to the Department of Human Services within 4 weeks.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

For second and subsequent courses of PBS-subsidised bDMARD (excluding rituximab) treatment it is recommended that a patient is reviewed in the month prior to completing their current course of treatment and that an application is submitted to the Department of Human Services no later than 2 weeks prior to the patient completing their current treatment course.

Abatacept patients:

Patients are eligible to receive one I.V. loading dose when commencing treatment with the subcutaneous formulation. For these patients two prescriptions are required, the first prescription for the I.V. loading dose for sufficient vials for one dose based on the patient's weight with no repeats. The second prescription for the pre-filled syringes, with a maximum quantity of 4 and up to 3 repeats, must be submitted with the initial application.

Rituximab patients:

A further application may be submitted to the Department of Human Services 24 weeks after the first infusion. New baselines may be submitted with this application if appropriate.

(b) Continuing treatment.

Following the completion of an initial treatment course with a specific bDMARD (excluding rituximab), a patient may qualify to receive up to 24 weeks of continuing treatment with that drug providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing bDMARD treatment with the same drug in courses of up to 24 weeks providing they continue to sustain the response.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted bDMARD supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to the Department of Human Services no later than 4 weeks from the date that course was ceased.

Rituximab patients:

A patient may qualify to receive a further course of treatment (every 24 weeks) with this agent providing they have demonstrated an adequate response to treatment following a minimum of 12 weeks after the first infusion of their most recent treatment with rituximab. The patient remains eligible to receive a course of rituximab every 24 weeks providing they continue to demonstrate a response as specified in the restriction.

Where a response assessment is not submitted to the Department of Human Services within these timeframes, the patient will be deemed to have failed to respond to treatment with that bDMARD.

(2) Swapping therapy.

Once initial treatment with the first PBS-subsidised bDMARD is approved, a patient may swap to an alternate bDMARD without having to requalify with respect to the indices of disease severity (i.e. the erythrocyte sedimentation rate (ESR), the C-reactive protein (CRP) levels and the joint count) or the prior non-bDMARD therapy requirements, except if the patient has had a break in therapy of more than 24 months. However the requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialled.

Patients who are not able to complete a minimum of 12 weeks of an initial treatment course will be deemed to have failed treatment with that agent.

A patient may trial an alternate bDMARD at any time, regardless of whether they are receiving therapy (initial or continuing) with a bDMARD at the time of the application. However, they cannot swap to a particular bDMARD if they have failed to respond to prior treatment with that drug.

Abatacept patients:

Patients swapping from I.V. abatacept to subcutaneous abatacept will not be eligible for an I.V. loading dose when commencing treatment with the subcutaneous formulation.

In order to trial rituximab, a patient must have trialled and failed to demonstrate a response to at least 1 PBS-subsidised TNF-alfa antagonist treatment.

To ensure a patient receives the maximum treatment opportunities allowed under the interchangeability arrangements, it is important that they are assessed for response to every course of treatment approved, within the timeframes specified in the relevant restriction.

PBS subsidy does not allow for patients to receive treatment with another PBS-subsidised biological agent during the required treatment-free period applying to patients who have demonstrated a response to their most recent course of rituximab. This means that patients who have demonstrated a response to a course of rituximab must have a PBS-subsidised biological therapy treatment-free period of at least 22 weeks, immediately following the second infusion, before swapping to an alternate bDMARD. Patients who fail to respond to rituximab and who qualify and wish to trial a course of an alternate bDMARD may do so without having to have any treatment-free period.

To avoid confusion, an application for a patient who wishes to swap to an alternate bDMARD should be accompanied by the approved authority prescription or remaining repeats for the bDMARD the patient is ceasing.

(3) Baseline measurements to determine response.

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the joint count, ESR and/or CRP submitted with the first authority application for a bDMARD. However, prescribers may provide new baseline measurements any time that an initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.

To ensure consistency in determining response, the same indices of disease severity used to establish baseline at the commencement of treatment with each initial treatment application must be provided for all subsequent continuing treatment applications. Therefore, where only an ESR or CRP level is provided at baseline, an ESR or CRP level respectively must be provided to determine response. Similarly, where the baseline active joint count is based on total active joints (i.e. more than 20 active joints), response will be determined according to the reduction in the total number of active joints. Where the baseline is determined on total number of major joints, the response must be demonstrated on the total number of major joints.

Except as specified under the Initial 1 treatment restriction, a baseline joint count and ESR and/or CRP should be performed whilst the patient is still on treatment or within 1 month of ceasing prior treatment. Applications under the Initial 1 treatment restriction for new or re-commencing patients must include a joint count and ESR and/or CRP measured at the completion of the 6 month intensive DMARD trial, but prior to ceasing DMARD therapy.

rituximab 500 mg/50 mL injection, 1 x 50 mL vial

9544H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	2032.91	Mabthera [RO]

■ THALIDOMIDE**Caution**

Thalidomide is a category X drug and must not be given to pregnant women. Pregnancy in female patients or in the partners of male patients must be avoided during treatment and for 1 month after cessation of treatment.

Authority required (STREAMLINED)

3342

Multiple myeloma

Note

Patients receiving thalidomide under the PBS listing must be registered in the i-access risk management program.

thalidomide 100 mg capsule, 28

9667T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	..	..	*1680.00	Thalomid [CJ]

thalidomide 50 mg capsule, 28

9566L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	4	..	..	*1680.00	Thalomid [CJ]

MUSCULO-SKELETAL SYSTEM

MUSCLE RELAXANTS

MUSCLE RELAXANTS, CENTRALLY ACTING AGENTS

Other centrally acting agents

BACLOFEN

Authority required (STREAMLINED)

3318

Severe chronic spasticity, where oral antispastic agents have failed or have caused unacceptable side effects, in patients with chronic spasticity of cerebral origin

Authority required (STREAMLINED)

3319

Severe chronic spasticity, where oral antispastic agents have failed or have caused unacceptable side effects, in patients with chronic spasticity due to multiple sclerosis

Authority required (STREAMLINED)

3320

Severe chronic spasticity, where oral antispastic agents have failed or have caused unacceptable side effects, in patients with chronic spasticity due to spinal cord injury

Authority required (STREAMLINED)

3321

Severe chronic spasticity, where oral antispastic agents have failed or have caused unacceptable side effects, in patients with chronic spasticity due to spinal cord disease

baclofen 10 mg/5 mL injection: intrathecal, 1 x 5 mL ampoule

5617P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	10	..	..	*1483.70	Lioresal Intrathecal [NV]

DRUGS FOR TREATMENT OF BONE DISEASES

DRUGS AFFECTING BONE STRUCTURE AND MINERALIZATION

Bisphosphonates

IBANDRONIC ACID

Authority required (STREAMLINED)

3343

Bone metastases from breast cancer

ibandronic acid 6 mg/6 mL injection, 1 x 6 mL vial

5750P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	11	..	341.36	Bondronat [RO]

PAMIDRONATE DISODIUM

Authority required (STREAMLINED)

4433

Hypercalcaemia of malignancy

Clinical criteria:

Patient must have a malignancy refractory to anti-neoplastic therapy.

pamidronate disodium 15 mg/5 mL injection, 1 x 5 mL vial

5667G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	4	2	..	*68.64	Pamisol [HH]

pamidronate disodium 60 mg/10 mL injection, 1 x 10 mL vial

5669J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	2	..	68.65	Pamisol [HH]

■ PAMIDRONATE DISODIUM**Authority required (STREAMLINED)****4425**

Hypercalcaemia of malignancy

Clinical criteria:

Patient must have a malignancy refractory to anti-neoplastic therapy.

Note

Pharmaceutical benefits that have the form disodium pamidronate powder for I.V. infusion 30 mg (after reconstitution) and pharmaceutical benefits that have the form disodium pamidronate concentrated injection 30 mg are equivalent for the purposes of substitution.

pamidronate disodium 30 mg injection [2 x 30 mg vials] (&) inert substance diluent [2 x 10 mL ampoules], 1 pack

5702D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	2	..	68.66	^a Aredia 30 mg [NV]

pamidronate disodium 30 mg/10 mL injection, 1 x 10 mL vial

5668H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	2	..	*68.66	^a Pamisol [HH]

■ PAMIDRONATE DISODIUM**Authority required (STREAMLINED)****4421**

Hypercalcaemia of malignancy

Clinical criteria:

Patient must have a malignancy refractory to anti-neoplastic therapy.

Authority required (STREAMLINED)**4432**

Multiple myeloma

Authority required (STREAMLINED)**4426**

Bone metastases

Clinical criteria:

The condition must be due to breast cancer.

Note

Pharmaceutical benefits that have the form disodium pamidronate powder for I.V. infusion 90 mg (after reconstitution) and pharmaceutical benefits that have the form disodium pamidronate concentrated injection 90 mg are equivalent for the purposes of substitution.

pamidronate disodium 90 mg injection [1 x 90 mg vial] (&) inert substance diluent [1 x 10 mL ampoule], 1 pack

5703E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	11	..	102.98	^a Aredia 90 mg [NV]

pamidronate disodium 90 mg/10 mL injection, 1 x 10 mL vial

5670K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	11	..	102.98	^a Pamisol [HH]

■ ZOLEDRONIC ACID**Authority required (STREAMLINED)****3342**

Multiple myeloma

Authority required (STREAMLINED)**3343**

Bone metastases from breast cancer

Authority required (STREAMLINED)**4052**

Bone metastases from castration-resistant prostate cancer

Authority required (STREAMLINED)**3341**

Treatment of hypercalcaemia of malignancy refractory to anti-neoplastic therapy

Note

Special Pricing Arrangements apply.

zoledronic acid 4 mg/5 mL injection, 1 x 5 mL vial

9653C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	11	..	450.00	Zometa [NV]

■ **NERVOUS SYSTEM**

■ **ANTI-PARKINSON DRUGS**

DOPAMINERGIC AGENTS

Dopa and dopa derivatives

■ **LEVODOPA + CARBIDOPA ANHYDROUS**

Authority required (STREAMLINED)

3704

Management of advanced Parkinson disease in a patient with severe disabling motor fluctuations not adequately controlled by oral therapy.

Treatment must be commenced in a hospital-based movement disorder clinic

Note

Patients should have adequate cognitive function to manage administration with a portable continuous infusion pump.

A positive clinical response to Duodopa administered via a temporary nasoduodenal tube should be confirmed before a permanent percutaneous endoscopic gastrostomy (PEG) tube is inserted.

levodopa 20 mg/mL + carbidopa monohydrate 5 mg/mL gel: intestinal, 7 x 100 mL bags

9743T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	8	5	..	*11536.00	Duodopa [VE]

Dopamine agonists

■ **APOMORPHINE**

Authority required (STREAMLINED)

4833

Parkinson disease

Clinical criteria:

Patient must have experienced severely disabling motor fluctuations which have not responded to other therapy.

apomorphine hydrochloride 10 mg/mL injection, 5 x 1 mL ampoules

10227G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	72	5	..	*3596.40	Apomine [HH]

apomorphine hydrochloride 20 mg/2 mL injection, 5 x 2 mL ampoules

5609F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	72	5	..	*7196.40	Apomine [HH]

apomorphine hydrochloride 50 mg/10 mL injection: subcutaneous infusion, 5 x 10 mL syringes

5611H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	36	5	..	*7007.40	Apomine PFS [HH]

apomorphine hydrochloride 50 mg/5 mL injection, 5 x 5 mL ampoules

5610G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	36	5	..	*9003.60	Apomine [HH]

■ **PSYCHOLEPTICS**

ANTIPSYCHOTICS

Diazepines, oxazepines, thiazepines and oxepines

■ **CLOZAPINE**

Authority required (STREAMLINED)

4411

Schizophrenia

Clinical criteria:

Patient must be non-responsive to other neuroleptic agents; OR

Patient must be intolerant of other neuroleptic agents.

A medical practitioner should request a quantity sufficient for up to one month's supply. Up to 5 repeats will be authorised.

Note

Patients receiving clozapine under the PBS listing must be registered in a clozapine patient monitoring program; Novartis Clozaril Patient Monitoring System (eCPMS) or Clopineconnect.

clozapine 100 mg tablet, 100

5629G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	..	..	*242.38	^a Clopine 100 [HH]	^a Clozaril 100 [NV]

clozapine 200 mg tablet, 100

5627E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	..	..	*484.76	Clopine 200 [HH]	

clozapine 25 mg tablet, 100

5628F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	..	..	*64.64	^a Clopine 25 [HH]	^a Clozaril 25 [NV]

clozapine 50 mg tablet, 100

5626D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	..	..	*129.28	Clopine 50 [HH]	

clozapine 50 mg/mL oral liquid, 100 mL

5630H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	..	..	135.00	Clopine Suspension [HH]	

■ **RESPIRATORY SYSTEM**■ **DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES****OTHER SYSTEMIC DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES**

Other systemic drugs for obstructive airway diseases

■ **OMALIZUMAB****Authority required**

Uncontrolled severe allergic asthma

Treatment Phase: Initial treatment

Clinical criteria:

Patient must be under the care of the same physician for at least 12 months, **AND**

Patient must have a diagnosis of asthma confirmed and documented by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma, defined by the following standard clinical features: (i) forced expiratory volume (FEV1) reversibility greater than or equal to 12% and greater than or equal to 200 mL at baseline within 30 minutes after administration of salbutamol (200 to 400 micrograms), or (ii) airway hyperresponsiveness defined as a greater than 20% decline in FEV1 during a direct bronchial provocation test or greater than 15% decline during an indirect bronchial provocation test, or (iii) peak expiratory flow (PEF) variability of greater than 15% between the two highest and two lowest peak expiratory flow rates during 14 days, **AND**

Patient must have a duration of asthma of at least 1 year, **AND**

Patient must have forced expiratory volume (FEV1) less than or equal to 80% predicted, documented on 3 or more occasions in the previous 12 months, **AND**

Patient must have past or current evidence of atopy, documented by skin prick testing or RAST, **AND**

Patient must have total serum human immunoglobulin E greater than or equal to 76 IU/mL, **AND**

Patient must have signed a patient acknowledgement indicating they understand and acknowledge that PBS-subsidised treatment will cease if they do not meet the predetermined response criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment, **AND**

Patient must have failed to achieve adequate control with optimised asthma therapy, despite formal assessment of and adherence to correct inhaler technique, which has been documented, **AND**

Patient must not receive more than 28 weeks of treatment under this restriction.

Population criteria:

Patient must be aged 12 years or older.

Treatment criteria:

Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

Optimised asthma therapy includes:

(i) adherence to maximal inhaled therapy, including high dose inhaled corticosteroid (budesonide 1600 micrograms per day or fluticasone propionate 1000 micrograms per day or equivalent), plus long-acting beta-2 agonist therapy (at least salmeterol 50 micrograms bd or eformoterol 12 micrograms bd) for at least 12 months, unless contraindicated or not tolerated, **AND**

(ii) treatment with oral corticosteroids, either daily oral corticosteroids for at least 6 weeks, OR a cumulative dose of oral corticosteroids of at least 500 mg prednisolone equivalent in the previous 12 months, unless contraindicated or not tolerated.

If the requirement for treatment with optimised asthma therapy cannot be met because of contraindications according to the relevant TGA-approved Product Information and/or intolerances of a severity necessitating permanent treatment withdrawal, details of the contraindication and/or intolerance must be provided in the authority application.

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

The following initiation criteria indicate failure to achieve adequate control and must be demonstrated in all patients at the time of the application:

- (a) an Asthma Control Questionnaire (ACQ-5) score of at least 2.0, as assessed in the previous month, AND
- (b) while receiving optimised asthma therapy in the past 12 months, experienced at least 1 admission to hospital for a severe asthma exacerbation, OR 1 severe asthma exacerbation, requiring documented use of systemic corticosteroids (oral corticosteroids initiated or increased for at least 3 days, or parenteral corticosteroids) prescribed/supervised by a physician. The Asthma Control Questionnaire (5 item version) assessment of the patient's response to this initial course of treatment, and the assessment of oral corticosteroid dose, must be made at around 22 to 26 weeks after the first dose so that there is adequate time for a response to be demonstrated and for the application for continuing therapy to be processed.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted within 4 weeks of the date of assessment, and no later than 2 weeks prior to the patient completing their current treatment course, to avoid an interruption to supply. Where a response assessment is not undertaken and submitted within this timeframe, the patient will be deemed to have failed to respond to treatment with omalizumab.

A patient who fails to respond to a course of PBS-subsidised omalizumab for the treatment of uncontrolled severe allergic asthma will not be eligible to receive further PBS-subsidised treatment with omalizumab for this condition within 6 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate maximum quantity and number of repeats to provide for an initial course of omalizumab consisting of the recommended number of doses for the baseline IgE level and body weight of the patient (refer to the TGA-approved Product Information) to be administered every 2 or 4 weeks.

The authority application must be made in writing and must include:

- (a) a completed authority prescription form; and
- (b) a completed Severe Allergic Asthma PBS Authority Application - Supporting Information Form, which includes the following:
 - (i) details of prior optimised asthma drug therapy (dosage, date of commencement and duration of therapy); and
 - (ii) details of severe exacerbation/s experienced in the past 12 months while receiving optimised asthma therapy (date and treatment); and
 - (iii) the signed patient acknowledgement; and
- (c) the IgE pathology report; and
- (d) a completed Asthma Control Questionnaire (ACQ-5) calculation sheet including the date of assessment of the patient's symptoms.

Note

The Department of Human Services website (www.humanservices.gov.au) has details of the accepted toxicities, including severity, which will be accepted for the purposes of exempting a patient from the requirement of treatment with optimised asthma therapy.

It is recommended that an application for continuing treatment is submitted at the time of the 22 to 26 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised omalizumab treatment.

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Initial treatment - balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Initial treatment restriction to complete 28 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 28 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

Note

Authority approval for sufficient therapy to complete a maximum of 28 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 28 weeks of treatment should be forwarded to:

Department of Human Services
Prior Written Approval of Complex Drugs
Reply Paid 9826
GPO Box 9826

HOBART TAS 7001

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have a documented history of severe allergic asthma, **AND**

Patient must have demonstrated or sustained an adequate response to treatment with this drug, **AND**

Patient must not receive more than 24 weeks of treatment under this restriction.

Treatment criteria:

Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

An adequate response to omalizumab treatment is defined as:

(a) a reduction in the Asthma Control Questionnaire (ACQ-5) score of at least 0.5 from baseline, OR

(b) maintenance oral corticosteroid dose reduced by at least 25% from baseline, and no deterioration in ACQ-5 score from baseline.

All applications for continuing treatment with omalizumab must include a measurement of response to the prior course of therapy. The Asthma Control Questionnaire (5 item version) assessment of the patient's response to the prior course of treatment, and the assessment of oral corticosteroid dose, must be made at around 18 to 22 weeks after the first dose so that there is adequate time for a response to be demonstrated and for the application for continuing therapy to be processed.

The first assessment should, where possible, be completed by the same physician who initiated treatment with omalizumab. This assessment, which will be used to determine eligibility for continuing treatment, must be submitted within 4 weeks of the date of assessment, and no later than 2 weeks prior to the patient completing their current treatment course, to avoid an interruption to supply. Where a response assessment is not undertaken and submitted within this timeframe, the patient will be deemed to have failed to respond to treatment with omalizumab.

A patient who fails to respond to a course of PBS-subsidised omalizumab for the treatment of uncontrolled severe allergic asthma will not be eligible to receive further PBS-subsidised treatment with omalizumab for this condition within 6 months of the date on which treatment was ceased.

At the time of the authority application, medical practitioners should request the appropriate maximum quantity and number of repeats to provide for a continuing course of omalizumab consisting of the recommended number of doses for the baseline IgE level and body weight of the patient (refer to the TGA-approved Product Information), sufficient for 24 weeks of therapy.

The authority application must be made in writing and must include:

(a) a completed authority prescription form; and

(b) a completed Severe Allergic Asthma PBS Authority Application - Supporting Information Form which includes details of maintenance oral corticosteroid dose; and

(c) a completed Asthma Control Questionnaire (ACQ-5) calculation sheet including the date of assessment of the patient's symptoms.

Note

If the same physician cannot assess the patient please call the Department of Human Services on 1800 700 270.

For copies of the ACQ please contact Novartis Medical Information on 1800 671 203 or medinfo.phauno@novartis.com

It is recommended that an application for continuing treatment is submitted at the time of the 18 to 22 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised omalizumab treatment.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

TREATMENT OF ADULT AND ADOLESCENT PATIENTS WITH UNCONTROLLED SEVERE ALLERGIC ASTHMA

Patients are eligible to commence an 'omalizumab treatment cycle' (initial treatment course with or without continuing treatment course/s) if they satisfy the eligibility criteria as detailed under the initial treatment restriction.

Once a patient has either failed to achieve or maintain a response to omalizumab, they are deemed to have completed a treatment cycle and they must have, at a minimum, a 6 month break in PBS-subsidised omalizumab therapy before they are eligible to commence the next cycle. The length of a treatment break is measured from the date the most recent treatment with PBS-subsidised omalizumab treatment is stopped to the date of the first application for initial treatment with omalizumab under the new treatment cycle.

There is no limit to the number of treatment cycles a patient may undertake in their lifetime.

(1) How to prescribe PBS-subsidised omalizumab therapy:

(a) Initial treatment:

Applications for initial treatment should be made where a patient has received no prior PBS-subsidised omalizumab treatment in this treatment cycle and wishes to commence such therapy.

(b) Continuing treatment:

Following the completion of the initial treatment course with omalizumab, a patient may qualify to receive up to a further 24 weeks of continuing treatment with omalizumab providing they have demonstrated an adequate response to treatment. The patient remains eligible to receive continuing omalizumab treatment in courses of up to 24 weeks providing they continue to sustain the response.

(2) Baseline measurements to determine response:

The Department of Human Services will determine whether a response to treatment has been demonstrated based on the baseline measurements of the Asthma Control Questionnaire (ACQ; 5 item version) and oral corticosteroid dose, submitted

with the Initial authority application for omalizumab. However, prescribers may provide new baseline measurements when a new Initial treatment authority application is submitted and the Department of Human Services will assess response according to these revised baseline measurements.

(3) Re-commencement of treatment after a 6 month break in PBS-subsidised therapy:

A patient who wishes to trial a second or subsequent treatment cycle following a break in PBS-subsidised omalizumab therapy of at least 6 months, must re-qualify for initial treatment with respect to the indices of disease severity (oral corticosteroid dose, Asthma Control Questionnaire (ACQ-5) score, and relevant exacerbation history). Patients must have received optimised standard therapy, at adequate doses and for the minimum period specified, immediately prior to the time the new baseline assessments are performed.

(4) Monitoring of patients:

Anaphylaxis and anaphylactoid reactions have been reported following first or subsequent administration of omalizumab (see Product Information). Patients should be monitored post-injection, and medications for the treatment of anaphylactic reactions should be available for immediate use following administration of omalizumab. Patients should be informed that such reactions are possible and prompt medical attention should be sought if allergic reactions occur.

Formal assessment and correction of inhaler technique should be performed in accordance with the National Asthma Council (NAC) Information Paper for Health Professionals on Inhaler Technique (available at www.humanservices.gov.au or www.nationalasthma.org.au); the assessment and adherence to correct technique should be documented in the patient's medical records. Patients can obtain support with inhaler technique through their local Asthma Foundation (1800 645 130).

Authority required

Uncontrolled severe allergic asthma

Treatment Phase: Continuing treatment - balance of supply

Clinical criteria:

Patient must have received insufficient therapy with this drug under the Continuing treatment restriction to complete 24 weeks treatment, **AND**

The treatment must provide no more than the balance of up to 24 weeks treatment available under the above restriction.

Treatment criteria:

Must be treated by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma.

Note

Authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment may be requested by telephone by contacting the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Written application for authority approval for sufficient therapy to complete a maximum of 24 weeks of treatment should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Special Pricing Arrangements apply.

omalizumab 150 mg/mL injection, 1 x 1 mL syringe

10109C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	410.00	Xolair [NV]

omalizumab 75 mg/0.5 mL injection, 1 x 0.5 mL syringe

10118M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	..	..	205.00	Xolair [NV]

■ COUGH AND COLD PREPARATIONS

EXPECTORANTS, EXCL. COMBINATIONS WITH COUGH SUPPRESSANTS

Mucolytics

■ DORNASE ALFA

Authority required (STREAMLINED)

4288

Cystic fibrosis

Clinical criteria:

Patient must have a forced vital capacity (FVC) greater than 40% predicted for age, gender and weight, **AND**

Patient must have evidence of chronic suppurative lung disease (cough and sputum most days of the week, or greater than 3 respiratory tract infections of more than 2 weeks' duration in any 12 months, or objective evidence of obstructive airways disease).

Population criteria:

Patient must be 5 years of age or older.

Patient must be assessed at a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. The prescribing of dornase alfa therapy under the HSD program is limited to such physicians. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be by a specialist physician or paediatrician in consultation with such a unit. The measurement of lung function is to be conducted by independent (other than the treating doctor) experienced personnel at an established lung function testing laboratory, unless this is not possible because of geographical isolation.

Prior to dornase alfa therapy, a baseline measurement of forced expiratory volume in 1 second (FEV1) must be undertaken during a stable period of the disease.

Initial therapy is limited to 3 months treatment with dornase alfa at a dose of 2.5 mg daily.

FEV1 measurement (single test under conditions as above) and a global assessment of the patient involving the patient, the patient's family (in the case of paediatric patients), the treating physician(s) and an additional independent member of the cystic fibrosis treatment team must be undertaken and documented following 3 months of initial therapy.

To be eligible for continued PBS-subsidised treatment with dornase alfa following 3 months of initial treatment:

(1) the patient must demonstrate no deterioration in FEV1 compared to baseline; AND

(2) the patient or the patient's family (in the case of paediatric patients) must report improvement in the patient's airway clearance; AND

(3) the treating physician(s) must report a benefit in the clinical status of the patient.

Further reassessments involving the patient, the patient's family (in the case of paediatric patients), the treating physician(s) and an additional independent member of the cystic fibrosis treatment team must be undertaken and documented at six-monthly intervals to establish that all agree that dornase alfa treatment is continuing to produce worthwhile benefits.

Dornase alfa therapy should cease if there is not general agreement of benefit as there is always the possibility of harm from unnecessary use.

Other aspects of treatment, such as physiotherapy, must be continued.

Where there is documented evidence that a patient already receiving dornase alfa therapy would have met the criteria for subsidy, then the patient is eligible to continue treatment under the HSD program. Where such evidence is not available, patients will need to satisfy the initiation and continuation criteria as for new patients. (Four weeks is considered a suitable wash-out period.)

Authority required (STREAMLINED)

4300

Cystic fibrosis

Clinical criteria:

Patient must have a severe clinical course with frequent respiratory exacerbations or chronic respiratory symptoms (including chronic or recurrent cough, wheeze or tachypnoea) requiring hospital admissions more frequently than 3 times per year; OR

Patient must have significant bronchiectasis on chest high resolution computed tomography scan; OR

Patient must have severe cystic fibrosis bronchiolitis with persistent wheeze non-responsive to conventional medicines; OR

Patient must have severe physiological deficit measure by forced oscillation technique or multiple breath nitrogen washout and failure to respond to conventional therapy.

Population criteria:

Patient must be less than 5 years of age.

Patient must be assessed at a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. The prescribing of dornase alfa therapy under the HSD program is limited to such physicians. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be by a specialist physician or paediatrician in consultation with such a unit.

Following an initial 6 months therapy, a comprehensive assessment must be undertaken and documented involving the patient, the patient's family, the treating physician and an additional independent member of the cystic fibrosis treatment team to establish agreement that dornase alfa treatment is continuing to produce worthwhile benefit. Treatment with dornase alfa should cease if there is not agreement of benefit, as there is always the possibility of harm from unnecessary use. Further reassessments must be undertaken and documented at six-monthly intervals.

Authority required (STREAMLINED)

4296

Cystic fibrosis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must have initiated treatment with dornase alfa at an age of less than 5 years, AND

Patient must have undergone a comprehensive assessment, involving the patient's family, the treating physician and an additional independent member of the cystic fibrosis treatment team which documents agreement that dornase alfa treatment is continuing to produce worthwhile benefit.

Population criteria:

Patient must be 5 years of age or older.

Further reassessments must be undertaken and documented at six-monthly intervals. Treatment with dornase alfa should cease if there is not agreement of benefit as there is always the possibility of harm from unnecessary use.

Authority required (STREAMLINED)

4298

Cystic fibrosis

Clinical criteria:

Patient must have initiated treatment with dornase alfa prior to 1 November 2009, AND

Patient must have undergone a comprehensive assessment, involving the patient's family, the treating physician and an additional independent member of the cystic fibrosis treatment team which documents agreement that dornase alfa treatment is continuing to produce worthwhile benefit.

Population criteria:

Patient must be less than 5 years of age.

Further reassessments must be undertaken and documented at six-monthly intervals. Treatment with dornase alfa should cease if there is not agreement of benefit as there is always the possibility of harm from unnecessary use.

Note

Dornase alfa is not PBS-subsidised for use in combination with PBS-subsidised mannitol.

It is highly desirable that all patients be included in the national cystic fibrosis patient database.

dornase alfa 2.5 mg/2.5 mL inhalation: solution, 30 x 2.5 mL ampoules

5704F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*2360.00	Pulmozyme [RO]

▪ **MANNITOL**

Authority required (STREAMLINED)

4299

Cystic fibrosis

Clinical criteria:

Patient must have been assessed for bronchial hyperresponsiveness as per the TGA approved Product Information mannitol initiation dose assessment, prior to mannitol therapy. If the patient has a negative hyperresponsiveness test they may be eligible for PBS subsidised treatment with mannitol, **AND**

Patient must have a forced expiratory volume in 1 second (FEV1) greater than 30% predicted for age, gender and height, **AND**

Patient must be intolerant or inadequately responsive to dornase alfa, **AND**

Patient must have evidence of chronic suppurative lung disease (cough and sputum most days of the week, or greater than 3 respiratory tract infections of more than 2 weeks' duration in any 12 months, or objective evidence of obstructive airways disease).

Population criteria:

Patient must be 6 years of age or older.

Patient must be assessed at a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. The prescribing of mannitol therapy under the HSD program is limited to such physicians. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be by a specialist physician or paediatrician in consultation with such a unit.

The measurement of lung function is to be conducted by independent (other than the treating doctor) experienced personnel at an established lung function testing laboratory, unless this is not possible because of geographical isolation.

Prior to mannitol therapy, a baseline measurement of FEV1 must be undertaken during a stable period of the disease.

Initial therapy is limited to 3 months treatment with mannitol at a dose of 400 mg twice daily.

FEV1 measurement (single test under conditions as above) and a global assessment of the patient involving the patient, the patient's family (in the case of paediatric patients), the treating physician(s) and an additional independent member of the cystic fibrosis treatment team must be undertaken and documented following 3 months of initial therapy.

To be eligible for continued PBS-subsidised treatment with mannitol following 3 months of initial treatment:

(1) the patient must demonstrate no deterioration in FEV1 compared to baseline; **AND**

(2) the patient or the patient's family (in the case of paediatric patients) must report improvement in the patient's airway clearance; **AND**

(3) the treating physician(s) must report a benefit in the clinical status of the patient.

Further reassessments involving the patient, the patient's family (in the case of paediatric patients), the treating physician(s) and an additional independent member of the cystic fibrosis treatment team must be undertaken and documented at six-monthly intervals to establish that all agree that mannitol treatment is continuing to produce worthwhile benefits. Mannitol therapy should cease if there is not general agreement of benefit as there is always the possibility of harm from unnecessary use.

Other aspects of treatment, such as physiotherapy, must be continued.

Where there is documented evidence that a patient already receiving mannitol therapy would have met the criteria for subsidy then the patient is eligible to continue treatment under the HSD program. Where such evidence is not available, patients will need to satisfy the initiation and continuation criteria as for new patients. (Four weeks is considered a suitable wash-out period.)

Authority required (STREAMLINED)

4293

Cystic fibrosis

Clinical criteria:

Patient must have initiated treatment with mannitol prior to 1 August 2012, **AND**

Patient must have undergone a comprehensive assessment involving the patient's family, the treating physician and an additional independent member of the cystic fibrosis team, which documents agreement that mannitol treatment is continuing to produce a worthwhile benefit.

Population criteria:

Patient must be 6 years of age or older.

Further reassessments are to be undertaken and documented every 6 months. Treatment with mannitol should cease if there is not agreement of benefit as there is always the possibility of harm from unnecessary use.

Note

Mannitol is not PBS-subsidised for use in combination with PBS-subsidised dornase alfa.

It is highly desirable that all patients be included in the national cystic fibrosis patient database.

MANNITOL Pack containing 280 capsules containing powder for inhalation 40 mg and 2 inhalers, 1

2015C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	4	5	..	*1736.00	bronchitol [XA]

OTHER RESPIRATORY SYSTEM PRODUCTS

OTHER RESPIRATORY SYSTEM PRODUCTS

Other respiratory system products

IVACAFTOR

Authority required

Cystic fibrosis

Treatment Phase: Initial treatment – New patients

Clinical criteria:

Patient must be assessed through a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be in consultation with such a unit, **AND**

Patient must have G551D mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene on at least 1 allele; OR

Patient must have other gating (class III) mutation in the CFTR gene on at least 1 allele, **AND**

Patient must not receive more than 24 weeks of treatment under this restriction, **AND**

The treatment must be given concomitantly with standard therapy for this condition.

Population criteria:

Patient must be 6 years of age or older.

Patients receiving PBS-subsidised ivacaftor must be registered in the Australian Cystic Fibrosis Database Registry.

Treatment must not be given to a patient who has an acute upper or lower respiratory infection, pulmonary exacerbation, or changes in therapy (including antibiotics) for pulmonary disease in the last 4 weeks prior to commencing this drug.

Dosage of ivacaftor must not exceed the dose of 150 mg twice a week, if the patient is concomitantly receiving one of the following strong CYP3A4 drugs inhibitors: boceprevir, clarithromycin, conivaptan, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, mibefradil, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin, voriconazole.

Where a patient is concomitantly receiving a strong CYP3A4 inhibitor, a single supply of 56 tablets of ivacaftor will last for 28 weeks.

Dosage of ivacaftor must not exceed the dose of 150 mg daily, if the patient is concomitantly receiving one of the following moderate CYP3A4 inhibitors: amprenavir, aprepitant, atazanavir, darunavir/ritonavir, diltiazem, erythromycin, fluconazole, fosamprenavir, imatinib, verapamil.

Where a patient is concomitantly receiving a moderate CYP3A4 inhibitor, a single supply of 56 tablets of ivacaftor will last for 8 weeks.

Ivacaftor is not PBS-subsidised for this condition as a sole therapy.

Ivacaftor is not PBS-subsidised for this condition in a patient who is currently receiving one of the following CYP3A4 inducers:

Strong CYP3A4 inducers: avasimibe, carbamazepine, phenobarbital, phenytoin, rifabutin, rifampicin, St. John's wort

Moderate CYP3A4 inducers: bosentan, efavirenz, etravirine, modafinil, nafcillin

Weak CYP3A4 inducers: armodafinil, echinacea, pioglitazone, prednisone, rufinamide.

The authority application must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Cystic Fibrosis Ivacaftor Authority Application Supporting Information Form; and
- (3) a signed patient acknowledgement; or an acknowledgement signed by a parent or authorised guardian, if applicable; and
- (4) a copy of the pathology report detailing the molecular testing for G551D mutation or other gating (class III) mutation on the CFTR gene; and
- (5) the result of a FEV1 measurement performed within a month prior to the date of application. Note: FEV1, must be measured in an accredited pulmonary function laboratory, with documented no acute infective exacerbation at the time FEV1 is measured; and
- (6) evidence that the patient has either chronic sinopulmonary disease or gastrointestinal and nutritional abnormalities; and
- (7) a copy of a current medication history, including any CYP3A4 inhibitors and/or CYP3A4 inducers; and
- (8) a copy of a sweat chloride result; and
- (9) height and weight measurements at the time of application; and
- (10) a baseline measurement of the number of days of CF-related hospitalisation (including hospital-in-the home) in the previous 12 months.

Authority required

Cystic fibrosis

Treatment Phase: Continuing treatment

Clinical criteria:

Patient must be assessed through a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be in consultation with such a unit, **AND**

Patient must have received PBS-subsidised initial therapy with ivacaftor, given concomitantly with standard therapy, for this condition, **AND**

Patient must not receive more than 24 weeks of treatment under this restriction, **AND**

The treatment must be given concomitantly with standard therapy for this condition.

Population criteria:

Patient must be 6 years of age or older.

Patients receiving PBS-subsidised ivacaftor must be registered in the Australian Cystic Fibrosis Database Registry.

Treatment must not be given to a patient who has an acute upper or lower respiratory infection, pulmonary exacerbation, or changes in therapy (including antibiotics) for pulmonary disease in the last 4 weeks prior to commencing this drug.

Patients who have an acute infective exacerbation at the time of assessment for continuing therapy may receive an additional one month's supply in order to enable the assessment to be repeated following resolution of the exacerbation.

Dosage of ivacaftor must not exceed the dose of 150 mg twice a week, if the patient is concomitantly receiving one of the following strong CYP3A4 drugs inhibitors: boceprevir, clarithromycin, conivaptan, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, mibefradil, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin, voriconazole.

Where a patient is concomitantly receiving a strong CYP3A4 inhibitor, a single supply of 56 tablets of ivacaftor will last for 28 weeks.

Dosage of ivacaftor must not exceed the dose of 150 mg daily, if the patient is concomitantly receiving one of the following moderate CYP3A4 inhibitors: amprenavir, aprepitant, atazanavir, darunavir/ritonavir, diltiazem, erythromycin, fluconazole, fosamprenavir, imatinib, verapamil.

Where a patient is concomitantly receiving a moderate CYP3A4 inhibitor, a single supply of 56 tablets of ivacaftor will last for 8 weeks.

Ivacaftor is not PBS-subsidised for this condition as a sole therapy.

Ivacaftor is not PBS-subsidised for this condition in a patient who is currently receiving one of the following CYP3A4 inducers:

Strong CYP3A4 inducers: avasimibe, carbamazepine, phenobarbital, phenytoin, rifabutin, rifampicin, St. John's wort

Moderate CYP3A4 inducers: bosentan, efavirenz, etravirine, modafinil, nafcillin

Weak CYP3A4 inducers: armodafinil, echinacea, pioglitazone, prednisone, rufinamide.

The authority application must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Cystic Fibrosis Ivacaftor Authority Continuing Application Supporting Information Form; and
- (3) the result of a FEV1 measurement performed within one month prior to the date of application. Note: FEV1, must be measured in an accredited pulmonary function laboratory, with documented no acute infective exacerbation at the time FEV1 is measured; and
- (4) a copy of a current medication history, including any CYP3A4 inhibitors and/or CYP3A4 inducers; and
- (5) a recent sweat chloride result; and
- (6) height and weight measurements at the time of application; and
- (7) a measurement of number of days of CF-related hospitalisation (including hospital in the home) in the previous 6 months.

Authority required

Cystic fibrosis

Treatment Phase: Initial treatment - Grandfather patients

Clinical criteria:

Patient must be assessed through a cystic fibrosis clinic/centre which is under the control of specialist respiratory physicians with experience and expertise in the management of cystic fibrosis. If attendance at such a unit is not possible because of geographical isolation, management (including prescribing) may be in consultation with such a unit, **AND**

Patient must have G551D mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene on at least 1 allele; OR

Patient must have other gating (class III) mutation in the CFTR gene on at least 1 allele, **AND**

Patient must have received treatment with ivacaftor for this condition prior to 1 December 2014, **AND**

Patient must have received treatment with ivacaftor within the last 6 months at the time of application, **AND**

Patient must not receive more than 24 weeks of treatment under this restriction, **AND**

The treatment must be given concomitantly with standard therapy for this condition.

Population criteria:

Patient must be 6 years of age or older.

Patients receiving PBS-subsidised ivacaftor must be registered in the Australian Cystic Fibrosis Database Registry.

Treatment must not be given to a patient who has an acute upper or lower respiratory infection, pulmonary exacerbation, or changes in therapy (including antibiotics) for pulmonary disease in the last 4 weeks prior to commencing this drug.

Dosage of ivacaftor must not exceed the dose of 150 mg twice a week, if the patient is concomitantly receiving one of the following strong CYP3A4 drugs inhibitors: boceprevir, clarithromycin, conivaptan, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, mibefradil, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin, voriconazole.

Where a patient is concomitantly receiving a strong CYP3A4 inhibitor, a single supply of 56 tablets of ivacaftor will last for 28 weeks.

Dosage of ivacaftor must not exceed the dose of 150 mg daily, if the patient is concomitantly receiving one of the following moderate CYP3A4 inhibitors: amprenavir, aprepitant, atazanavir, darunavir/ritonavir, diltiazem, erythromycin, fluconazole, fosamprenavir, imatinib, verapamil.

Where a patient is concomitantly receiving a moderate CYP3A4 inhibitor, a single supply of 56 tablets of ivacaftor will last for 8 weeks.

Ivacaftor is not PBS-subsidised for this condition as a sole therapy.

Ivacaftor is not PBS-subsidised for this condition in a patient who is currently receiving one of the following CYP3A4 inducers:

Strong CYP3A4 inducers: avasimibe, carbamazepine, phenobarbital, phenytoin, rifabutin, rifampicin, St. John's wort

Moderate CYP3A4 inducers: bosentan, efavirenz, etravirine, modafinil, nafcillin

Weak CYP3A4 inducers: armodafinil, echinacea, pioglitazone, prednisone, rufinamide.

The authority application must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Cystic Fibrosis Ivacaftor Application Supporting Information Form; and
- (3) a signed patient acknowledgement; or an acknowledgement signed by a parent or authorised guardian, if applicable; and
- (4) a copy of the pathology report detailing the molecular testing for G551D mutation or other gating (class III) mutation on the CFTR gene performed prior to commencing treatment with ivacaftor; and
- (5) the result of a FEV1 measurement performed prior to commencing treatment with ivacaftor for this condition; and
- (6) the result of a FEV1 measurement performed within a month prior to date of application. Note: FEV1, must be measured in an accredited pulmonary function laboratory, with documented no acute infective exacerbation at the time FEV1 is measured; and
- (7) evidence that the patient had either chronic sinopulmonary disease or gastrointestinal and nutritional abnormalities prior to commencing treatment with ivacaftor for this condition; and
- (8) a copy of a current medication history, including any CYP3A4 inhibitors and/or CYP3A4 inducers; and
- (9) a copy of sweat chloride result performed prior to commencing treatment with ivacaftor for this condition; and
- (10) a recent sweat chloride result prior to commencing PBS-subsidised ivacaftor; and
- (11) height and weight measurements at the time of application; and
- (12) height and weight measurements performed immediately prior to commencement of ivacaftor; and
- (13) a baseline measurement of number of days of CF-related hospitalisation (including hospital-in-the home) in the 12 months prior to commencement of ivacaftor; and
- (14) a measurement of the number of days of CF-related hospitalisation (including hospital-in the home) in the 6 months prior to the date of application; and
- (15) dates of prior ivacaftor therapy.

Note

Special Pricing Arrangements apply.

No increase in the maximum number of repeats may be authorised.

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation 8 a.m. to 5 p.m. EST Monday to Friday).

Prescribing information (including Authority Application forms and other relevant documentation as applicable) is available on the Department of Human Services website at www.humanservices.gov.au

Applications for authority to prescribe should be forwarded to:

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

ivacaftor 150 mg tablet, 56

10170G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	1	5	..	22500.00	Kalydeco [VR]

VARIOUS

ALL OTHER THERAPEUTIC PRODUCTS

ALL OTHER THERAPEUTIC PRODUCTS

Iron chelating agents

DEFERASIROX

Authority required (STREAMLINED)

3828

Chronic iron overload in patients with disorders of erythropoiesis

Note

Special Pricing Arrangements apply.

deferasirox 125 mg tablet: dispersible, 28

5654N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	6	5	..	*1401.48	Exjade [NV]

deferasirox 250 mg tablet: dispersible, 28

5655P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	6	5	..	*2802.90	Exjade [NV]

deferasirox 500 mg tablet: dispersible, 28

5656Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	6	5	..	*5605.80	Exjade [NV]

▪ DEFERIPRONE**Authority required (STREAMLINED)****3338**

Iron overload in patients with thalassaemia major who are unable to take desferrioxamine therapy

Authority required (STREAMLINED)**3339**

Iron overload in patients with thalassaemia major in whom desferrioxamine therapy has proven ineffective

deferiprone 100 mg/mL oral liquid, 250 mL

5658T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	5	5	..	*1126.40	Ferriprox [TX]

deferiprone 500 mg tablet, 100

5657R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	6	5	..	*2703.36	Ferriprox [TX]

▪ DESFERRIOXAMINE**Authority required (STREAMLINED)****3340**

Disorders of erythropoiesis associated with treatment-related chronic iron overload

desferrioxamine mesylate 2 g injection, 1 x 2 g vial

5661Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	60	5	..	*1724.40	^a Hospira Pty Limited [HH]
			^B 17.40	*1741.80	^a Desferal 2 g [NV]

desferrioxamine mesylate 500 mg injection, 10 x 500 mg vials

5662B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	40	5	..	*2874.40	^a Hospira Pty Limited [HH]
			^B 238.40	*3112.80	^a Desferal 500 mg [NV]

Drugs for treatment of hyperkalemia and hyperphosphatemia**▪ LANTHANUM****Authority required (STREAMLINED)****4832**

Hyperphosphataemia

Treatment Phase: Initiation and stabilisation

Clinical criteria:

The condition must not be adequately controlled by calcium, **AND**

Patient must have a serum phosphate of greater than 1.6 mmol per L at the commencement of therapy; OR

The condition must be where a serum calcium times phosphate product is greater than 4 at the commencement of therapy, **AND**

The treatment must not be used in combination with any other phosphate binding agents.

Treatment criteria:

Patient must be undergoing dialysis for chronic kidney disease.

LANTHANUM Tablet, chewable, 1000 mg (as carbonate hydrate), 90

5782H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*890.02	Fosrenol [ZI]

LANTHANUM Tablet, chewable, 500 mg (as carbonate hydrate), 90

5780F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*523.54	Fosrenol [ZI]

LANTHANUM Tablet, chewable, 750 mg (as carbonate hydrate), 90

5781G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*790.56	Fosrenol [ZI]

▪ **SEVELAMER****Authority required (STREAMLINED)****4832**

Hyperphosphataemia

Treatment Phase: Initiation and stabilisation

Clinical criteria:The condition must not be adequately controlled by calcium, **AND**

Patient must have a serum phosphate of greater than 1.6 mmol per L at the commencement of therapy; OR

The condition must be where a serum calcium times phosphate product is greater than 4 at the commencement of therapy, **AND**

The treatment must not be used in combination with any other phosphate binding agents.

Treatment criteria:

Patient must be undergoing dialysis for chronic kidney disease.

sevelamer hydrochloride 800 mg tablet, 180

9546K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*620.00	Renagel [GZ]

▪ **SUCROFERRIC OXYHYDROXIDE****Authority required (STREAMLINED)****4832**

Hyperphosphataemia

Treatment Phase: Initiation and stabilisation

Clinical criteria:The condition must not be adequately controlled by calcium, **AND**

Patient must have a serum phosphate of greater than 1.6 mmol per L at the commencement of therapy; OR

The condition must be where a serum calcium times phosphate product is greater than 4 at the commencement of therapy, **AND**

The treatment must not be used in combination with any other phosphate binding agents.

Treatment criteria:

Patient must be undergoing dialysis for chronic kidney disease.

iron (as sucroferric oxyhydroxide) 500 mg tablet: chewable, 90

10233N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	Brand Name and Manufacturer
	2	5	..	*753.46	Velphoro [FN]

Botulinum Toxin Program

MUSCULO-SKELETAL SYSTEM	984
MUSCLE RELAXANTS	984
MUSCLE RELAXANTS, PERIPHERALLY ACTING AGENTS	984
Other muscle relaxants, peripherally acting agents	984

■ MUSCULO-SKELETAL SYSTEM

■ MUSCLE RELAXANTS

MUSCLE RELAXANTS, PERIPHERALLY ACTING AGENTS

Other muscle relaxants, peripherally acting agents

■ BOTULINUM TOXIN TYPE A

Restricted benefit

Blepharospasm or hemifacial spasm

Population criteria:

Patient must be aged 12 years or older.

Restricted benefit

Dynamic equinus foot deformity

Clinical criteria:

The condition must be due to spasticity, **AND**

Patient must be an ambulant cerebral palsy patient.

Population criteria:

Patient must be aged from 2 to 17 years inclusive.

Restricted benefit

Dynamic equinus foot deformity

Clinical criteria:

The condition must be due to spasticity, **AND**

Patient must be an ambulant cerebral palsy patient, **AND**

Patient must have commenced on PBS-subsidised treatment with botulinum toxin type A purified neurotoxin complex as a paediatric patient.

Population criteria:

Patient must be aged 18 years or older.

Restricted benefit

Spasmodic torticollis

Clinical criteria:

The treatment must be as monotherapy; OR

The treatment must be as adjunctive therapy to current standard care.

Restricted benefit

Moderate to severe spasticity of the upper limb

Clinical criteria:

Patient must have cerebral palsy.

Population criteria:

Patient must be aged from 2 to 17 years inclusive.

Restricted benefit

Moderate to severe spasticity of the upper limb

Clinical criteria:

Patient must have cerebral palsy, **AND**

Patient must have commenced on PBS-subsidised treatment with botulinum toxin type A purified neurotoxin complex as a paediatric patient.

Population criteria:

Patient must be aged 18 years or older.

Note

Contact the Department of Human Services before commencing PBS-subsidised treatment in cerebral palsy patients who have been treated for moderate to severe spasticity of the upper limb with non-PBS-subsidised botulinum toxin prior to the age of 18.

Restricted benefit

Moderate to severe spasticity of the upper limb following a stroke

Clinical criteria:

The treatment must be used as second line therapy when standard management has failed (e.g. physiotherapy and/or oral spasticity agents) or as an adjunct to physical therapy.

Population criteria:

Patient must be an adult.

Moderate to severe spasticity is defined as MAS greater than or equal to 3 using modified Ashworth scale.

Maximum number of treatments to be authorised is 4 (total Xeomin®, Botox® and Dysport®) per upper limb per lifetime.

Treatment should not be initiated until 3 months post-stroke in patients who do not have established severe contracture.

Treatment should be discontinued if the patient does not respond (decrease of MAS greater than 1 in at least one joint) after two treatments.

The date of the stroke must be provided.

Contraindications to treatment include established severe contracture and known sensitivity to botulinum toxin.

Restricted benefit

Severe primary axillary hyperhidrosis

Clinical criteria:

Patient must have previously failed or be intolerant to topical aluminium chloride hexahydrate after one to two months of treatment.

Population criteria:

Patient must be aged 12 years or older.

Maximum number of treatments per year is 3, with no less than 4 months to elapse between treatments.

Restricted benefit

Urinary incontinence

Clinical criteria:

The condition must be due to neurogenic detrusor overactivity, as demonstrated by urodynamic study, **AND**

The condition must be inadequately controlled by anti-cholinergic therapy, **AND**

Patient must experience at least 14 episodes of urinary incontinence per week prior to commencement of treatment with botulinum toxin, **AND**

The treatment must not continue if the patient does not achieve a 50% or greater reduction from baseline in urinary incontinence episodes 6-12 weeks after the first treatment, **AND**

Patient must be willing and able to self-catheterise.

Population criteria:

Patient must have multiple sclerosis; OR

Patient must have a spinal cord injury; OR

Patient must be aged 18 years or older and have spina bifida.

Restricted benefit

Chronic migraine

Clinical criteria:

Patient must have experienced an average of 15 or more headache days per month, with at least 8 days of migraine, over a period of at least 6 months, prior to commencement of treatment with botulinum toxin, **AND**

Patient must have experienced an inadequate response, intolerance or a contraindication to at least three prophylactic migraine medications prior to commencement of treatment with botulinum toxin, **AND**

Patient must have achieved and maintained a 50% or greater reduction from baseline in the number of headache days per month after two treatment cycles (each of 12 weeks duration) in order to be eligible for continuing PBS-subsidised treatment.

Population criteria:

Patient must be an adult.

Medication overuse headache must be appropriately managed prior to initiation of treatment with botulinum toxin.

Restricted benefit

Urinary incontinence

Clinical criteria:

The condition must be due to idiopathic overactive bladder, **AND**

The condition must have been inadequately controlled by therapy involving at least two alternative anti-cholinergic agents, **AND**

Patient must experience at least 14 episodes of urinary incontinence per week prior to commencement of treatment with botulinum toxin, **AND**

The treatment must not continue if the patient does not achieve a 50% or greater reduction from baseline in urinary incontinence episodes 6-12 weeks after the first treatment, **AND**

Patient must be willing and able to self-catheterise.

Population criteria:

Patient must be aged 18 years or older.

Note

Arrangements to prescribe this item should be made by medical practitioners with the Department of Human Services, contact telephone number 1800 700 270.

The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent. Special Pricing Arrangements apply.

botulinum toxin type A 100 units injection, 1 x 100 units vial

6103F

Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
1	415.50	Botox [AG]

▪ CLOSTRIDIUM BOTULINUM TYPE A TOXIN-HAEMAGGLUTININ COMPLEX**Restricted benefit**

Moderate to severe spasticity of the upper limb following a stroke

Clinical criteria:

The treatment must be used as second line therapy when standard management has failed (e.g. physiotherapy and/or oral spasticity agents) or as an adjunct to physical therapy.

Population criteria:

Patient must be an adult.

Moderate to severe spasticity is defined as MAS greater than or equal to 3 using modified Ashworth scale.

Maximum number of treatments to be authorised is 4 (total Xeomin®, Botox® and Dysport®) per upper limb per lifetime. Treatment should not be initiated until 3 months post-stroke in patients who do not have established severe contracture. Treatment should be discontinued if the patient does not respond (decrease of MAS greater than 1 in at least one joint) after two treatments.

The date of the stroke must be provided.

Contraindications to treatment include established severe contracture and known sensitivity to botulinum toxin.

Restricted benefit

Dynamic equinus foot deformity

Clinical criteria:

The condition must be due to spasticity, **AND**

Patient must be an ambulant cerebral palsy patient.

Population criteria:

Patient must be aged from 2 to 17 years inclusive.

Restricted benefit

Dynamic equinus foot deformity

Clinical criteria:

The condition must be due to spasticity, **AND**

Patient must be an ambulant cerebral palsy patient, **AND**

Patient must have commenced on PBS-subsidised treatment with clostridium botulinum type A toxin-haemagglutinin complex as a paediatric patient.

Population criteria:

Patient must be aged 18 years or older.

Restricted benefit

Spasmodic torticollis

Clinical criteria:

The treatment must be as monotherapy; OR

The treatment must be as adjunctive therapy to current standard care.

Restricted benefit

Blepharospasm or hemifacial spasm

Population criteria:

Patient must be an adult.

Note

The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent. Arrangements to prescribe this item should be made by medical practitioners with the Department of Human Services, contact telephone number 1800 700 270.

clostridium botulinum type A toxin-haemagglutinin complex 300 units injection, 1 x 300 units vial

1152P	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	361.52	Dysport [IS]

clostridium botulinum type A toxin-haemagglutinin complex 500 units injection, 1 x 500 units vial

6293F	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	644.81	Dysport [IS]

▪ **INCOBOTULINUMTOXINA**

Restricted benefit

Spasmodic torticollis

Clinical criteria:

The treatment must be as monotherapy; OR

The treatment must be as adjunctive therapy to current standard care.

Restricted benefit

Blepharospasm

Population criteria:

Patient must be an adult.

Restricted benefit

Moderate to severe spasticity of the upper limb following a stroke

Clinical criteria:

The treatment must be used as second line therapy when standard management has failed (e.g. physiotherapy and/or oral spasticity agents) or as an adjunct to physical therapy.

Population criteria:

Patient must be an adult.

Moderate to severe spasticity is defined as MAS greater than or equal to 3 using modified Ashworth scale.

Maximum number of treatments to be authorised is 4 (total Xeomin®, Botox® and Dysport®) per upper limb per lifetime.

Treatment should not be initiated until 3 months post-stroke in patients who do not have established severe contracture.

Treatment should be discontinued if the patient does not respond (decrease of MAS greater than 1 in at least one joint) after two treatments.

The date of the stroke must be provided.

Contraindications to treatment include established severe contracture and known sensitivity to botulinum neurotoxin.

Note

Arrangements to prescribe this item should be made by medical practitioners with the Department of Human Services, contact telephone number 1800 700 270.

The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.

incobotulinumtoxinA 100 mouse LD50 units injection, 1 x 100 mouse LD50 units vial

10253P

Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
1	375.00	Xeomin [EZ]

Growth Hormone Program

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS.....	990
PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES	990
ANTERIOR PITUITARY LOBE HORMONES AND ANALOGUES	990
Somatropin and somatropin agonists.....	990

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES

ANTERIOR PITUITARY LOBE HORMONES AND ANALOGUES

Somatropin and somatropin agonists

■ SOMATROPIN

Restricted benefit

Short stature in accordance with the 'Guidelines for the Pharmaceutical Benefits Scheme Growth Hormone Program. The program also aims to correct neonatal hypoglycaemia due to biochemical growth hormone deficiency and improve body composition for children with Prader-Willi Syndrome.

The Guidelines specify the eligibility criteria for the conditions that are eligible for treatment through the program which include:

- (i) short stature and slow growth;
- (ii) short stature associated with biochemical growth hormone deficiency;
- (iii) growth retardation secondary to intracranial lesion or cranial irradiation;
- (iv) neonates/infants at risk of hypoglycaemia secondary to growth hormone deficiency;
- (v) short stature associated with Turner Syndrome;
- (vi) short stature due to short stature homeobox (SHOX) gene disorders;
- (vii) short stature associated with chronic renal insufficiency;
- (viii) biochemical growth hormone deficiency and precocious puberty;
- (ix) Prader-Willi syndrome.

Genotropin branded products are available for the treatment of Prader-Willi Syndrome in accordance with the Guidelines

Note

Growth hormone (Somatropin) for adults is currently not subsidised through the Pharmaceutical Benefits Scheme.

These guidelines may be obtained from the Department of Health and Ageing's internet site at

<http://www.health.gov.au/hGH>, or from:

Growth Hormone Program
Access and Systems Branch
Department of Health and Ageing
GPO Box 9848
CANBERRA ACT 2601

Contact telephone number (02) 6289 7274

SOMATROPIN (Recombinant human growth hormone) Injection 8 mg (24 i.u.) vial with 1.37 mL diluent cartridge (with preservative) (for use with one.click auto-injector), 1

6329D	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	396.00	Saizen 8 mg click.easy [SG]

SOMATROPIN (Recombinant human growth hormone) Powder for injection 12 mg (36 i.u.) with diluent in pre-filled pen (with preservative), 1

9586M	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	594.00	Genotropin GoQuick [PF]

SOMATROPIN (Recombinant human growth hormone) Powder for injection 5 mg (15 i.u.) with diluent in pre-filled pen (with preservative), 1

9585L	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	247.50	Genotropin GoQuick [PF]

somatropin 1.8 international units (600 microgram) injection [7 x 600 microgram syringes] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

9628R	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	207.90	Genotropin MiniQuick [PF]

somatropin 12 international units (4 mg) injection [1 x 4 mg vial] (&) inert substance diluent [1 vial], 1 pack

6266T	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	198.00	Zomacton [FP]

somatropin 15 international units (5 mg/1.5 mL) injection, 1 x 1.5 mL cartridge

6295H	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	247.50	Norditropin SimpleXx [NO]

somatropin 15 international units (5 mg/1.5 mL) injection, 1 x 1.5 mL cartridge

6476W	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	247.50	Omnitrope [SZ]

somatropin 18 international units (6 mg) injection [1 x 6 mg cartridge] (&) inert substance diluent [1 x 3.15 mL syringe], 1 pack

6169Q	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	297.00	Humatrope [LY]

somatropin 18 international units (6 mg/1.03 mL) injection, 1 x 1.03 mL cartridge

5822K	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	297.00	Saizen [SG]

somatropin 2.4 international units (800 microgram) injection [7 x 800 microgram syringes] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

6313G	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	277.20	Genotropin MiniQuick [PF]

somatropin 3 international units (1 mg) injection [7 x 1 mg syringes] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

6314H	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	346.50	Genotropin MiniQuick [PF]

somatropin 3.6 international units (1.2 mg) injection [7 x 1.2 mg syringes] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

6315J	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	415.80	Genotropin MiniQuick [PF]

somatropin 30 international units (10 mg) injection [1 x 10 mg vial] (&) inert substance diluent [1 x 1 mL syringe], 1 pack

6310D	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	495.00	Zomacton [FP]

somatropin 30 international units (10 mg/1.5 mL) injection, 1 x 1.5 mL cartridge

6296J	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	495.00	Norditropin SimpleXx [NO]

somatropin 30 international units (10 mg/1.5 mL) injection, 1 x 1.5 mL cartridge

6311E	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	495.00	Omnitrope [SZ]

somatropin 30 international units (10 mg/2 mL) injection, 1 x 2 mL cartridge

9604L	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	495.00	NutropinAq [IS]

somatropin 36 international units (12 mg) injection [1 x 12 mg cartridge] (&) inert substance diluent [1 x 1 mL cartridge], 1 pack

6312F	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	594.00	Genotropin [PF]

somatropin 36 international units (12 mg) injection [1 x 12 mg cartridge] (&) inert substance diluent [1 x 3.15 mL syringe], 1 pack

6170R	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	594.00	Humatrope [LY]

somatropin 36 international units (12 mg/1.5 mL) injection, 1 x 1.5 mL cartridge

5824M	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	594.00	Saizen [SG]

somatropin 4.2 international units (1.4 mg) injection [7 x 1.4 mg syringes] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

6316K	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	485.10	Genotropin MiniQuick [PF]

somatropin 4.8 international units (1.6 mg) injection [7 x 1.6 mg syringes] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

6317L	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	554.40	Genotropin MiniQuick [PF]

somatropin 45 international units (15 mg/1.5 mL) injection, 1 x 1.5 mL cartridge

6297K	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	742.50	Norditropin SimpleXx [NO]

somatropin 5.4 international units (1.8 mg) injection [7 x 1.8 mg syringes] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

6318M	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	623.70	Genotropin MiniQuick [PF]

somatropin 6 international units (2 mg) injection [7 x 2 mg syringes] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack

6319N	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	693.00	Genotropin MiniQuick [PF]

somatropin 60 international units (20 mg/2.5 mL) injection, 1 x 2.5 mL cartridge

3388H	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	990.00	Saizen [SG]

somatropin 72 international units (24 mg) injection [1 x 24 mg cartridge] (&) inert substance diluent [1 x 3.15 mL syringe], 1 pack

6345Y	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	1188.00	Humatrope [LY]

▪ SOMATROPIN

Restricted benefit

Short stature in accordance with the 'Guidelines for the Pharmaceutical Benefits Scheme Growth Hormone Program. The program also aims to correct neonatal hypoglycaemia due to biochemical growth hormone deficiency and improve body composition for children with Prader-Willi Syndrome.

The Guidelines specify the eligibility criteria for the conditions that are eligible for treatment through the program which include:

- (i) short stature and slow growth;
- (ii) short stature associated with biochemical growth hormone deficiency;
- (iii) growth retardation secondary to intracranial lesion or cranial irradiation;
- (iv) neonates/infants at risk of hypoglycaemia secondary to growth hormone deficiency;
- (v) short stature associated with Turner Syndrome;
- (vi) short stature due to short stature homeobox (SHOX) gene disorders;
- (vii) short stature associated with chronic renal insufficiency;
- (viii) biochemical growth hormone deficiency and precocious puberty;
- (ix) Prader-Willi syndrome.

Genotropin branded products are available for the treatment of Prader-Willi Syndrome in accordance with the Guidelines

Note

Growth hormone (Somatropin) for adults is currently not subsidised through the Pharmaceutical Benefits Scheme.

These guidelines may be obtained from the Department of Health and Ageing's internet site at

<http://www.health.gov.au/hGH>, or from:

Growth Hormone Program
Access and Systems Branch
Department of Health and Ageing
GPO Box 9848
CANBERRA ACT 2601

Contact telephone number (02) 6289 7274

Special Pricing Arrangements apply.

somatropin 15 international units (5 mg/1.5 mL) injection, 1 x 1.5 mL cartridge

5818F	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	315.50	Norditropin FlexPro [NO]

somatropin 30 international units (10 mg/1.5 mL) injection, 1 x 1.5 mL cartridge

5819G	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	631.00	Norditropin FlexPro [NO]

somatropin 45 international units (15 mg/1.5 mL) injection, 1 x 1.5 mL cartridge

5820H	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	946.50	Norditropin FlexPro [NO]

IVF Treatment Program

GENITO URINARY SYSTEM AND SEX HORMONES	996
SEX HORMONES AND MODULATORS OF THE GENITAL SYSTEM	996
PROGESTOGENS.....	996
Pregnen (4) derivatives	996
GONADOTROPINS AND OTHER OVULATION STIMULANTS	996
Gonadotropins	996
SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS.....	998
PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES	998
HYPOTHALAMIC HORMONES.....	998
Gonadotropin-releasing hormones.....	998
Anti-gonadotropin-releasing hormones	999

GENITO URINARY SYSTEM AND SEX HORMONES

SEX HORMONES AND MODULATORS OF THE GENITAL SYSTEM

PROGESTOGENS

Pregnen (4) derivatives

PROGESTERONE

Restricted benefit

Luteal support as part of an assisted reproductive technology (ART) treatment programme for infertile women

Clinical criteria:

The treatment must be for luteal phase support, **AND**

Patient must be receiving medical treatment as described in items 13200 or 13201 of the Health Insurance (General Medical Services Table) Regulations.

The luteal phase is defined as the time span from embryo transfer until implantation confirmed by positive B-hCG measurement.

Note

Supply of these items is through an accredited IVF/GIFT clinic. For enquiries relating to the IVF/GIFT Program, medical practitioners should contact the Department of Human Services on 1800 700 270.

progesterone 100 mg pessary, 15

9608Q	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	50.40	Oripro [ON]

progesterone 100 mg pessary, 21

10116K	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	49.39	Endometrin [FP]

progesterone 200 mg pessary, 15

9609R	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	55.60	Oripro [ON]

PROGESTERONE

Restricted benefit

Luteal support as part of an assisted reproductive technology (ART) treatment programme for infertile women

Clinical criteria:

The treatment must be for luteal phase support, **AND**

Patient must be receiving medical treatment as described in items 13200 or 13201 of the Health Insurance (General Medical Services Table) Regulations.

The luteal phase is defined as the time span from embryo transfer until implantation confirmed by positive B-hCG measurement.

Note

Supply of these items is through an accredited IVF/GIFT clinic. For enquiries relating to the IVF/GIFT Program, medical practitioners should contact the Department of Human Services on 1800 700 270.

Special Pricing Arrangements apply.

progesterone 8% vaginal gel, 15 applications

6366C	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	148.50	Crinone 8% [SG]

GONADOTROPINS AND OTHER OVULATION STIMULANTS

Gonadotropins

CHORIOGONADOTROPIN ALFA

Restricted benefit

Patients who are receiving medical treatment as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule

Note

Supply of this item is through an accredited IVF/GIFT clinic. For enquiries relating to the IVF/GIFT Program, medical practitioners should contact Medicare Australia on 1800 700 270.

Special Pricing Arrangements apply.

choriogonadotropin alfa 250 microgram/0.5 mL injection, 1 x 0.5 mL cartridge

6182J	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	54.80	Ovidrel [SG]

choriogonadotropin alfa 250 microgram/0.5 mL injection, 1 x 0.5 mL syringe

9631X	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	54.80	Ovidrel [SG]

▪ **CORIFOLLITROPIN ALFA**

Restricted benefit

Controlled ovarian stimulation

Clinical criteria:

Patient must have an antral follicle count of 20 or less.

Treatment criteria:

Patient must be undergoing treatment as described in items 13200, 13201 or 13202 of the Health Insurance (General Medical Services Table) Regulations, **AND**

Patient must be undergoing a gonadotrophin releasing hormone antagonist cycle.

Note

Supply of these items is through an accredited IVF/GIFT clinic. For enquiries relating to the IVF/GIFT Program, medical practitioners should contact the Department of Human Services on 1800 700 270.

corifollitropin alfa 100 microgram/0.5 mL injection, 1 x 0.5 mL syringe

5816D	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	410.14	Elonva [MK]

corifollitropin alfa 150 microgram/0.5 mL injection, 1 x 0.5 mL syringe

5817E	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	673.51	Elonva [MK]

▪ **FOLLITROPIN ALFA**

Restricted benefit

Patients who are receiving medical treatment as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule

Note

Supply of these items is through an accredited IVF/GIFT clinic. For enquiries relating to the IVF/GIFT Program, medical practitioners should contact Medicare Australia on 1800 700 270.

follitropin alfa 300 international units / 0.5 mL (21.84 microgram/0.5 mL) injection, 1 x 0.5 mL cartridge

6431L	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	145.20	Gonal-f Pen [SG]

follitropin alfa 450 international units / 0.75 mL (32.76 microgram/0.75 mL) injection, 1 x 0.75 mL cartridge

6432M	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	217.80	Gonal-f Pen [SG]

follitropin alfa 900 international units / 1.5 mL (65.52 microgram/1.5 mL) injection, 1 x 1.5 mL cartridge

6433N	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	435.60	Gonal-f Pen [SG]

▪ **FOLLITROPIN BETA**

Restricted benefit

Patients who are receiving medical treatment as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule

Note

Supply of these items is through an accredited IVF/GIFT clinic. For enquiries relating to the IVF/GIFT Program, medical practitioners should contact Medicare Australia on 1800 700 270.

follitropin beta 300 international units/0.36 mL injection, 1 x 0.36 mL cartridge

6335K	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	150.00	Puregon 300 IU/0.36 mL [MK]

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

follitropin beta 600 international units/0.72 mL injection, 1 x 0.72 mL cartridge

6336L	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	292.72	Puregon 600 IU/0.72 mL [MK]

follitropin beta 900 international units/1.08 mL injection, 1 x 1.08 mL cartridge

6464F	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	435.15	Puregon 900 IU/1.08 mL [MK]

■ GONADOTROPHIN CHORIONIC HUMAN

Restricted benefit

Patients who are receiving medical treatment as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule

Note

Supply of these items is through an accredited IVF/GIFT clinic. For enquiries relating to the IVF/GIFT Program, medical practitioners should contact Medicare Australia on 1800 700 270.

gonadotrophin chorionic human 1500 international units injection [3 x 1500 international units ampoules] (& inert substance diluent [3 x 1 mL ampoules], 1 pack

6178E	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	39.57	Pregnyl [MK]

gonadotrophin chorionic human 5000 international units injection [1 x 5000 international units ampoule] (& inert substance diluent [1 x 1 mL ampoule], 1 pack

6181H	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	11.49	Pregnyl [MK]

■ GONADOTROPHIN-MENOPAUSAL HUMAN

Restricted benefit

Patients who are receiving medical treatment as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule

Note

Supply of these items is through an accredited IVF/GIFT clinic. For enquiries relating to the IVF/GIFT Program, medical practitioners should contact Medicare Australia on 1800 700 270.

gonadotrophin-menopausal human 1200 international units injection [1 x 1200 international units vial] (& inert substance diluent [2 x 1 mL syringes], 1 pack

2038G	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	531.18	Menopur 1200 [FP]

gonadotrophin-menopausal human 600 international units injection [1 x 600 international units vial] (& inert substance diluent [1 x 1 mL syringe], 1 pack

2036E	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	265.59	Menopur 600 [FP]

■ SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

■ PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES

HYPOTHALAMIC HORMONES

Gonadotropin-releasing hormones

■ NAFARELIN

Restricted benefit

For the prevention of premature luteinisation and ovulation in patients undergoing controlled ovarian stimulation, followed by oocyte pick-up and assisted reproductive techniques as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule

Note

Supply of this item is through an accredited IVF/GIFT clinic. For enquiries relating to the IVF/GIFT Program, medical practitioners should contact Medicare Australia on 1800 700 270.

nafarelin 200 microgram/actuation nasal spray, 60 actuations

5815C	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	106.00	Synarel [PF]

Anti-gonadotropin-releasing hormones▪ **CETRORELIX****Restricted benefit**

For the prevention of premature luteinisation and ovulation in patients undergoing controlled ovarian stimulation, followed by oocyte pick-up and assisted reproductive techniques as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule

Note

Supply of these items is through an accredited IVF/GIFT clinic. For enquiries relating to the IVF/GIFT Program, medical practitioners should contact Medicare Australia on 1800 700 270.

cetrorelix 250 microgram injection [1 x 250 microgram vial] (&) inert substance diluent [1 x 1 mL syringe], 1 pack

9599F	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	46.08	Cetrotide [SG]

▪ **GANIRELIX****Restricted benefit**

For the prevention of premature luteinisation and ovulation in patients undergoing controlled ovarian stimulation, followed by oocyte pick-up and assisted reproductive techniques as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule

Note

Supply of these items is through an accredited IVF/GIFT clinic. For enquiries relating to the IVF/GIFT Program, medical practitioners should contact Medicare Australia on 1800 700 270.

ganirelix 250 microgram/0.5 mL injection, 1 x 0.5 mL syringe

9583J	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	46.08	Orgalutran [MK]

ganirelix 250 microgram/0.5 mL injection, 5 x 0.5 mL syringes

9584K	Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
	1	230.40	Orgalutran [MK]

Opiate Dependence Treatment Program

NERVOUS SYSTEM.....	1003
OTHER NERVOUS SYSTEM DRUGS.....	1003
DRUGS USED IN ADDICTIVE DISORDERS.....	1003
Drugs used in opioid dependence.....	1003

■ NERVOUS SYSTEM

■ OTHER NERVOUS SYSTEM DRUGS

DRUGS USED IN ADDICTIVE DISORDERS

Drugs used in opioid dependence

■ BUPRENORPHINE

Restricted benefit

Treatment of opiate dependence, including maintenance and detoxification (withdrawal), within a framework of medical, social and psychological treatment

Note

Treatment must be in accordance with the law of the relevant State or Territory.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

buprenorphine 2 mg tablet, 7

6308B

NP

Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
1	10.50	Subutex [RC]

buprenorphine 400 microgram tablet, 7

6307Y

NP

Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
1	6.16	Subutex [RC]

buprenorphine 8 mg tablet, 7

6309C

NP

Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
1	30.10	Subutex [RC]

■ BUPRENORPHINE + NALOXONE

Caution

Buprenorphine with naloxone soluble film and buprenorphine with naloxone sublingual tablet do not meet all the criteria for bioequivalence. Patients being switched between sublingual tablets and soluble films may therefore require a dosage adjustment.

Restricted benefit

Treatment of opiate dependence within a framework of medical, social and psychological treatment

Note

Treatment must be in accordance with the law of the relevant State or Territory.

Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

buprenorphine 2 mg + naloxone 500 microgram film: sublingual, 28 films

9749D

NP

Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
1	46.20	Suboxone Film 2/0.5 [RC]

buprenorphine 8 mg + naloxone 2 mg film: sublingual, 28 films

9750E

NP

Max.Qty Packs	Price ex manufacturer \$	Brand Name and Manufacturer
1	132.44	Suboxone Film 8/2 [RC]

■ METHADONE

Caution

The risk of drug dependence is high.

Restricted benefit


Treatment of opiate dependence in accordance with the law of the relevant State or Territory

Note


Shared Care Model:

For prescribing by nurse practitioners where care of a patient is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.

methadone hydrochloride 5 mg/mL oral liquid, 1000 mL

6172W	Max.Qty Packs		Price ex	Brand Name and Manufacturer	Brand Name and Manufacturer
			manufacturer \$		
	1		33.20	^a Aspen Methadone Syrup [QA]	^a Biodone Forte [MW]

methadone hydrochloride 5 mg/mL oral liquid, 200 mL

6171T	Max.Qty Packs		Price ex	Brand Name and Manufacturer	Brand Name and Manufacturer
			manufacturer \$		
	1		7.91	^a Aspen Methadone Syrup [QA]	^a Biodone Forte [MW]

Repatriation Pharmaceutical Benefits Scheme

BENEFICIARIES' ENTITLEMENT CARDS AND ELIGIBILITY FOR REPATRIATION PHARMACEUTICAL BENEFITS

Gold card

This card is issued to those veterans of Australia's defence force, their widows/widowers and dependants entitled to treatment for all medical conditions.

White card

A White Card is issued to Australian veterans or mariners under the Veterans' Entitlements Act 1986 with:

- an accepted war or service-caused injury or disease;
- malignant cancer (neoplasia) whether war-caused or not;
- pulmonary tuberculosis whether war-caused or not;
- post-traumatic stress disorder whether war-caused or not; or
- anxiety and/or depression whether war-caused or not.

Orange card

Orange Repatriation pharmaceutical benefits cards are issued to Commonwealth and allied veterans and mariners who:

- have qualifying service from World War I or II and
- are aged 70 or over and
- have been resident in Australia for 10 years or more.



For more information go to the Department of Veterans' Affairs website:
<http://www.dva.gov.au>

RPBS Explanatory Notes

Introduction

The Australian Repatriation System

- The Australian Repatriation system is based primarily on the principle of compensation to veterans and eligible dependants for injury or death related to war service. In certain cases, treatment is also provided for accepted injuries or conditions that are not service-related or have occurred as a result of other than war service.
- Through the *Veterans' Entitlements Act 1986* the Department of Veterans' Affairs provides programs of compensation, income support and treatment for eligible veterans and their dependants. One of the defined benefits for eligible veterans is the Repatriation Pharmaceutical Benefits Scheme. This range of medications and dressings is more comprehensive than is available through the Pharmaceutical Benefits Scheme.

RPBS prescribing provisions

- Unless otherwise stated, Repatriation Pharmaceutical Benefits Scheme (RPBS) prescriptions must conform with the requirements of Pharmaceutical Benefits Scheme (PBS) prescriptions, as detailed in Section 1 – Explanatory Notes in the *Schedule of Pharmaceutical Benefits* book. The prescriber shall ensure that a prescription contains the following details:
 - the category of benefit, i.e., RPBS, by placing a cross in the relevant box;
 - the patient's full name and address;
 - the prescription date;
 - the DVA file number of the patient as evidence of entitlement;
 - in the case of authority prescriptions, the Authority approval number or the four digit streamlined authority code;
 - the item, form, strength, quantity and directions;
 - the number of repeats, if applicable;
 - indicate when brand substitution is not permitted; and
 - the name, signature, the prescriber number and address of the prescriber.

Prior Approval Arrangements

- The prior approval of the Department is required to prescribe the following:
 - 'Authority required' items (excluding 'Authority required (STREAMLINED)' items) listed in either the PBS or RPBS Schedule;
 - increased quantities and/or repeats of items listed in either the PBS or RPBS Schedule;
 - items listed under section 100 of the *National Health Act 1953*; and
 - other items not listed in either Schedule (non-Schedule items).
- The above items are to be prescribed on the common PBS/RPBS authority prescription form in accordance with the directions stated in the Explanatory Notes in the *Schedule of Pharmaceutical Benefits* (See also information regarding dental prescribing and prescribing by optometrists under the RPBS in these Notes.)
- All Authority required prescriptions and requests for non-Schedule items must receive prior approval from the Department. This can be achieved by either:
 - using the Department's national free call number 1800 552 580; or
 - by mailing the written authority prescription to the Veterans' Affairs Pharmaceutical Advisory Centre (VAPAC) at the reply paid address shown at the end of these RPBS Explanatory Notes.

Prior approval is not required from DVA to prescribe an Authority required (STREAMLINED) item (except where increased quantities and/or repeats are required). Instead the authority prescription form must include a four digit streamlined authority code.

- Some requests for prior approval (including some non-Schedule items) need to be referred by VAPAC to the Repatriation Pharmaceutical Reference Committee for consideration. In such cases a VAPAC pharmacist will advise the prescriber to submit a request in writing that provides the following information:
 - A current clinical report on the patient's condition (such as age, co-morbidities, renal, liver failure) and clinical reports including pathology, biochemistry, diagnostic and other investigations if appropriate.
 - Details of past and current therapy for the condition. Include details of PBS, RPBS and non-Schedule items utilised, and the results of those therapies.
 - Details of the proposed treatment regimen. Include intended dose and duration of treatment and objective measures of response.
 - When the proposed use of the item is outside the TGA-approved indications for use in Australia, provide copies of articles from peer reviewed publications supporting the proposed treatment.
 - Signed, informed patient consent where the item is to be used for a non-TGA-approved indication.
 - For items without Australian marketing approval, a copy of the TGA Special Access Scheme approval to prescribe the drug.
- Requests for prior approval to prescribe a non-Schedule (PBS or RPBS) item that is of the same therapeutic class (ATC level 3) as an item that is listed on the Schedule, will not be approved unless unequivocal clinical evidence is presented to demonstrate that the requested item is essential for effective treatment of the nominated patient.
- A pharmacist should not supply an item prescribed on an RPBS Authority Prescription Form unless the form has been approved and stamped by VAPAC, or has been endorsed by the prescriber with a telephone Authority approval number provided by VAPAC. Medicare Australia will not accept RPBS Authority prescriptions that have not been approved by the Department of Veterans' Affairs for payment.

Palliative Care Drugs

- The following medications may be available, or made available in increased quantities or doses under prior approval arrangements for use only in the palliative care of terminal disease:

- clonazepam
- cyclizine
- dexamethasone
- disodium pamidronate
- fentanyl
- glycopyrrolate
- hyoscine butylbromide
- hyoscine hydrobromide
- ketamine
- midazolam
- octreotide
- For further information telephone VAPAC on 1800 552 580.

Dental Prescribing

- Under Department of Veterans' Affairs arrangements, financial responsibility for pharmaceutical benefits prescribed by a Local Dental Officer (LDO) is limited to treatment to which holders of the following cards are entitled: Where possible the LDO shall prescribe in accordance with the provisions governing dental prescribing under the Pharmaceutical Benefits Scheme (PBS).
 - a Gold Repatriation Health Card – For All Conditions; or
 - a White Repatriation Health Card – For Specific Conditions; or
 - an Orange Repatriation Pharmaceutical Benefits Card.
- Prescriptions for PBS Dental Schedule items for Gold, White and Orange Card holders are to be dispensed at the PBS concessional rate. Claims for payment by the dispensing pharmacist are to be included with other Repatriation prescriptions. The card holder is required to meet the cost of any applicable brand premium.
- When a non-PBS Dental Schedule item is prescribed for an eligible card holder, the LDO's private prescription form should be used. The dispensing pharmacist may charge the patient the full cost of the prescription. The patient may claim a refund for the full cost of a non-Schedule item from the Department if an itemised receipt (not a cash register receipt) and a copy of the prescription are provided.

Prescribing by optometrists

- Optometrists approved as 'PBS prescribers' may write RPBS prescriptions as outlined in Section 1 for medicines listed in Section 2 of the PBS Schedule as pharmaceutical benefits for optometrical use.
- Medicines in the optometrist list include non-Authority and Authority required items. Procedures for obtaining VAPAC approval to prescribe 'Authority required' optometrist items or increased quantities and/or repeats of optometrist items under the RPBS are the same as indicated under prior approval arrangements above.
- The list of medicines for prescribing by optometrists under the RPBS is the same as applies under the PBS. There are no optometrist listings in the RPBS Schedule for prescribing for veterans only. There is no provision for optometrist prescribers to request approval to prescribe items that are not included in the PBS optometrist list (non-Schedule items).
- Optometrist PBS/RPBS prescription forms are for use for prescribing non-Authority or Authority required optometrist items under the RPBS with one item per form only.

Provisions governing pricing and payment for RPBS benefits

Introduction

- Unless otherwise stated, the pricing and payment principles and arrangements for approved pharmacists supplying pharmaceutical benefits under the RPBS will be the same as those arrangements applying under the PBS.
- Where a pharmaceutical benefit that is not listed on the PBS or RPBS Schedule is dispensed on an RPBS Authority prescription, a pharmacist will price the benefit and enter the serial number, prescription identifying number and price on the sticker or stamp imprint affixed to the prescription.

Pricing of Schedule Items

- Items supplied under the RPBS from the PBS Schedule, both ready-prepared and extemporaneously-prepared, will be paid on the same basis as benefits supplied under the PBS. Items supplied under the RPBS from the Repatriation Schedule, including wound dressings, will be paid on the basis of the price as given in the Repatriation Pharmaceutical Benefits section (Section 1 – RPBS Schedule, Drugs, Medicines and Dressings) of the *Schedule of Pharmaceutical Benefits*.

Pricing of Non-Schedule Ready Prepared Items

- Non-Schedule ready-prepared items are to be priced on the basis of the invoiced, GST-exclusive wholesale price to pharmacists plus the appropriate PBS mark-up and the PBS dispensing fee. Where the item price to pharmacists is greater than \$100.00, a copy of the invoice pertaining to the supply of that item is to be submitted together with the appropriate copy of the authority prescription as part of the claim for payment.

Pricing of Non-Schedule Extemporaneously Prepared Items

- When an ingredient drug is not listed in the PBS Drug Tariff, the recovery price will be based on the invoiced wholesale price to pharmacists, increased by a mark-up of 100%, calculated in accordance with the directions contained in the pricing instructions for pricing of PBS extemporaneously-prepared benefits in this Schedule. The price paid by the pharmacist for the commercial pack from which the ingredient is used shall be endorsed on the prescription form.

Miscellaneous Pricing Rules

- The price to pharmacists used as the basis of pricing will be the invoiced, GST-exclusive price from the wholesaler.

- If multiple quantities of a manufacturer's original pack are supplied, the PBS mark-up is applied to the price to pharmacist of each pack and then totalled. The PBS dispensing fee, and the PBS dangerous drug fee if applicable, are then added to the total of the marked-up prices.
- When the quantity prescribed corresponds with the quantity of a manufacturer's original pack, in no circumstances will the price payable for one pack exceed that payable for multiples or combinations of packs to supply the quantity prescribed.
- The list of ingredient drugs and prices included in the PBS Drug Tariff are common to both the PBS and RPBS. Certain restrictions apply regarding the prescribing and dispensing of some of these ingredient drugs as pharmaceutical benefits, e.g., use as additive only.
- For items prescribed generically, including non-Schedule and wound dressings, the pharmacist should indicate on the prescription the quantity and brand supplied. If prescriptions are not endorsed, the Department will pay the lowest priced acceptable product available.

General

Packaging Material, Postage or Freight

- Payment to a pharmacist for the costs of packaging materials, postage or freight required to supply a pharmaceutical benefit is to be paid by the patient, who may then claim reimbursement from the Department through the provision of a pharmacist's itemised receipt.

Payment for Items Supplied at Short Intervals

- For all items dispensed at specific short intervals of time, the Department will pay a separate PBS dispensing fee for each occasion that the drug is supplied and which is acknowledged on receipt by the patient or agent.
- The price payable on the items supplied will be based on the individual dose quantity supplied. Where applicable, a PBS dangerous drug fee and a minimum container charge will be payable for each supply.

Receipts for Patient Charges

- Where a charge is paid by a patient in any of the circumstances of paragraphs 13 or 24, the pharmacist is required to provide a printed receipt to the patient with the details of the items or services provided, the amount paid, date of supply and the patient's name and address. The patient may apply for reimbursement from the Department.

Special Patient Contributions

- The Special Patient Contribution for items listed as Special Pharmaceutical Benefits in the PBS Schedule is not payable by veterans entitled to pharmaceutical benefits under the RPBS. Eligible veterans receiving Special Pharmaceutical Benefits under the RPBS are required to pay only the concessional patient contribution and any applicable brand premium. If a Safety Net Entitlement card is held, the veteran should receive a Special Pharmaceutical Benefit free of charge, subject to any brand premium applicable. Medicare Australia will reimburse the dispensing pharmacist the total dispensed price, less the concessional patient contribution and/or brand premium if applicable.

Therapeutic Group Premiums — Authority Processing

- Items attracting a therapeutic group premium are dual listed. Dispensing pharmacists are therefore required to select the appropriate code for those items that are dual listed as authority and non-authority items, in order to correctly charge the patient and claim from Medicare Australia. Those authority prescriptions that grant exemption from a therapeutic group premium will have the letters 'TPX' at the beginning of the telephone Authority approval number, or, in the case of a written approval, will be stamped with the words "This prescription does not attract a therapeutic group premium".

Contact the Department of Veterans' Affairs

Authority Prescription Applications

Applications for authority to prescribe under the Repatriation Pharmaceutical Benefits Scheme (RPBS) should be sent to the Veterans' Affairs Pharmaceutical Advisory Centre (VAPAC) using the free postal service:

REPLY PAID 9998

VAPAC (Veterans' Affairs Pharmaceutical Advisory Centre)

Department of Veterans' Affairs

GPO Box 9998

BRISBANE QLD 4001

For RPBS enquiries and telephone approvals 24 hours a day the Freecall number is: 1800 552 580

Departmental pharmacists answer applications for prior approval for non-Schedule items and Authority application calls.

WOUND ASSESSMENT AND DRESSING IDENTIFICATION

It is essential to define the aetiology of the wound before selecting a dressing. Recommendations are based on wound type, colour of wound base, depth of wound, and amount of exudate.

This wound chart adheres to the MOIST WOUND concept of healing and wound dressings are described below as ABSORBING or MOISTURE DONATING.

Most wound healing products are designed to remain in situ for several days, with the exception of those for infected wounds which should be changed daily. The quantities and repeats listed in the Repatriation Schedule are considered to be adequate to manage the treatment of a wound for two weeks to one month, when an assessment of the wound's healing process should be undertaken.

DRESSINGS

PINK EPITHELIALISING WOUND

Aim: To protect and promote epithelialisation. Epithelialising wounds normally are superficial and only produce a light exudate.

- | | | |
|---------------|--|--|
| (A) Covering | <ul style="list-style-type: none"> Film; Film Island | <ul style="list-style-type: none"> Gauze—Paraffin; Non-adherent |
| (B) Absorbing | <ul style="list-style-type: none"> Foam (Light Exudate); Hydroactive (Superficial Wound—Light Exudate) | <ul style="list-style-type: none"> Hydrocolloid (Superficial Wound—Light Exudate) |

RED GRANULATING WOUND

Aims: (1) to protect the granulating tissue; (2) to encourage epithelialisation; (3) to absorb excess exudate.

- | LIGHT EXUDATE: | | Superficial | Cavity |
|-----------------------|--|---|--|
| (A) Absorbing | | <ul style="list-style-type: none"> Foam (Light Exudate); Hydroactive (Superficial Wound—Light Exudate); Hydrocolloid (Superficial Wound—Light Exudate) | <ul style="list-style-type: none"> Hydrocolloid (Cavity Wound) |
| (B) Moisture donating | | <ul style="list-style-type: none"> Hydrogel—Amorphous; Hydrogel—Sheet | <ul style="list-style-type: none"> Hydrogel—Amorphous |
| HIGH EXUDATE: | | Superficial | Cavity |
| (A) Absorbing | | <ul style="list-style-type: none"> Alginate (Superficial Wound); Foam—Heavy Exudate; Hydroactive (Superficial Wound—Moderate Exudate); Hydrocolloid (Superficial Wound—Moderate/High Exudate) | <ul style="list-style-type: none"> Alginate (Cavity Wound); Foam—Moderate Exudate (see “cavity conforming” product); Hydroactive (Cavity Wound); Hydrocolloid (Cavity Wound) |
| (B) Moisture donating | | NOT APPROPRIATE | |

YELLOW SLOUGHY WOUND

Aims: (1) to remove slough; (2) to encourage granulation; (3) to absorb excess exudate.

- | LIGHT EXUDATE: | | Superficial | Cavity |
|-----------------------|--|---|--|
| (A) Absorbing | | <ul style="list-style-type: none"> Cadexomer Iodine; Foam—Light Exudate; Foam with Charcoal; Hydroactive (Superficial Wound—Moderate Exudate); Hydrocolloid (Superficial Wound—Moderate Exudate) | <ul style="list-style-type: none"> Cadexomer Iodine; Hydrocolloid (Cavity Wound) |
| (B) Moisture Donating | | <ul style="list-style-type: none"> Hydrogel—Amorphous; Hydrogel—Sheet | <ul style="list-style-type: none"> Hydrogel—Amorphous |
| HIGH EXUDATE: | | Superficial | Cavity |
| (A) Absorbing | | <ul style="list-style-type: none"> Alginate (Superficial Wound); Cadexomer Iodine; Foam—Heavy Exudate; Hydroactive (Superficial Wound—Moderate/High Exudate); Hydrocolloid (Superficial Wound—Moderate/High Exudate) | <ul style="list-style-type: none"> Alginate (Cavity Wound); Cadexomer Iodine; Hydrocolloid (Cavity Wound) |
| (B) Moisture donating | | NOT APPROPRIATE | |

BLACK NECROTIC WOUND

Aim: To remove eschar by — (1) sharp debridement, e.g., scissor/scalpel and/or (2) rehydration and autolytic debridement. (These wounds usually produce a LIGHT EXUDATE.)

- | | | |
|----------------------|-------------|--------|
| DRY / LIGHT EXUDATE: | Superficial | Cavity |
|----------------------|-------------|--------|

(A) Absorbing	<ul style="list-style-type: none"> • Hydroactive (Superficial Wound—Light Exudate); • Hydrocolloid (Superficial Wound—Light/Moderate Exudate) 	<ul style="list-style-type: none"> • Hydrocolloid (Cavity Wound)
(B) Moisture donating	<ul style="list-style-type: none"> • Hydrogel—Amorphous; • Hydrogel—Sheet 	<ul style="list-style-type: none"> • Hydrogel—Amorphous; • Hydrogel—Sheet

INFECTED WOUNDS

Aims: (1) to clear the infection with systemic antibiotics; (2) to absorb excess exudate; (3) to remove slough if present; (4) to decrease bacterial burden - by applying a Silver dressing or Cadexomer Iodine dressing.

MALODOROUS WOUNDS

Aims: (1) to clear infection if present; (2) to remove slough if present; (3) to clear colonising odour-producing bacteria in slough — by applying metronidazole gel, a Silver dressing or a Cadexomer Iodine dressing; (4) to absorb excess exudate.

Products: Activated Charcoal; Alginate with Charcoal; Foam with Charcoal; Silver dressing; Cadexomer Iodine dressing.

MINOR SKIN TRAUMA

Aims: (1) to stop bleeding; (2) to prevent infection; (3) to minimise the surface defect; (4) to promote epithelialisation.

ORDERING COLOPLAST PRODUCTS

Coloplast dressings are available via a range of distributors. However, Coloplast's principal agreement to ensure correct RPBS Price to Pharmacy, and ready supply has only been secured with Independence Australia on 1300 788 855. Please note that Coloplast are unable to guarantee ready supply or rebate for price differences on purchases outside this distributor.

ORDERING HARTMANN PRODUCTS

Hartmann wound dressings are available through HARTMANN and Independence Australia only. If you would like to order Hartmann Wound Care products, please call HARTMANN customer service on 1800 805 839 or Independence Australia on 1300 788 855.

ORDERING MOLNLYCKE HEALTHCARE PRODUCTS

Molnlycke Healthcare products are distributed through leading pharmacy distributors. To best ensure product availability at RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email customerservice@independenceaustralia.com. Molnlycke Healthcare are not able to ensure product availability or pricing on listed products beyond these two suppliers.

ORDERING SMITH & NEPHEW PRODUCTS

Smith & Nephew products are distributed via the three major wholesalers, API, SIGMA & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

ALIMENTARY TRACT AND METABOLISM.....	1015
STOMATOLOGICAL PREPARATIONS	1015
STOMATOLOGICAL PREPARATIONS.....	1015
Antifectives and antiseptics for local oral treatment	1015
DRUGS FOR ACID RELATED DISORDERS.....	1015
ANTACIDS	1015
Calcium compounds	1015
Combinations and complexes of aluminium, calcium and magnesium compounds.....	1015
DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS.....	1015
DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS	1015
Synthetic anticholinergics, esters with tertiary amino group.....	1015
BELLADONNA AND DERIVATIVES, PLAIN	1015
Belladonna alkaloids, semisynthetic, quaternary ammonium compounds	1015
DRUGS FOR CONSTIPATION	1015
DRUGS FOR CONSTIPATION.....	1015
Softeners, emollients	1015
Contact laxatives.....	1016
Bulk-forming laxatives.....	1016
Enemas.....	1016
Other drugs for constipation.....	1016
ANTIOBESITY PREPARATIONS, EXCL. DIET PRODUCTS	1017
ANTIOBESITY PREPARATIONS, EXCL. DIET PRODUCTS	1017
Peripherally acting antiobesity products.....	1017
VITAMINS.....	1017
VITAMIN B1, PLAIN AND IN COMBINATION WITH VITAMIN B6 AND B12.....	1017
Vitamin B1, plain.....	1017
VITAMIN B-COMPLEX, INCL. COMBINATIONS	1017
Vitamin B-complex, plain	1017
MINERAL SUPPLEMENTS	1018
CALCIUM.....	1018
Calcium.....	1018
OTHER MINERAL SUPPLEMENTS.....	1018
Magnesium	1018
BLOOD AND BLOOD FORMING ORGANS	1018
ANTITHROMBOTIC AGENTS.....	1018
ANTITHROMBOTIC AGENTS.....	1018
Platelet aggregation inhibitors excl. heparin	1018
BLOOD SUBSTITUTES AND PERFUSION SOLUTIONS	1019
IRRIGATING SOLUTIONS	1019
Salt solutions.....	1019
CARDIOVASCULAR SYSTEM.....	1019
VASOPROTECTIVES	1019
AGENTS FOR TREATMENT OF HEMORRHOIDS AND ANAL FISSURES FOR TOPICAL USE.....	1019
Other agents for treatment of hemorrhoids and anal fissures for topical use.....	1019
DERMATOLOGICALS	1019

ANTIFUNGALS FOR DERMATOLOGICAL USE	1019
ANTIFUNGALS FOR TOPICAL USE.....	1019
Antibiotics	1019
Imidazole and triazole derivatives	1020
Other antifungals for topical use	1020
ANTIFUNGALS FOR SYSTEMIC USE.....	1021
Antifungals for systemic use	1021
EMOLLIENTS AND PROTECTIVES	1021
EMOLLIENTS AND PROTECTIVES	1021
Silicone products.....	1021
Soft paraffin and fat products	1021
Carbamide products.....	1021
Other emollients and protectives.....	1021
PROTECTIVES AGAINST UV-RADIATION	1022
Protectives against UV-radiation for topical use.....	1022
ANTIPRURITICS, INCL. ANTIHISTAMINES, ANESTHETICS, ETC.	1022
ANTIPRURITICS, INCL. ANTIHISTAMINES, ANESTHETICS, ETC.....	1022
Anesthetics for topical use	1022
Other antipruritics.....	1022
ANTIPSORIATICS.....	1022
ANTIPSORIATICS FOR TOPICAL USE.....	1022
Tars.....	1022
ANTIBIOTICS AND CHEMOTHERAPEUTICS FOR DERMATOLOGICAL USE	1022
ANTIBIOTICS FOR TOPICAL USE	1022
Other antibiotics for topical use.....	1022
CHEMOTHERAPEUTICS FOR TOPICAL USE.....	1023
Antivirals	1023
Other chemotherapeutics.....	1023
CORTICOSTEROIDS, DERMATOLOGICAL PREPARATIONS	1023
CORTICOSTEROIDS, PLAIN.....	1023
Corticosteroids, potent (group III).....	1023
ANTISEPTICS AND DISINFECTANTS	1024
ANTISEPTICS AND DISINFECTANTS	1024
Iodine products	1024
OTHER DERMATOLOGICAL PREPARATIONS	1024
OTHER DERMATOLOGICAL PREPARATIONS.....	1024
Medicated shampoos.....	1024
Wart and anti-corn preparations.....	1024
Other dermatologicals.....	1024
GENITO URINARY SYSTEM AND SEX HORMONES	1026
GYNECOLOGICAL ANTIINFECTIVES AND ANTISEPTICS	1026
ANTIINFECTIVES AND ANTISEPTICS, EXCL. COMBINATIONS WITH CORTICOSTEROIDS	1026
Antibiotics	1026
Imidazole derivatives	1026
OTHER GYNECOLOGICALS.....	1026
OTHER GYNECOLOGICALS	1026
UROLOGICALS.....	1026
UROLOGICALS	1026
Drugs used in erectile dysfunction	1026
Other urologicals.....	1027
DRUGS USED IN BENIGN PROSTATIC HYPERTROPHY	1027
Alpha-adrenoreceptor antagonists	1027
Testosterone-5-alpha reductase inhibitors	1028

ANTIINFECTIVES FOR SYSTEMIC USE	1029
ANTIBACTERIALS FOR SYSTEMIC USE	1029
MACROLIDES, LINCOSAMIDES AND STREPTOGRAMINS	1029
Macrolides	1029
ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	1029
ANTINEOPLASTIC AGENTS	1029
ANTIMETABOLITES	1029
Pyrimidine analogues	1029
IMMUNOSUPPRESSANTS	1029
IMMUNOSUPPRESSANTS	1029
Tumor necrosis factor alpha (TNF-) inhibitors	1029
MUSCULO-SKELETAL SYSTEM	1030
ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS	1030
ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS, NON-STERIODS	1030
Acetic acid derivatives and related substances	1030
TOPICAL PRODUCTS FOR JOINT AND MUSCULAR PAIN	1030
TOPICAL PRODUCTS FOR JOINT AND MUSCULAR PAIN	1030
Preparations with salicylic acid derivatives	1030
DRUGS FOR TREATMENT OF BONE DISEASES	1030
DRUGS AFFECTING BONE STRUCTURE AND MINERALIZATION	1030
Bisphosphonates	1030
Bisphosphonates, combinations	1031
NERVOUS SYSTEM	1032
ANALGESICS	1032
OPIOIDS	1032
Natural opium alkaloids	1032
OTHER ANALGESICS AND ANTIPYRETICS	1032
Salicylic acid and derivatives	1032
Anilides	1032
Other analgesics and antipyretics	1032
PSYCHOLEPTICS	1033
ANXIOLYTICS	1033
Benzodiazepine derivatives	1033
Azaspirodecanedione derivatives	1033
HYPNOTICS AND SEDATIVES	1034
Benzodiazepine derivatives	1034
Benzodiazepine related drugs	1034
OTHER NERVOUS SYSTEM DRUGS	1034
DRUGS USED IN ADDICTIVE DISORDERS	1034
Drugs used in nicotine dependence	1034
ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS	1035
ANTHELMINTICS	1035
ANTINEMATODAL AGENTS	1035
Benzimidazole derivatives	1035
RESPIRATORY SYSTEM	1035
NASAL PREPARATIONS	1035

DECONGESTANTS AND OTHER NASAL PREPARATIONS FOR TOPICAL USE	1035
Sympathomimetics, plain	1035
Antiallergic agents, excl. corticosteroids	1035
Corticosteroids	1035
Other nasal preparations	1035
NASAL DECONGESTANTS FOR SYSTEMIC USE.....	1036
Sympathomimetics.....	1036
COUGH AND COLD PREPARATIONS.....	1036
EXPECTORANTS, EXCL. COMBINATIONS WITH COUGH SUPPRESSANTS.....	1036
Expectorants	1036
COUGH SUPPRESSANTS, EXCL. COMBINATIONS WITH EXPECTORANTS.....	1036
Opium alkaloids and derivatives	1036
ANTI-HISTAMINES FOR SYSTEMIC USE	1036
ANTI-HISTAMINES FOR SYSTEMIC USE.....	1036
Piperazine derivatives.....	1036
Other antihistamines for systemic use	1036
SENSORY ORGANS	1037
OPHTHALMOLOGICALS	1037
DECONGESTANTS AND ANTIALLERGICS.....	1037
Sympathomimetics used as decongestants.....	1037
Other antiallergics	1037
OTOLOGICALS	1037
OTHER OTOLOGICALS.....	1037
Indifferent preparations	1037
VARIOUS	1037
ALL OTHER THERAPEUTIC PRODUCTS	1037
ALL OTHER THERAPEUTIC PRODUCTS.....	1037
Drugs for treatment of hyperkalemia and hyperphosphatemia	1037
ALL OTHER NON-THERAPEUTIC PRODUCTS	1038
ALL OTHER NON-THERAPEUTIC PRODUCTS	1038
Other non-therapeutic auxiliary products	1038

ALIMENTARY TRACT AND METABOLISM

STOMATOLOGICAL PREPARATIONS

STOMATOLOGICAL PREPARATIONS

Antifungives and antiseptics for local oral treatment

CHLORHEXIDINE

chlorhexidine gluconate 0.2% (2 mg/mL) mouthwash, 250 mL

4161B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	12.23	6.10	Plaqacide [OB]

chlorhexidine gluconate 0.2% (2 mg/mL) mouthwash, 300 mL

4204G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	15.62	6.10	Savacol Mouth and Throat Rinse [OM]

DRUGS FOR ACID RELATED DISORDERS

ANTACIDS

Calcium compounds

CALCIUM CARBONATE + GLYCINE

Note

For patients with chronic renal failure.

calcium carbonate 420 mg + glycine 180 mg tablet: chewable, 100

4055K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*23.52	6.10	Titralac [MM]

Combinations and complexes of aluminium, calcium and magnesium compounds

ALUMINIUM HYDROXIDE WITH MAGNESIUM HYDROXIDE AND SIMETHICONE

ALUMINIUM HYDROXIDE with MAGNESIUM HYDROXIDE and SIMETHICONE Oral suspension 400 mg-400 mg-30 mg per 5 mL, 500 mL, 1

4118R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*22.98	6.10	Mylanta Double Strength [JT]

ALUMINIUM HYDROXIDE with MAGNESIUM HYDROXIDE and SIMETHICONE Tablet 400 mg-400 mg-40 mg, 100

4453J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	5	..	*46.46	6.10	Mylanta Double Strength [JT]

DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS

DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS

Synthetic anticholinergics, esters with tertiary amino group

MEBEVERINE

mebeverine hydrochloride 135 mg tablet, 90

4328T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	27.25	6.10	^a Colese [AF]
			..	32.43	6.10	^a Colofac [GO]

BELLADONNA AND DERIVATIVES, PLAIN

Belladonna alkaloids, semisynthetic, quaternary ammonium compounds

HYOSCINE BUTYLBROMIDE

hyoscine butylbromide 20 mg/mL injection, 5 x 1 mL ampoules

4279F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	24.55	6.10	Buscopan [BY]

DRUGS FOR CONSTIPATION

DRUGS FOR CONSTIPATION

Softeners, emollients

■ **DOCUSATE****docusate sodium 50 mg tablet, 100**

4200C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	14.65	6.10	Coloxyl 50 [FM]

Contact laxatives■ **DOCUSATE + SENNOSIDE B****docusate sodium 50 mg + sennoside B 8 mg tablet, 100**

4028B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	14.75	6.10	Soflax [GN]

docusate sodium 50 mg + sennoside B 8 mg tablet, 90

10177P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	13.48	6.10	Pharmacy Action Laxative with Senna [GQ]

■ **DOCUSATE + SENNOSIDES****docusate sodium 50 mg + sennosides 11.27 mg tablet, 90**

4198Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	2	..	13.52	6.10	^a Chemists' Own Laxative with Senna [AS]	^a Colaxsen [QA]
						^a Co-Senna [PP]	
			..	17.03	6.10	^a Coloxyl with Senna [FM]	

■ **SENNOSIDE B****sennoside B 7.5 mg tablet, 100**

4455L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	12.94	6.10	^a Senna-Gen [PP]
			..	14.20	6.10	^a Senokot [RC]

Bulk-forming laxatives■ **ISPAGHULA HUSK DRY****ispaghula husk dry 3.5 g oral liquid: powder for, 30 x 3.5 g sachets**

4285M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	17.98	6.10	Fybogel [RC]

■ **PSYLLIUM HUSK POWDER****PSYLLIUM HYDROPHILIC MUCILLOID Oral powder (non-flavoured) 336 g, 1**

4422R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	18.36	6.10	Fibre Health Natural Granular [PP]
			..	22.01	6.10	Metamucil Natural Granular [PY]

PSYLLIUM HYDROPHILIC MUCILLOID Oral powder (orange-flavoured, sugar-free) 283 g, 1

4419N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	22.01	6.10	Metamucil Orange Smooth [PY]

■ **RHAMNUS FRANGULA + STERCULIA****rhamnus frangula 80 mg/g + sterculia 620 mg/g granules, 500 g**

4558X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	26.71	6.10	Normacol Plus [NE]

Enemas■ **SORBITOL + CITRATE + LAURYL SULFOACETATE SODIUM****sorbitol 3.125 g/5 mL + citrate sodium dihydrate 450 mg/5 mL + lauryl sulfoacetate sodium 45 mg/5 mL enema, 4 x 5 mL**

4462W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	‡1	..	..	12.44	6.10	Micolette [AE]	Microlax [JT]

Other drugs for constipation

■ GLYCEROL

Restricted benefit

Short-term use when oral laxative therapy has failed or is inappropriate

glycerol 2.8 g suppository, 12

4246L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	3	..	..	*22.15	6.10	Petrus Pharmaceuticals Pty Ltd [PP]

■ ANGIOBESITY PREPARATIONS, EXCL. DIET PRODUCTS

ANGIOBESITY PREPARATIONS, EXCL. DIET PRODUCTS

Peripherally acting antiobesity products

■ ORLISTAT

Authority required

For the treatment of obese patients.

Total treatment will not exceed 12 months from initial application.

Patients are eligible for 1 continuous treatment in a lifetime.

The patient must be receiving, or enrolled to receive, professional dietetic and weight management advice (where this is available).

Initial treatment for patients who meet the following criteria to qualify:

(a) Body Mass Index (BMI) greater than or equal to 35 with no known co-morbidities; or

(b) BMI greater than or equal to 30 with 1 or more of the following co-morbidities:

(i) diabetes;

(ii) ischaemic heart disease;

(iii) psychiatric conditions;

(iv) hypertension.

The prescriber must provide the following:

(a) initial body weight; and

(b) BMI.

Continuing treatment for patients who have previously been issued with an authority prescription for orlistat. After 3 months and up to 6 months following commencement of orlistat treatment, patient's initial body weight must have been reduced by 2.5 kg or 2.5% (whichever is the lesser).

Continuing treatment for patients who have previously been issued with an authority prescription for orlistat. After 6 months and up to 12 months following commencement of orlistat treatment, patient's initial body weight must have been reduced by 5 kg or 5% (whichever is the lesser)

Note

The patient should be ideally enrolled in an exercise program and be receiving supplemental vitamins.

orlistat 120 mg capsule, 84

4570M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	140.50	6.10	Xenical [RO]

■ VITAMINS

VITAMIN B1, PLAIN AND IN COMBINATION WITH VITAMIN B6 AND B12

Vitamin B1, plain

■ THIAMINE

thiamine hydrochloride 100 mg tablet, 100

4043T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	10.45	6.10	Betavit [PP]

VITAMIN B-COMPLEX, INCL. COMBINATIONS

Vitamin B-complex, plain

■ CYANOCOBALAMIN + FERRIC PYROPHOSPHATE + LYSINE + PYRIDOXINE + THIAMINE

cyanocobalamin 25 microgram/10 mL + iron (as ferric pyrophosphate) 10 mg/10 mL + lysine hydrochloride 300 mg/10 mL + pyridoxine hydrochloride 5 mg/10 mL + thiamine hydrochloride 10 mg/10 mL oral liquid, 200 mL

4493L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	2	..	13.68	6.10	Accomin Adult Tonic [PF]

MINERAL SUPPLEMENTS

CALCIUM

Calcium

CALCIUM

Restricted benefit

Hyperphosphataemia in chronic renal failure

CALCIUM Tablet (chewable) 500 mg (as carbonate), 60

4094L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	4	1	..	*29.24	6.10	^a Cal-500 [PP]	^a Cal-Sup [IA]

CALCIUM Tablet 600 mg (as carbonate), 120

4142B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	1	..	*22.54	6.10	CAL-600 [PP]

CALCIUM

Restricted benefit

Hypocalcaemia

Restricted benefit

Osteoporosis

Restricted benefit

Proven calcium malabsorption

CALCIUM Tablet (chewable) 500 mg (as carbonate), 60

4333C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	2	1	..	*18.00	6.10	^a Cal-500 [PP]	^a Cal-Sup [IA]

CALCIUM Tablet 600 mg (as carbonate), 120

4082W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	14.65	6.10	CAL-600 [PP]

OTHER MINERAL SUPPLEMENTS

Magnesium

MAGNESIUM ASPARTATE DIHYDRATE

Restricted benefit

Patients with documented hypomagnesaemia

magnesium aspartate dihydrate 500 mg (equivalent to 37.4 mg of magnesium) tablet, 50

4321K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	14.04	6.10	Mag-Sup [PP]
			..	14.73	6.10	Magmin [BB]

BLOOD AND BLOOD FORMING ORGANS

ANTITHROMBOTIC AGENTS

ANTITHROMBOTIC AGENTS

Platelet aggregation inhibitors excl. heparin

ASPIRIN

aspirin 100 mg tablet, 90

4076M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	16.01	6.10	Cardiprin 100 [RC]

ASPIRIN

Note

The enteric coated preparations are for patients with a significant risk of gastrointestinal bleeding.

aspirin 100 mg capsule: enteric, 84

4078P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	14.96	6.10	Astrix [YN]

aspirin 100 mg tablet: enteric, 84

4077N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	1	..	14.05	6.10	^a Cartia [AS]	^a Pharmacy Action Low Dose Aspirin [GQ]

▪ **CLOPIDOGREL**

Authority required

For use in patients pre- and post-angioplasty

Note

Pharmaceutical benefits that have the forms clopidogrel tablet 75 mg (as besilate) and clopidogrel tablet 75 mg (as hydrogen sulfate) are equivalent for the purposes of substitution.

clopidogrel 75 mg tablet, 28

10169F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	3	..	15.70	6.10	^a Clopidogrel GH [GQ]

clopidogrel 75 mg tablet, 28

4179Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	3	..	15.70	6.10	^a APO-Clopidogrel [TX] ^a Iscover [AV] ^a Plavix [SW]	^a Chem mart Clopidogrel [CH] ^a Piax [AF] ^a Terry White Chemists Clopidogrel [TW]

▪ **BLOOD SUBSTITUTES AND PERFUSION SOLUTIONS**

IRRIGATING SOLUTIONS

Salt solutions

▪ **SODIUM CHLORIDE**

sodium chloride 0.9% (4.5 g/500 mL) solution, 1 x 500 mL bottle

4460R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	10.67	6.10	Baxter Healthcare Pty Ltd [BX]

sodium chloride 0.9% (9 g/1000 mL) solution, 1 x 1000 mL bottle

4461T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	10.99	6.10	Baxter Healthcare Pty Ltd [BX]

▪ **CARDIOVASCULAR SYSTEM**

▪ **VASOPROTECTIVES**

AGENTS FOR TREATMENT OF HEMORRHOIDS AND ANAL FISSURES FOR TOPICAL USE

Other agents for treatment of hemorrhoids and anal fissures for topical use

▪ **ZINC OXIDE + PERU BALSAM + BENZYL BENZOATE**

zinc oxide 10.75% (107.5 mg/g) + peru balsam 1.88% (18.8 mg/g) + benzyl benzoate 1.25% (12.5 mg/g) ointment, 50 g

4039N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	14.78	6.10	Anusol [JT]

zinc oxide 300 mg + peru balsam 50 mg + benzyl benzoate 33 mg suppository, 12

4040P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	13.69	6.10	Anusol [JT]

▪ **DERMATOLOGICALS**

▪ **ANTIFUNGALS FOR DERMATOLOGICAL USE**

ANTIFUNGALS FOR TOPICAL USE

Antibiotics

▪ **NYSTATIN**

nystatin 100 000 international units/g cream, 15 g

4001N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	12.83	6.10	Mycostatin [FM]

Imidazole and triazole derivatives■ **CLOTRIMAZOLE****clotrimazole 1% (10 mg/g) cream, 20 g**

4004R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	8.78	6.10	^a Pharmacy Action Anti-Fungal Cream [GQ]
			..	9.18	6.10	^a Clonea [AF]

■ **KETOCONAZOLE**Restricted benefit

Severe seborrhoeic dermatitis

ketoconazole 2% (20 mg/g) shampoo, 100 mL

4007X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	19.71	6.10	Sebizole [GN]

ketoconazole 2% (20 mg/g) shampoo, 60 mL

4008Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	18.65	6.10	Nizoral 2% [JT]

■ **MICONAZOLE****miconazole 2% solution, 30 mL**

4341L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	19.81	6.10	Daktarin Tincture [JT]

miconazole nitrate 2% (20 mg/g) cream, 30 g

4454K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	15.13	6.10	Daktarin [JT]

miconazole nitrate 2% (20 mg/g) cream, 40 g

3400Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	14.02	6.10	Resolve Thrush [EO]

Other antifungals for topical use■ **AMOROLFINE**Restricted benefit

Onychomycosis

amorolfine 5% application, 5 mL

4010C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	86.85	6.10	Aporyl [TX]
			..	96.48	6.10	Loceryl [GA]

■ **CICLOPIROX**Restricted benefit

Severe seborrhoeic dermatitis

ciclopirox olamine 1.5% (15 mg/g) shampoo, 60 mL

4106D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	19.08	6.10	Stieprox Liquid [GK]

■ **TERBINAFINE**Restricted benefit

Tinea pedis

terbinafine 1% gel, 15 g

4463X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	23.69	6.10	Lamisil DermGel [NC]

terbinafine hydrochloride 1% cream, 15 g

4473K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	22.23	6.10	Lamisil [NC]

■ TOLNAFTATE

tolnaftate 0.07% (700 microgram/g) spray, 100 g

4481W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	15.43	6.10	Tinaderm [BN]

ANTIFUNGALS FOR SYSTEMIC USE

Antifungals for systemic use

■ TERBINAFINE

Authority required

Onychomycosis due to dermatophyte infection proven by microscopy or culture and confirmed by an approved pathology provider

terbinafine 250 mg tablet, 42

4011D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	1	..	38.82	6.10	^a GenRx Terbinafine [GX]	^a Lamisil (Novartis Pharmaceuticals Australia Pty Limited) [NV]
						^a Tamsil [QA]	^a Terbinafine GH [GQ]
						^a Terbinafine Sandoz [SZ]	^a Tinasil [AF]

■ EMOLLIENTS AND PROTECTIVES

EMOLLIENTS AND PROTECTIVES

Silicone products

■ DIMETHICONE-350 + GLYCEROL

Restricted benefit

For colostomy and ileostomy use

Restricted benefit

For use by paraplegic and quadriplegic patients

Restricted benefit

For use with surgical appliances

dimethicone-350 15% (150 mg/g) + glycerol 2% (20 mg/g) cream, 500 g

4551M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	26.75	6.10	Silic 15 [EO]

dimethicone-350 15% (150 mg/g) + glycerol 2% (20 mg/g) cream, 75 g

4556T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	12.87	6.10	Silic 15 [EO]

Soft paraffin and fat products

■ WOOL ALCOHOLS

wool alcohols 6% (60 mg/g) ointment, 100 g

4041Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	14.52	6.10	Eucerin [BE]

Carbamide products

■ UREA

urea 10% (100 mg/g) cream, 100 g

4042R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	12.53	6.10	Aquacare H.P. [AG]
			..	12.79	6.10	Urederm [IA]
			..	13.11	6.10	Calmurid [OL]

Other emollients and protectives

■ CARMELLOSE SODIUM + GELATIN + PECTIN

carmellose sodium 16.7% + gelatin 16.7% + pectin 16.7% paste: oromucosal, 5 g

4518T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	12.19	6.10	Orabase [QA]

■ SKIN EMOLLIENT

SKIN EMOLLIENT Bath oil 500 mL, 1

4122Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	17.69	6.10	Alpha Keri Bath Oil [MT]
			..	20.10	6.10	QV Bath Oil [EO]
			..	20.19	6.10	Hamilton Skin Therapy Oil [KY]

SKIN EMOLLIENT Lotion 500 mL, 1

4107E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	17.69	6.10	Alpha Keri Lotion [MT]

PROTECTIVES AGAINST UV-RADIATION

Protectives against UV-radiation for topical use

■ SUNSCREENS

SUNSCREENS Cream 75 g, 1

4307Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	18.39	6.10	Sunsense Sensitive SPF 50+ [EO]

SUNSCREENS Lotion (non-alcoholic) 125 mL, 1

4546G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	16.32	6.10	Aquasun Lotion SPF 18 [PF]
			..	18.39	6.10	Sunsense Ultra SPF 50+ [EO]

■ ANTIPRURITICS, INCL. ANTIHISTAMINES, ANESTHETICS, ETC.

ANTIPRURITICS, INCL. ANTIHISTAMINES, ANESTHETICS, ETC.

Anesthetics for topical use

■ LIGNOCAINE

lignocaine hydrochloride anhydrous 2% (20 mg/mL) oral liquid, 200 mL

4308R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	99.72	6.10	Xylocaine Viscous [AP]

Other antipruritics

■ PINE TAR WITH TRIETHANOLAMINE LAURYL SULFATE

Note

For patients who have failed to respond to simple moisturising agents.

PINE TAR with TRIETHANOLAMINE LAURYL SULFATE Solution 23 mg-60 mg per mL (2.3%-6%), 500 mL, 1

4408B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	23.26	6.10	Pinetarsol [EO]

■ ANTIPSORIATICS

ANTIPSORIATICS FOR TOPICAL USE

Tars

■ COAL TAR SOLUTION + PHENOL + SULFUR-PRECIPIATED

coal tar solution 5% + phenol 0.5% + sulfur-precipitated 0.5% gel, 30 g

4505D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	16.36	6.10	Egopsoryl-TA [EO]

■ ANTIBIOTICS AND CHEMOTHERAPEUTICS FOR DERMATOLOGICAL USE

ANTIBIOTICS FOR TOPICAL USE

Other antibiotics for topical use

■ MUPIROCIN

Restricted benefit

For the topical treatment of secondarily infected traumatic skin lesions

mupirocin 2% (20 mg/g) cream, 15 g

4348W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	17.59	6.10	Bactroban [GK]

mupirocin 2% (20 mg/g) ointment, 15 g

4350Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	17.59	6.10	Bactroban [GK]

CHEMOTHERAPEUTICS FOR TOPICAL USE*Antivirals***▪ PODOPHYLLOTOXIN****Authority required**

For the treatment of ano-genital warts

podophyllotoxin 0.15% (1.5 mg/g) cream, 5 g

4390C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	53.00	6.10	Wartec Cream [GK]

podophyllotoxin 0.5% solution, 3.5 mL

4566H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	40.09	6.10	Condyline Paint [NQ]

*Other chemotherapeutics***▪ INGENOL MEBUTATE****Authority required**

Solar keratosis

Clinical criteria:

Patient must require topical drug therapy on the face and scalp as field treatment for clinically visible and subclinical lesions where other standard treatments are inappropriate.

ingenol mebutate 0.015% gel, 3 x 470 mg tubes

2464Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	139.60	6.10	Picato [LO]

▪ INGENOL MEBUTATE**Authority required**

Solar (actinic) keratosis

Clinical criteria:

Patient must require topical drug therapy as field treatment for clinically visible and subclinical lesions where other standard treatments are inappropriate.

ingenol mebutate 0.05% gel, 2 x 470 mg tubes

2468X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	139.60	6.10	Picato [LO]

▪ CORTICOSTEROIDS, DERMATOLOGICAL PREPARATIONS**CORTICOSTEROIDS, PLAIN***Corticosteroids, potent (group III)***▪ BETAMETHASONE VALERATE****betamethasone (as valerate) 0.1% (1 mg/g) cream, 30 g**

4131K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	22.77	6.10	Betnovate [QA]

betamethasone (as valerate) 0.1% (1 mg/g) ointment, 30 g

4132L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	22.77	6.10	Betnovate [QA]

▪ MOMETASONE**Note**

Application to large areas of skin for longer than four weeks is not recommended.

mometasone furoate 0.1% (1 mg/g) cream, 50 g

4342M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	33.82	6.10	Elocon [MK]

mometasone furoate 0.1% (1 mg/g) ointment, 50 g

4343N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	33.82	6.10	Elocon [MK]

■ **ANTISEPTICS AND DISINFECTANTS****ANTISEPTICS AND DISINFECTANTS***Iodine products*■ **POVIDONE-IODINE****povidone-iodine 10% solution, 100 mL**

4411E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	22.45	6.10	Betadine Antiseptic Liquid [SW]

■ **OTHER DERMATOLOGICAL PREPARATIONS****OTHER DERMATOLOGICAL PREPARATIONS***Medicated shampoos*■ **COAL TAR SOLUTION + TAR + SALICYLIC ACID****coal tar solution 1% (10 mg/g) + tar 1% (10 mg/g) + salicylic acid 2% (20 mg/g) solution, 250 mL**

4447C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	19.18	6.10	Sebitar [EO]

■ **SALICYLIC ACID + BENZALKONIUM CHLORIDE + ALCOHOL + COAL TAR SOLUTION + POLYOXYETHYLENE ETHERS****SALICYLIC ACID with COAL TAR SOLUTION Scalp cleanser 20 mg-50 mg per mL (2%-5%), 200 mL, 1**

4560B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	20.72	6.10	Ionil-T [GA]

■ **SELENIUM SULFIDE****selenium sulfide 2.5% (25 mg/mL) shampoo, 125 mL**

4452H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	14.48	6.10	Selsun [DQ]

■ **TAR + CADE OIL + COAL TAR + ARACHIS OIL EXTRACT OF COAL TAR****tar 0.3% (300 microgram/mL) + cade oil 0.03% (300 microgram/mL) + coal tar 0.01% (100 microgram/mL) + arachis oil extract of coal tar 0.3% (3 mg/mL) lotion, 300 mL**

4405W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	24.48	6.10	Polytar [GK]

Wart and anti-corn preparations■ **LACTIC ACID + SALICYLIC ACID****lactic acid 16.7% (167 mg/mL) + salicylic acid 16.7% (167 mg/mL) application, 15 mL**

4386W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	18.49	6.10	Duofilm Solution [GK]

Other dermatologicals■ **DICLOFENAC**Authority required

For the management of actinic keratoses in patients where other standard treatments are inappropriate, and topical drug therapy is required as field treatment for clinically visible and subclinical lesions

Note

Maximum quantity of four tubes (original + 3 repeats) in 12 months.

diclofenac sodium 3% gel, 25 g

4046Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	3	..	58.53	6.10	Solaraze 3% Gel [CS]

■ ICHTHAMMOL**Note**

For patients who have failed to respond to simple moisturising agents.

ichthammol Cream 5 mg-10 mg-10 mg per g (0.5%-1%-1%), 50 g, 1

4281H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	18.44	6.10	Egoderm Cream [EO]

■ ICHTHAMMOL + ZINC OXIDE**Note**

For patients who have failed to respond to simple moisturising agents.

ichthammol 1% (10 mg/g) + zinc oxide 15% (150 mg/g) ointment, 50 g

4280G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	18.44	6.10	Egoderm Ointment [EO]

■ IMIQUIMOD**Authority required**

Primary treatment of histopathologically confirmed superficial basal cell carcinoma where other standard treatments are inappropriate and topical drug therapy is required

imiquimod 5% cream, 12 x 250 mg sachets

4559Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	1	..	135.72	6.10	^a Aldara [IA] ^a APO-Imiquimod [TX]	^a Aldiq [QA]

■ IMIQUIMOD**Authority required**

Solar keratosis

Clinical criteria:

Patient must require topical drug therapy on the face and scalp as field treatment for clinically visible and subclinical lesions where other standard treatments are inappropriate.

Note

Pharmaceutical benefits that have the form imiquimod single use sachets and pharmaceutical benefits that have the form imiquimod multi-use pump are equivalent for the purposes of substitution.

imiquimod 5% cream, 12 x 250 mg sachets

4134N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	1	..	135.72	6.10	^a Aldara [IA] ^a APO-Imiquimod [TX]	^a Aldiq [QA]

imiquimod 5% cream, 2 x 2 g pump packs

10106X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	135.72	6.10	^a Aldara Pump [IA]

■ PANTHENOL**Note**

To be used in conjunction with the scalp cleanser salicylic acid with coal tar solution and pine tar (code 4447C).

panthenol conditioner, 200 g

4510J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	14.59	6.10	SebiRinse [EO]

■ PARAFFIN LIGHT LIQUID + COCOAMPHODIACETATE DISODIUM**paraffin light liquid 3.5% (35 mg/mL) + cocoamphodiacetate disodium 3% (30 mg/mL) lotion, 500 mL**

4549K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	21.08	6.10	Hamilton Skin Therapy Wash [KY]

ZINC OXIDE + MAIZE STARCH + CHLORPHENESIN + TALC-PURIFIED

zinc oxide 25% (250 mg/g) + maize starch 55.85% (558.5 mg/g) + chlorphenesin 1% (10 mg/g) + talc-purified 18.07% (180.7 mg/g) powder: dusting, 100 g

4497Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	12.59	6.10	Z.S.C. [QA]

GENITO URINARY SYSTEM AND SEX HORMONES

GYNECOLOGICAL ANTIINFECTIVES AND ANTISEPTICS

ANTIINFECTIVES AND ANTISEPTICS, EXCL. COMBINATIONS WITH CORTICOSTEROIDS

Antibiotics

NYSTATIN

nystatin 20 000 international units/g vaginal cream, 75 g

4013F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	14.13	6.10	Nilstat [QA]

Imidazole derivatives

CLOTRIMAZOLE

clotrimazole 1% (10 mg/g) cream, 35 g

4016J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	14.03	6.10	^a Pharmacy Action FemCream [GQ]
			..	15.42	6.10	^a APO-Clotrimazole 6 Day Cream [TX]

clotrimazole 2% (20 mg/g) cream, 20 g

4017K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	15.42	6.10	APO-Clotrimazole 3 Day Cream [TX]

OTHER GYNECOLOGICALS

OTHER GYNECOLOGICALS

ACETIC ACID + HYDROXYQUINOLINE + RICINOLEIC ACID

acetic acid 0.94% + hydroxyquinoline sulfate 0.025% + ricinoleic acid 0.75% vaginal gel, 100 g

4434J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	33.24	6.10	Aci-Jel [CU]

UROLOGICALS

UROLOGICALS

Drugs used in erectile dysfunction

ALPROSTADIL

Authority required

Males with vasculogenic, psychogenic or neurogenic erectile dysfunction

Clinical criteria:

Patient must have a specific accepted war-caused or service-related disability.

Authorisation will not be given for any additional prescriptions within 6 months or for any increased quantities or repeats.

alprostadil 10 microgram injection [1 x 10 microgram vial] (&) inert substance diluent [1 syringe], 1 pack

10031Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	6	3	..	*105.82	6.10	Caverject [PF]

alprostadil 20 microgram injection [1 x 20 microgram vial] (&) inert substance diluent [1 syringe], 1 pack

10030X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	6	3	..	*133.18	6.10	Caverject [PF]

SILDENAFIL

Authority required

Specific accepted war-caused or service-related disabilities for males with vasculogenic, psychogenic or neurogenic erectile dysfunction.

Authorisation will not be given for any additional prescriptions within 6 months or for any increased quantities or repeats

sildenafil 100 mg tablet, 4

4586J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	73.33	6.10	^a APO-Sildenafil [TX] ^a Sildenafil Actavis [UA] ^a Terry White Chemists Sildenafil [TW] ^a Vedafile [AF] ^a Silaran [RA]	^a Chem mart Sildenafil [CH] ^a Sildenafil GH [GQ] ^a Vasafil 100 [QA] ^a Viagra [PF]

sildenafil 25 mg tablet, 4

4584G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	55.21	6.10	^a Sildenafil Actavis [UA] ^a Vedafile [AF] ^a APO-Sildenafil [TX] ^a Viagra [PF]	^a Vasafil 25 [QA]

sildenafil 50 mg tablet, 4

4585H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	68.31	6.10	^a APO-Sildenafil [TX] ^a Vasafil 50 [QA] ^a Viagra [PF]	^a Sildenafil Actavis [UA] ^a Vedafile [AF]

▪ **TADALAFIL**

Authority required

Specific accepted war-caused or service-related disabilities for males with vasculogenic, psychogenic or neurogenic erectile dysfunction.

Authorisation will not be given for any additional prescriptions within 6 months or for any increased quantities or repeats

tadalafil 10 mg tablet, 4

4596X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	98.96	6.10	Cialis [LY]

tadalafil 20 mg tablet, 4

4597Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	98.96	6.10	Cialis [LY]

▪ **VARDENAFIL**

Authority required

Specific accepted war-caused or service-related disabilities for males with vasculogenic, psychogenic or neurogenic erectile dysfunction.

Authorisation will not be given for any additional prescriptions within 6 months or for any increased quantities or repeats

vardenafil 10 mg tablet, 4

4290T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	73.13	6.10	Levitra [BN]

vardenafil 20 mg tablet, 4

4302K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	83.86	6.10	Levitra [BN]

Other urologicals

▪ **BICARBONATE + CITRATE + TARTARIC ACID**

Restricted benefit

For relief of urinary symptoms when antibiotic or other therapy alone is inappropriate

sodium bicarbonate 1.76 g + citrate sodium 630 mg + citrate 720 mg + tartaric acid 890 mg oral liquid: powder for, 28 x 4 g sachets

4049D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	±1	4	..	13.89	6.10	Uracol [GN]	Ural Sachets [QA]

DRUGS USED IN BENIGN PROSTATIC HYPERTROPHY

Alpha-adrenoreceptor antagonists

▪ **ALFUZOSIN**

Authority required

Treatment of benign prostatic hyperplasia where surgery is inappropriate, or where other drug treatment has failed or is contraindicated

alfuzosin hydrochloride 10 mg tablet: modified release, 30 tablets

4277D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	63.70	6.10	Xatral SR [SW]

■ DUTASTERIDE + TAMSULOSIN
Authority required

Benign prostatic hyperplasia

Clinical criteria:

Patient must be one in whom surgery is inappropriate; OR

Patient must have failed to respond to other drug treatment or other drug treatment must be contraindicated.

dutasteride 500 microgram + tamsulosin hydrochloride 400 microgram capsule: modified release, 30

10102Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	35.63	6.10	Duodart 500ug/400ug [GK]

■ TAMSULOSIN
Authority required

Treatment of benign prostatic hyperplasia where surgery is inappropriate, or where other drug treatment has failed or is contraindicated

tamsulosin hydrochloride 400 microgram tablet: modified release, 30

4070F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	63.70	6.10	Flomaxtra [LS]	Tamsulosin Sandoz SR [SZ]

■ TERAZOSIN
Authority required

Treatment of benign prostatic hyperplasia where surgery is inappropriate, or where other drug treatment has failed or is contraindicated

terazosin 1 mg tablet [7 tablets] (&) terazosin 2 mg tablet [7 tablets], 14

4396J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	20.39	6.10	Hytrin [GO]

terazosin 10 mg tablet, 28

4399M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	86.40	6.10	Hytrin [GO]

terazosin 2 mg tablet, 28

4397K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	42.03	6.10	Hytrin [GO]

terazosin 5 mg tablet, 28

4398L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	58.53	6.10	Hytrin [GO]

Testosterone-5-alpha reductase inhibitors
■ DUTASTERIDE
Authority required

Benign prostatic hyperplasia

Clinical criteria:

Patient must be one in whom surgery is inappropriate; OR

Patient must have failed to respond to other drug treatment or other drug treatment must be contraindicated.

dutasteride 500 microgram capsule, 30

10095H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	30.77	6.10	Avodart [GK]

■ FINASTERIDE
Authority required

Treatment of benign prostatic hyperplasia where surgery is inappropriate, or where other drug treatment has failed or is contraindicated

finasteride 5 mg tablet, 28

4303L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	91.60	6.10	^a Finpro [RZ]	^a Pharmacy Choice Finasteride [RI]

finasteride 5 mg tablet, 30

4233T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	78.03	6.10	^a Finasteride GH 5 [GQ]	
			..	97.66	6.10	^a Finasteride RBX [RA]	^a Finnacar [QA]
			..	102.45	6.10	^a APO-Finasteride [TX]	^a Finasta [SZ]
						^a Finasteride Alphapharm [AF]	^a Finasteride-GA 5 [GN]
						^a Pharmacor Finasteride 5 [CR]	^a Proscar [MK]

■ **ANTIINFECTIVES FOR SYSTEMIC USE**

■ **ANTIBACTERIALS FOR SYSTEMIC USE**

MACROLIDES, LINCOSAMIDES AND STREPTOGRAMINS

Macrolides

■ **AZITHROMYCIN**

Restricted benefit

Upper and lower respiratory tract infections

azithromycin 500 mg tablet, 3

4115N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	..	..	31.85	6.10	Zedd 500 [QA]	
						^a APO-Azithromycin [TX]	^a Azithromycin-GA [UA]
						^a Azithromycin Sandoz [SZ]	^a Chem mart Azithromycin [CH]
						^a Terry White Chemists	^a Zithromax [PF]
						Azithromycin [TW]	
						^a Zitrocin [GN]	

■ **ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS**

■ **ANTINEOPLASTIC AGENTS**

ANTIMETABOLITES

Pyrimidine analogues

■ **FLUOROURACIL**

fluorouracil 5% (50 mg/g) cream, 20 g

4222F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	60.96	6.10	Efudix [IA]

■ **IMMUNOSUPPRESSANTS**

IMMUNOSUPPRESSANTS

Tumor necrosis factor alpha (TNF-) inhibitors

■ **INFLIXIMAB**

Authority required

Initial treatment, in combination with methotrexate, of specific accepted war-caused or service-related disability of refractory rheumatoid arthritis. Initial treatment may be prescribed by rheumatologists or consultant physicians for the reduction of signs and symptoms and prevention of structural joint damage in adult patients with active rheumatoid arthritis who satisfy all of the following criteria:

- (1) (a) Proven raised erythrocyte sedimentation rate (ESR) and/or C-reactive protein (CRP); and
- (1) (b) Proven erosive rheumatoid arthritis without end-stage disease;
- (2) Failure of an adequate trial of methotrexate and 2 other disease modifying anti-rheumatic drugs (such as sulfasalazine, hydroxychloroquine, leflunomide or cyclosporin) — unless these drugs were contraindicated or intolerance had developed;
- (3) No history of active tuberculosis requiring treatment in the last 3 years;
- (4) No history of opportunistic infection in the last 2 months;
- (5) Female patients of child-bearing age are not pregnant, not breast-feeding, and are using an effective form of contraception.

Applications for authorisation must be in writing and must include:

- (1) a completed authority prescription form; and
- (2) a completed Infliximab (Remicade) RPBS Authority Application - Supporting Information form (contact the VAPAC on 1800 552 580 for a copy of the form)

Authority required

Continuing treatment, in combination with methotrexate, of specific accepted war-caused or service-related disability of refractory rheumatoid arthritis. Continuing treatment may be prescribed by rheumatologists or consultant physicians, following initial therapy of 3 doses, in patients who satisfy the following criteria:

- (1) There is improvement in ESR and/or CRP; and

- (2) An ACR20 (American College of Rheumatology) response is achieved by 14 weeks after the commencement of therapy. Applications for authorisation must be in writing and must include:
- (1) a completed authority prescription form; and
 - (2) a completed Infliximab (Remicade) RPBS Authority Application - Supporting Information form (contact the VAPAC on 1800 552 580 for a copy of the form)

Note

Any queries concerning the arrangements to prescribe infliximab may be directed to the Veterans' Affairs Pharmaceutical Advisory Centre (VAPAC) on 1800 552 580.

Written applications for authority to prescribe infliximab should be forwarded to:

Reply Paid 9998
Veterans' Affairs Pharmaceutical Advisory Centre (VAPAC)
Department of Veterans' Affairs
GPO Box 9998

BRISBANE QLD 4001

infliximab 100 mg injection, 1 x 100 mg vial

4284L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	847.32	6.10	Remicade [JC]

MUSCULO-SKELETAL SYSTEM

ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS

ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS, NON-STERIODS

Acetic acid derivatives and related substances

DICLOFENAC + MISOPROSTOL

Authority required

Patients requiring an NSAID in whom a risk of upper gastrointestinal complications is high or with a history of peptic ulcer disease

diclofenac sodium 50 mg + misoprostol 200 microgram tablet, 60

4190M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	38.12	6.10	Arthrotec 50 [PF]

TOPICAL PRODUCTS FOR JOINT AND MUSCULAR PAIN

TOPICAL PRODUCTS FOR JOINT AND MUSCULAR PAIN

Preparations with salicylic acid derivatives

METHYL SALICYLATE

methyl salicylate 25% (0.25 mL/mL) liniment, 100 mL

4026X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	1	..	10.28	6.10	Gold Cross [BI]

methyl salicylate 50% (500 mg/g) ointment, 100 g

4023R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	1	..	12.51	6.10	Gold Cross [BI]

METHYL SALICYLATE + MENTHOL + EUCALYPTUS OIL

methyl salicylate 25% (250 mg/g) + menthol 4% (40 mg/g) + eucalyptus oil 10% (100 mg/g) cream, 100 g

4022Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	1	..	14.36	6.10	Gold Cross [BI]

DRUGS FOR TREATMENT OF BONE DISEASES

DRUGS AFFECTING BONE STRUCTURE AND MINERALIZATION

Bisphosphonates

RISEDRONATE

Authority required

For preservation of bone mineral density in patients on long-term glucocorticoid therapy where patients are undergoing continuous treatment with a dose equal to or greater than 7.5 mg of prednisone or equivalent per day. Prescribers need to demonstrate that the patient has been on continuous therapy for 3 months or more and demonstrate that the patient is osteopenic (bone mineral density t-score of less than -1.0)

RISEDRONATE SODIUM Tablet 35 mg (enteric coated), 4

2191H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	42.11	6.10	Actonel EC [UA]

risedronate sodium 35 mg tablet, 4

4444X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	42.11	6.10	^a Acris Once-a-Week [AF] ^a Risedronate-GA [GN] ^a Risedro once a week [QA]	^a APO-Risedronate [TX] ^a Risedronate Sandoz [SZ]

risedronate sodium 5 mg tablet, 28

4443W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	5	..	42.11	6.10	Actonel [UA]

Bisphosphonates, combinations**■ ALENDRONATE + COLECALCIFEROL****Authority required**

For preservation of bone mineral density in patients on long-term glucocorticoid therapy where patients are undergoing continuous treatment with a dose equal to or greater than 7.5 mg of prednisone or equivalent per day. Prescribers need to demonstrate that the patient has been on continuous therapy for 3 months or more and demonstrate that the patient is osteopenic (bone mineral density t-score of less than -1.0)

alendronate 70 mg + colecalciferol 140 microgram tablet, 4

2224C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	45.51	6.10	^a Alendronate plus D3-DRLA [RZ] ^a Fosamax Plus 70 mg/140 mcg [MK]	^a FonatPLUS [AF]

alendronate 70 mg + colecalciferol 70 microgram tablet, 4

2194L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	45.51	6.10	^a Alendronate plus D3-DRLA [RZ] ^a Fosamax Plus [MK]	^a FonatPLUS [AF]

■ ALENDRONATE + COLECALCIFEROL (&) CALCIUM CARBONATE**Authority required**

For preservation of bone mineral density in patients on long-term glucocorticoid therapy where patients are undergoing continuous treatment with a dose equal to or greater than 7.5 mg of prednisone or equivalent per day. Prescribers need to demonstrate that the patient has been on continuous therapy for 3 months or more and demonstrate that the patient is osteopenic (bone mineral density t-score of less than -1.0)

alendronate 70 mg + colecalciferol 140 microgram tablet [4] (&) calcium (as carbonate) 500 mg tablet [48], 1 pack

2273P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	45.51	6.10	Fosamax Plus D-Cal [MK]

■ RISEDRONATE (&) CALCIUM CARBONATE**Authority required**

For preservation of bone mineral density in patients on long-term glucocorticoid therapy where patients are undergoing continuous treatment with a dose equal to or greater than 7.5 mg of prednisone or equivalent per day. Prescribers need to demonstrate that the patient has been on continuous therapy for 3 months or more and demonstrate that the patient is osteopenic (bone mineral density t-score of less than -1.0)

RISEDRONATE SODIUM and CALCIUM CARBONATE Pack containing 4 enteric coated tablets risedronate sodium 35 mg and 24 tablets calcium carbonate 1.25 g (equivalent to 500 mg calcium), 1

2220W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	45.73	6.10	Actonel EC Combi [UA]

risedronate sodium 35 mg tablet [4] (&) calcium (as carbonate) 500 mg tablet [24], 28

4059P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	45.73	6.10	Acris Combi [AF]

■ RISEDRONATE (&) CALCIUM CARBONATE + COLECALCIFEROL**Authority required**

For preservation of bone mineral density in patients on long-term glucocorticoid therapy where patients are undergoing continuous treatment with a dose equal to or greater than 7.5 mg of prednisone or equivalent per day. Prescribers need to

demonstrate that the patient has been on continuous therapy for 3 months or more and demonstrate that the patient is osteopenic (bone mineral density t-score of less than -1.0)

RISEDRONATE SODIUM and CALCIUM CARBONATE with COLECALCIFEROL Pack containing 4 enteric coated tablets risedronate sodium 35 mg and 24 sachets containing granules of calcium carbonate 2.5 g (equivalent to 1 g calcium) with colecalciferol 22 micrograms, 1

2254P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	45.73	6.10	Actonel EC Combi D [UA]

■ NERVOUS SYSTEM

■ ANALGESICS

OPIOIDS

Natural opium alkaloids

■ MORPHINE

Caution

The risk of drug dependence is high.

Restricted benefit

Chronic severe disabling pain not responding to non-narcotic analgesics

Note

Authorities for increased maximum quantities and/or repeats will be granted only for

(i) chronic severe disabling pain associated with proven malignant neoplasia; or

(ii) chronic severe disabling pain where treatment has been initiated by a specialist with appropriate expertise in pain management.

morphine sulfate 200 mg tablet: modified release, 28 tablets

4349X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	122.20	6.10	MS Contin [MF]

OTHER ANALGESICS AND ANTIPYRETICS

Salicylic acid and derivatives

■ ASPIRIN + CODEINE

aspirin 300 mg + codeine phosphate 8 mg tablet: dispersible, 40

4286N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	14.52	6.10	Aspalgin 40 [QA]

Anilides

■ PARACETAMOL + CODEINE

paracetamol 500 mg + codeine phosphate 15 mg tablet, 20

4170L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	10.07	6.10	Prodeine 15 [SW]

paracetamol 500 mg + codeine phosphate 8 mg tablet, 40

4275B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	11.03	6.10	Panamax Co. 40 [SW]

paracetamol 500 mg + codeine phosphate 8 mg tablet, 50

4171M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	13.20	6.10	Codalgin [FM]

paracetamol 500 mg + codeine phosphate hemihydrate 15 mg tablet, 20

10186D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	2	..	10.07	6.10	Pharmacy Action Paracetamol Plus Codeine [GQ]

Other analgesics and antipyretics

■ GABAPENTIN

Authority required

To be approved for the treatment of refractory neuropathic pain not controlled by other drugs

gabapentin 100 mg capsule, 100

4591P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	12.95	6.10	^a APO-Gabapentin [TX] ^a Neurontin [PF]	^a Gabapentin Aspen 100 [FM] ^a Nupentin 100 [AF]

gabapentin 300 mg capsule, 100

4592Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	27.43	6.10	^a DBL Gabapentin [HH] ^a Gabapentin Aspen 300 [FM] ^a GenRx Gabapentin [GX] ^a Nupentin 300 [AF]	^a Gabapentin 300 [CR] ^a Gantin [GN] ^a Neurontin [PF]

gabapentin 400 mg capsule, 100

4593R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	34.94	6.10	^a DBL Gabapentin [HH] ^a Gabapentin Aspen 400 [FM] ^a GenRx Gabapentin [GX] ^a Nupentin 400 [AF]	^a Gabapentin 400 [CR] ^a Gantin [GN] ^a Neurontin [PF]

gabapentin 600 mg tablet, 100

4594T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	50.16	6.10	^a Gabapentin Aspen 600 [FM] ^a Neurontin [PF]	^a GenRx Gabapentin [GX] ^a Nupentin Tabs [AF]

gabapentin 800 mg tablet, 100

4595W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	5	..	63.81	6.10	^a Gabapentin Aspen 800 [FM] ^a GenRx Gabapentin [GX] ^a Nupentin Tabs [AF]	^a Gantin [GN] ^a Neurontin [PF]

■ PSYCHOLEPTICS**ANXIOLYTICS***Benzodiazepine derivatives***■ BROMAZEPAM****Authority required**

Patients with terminal disease

Authority required

Patients with refractory phobic or anxiety states

Note

For short-term use and palliative care. This drug should not be used as the first line of treatment. Other PBS-listed benzodiazepines should have been adequately tried and found to be ineffective or inappropriate. Authorities for increased quantities and/or repeats may be granted to patients with terminal disease, and other patients who have been shown to be dependent on this item by an unsuccessful attempt at gradual withdrawal.

bromazepam 3 mg tablet, 30

4150K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*29.82	6.10	Lexotan [RO]

bromazepam 6 mg tablet, 30

4151L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*36.44	6.10	Lexotan [RO]

*Azaspironedione derivatives***■ BUSPIRONE****Authority required**

For the short-term treatment of anxiety

buspirone hydrochloride 10 mg tablet, 50

4145E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	55.18	6.10	Buspar [QA]

buspirone hydrochloride 5 mg tablet, 50

4144D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	38.33	6.10	Buspar [QA]

HYPNOTICS AND SEDATIVES

Benzodiazepine derivatives

■ FLUNITRAZEPAM

Authority required

Patients with terminal disease

Authority required

Patients with refractory phobic or anxiety states

Note

For short-term use and palliative care. This drug should not be used as the first line of treatment. Other PBS-listed benzodiazepines should have been adequately tried and found to be ineffective or inappropriate. Authorities for increased quantities and/or repeats may be granted to patients with terminal disease, and other patients who have been shown to be dependent on this item by an unsuccessful attempt at gradual withdrawal.

flunitrazepam 1 mg tablet, 30

4216X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	15.22	6.10	Hypnodorm [AF]

Benzodiazepine related drugs

■ ZOPICLONE

Restricted benefit

For the short-term treatment of insomnia

zopiclone 7.5 mg tablet, 30

4522B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer	Brand Name and Manufacturer
	1	..	..	22.10	6.10	^a APO-Zopiclone [TX] ^a Imrest [AF]	^a Chem mart Zopiclone [CH] ^a Terry White Chemists Zopiclone [TW]
			..	25.25	6.10	^a Imovane [SW]	

■ OTHER NERVOUS SYSTEM DRUGS

DRUGS USED IN ADDICTIVE DISORDERS

Drugs used in nicotine dependence

■ NICOTINE

Authority required

Patients who have indicated that they are ready to cease smoking and who have entered a support and counselling program

Note

Studies have shown that successful therapy with this drug is enhanced by patient participation in a support and counselling program.

nicotine 10 mg/16 hours patch, 7

4577X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*55.12	6.10	Nicorette Patch [JT]

nicotine 14 mg/24 hours patch, 7

4572P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*54.90	6.10	QuitX [AF]
			..	*69.08	6.10	Nicabate CQ 14 [GC]

nicotine 15 mg/16 hours patch, 7

4578Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	2	..	*60.30	6.10	Nicorette Patch [JT]

nicotine 21 mg/24 hours patch, 7

4573Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	2	..	*58.02	6.10	QuitX [AF]
			..	*69.08	6.10	Nicabate CQ 21 [GC]

nicotine 5 mg/16 hours patch, 7

4576W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*51.14	6.10	Nicorette Patch [JT]

nicotine 7 mg/24 hours patch, 7

4571N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*51.74	6.10	QuitX [AF]

ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS

ANTHELMINTICS

ANTINEMATODAL AGENTS

Benzimidazole derivatives

MEBENDAZOLE

mebendazole 100 mg tablet, 6

4325P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	15.26	6.10	Vermox [IA]

RESPIRATORY SYSTEM

NASAL PREPARATIONS

DECONGESTANTS AND OTHER NASAL PREPARATIONS FOR TOPICAL USE

Sympathomimetics, plain

OXYMETAZOLINE

oxymetazoline hydrochloride 0.05% (500 microgram/mL) nasal spray, 15 mL

4378K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	17.49	6.10	Drixine [BN]

oxymetazoline hydrochloride 0.05% (500 microgram/mL) nasal spray, 18 mL

4379L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	17.10	6.10	Logicin Rapid Relief [QA]

Antiallergic agents, excl. corticosteroids

CROMOGLYCATE

cromoglycate sodium 2% (20 mg/mL) nasal spray, 26 mL

4468E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	23.25	6.10	Rynacrom [SW]

LEVOCABASTINE

levocabastine 0.05% (500 microgram/mL) nasal spray, 100 actuations

4311X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	18.58	6.10	Livostin [JT]

Corticosteroids

BUDESONIDE

Restricted benefit

Severe intractable rhinitis

budesonide 64 microgram/actuation nasal spray, 120 actuations

4092J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	39.03	6.10	Budamax Aqueous [PM]

Other nasal preparations

IPRATROPIUM

Restricted benefit

Severe intractable rhinorrhoea, associated with perennial rhinitis, unresponsive to insufflated nasal steroids

ipratropium bromide anhydrous 21 microgram/actuation nasal spray, 180 actuations

4089F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	23.93	6.10	Atrovent Nasal Aqueous [BY]

ipratropium bromide anhydrous 42 microgram/actuation nasal spray, 180 actuations

4090G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	5	..	30.81	6.10	Atrovent Nasal Forte [BY]

NASAL DECONGESTANTS FOR SYSTEMIC USE*Sympathomimetics***■ PSEUDOEPHEDRINE****pseudoephedrine hydrochloride 60 mg tablet, 12**

4029C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	10.61	6.10	^a Pharmacy Action Sinus & Nasal Decongestant Relief [GQ]
			..	11.36	6.10	^a Logicin Sinus [QA]

■ COUGH AND COLD PREPARATIONS**EXPECTORANTS, EXCL. COMBINATIONS WITH COUGH SUPPRESSANTS***Expectorants***■ AMMONIUM + SENEGA ROOT****ammonium bicarbonate 25 mg/mL + senega root 25 mg/mL oral liquid, 200 mL**

4074K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	4	..	9.52	6.10	Gold Cross [BI]

COUGH SUPPRESSANTS, EXCL. COMBINATIONS WITH EXPECTORANTS*Opium alkaloids and derivatives***■ PHOLCODINE****pholcodine 1 mg/mL oral liquid, 100 mL**

4071G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	9.36	6.10	Gold Cross [BI]
			..	14.95	6.10	Duro-Tuss [IA]

■ ANTIHISTAMINES FOR SYSTEMIC USE**ANTI HISTAMINES FOR SYSTEMIC USE***Piperazine derivatives***■ CETIRIZINE****cetirizine hydrochloride 10 mg tablet, 30**

4175R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	26.28	6.10	^a Pharmacy Action Cetrelief [GQ]
			..	29.99	6.10	^a Alzene [AF]
			..	33.21	6.10	Zilarex [SZ]
			..	39.79	6.10	^a Zyrtec [JT]

*Other antihistamines for systemic use***■ FEXOFENADINE****fexofenadine hydrochloride 120 mg tablet, 30**

4238C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	29.76	6.10	^a Xergic [AF]
			..	35.05	6.10	^a Fexal [SZ]
			..	47.47	6.10	^a Telfast 120 [SW]

fexofenadine hydrochloride 60 mg tablet, 20

4237B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	3	..	..	*55.33	6.10	Telfast [SW]

■ LORATADINE

loratadine 10 mg tablet, 30

4313B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	29.07	6.10	^a Pharmacy Action Lorastyne [GQ]
			..	33.33	6.10	^a Allereze [AF]
			..	43.99	6.10	^a Lorano [SZ]
			..	46.26	6.10	^a Claratyne [BN]

■ SENSORY ORGANS

■ OPHTHALMOLOGICALS

DECONGESTANTS AND ANTIALLERGICS

Sympathomimetics used as decongestants

■ NAPHAZOLINE

naphazoline hydrochloride 0.1% eye drops, 15 mL

4035J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	15.43	6.10	Albalon Liquifilm [AG]

■ NAPHAZOLINE + ANTAZOLINE

naphazoline hydrochloride 0.05% + antazoline phosphate 0.5% eye drops, 15 mL

4032F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	15.14	6.10	Albalon-A [AG]

Other antiallergics

■ LEVOCABASTINE

levocabastine 0.05% eye drops, 4 mL

4310W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	18.58	6.10	Livostin [JT]

■ OTOLOGICALS

OTHER OTOLOGICALS

Indifferent preparations

■ CARBAMIDE PEROXIDE

carbamide peroxide 6.5% ear drops, 12 mL

4176T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	17.66	6.10	Ear Clear for Ear Wax Removal [KY]

■ DICHLOROBENZENE WITH CHLORBUTOL AND ARACHIS OIL

DICHLOROBENZENE with CHLORBUTOL and ARACHIS OIL Ear drops, ortho-dichlorobenzene 140 mg per mL, para-dichlorobenzene 20 mg per mL, chlorbutol 50 mg per mL, arachis oil 573 mg per mL, 10 mL, 1

4180B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	14.42	6.10	Cerumol [UN]

■ DOCUSATE

docusate sodium 0.5% (5 mg/mL) ear drops, 10 mL

4199B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	14.81	6.10	Waxsol [HM]

■ VARIOUS

■ ALL OTHER THERAPEUTIC PRODUCTS

ALL OTHER THERAPEUTIC PRODUCTS

Drugs for treatment of hyperkalemia and hyperphosphatemia

■ POLYSTYRENE SULFONATE SODIUM

polystyrene sulfonate sodium 999.3 mg/g powder, 454 g

4470G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	71.46	6.10	Resonium-A [SW]

■ ALL OTHER NON-THERAPEUTIC PRODUCTS

ALL OTHER NON-THERAPEUTIC PRODUCTS

■ LUBRICATING AGENT

lubricating agent jelly, 100 g

4306P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	10.47	6.10	Lubri-Gel [PP]

Other non-therapeutic auxiliary products

■ BANDAGE ABSORBENT WOOL

bandage absorbent wool 10 cm x 3 m bandage, 1

4653X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	20.66	6.10	Surepress 650948 [CC]

■ BANDAGE CALICO

Note

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

bandage calico large bandage: triangular, 1 bandage

4717G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	13.38	6.10	Handy 36361414 [BV]

■ BANDAGE COMPRESSION

Note

Treatment of varices and oedema associated with venous disease and lymphoedema; contraindicated in arterial disease. Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

bandage compression bandage: four layer, 1 bandage

4598B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	5	..	..	*160.01	6.10	Profore Lite 66050415 [SN]

bandage compression bandage: four layer, 1 bandage

4658E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	5	..	..	*234.36	6.10	Profore 66050016 [SN]

■ BANDAGE COMPRESSION

Note

Treatment of varices and oedema associated with venous disease and lymphoedema; contraindicated in arterial disease. Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

BANDAGE-COMPRESSION Bandage, short stretch, 8 cm x 2.6 m, 1

4654Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	5	..	..	*76.11	6.10	Comprilan 01027-00 [BV]

bandage compression 10 cm x 3 m bandage: high stretch, 1 bandage

4748X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	5	..	..	*73.26	6.10	Surepress 650947 [CC]
			..	*152.96	6.10	Tensopress 71723-00 [BV]

▪ BANDAGE COMPRESSION

Note

Treatment of varices and oedema associated with venous disease and lymphoedema; contraindicated in arterial disease. Molnlycke Health Care products are distributed through leading pharmacy distributors. To best ensure product availability at the RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email: customerservice@independenceaustralia.com. Molnlycke Health Care is not able to ensure product availability or pricing on listed products beyond these two suppliers.

bandage compression 10 cm x 3.5 m bandage: high stretch, 1 bandage

4657D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	5	..	..	*78.91	6.10	Setopress 3505 [MH]

▪ BANDAGE COMPRESSION

Restricted benefit

Initial treatment of venous ulcers

Restricted benefit

Continuation of treatment of venous ulcers where patient's ability to tolerate dressing has been demonstrated

Note

Treatment of varices and oedema associated with venous disease and lymphoedema; contraindicated in arterial disease. Bandage can be left in situ for up to 7 days as per manufacturer's instructions.

bandage compression bandage: two layer, 1 bandage

4050E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	43.02	6.10	Coban 2 [MM]

▪ BANDAGE RETENTION COHESIVE HEAVY

bandage retention cohesive heavy 10 cm x 1.3 m bandage, 1

4813H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*21.42	6.10	Peg 7423 [MM]

bandage retention cohesive heavy 10 cm x 2 m bandage, 1

4660G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*19.70	6.10	Coban 1584 [MM]

bandage retention cohesive heavy 15 cm x 1.3 m bandage, 1

4814J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*28.52	6.10	Peg 7425 [MM]

bandage retention cohesive heavy 5 cm x 1.3 m bandage, 1

4811F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*14.36	6.10	Peg 7420 [MM]

bandage retention cohesive heavy 7.5 cm x 1.3 m bandage, 1

4812G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*17.64	6.10	Peg 7422 [MM]

▪ BANDAGE RETENTION COHESIVE LIGHT

Note

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

bandage retention cohesive light 10 cm x 2 m bandage, 1

4662J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*31.42	6.10	Handygauze Cohesive 8635 [BV]

bandage retention cohesive light 2.5 cm x 2 m bandage, 2

4718H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	13.52	6.10	Handygauze Cohesive 8631 [BV]

bandage retention cohesive light 6 cm x 2 m bandage, 1

4719J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*16.14	6.10	Handygauze Cohesive 8633 [BV]

▪ BANDAGE RETENTION COTTON CREPE**Note**

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

bandage retention cotton crepe 10 cm x 2.3 m bandage, 1

4729X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*25.72	6.10	Telfa 8254F [KE]
			..	*30.92	6.10	Tensocrepe 36301001 [BV]

bandage retention cotton crepe 5 cm x 2.3 m bandage, 1

4727T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*17.76	6.10	Telfa 8252F [KE]
			..	*20.22	6.10	Tensocrepe 36300501 [BV]

bandage retention cotton crepe 7.5 cm x 2.3 m bandage, 1

4728W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*22.56	6.10	Telfa 8253F [KE]
			..	*25.22	6.10	Tensocrepe 36307501 [BV]

▪ BANDAGE TUBULAR**bandage tubular size C (15 cm to 25 cm) bandage: straight, 1 bandage**

4663K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	15.73	6.10	Elastoplast 2225 [BE]

bandage tubular size D (25 cm to 43 cm) bandage: straight, 1 bandage

4664L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	15.73	6.10	Elastoplast 2226 [BE]

bandage tubular size E (35 cm to 45 cm) bandage: straight, 1 bandage

4665M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	15.73	6.10	Elastoplast 2227 [BE]

▪ BANDAGE TUBULAR**Note**

Molnlycke Health Care products are distributed through leading pharmacy distributors. To best ensure product availability at the RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email: customerservice@independenceaustralia.com. Molnlycke Health Care is not able to ensure product availability or pricing on listed products beyond these two suppliers.

bandage tubular 10 cm x 1 m bandage, 1

4859R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	15.32	6.10	Tubigrip F 1548 [MH]

bandage tubular 6.25 cm x 1 m bandage, 1

4855M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	15.32	6.10	Tubigrip B 1520 [MH]

bandage tubular 6.75 cm x 1 m bandage, 1

4856N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	15.32	6.10	Tubigrip C 1545 [MH]

bandage tubular 7.5 cm x 1 m bandage, 1

4857P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	15.32	6.10	Tubigrip D 1546 [MH]

bandage tubular 8.75 cm x 1 m bandage, 1

4858Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	15.32	6.10	Tubigrip E 1547 [MH]

▪ BANDAGE TUBULAR FINGER**BANDAGE-TUBULAR (FINGER) Complete pack including applicator, 1**

4798M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	18.11	6.10	Tubegauz 0501633 [SS]

▪ BANDAGE TUBULAR LIGHT WEIGHT**Note**

Molnlycke Health Care products are distributed through leading pharmacy distributors. To best ensure product availability at the RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email: customerservice@independenceaustralia.com. Molnlycke Health Care is not able to ensure product availability or pricing on listed products beyond these two suppliers.

bandage tubular light weight 10 m bandage: large limb size, 1 bandage

4673Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	28.47	6.10	Tubifast 2438 [MH]

bandage tubular light weight 10 m bandage: medium limb size, 1 bandage

4672X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	27.06	6.10	Tubifast 2436 [MH]

bandage tubular light weight 10 m bandage: small limb size, 1 bandage

4671W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	23.10	6.10	Tubifast 2434 [MH]

▪ BANDAGE TUBULAR LONG STOCKING**Note**

Molnlycke Health Care products are distributed through leading pharmacy distributors. To best ensure product availability at the RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email: customerservice@independenceaustralia.com. Molnlycke Health Care is not able to ensure product availability or pricing on listed products beyond these two suppliers.

bandage tubular long stocking bandage: XX/large size, 1 bandage

4675C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*37.48	6.10	Tubigrip 1486 [MH]

bandage tubular long stocking bandage: large size, 1 bandage

4799N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*37.46	6.10	Tubigrip 1484 [MH]

bandage tubular long stocking bandage: medium size, 1 bandage

4797L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*37.46	6.10	Tubigrip 1483 [MH]

bandage tubular long stocking bandage: small size, 1 bandage

4674B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*37.46	6.10	Tubigrip 1482 [MH]

▪ BANDAGE TUBULAR SHORT STOCKING**Note**

Molnlycke Health Care products are distributed through leading pharmacy distributors. To best ensure product availability at the RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email: customerservice@independenceaustralia.com. Molnlycke Health Care is not able to ensure product availability or pricing on listed products beyond these two suppliers.

bandage tubular short stocking bandage: large D/E size, 1 bandage

4816L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*25.72	6.10	Tubigrip 1481 [MH]

bandage tubular short stocking bandage: medium C/D size, 1 bandage

4815K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*25.72	6.10	Tubigrip 1480 [MH]

bandage tubular short stocking bandage: small B/C size, 1 bandage

4661H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*25.72	6.10	Tubigrip 1479 [MH]

▪ BANDAGE ZINC PASTE**Note**

Used as an adjunct in the management of leg ulceration and associated eczema and skin conditions.

bandage zinc paste 10 cm x 9.1 m bandage, 1

4670T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	3	..	*29.12	6.10	Flexidress 650941 [CC]

▪ BANDAGE ZINC PASTE**Note**

Used as an adjunct in the management of leg ulceration and associated eczema and skin conditions.

Molnlycke Health Care products are distributed through leading pharmacy distributors. To best ensure product availability at the RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email: customerservice@independenceaustralia.com. Molnlycke Health Care is not able to ensure product availability or pricing on listed products beyond these two suppliers.

bandage zinc paste 7.5 cm x 6 m bandage, 1

4669R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	3	..	*30.00	6.10	Steripaste 3610 [MH]

▪ BANDAGE ZINC PASTE**Note**

Used as an adjunct in the management of leg ulceration and associated eczema and skin conditions.

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

bandage zinc paste 7.5 cm x 6 m bandage, 1

4750B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	3	..	*82.66	6.10	Viscopaste 4948 [SN]

bandage zinc paste 80 cm (stockings) bandage, 4

4760M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	3	..	95.42	6.10	ZipZoc 66000747 [SN]

▪ BETAINE + POLYAMINOPROPYL BIGUANIDE**betaine 0.1% (40 microgram/40 mL) + polyaminopropyl biguanide 0.1% (40 microgram/40 mL), 6 x 40 mL ampoules**

2525X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	27.01	6.10	Prontosan Wound Irrigation Solution [BR]

▪ CADEXOMER-IODINE**Note**

Suitable for yellow sloughy infected and malodorous wounds.

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

DRESSING with CADEXOMER IODINE Sheets 17 g (10 cm x 8 cm), 2, 1

4937W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	163.92	6.10	Iodosorb 66051360 [SN]

DRESSING with CADEXOMER IODINE Sheets 5 g (6 cm x 4 cm), 5, 1

4935R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	107.59	6.10	Iodosorb 66051330 [SN]

cadexomer-iodine 3 g powder: dusting sterile, 7 x 3 g sachets

4931M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	70.65	6.10	Iodosorb Powder 66051070 [SN]

cadexomer-iodine 50% (500 mg/g) ointment, 2 x 20 g tubes

4933P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	112.77	6.10	Iodosorb Ointment 66051230 [SN]

cadexomer-iodine 50% (500 mg/g) ointment, 4 x 10 g tubes

4932N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	113.83	6.10	Iodosorb Ointment 66051240 [SN]

cadexomer-iodine 8 cm x 6 cm dressing, 3 x 10 g sheets

4936T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	155.54	6.10	Iodosorb 66051340 [SN]

▪ DRESSING ACTIVATED CHARCOAL MALODOROUS WOUND**dressing activated charcoal malodorous wound 10 cm x 10 cm dressing, 10**

4742N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	79.32	6.10	CarboFLEX 403202 [CC]

dressing activated charcoal malodorous wound 10.5 cm x 10.5 cm dressing, 1

4681J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	10	..	..	*101.26	6.10	Actisorb Plus MAP105 [KI]

dressing activated charcoal malodorous wound 15 cm x 20 cm dressing, 5

4743P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	90.21	6.10	CarboFLEX 403204 [CC]

▪ DRESSING ALGINATE CAVITY WOUND**Note**

This dressing should be used only on moderately to heavily exuding wounds and should remain in place until saturated or for a maximum of 3 days.

DRESSING-ALGINATE (CAVITY WOUND) Rope 2 g, 1

4832H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	10	..	..	*109.46	6.10	Sorbsan 1411 [UM]

DRESSING-ALGINATE (CAVITY WOUND) Rope 2 g, 5

1905G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*115.60	6.10	Kaltostat 168117 [CC]

▪ DRESSING ALGINATE CAVITY WOUND**Note**

This dressing should be used only on moderately to heavily exuding wounds and should remain in place until saturated or for a maximum of 3 days.

Coloplast dressings are available via a range of distributors. However, Coloplast's principal agreement to ensure correct RPBS Price to Pharmacy and ready supply has been secured with Independence Australia on 1300 788 855 and BrightSky on 1300 290 400. Please note that Coloplast is unable to guarantee ready supply or rebate for price differences on purchases outside these distributors.

dressing alginate cavity wound 2 g (40 cm) rope, 6 x 2 g

4682K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*138.06	6.10	Comfeel SeaSorb Filler 3740 [CT]

▪ DRESSING ALGINATE SUPERFICIAL WOUND**Note**

This dressing should be used only on moderately to heavily exuding wounds and should remain in place until saturated or for a maximum of 3 days.

dressing alginate superficial wound 7.5 cm x 12 cm dressing, 10

4683L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	91.42	6.10	Kaltostat 168212 [CC]

▪ DRESSING ALGINATE SUPERFICIAL WOUND

Note

This dressing should be used only on moderately to heavily exuding wounds and should remain in place until saturated or for a maximum of 3 days.

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

dressing alginate superficial wound 10 cm x 10 cm dressing, 10

4700J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	110.35	6.10	Algisite M 66000520 [SN]

dressing alginate superficial wound 15 cm x 20 cm dressing, 10

4691X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	263.04	6.10	Algisite M 66000521 [SN]

dressing alginate superficial wound 5 cm x 5 cm dressing, 10

4699H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	49.74	6.10	Kaltostat 168210 [CC]
			..	56.74	6.10	Algisite M 66000519 [SN]

▪ DRESSING ALGINATE SUPERFICIAL WOUND

Note

This dressing should be used only on moderately to heavily exuding wounds and should remain in place until saturated or for a maximum of 3 days.

Coloplast dressings are available via a range of distributors. However, Coloplast's principal agreement to ensure correct RPBS Price to Pharmacy and ready supply has been secured with Independence Australia on 1300 788 855 and BrightSky on 1300 290 400. Please note that Coloplast is unable to guarantee ready supply or rebate for price differences on purchases outside these distributors.

dressing alginate superficial wound 10 cm x 10 cm dressing, 1

4831G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	10	1	..	*84.76	6.10	Sorbsan 1410 [UM]
			..	*90.46	6.10	Comfeel SeaSorb Dressing 3710 [CT]

dressing alginate superficial wound 5 cm x 5 cm dressing, 1

4684M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	10	1	..	*47.26	6.10	Comfeel SeaSorb Dressing 3705 [CT]

▪ DRESSING FILM

dressing film 10 cm x 12 cm dressing, 4

4687Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	19.99	6.10	Nexcare Tegaderm Transparent H1626 [MM]

dressing film 15 cm x 20 cm dressing, 1

4688R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	6	..	..	*31.00	6.10	Tegaderm Transparent 1628 [MM]

dressing film 6 cm x 7 cm dressing, 8

4686P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	15.98	6.10	Nexcare Tegaderm Transparent H1624 [MM]

▪ DRESSING FILM

Note

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

■ dressing film 10 cm x 12 cm dressing, 10

4893M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	..	..	34.08	6.10	Op-Site Flexigrid 4629 [SN]

■ DRESSING FILM ISLAND

dressing film island 5 cm x 7 cm dressing, 1

4689T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	10	..	..	*16.56	6.10	Tegaderm Transparent Island 3582 [MM]

dressing film island 9 cm x 10 cm dressing, 1

4690W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	10	..	..	*28.06	6.10	Tegaderm Transparent Island 3586 [MM]

■ DRESSING FILM ISLAND

Note

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

dressing film island 5 cm x 7.2 cm dressing, 5

4898T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*29.32	6.10	Cutifilm Plus 36361370 [SN]

dressing film island 8 cm x 10 cm dressing, 5

4899W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*45.92	6.10	Cutifilm Plus 36361371 [SN]

■ DRESSING FOAM HEAVY EXUDATE

Note

This dressing should remain in place until saturated or up to a maximum of 7 days. Allow a minimum of 2 cm to 3 cm in excess of the wound size of the dressing around the wound.

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

dressing foam heavy exudate 10 cm x 10 cm dressing, 10

4795J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	1	..	132.80	6.10	Allevyn 66007637 [SN]

■ DRESSING FOAM MODERATE EXUDATE

Note

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

dressing foam moderate exudate cavity conforming foam, 1 x 20 g sachet

4694C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	1	..	99.44	6.10	Cavicare 4563 [SN]

■ DRESSING FOAM MODERATE EXUDATE

Note

This dressing should remain in place until saturated or up to a maximum of 7 days. Allow a minimum of 2 cm to 3 cm in excess of the wound size of the dressing around the wound.

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler

cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

■ dressing foam moderate exudate 12.5 cm x 12.5 cm dressing, 10

4590N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	138.27	6.10	Allevyn Adhesive 66000044 [SN]

■ DRESSING FOAM WITH SILICONE

Note

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

■ dressing foam with silicone 10.3 cm x 10.3 cm dressing, 10

10017F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	56.71	6.10	Allevyn Life 66801067 [SN]

■ dressing foam with silicone 12.9 cm x 12.9 cm dressing, 10

10029W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	81.69	6.10	Allevyn Life 66801068 [SN]

■ dressing foam with silicone 15.4 cm x 15.4 cm dressing, 10

10023M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	113.56	6.10	Allevyn Life 66801069 [SN]

■ dressing foam with silicone 21 cm x 21 cm dressing, 10

10021K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	226.35	6.10	Allevyn Life 66801070 [SN]

■ DRESSING FOAM WITH SILICONE AND SILVER

Authority required

Wound critical colonisation or chronic wounds that have not responded to conventional dressings

Clinical criteria:

Patient must have a wound where there is evidence of critical colonisation; OR

Patient must have a well-assessed chronic wound that has not responded to conventional dressings.

Note

Molnlycke Health Care products are distributed through leading pharmacy distributors. To best ensure product availability at the RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email: customerservice@independenceaustralia.com. Molnlycke Health Care is not able to ensure product availability or pricing on listed products beyond these two suppliers.

■ dressing foam with silicone and silver 10 cm x 10 cm dressing, 5

2439J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	109.64	6.10	Mepilex Ag [MH]

■ dressing foam with silicone and silver 10 cm x 10 cm dressing, 5

2470B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	117.40	6.10	Mepilex Border Ag [MH]

■ DRESSING FOAM WITH SILICONE HEAVY EXUDATE

Note

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

■ dressing foam with silicone heavy exudate 10 cm x 10 cm dressing, 10

4196W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	76.78	6.10	Allevyn Gentle 66800248 [SN]

■ dressing foam with silicone heavy exudate 10 cm x 10 cm dressing, 10

4230P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	76.78	6.10	Allevyn Gentle Border 66800270 [SN]

dressings foam with silicone heavy exudate 7.5 cm x 7.5 cm dressing, 10

4207K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	53.70	6.10	Allevyn Gentle Border 66800269 [SN]

▪ DRESSING FOAM WITH SILICONE HEAVY EXUDATE**Note**

Molnlycke Healthcare products are distributed through leading pharmacy distributors. To best ensure product availability at RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email customerservice@independenceaustralia.com. Molnlycke Healthcare are not able to ensure product availability or pricing on listed products beyond these two suppliers.

dressings foam with silicone heavy exudate 10 cm x 10 cm dressing, 5

4643J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	43.02	6.10	Mepilex Border 295300 [MH]

dressings foam with silicone heavy exudate 7.5 cm x 7.5 cm dressing, 5

4642H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	31.11	6.10	Mepilex Border 295200 [MH]

▪ DRESSING FOAM WITH SILICONE LIGHT EXUDATE**Note**

Molnlycke Healthcare products are distributed through leading pharmacy distributors. To best ensure product availability at RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email customerservice@independenceaustralia.com. Molnlycke Healthcare are not able to ensure product availability or pricing on listed products beyond these two suppliers.

dressings foam with silicone light exudate 10 cm x 10 cm dressing, 5

4645L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	38.55	6.10	Mepilex Lite 284100 [MH]

dressings foam with silicone light exudate 6 cm x 8.5 cm dressing, 5

4644K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	28.40	6.10	Mepilex Lite 284000 [MH]

▪ DRESSING FOAM WITH SILICONE MODERATE EXUDATE**Note**

Molnlycke Healthcare products are distributed through leading pharmacy distributors. To best ensure product availability at RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email customerservice@independenceaustralia.com. Molnlycke Healthcare are not able to ensure product availability or pricing on listed products beyond these two suppliers.

dressings foam with silicone moderate exudate 10 cm x 10 cm dressing, 5

4626L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	43.02	6.10	Mepilex 294100 [MH]

▪ DRESSING FOAM WITH SILVER**Authority required**

For wounds where there is evidence of critical colonisation and for well-assessed chronic wounds that have not responded to conventional dressings

Note

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

dressings foam with silver 10 cm x 10 cm dressing, 10

4255Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	210.93	6.10	Allevyn Ag Adhesive 66800075 [SN]

dressings foam with silver 10 cm x 10 cm dressing, 10

4259E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	214.62	6.10	Allevyn Ag Non-Adhesive 66800086 [SN]

dressing foam with silver 10 cm x 10 cm dressing, 10

4266M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	210.93	6.10	Allevyn Ag Gentle Border 66800461 [SN]

dressing foam with silver 12.5 cm x 12.5 cm dressing, 10

4258D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	257.47	6.10	Allevyn Ag Adhesive 66800078 [SN]

dressing foam with silver 12.5 cm x 12.5 cm dressing, 10

4270R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	257.47	6.10	Allevyn Ag Gentle Border 66800462 [SN]

dressing foam with silver 7.5 cm x 7.5 cm dressing, 10

4252T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	142.27	6.10	Allevyn Ag Adhesive 66800073 [SN]

dressing foam with silver 7.5 cm x 7.5 cm dressing, 10

4263J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	142.27	6.10	Allevyn Ag Gentle Border 66800460 [SN]

▪ DRESSING GAUZE ABSORBENT**Note**

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

dressing gauze absorbent 10 cm x 10 cm pad, 100

4708T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	30.25	6.10	Handy 71117-06 [BV]

dressing gauze absorbent 5 cm x 5 cm pad, 100

4707R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	15.13	6.10	Handy 71117-05 [BV]

▪ DRESSING GAUZE EYE**dressing gauze eye pad, 12**

4768Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	13.17	6.10	Curity 4112 [KE]

▪ DRESSING GAUZE PARAFFIN**Note**

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

dressing gauze paraffin 10 cm x 10 cm dressing, 10

4759L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	21.96	6.10	Jelonet 7404 [SN]

▪ DRESSING GAUZE PARAFFIN WITH CHLORHEXIDINE ACETATE**Note**

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

dressing gauze paraffin with chlorhexidine acetate 10 cm x 10 cm dressing, 10

4845B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	24.65	6.10	Bactigras 7457 [SN]

▪ DRESSING HYDROACTIVE CAVITY WOUND

Note

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

dressings hydroactive cavity wound 10 cm x 10 cm dressing, 5

4919X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	1	..	*209.52	6.10	Allevyn Plus Cavity 66047573 [SN]

dressings hydroactive cavity wound 5 cm x 6 cm dressing, 10

4918W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	99.17	6.10	Allevyn Plus Cavity 66047571 [SN]

▪ DRESSING HYDROACTIVE DEBRIDEMENT

Note

Hartmann wound dressings are available through HARTMANN and Independence Australia only. If you would like to order Hartmann Wound Care products, please call HARTMANN customer service on 1800 805 839 or Independence Australia on 1300 788 855.

DRESSING-HYDROACTIVE (DEBRIDEMENT) Dressings 4 cm, 10, 1

4949L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	85.22	6.10	TenderWet 24 Active 609210 [HR]

DRESSING-HYDROACTIVE (DEBRIDEMENT) Dressings 5.5 cm, 10, 1

4948K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	87.27	6.10	TenderWet Active Cavity 609272 [HR]

DRESSING-HYDROACTIVE (DEBRIDEMENT) Dressings 7.5 cm x 7.5 cm, 10, 1

4950M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	115.58	6.10	TenderWet 24 Active 609213 [HR]

▪ DRESSING HYDROACTIVE SUPERFICIAL WOUND HIGH EXUDATE SEMI-PERMEABLE ABSORBENT FOAM

dressings hydroactive superficial wound high exudate semi-permeable absorbent foam 10 cm x 10 cm (foam alternative) dressing, 10

4692Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	55.24	6.10	CombiDERM 651031 [CC]

dressings hydroactive superficial wound high exudate semi-permeable absorbent foam 11 cm x 11 cm dressing: island, 10 dressings

4695D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	111.58	6.10	Tielle MTL101E [KI]

dressings hydroactive superficial wound high exudate semi-permeable absorbent foam 15 cm x 18 cm (foam alternative) dressing, 5

4693B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	72.06	6.10	CombiDERM 651027 [CC]

dressings hydroactive superficial wound high exudate semi-permeable absorbent foam 18 cm x 18 cm dressing: island, 5 dressings

4696E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	136.18	6.10	Tielle MT2442 [KI]

▪ DRESSING HYDROACTIVE SUPERFICIAL WOUND HIGH EXUDATE SEMI-PERMEABLE ABSORBENT FOAM

Note

Coloplast dressings are available via a range of distributors. However, Coloplast's principal agreement to ensure correct RPBS Price to Pharmacy and ready supply has been secured with Independence Australia on 1300 788 855 and BrightSky

on 1300 290 400. Please note that Coloplast is unable to guarantee ready supply or rebate for price differences on purchases outside these distributors.

dressing hydroactive superficial wound high exudate semi-permeable absorbent foam 10 cm x 10 cm pad: waterproof, 10 pads

4927H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	88.27	6.10	Biatain Non-adhesive 3410 [CT]

dressing hydroactive superficial wound high exudate semi-permeable absorbent foam 12 cm x 12 cm pad: waterproof, 10 pads

4929K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	97.29	6.10	Biatain Adhesive 3420 [CT]

dressing hydroactive superficial wound high exudate semi-permeable absorbent foam 15 cm x 15 cm pad: waterproof, 5 pads

4928J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	86.79	6.10	Biatain Non-adhesive 3413 [CT]

dressing hydroactive superficial wound high exudate semi-permeable absorbent foam 18 cm x 18 cm pad: waterproof, 5 pads

4930L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	94.16	6.10	Biatain Adhesive 3423 [CT]

▪ DRESSING HYDROACTIVE SUPERFICIAL WOUND LIGHT EXUDATE

Note

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

dressing hydroactive superficial wound light exudate 10 cm x 10 cm dressing, 5

4906F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	1	..	*113.60	6.10	Allevyn Thin 66047578 [SN]

dressing hydroactive superficial wound light exudate 5 cm x 6 cm dressing, 10

4905E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	62.07	6.10	Allevyn Thin 66047576 [SN]

▪ DRESSING HYDROACTIVE SUPERFICIAL WOUND MODERATE EXUDATE

Note

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

dressing hydroactive superficial wound moderate exudate 10 cm x 10 cm dressing, 5

4886E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	1	..	*88.96	6.10	Cutinova Hydro 66047443 [SN]

dressing hydroactive superficial wound moderate exudate 5 cm x 6 cm dressing, 10

4885D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	52.88	6.10	Cutinova Hydro 66047441 [SN]

▪ DRESSING HYDROCOLLOID CAVITY WOUND

Note

This dressing should remain in place until saturated or strike through occurs for a maximum of 7 days.

dressing hydrocolloid cavity wound paste, 30 g

4896Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	10	..	..	*145.46	6.10	DuoDERM Paste H7930 [CC]

▪ DRESSING HYDROCOLLOID CAVITY WOUND

Note

This dressing should remain in place until saturated or strike through occurs for a maximum of 7 days.

Coloplast dressings are available via a range of distributors. However, Coloplast's principal agreement to ensure correct RPBS Price to Pharmacy and ready supply has been secured with Independence Australia on 1300 788 855 and BrightSky on 1300 290 400. Please note that Coloplast is unable to guarantee ready supply or rebate for price differences on purchases outside these distributors.

dressing hydrocolloid cavity wound paste, 50 g

4895P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	3	..	*43.56	6.10	Comfeel Paste 4701 [CT]

▪ DRESSING HYDROCOLLOID SUPERFICIAL WOUND LIGHT EXUDATE

Note

This dressing should be applied to a thickness of 3 mm to 5 mm. It should be covered with a hydrocolloid dressing and may be left in place for up to 7 days.

dressing hydrocolloid superficial wound light exudate 10 cm x 10 cm dressing, 10

4907G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	72.06	6.10	DuoDERM Extra Thin H7955 [CC]

▪ DRESSING HYDROCOLLOID SUPERFICIAL WOUND LIGHT EXUDATE

Note

This dressing should be applied to a thickness of 3 mm to 5 mm. It should be covered with a hydrocolloid dressing and may be left in place for up to 7 days.

Coloplast dressings are available via a range of distributors. However, Coloplast's principal agreement to ensure correct RPBS Price to Pharmacy and ready supply has been secured with Independence Australia on 1300 788 855 and BrightSky on 1300 290 400. Please note that Coloplast is unable to guarantee ready supply or rebate for price differences on purchases outside these distributors.

dressing hydrocolloid superficial wound light exudate 10 cm x 10 cm dressing, 10

4924E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	70.12	6.10	Comfeel Plus Transparent 3533 [CT]

dressing hydrocolloid superficial wound light exudate 5 cm x 7 cm dressing, 10

4888G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	42.06	6.10	Comfeel Plus Transparent 3530 [CT]

dressing hydrocolloid superficial wound light exudate 9 cm x 14 cm dressing, 10

4889H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	84.86	6.10	Comfeel Plus Transparent 3536 [CT]

▪ DRESSING HYDROCOLLOID SUPERFICIAL WOUND LIGHT EXUDATE

Note

This dressing should be applied to a thickness of 3 mm to 5 mm. It should be covered with a hydrocolloid dressing and may be left in place for up to 7 days.

Hartmann wound dressings are available through HARTMANN and Independence Australia only. If you would like to order Hartmann Wound Care products, please call HARTMANN customer service on 1800 805 839 or Independence Australia on 1300 788 855.

dressing hydrocolloid superficial wound light exudate 10 cm x 10 cm dressing, 10

4947J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	48.49	6.10	Hydrocoll Thin 900758 [HR]

▪ DRESSING HYDROCOLLOID SUPERFICIAL WOUND MODERATE EXUDATE

Note

This dressing should remain in place until saturated or strike through occurs for a maximum of 7 days.

dressing hydrocolloid superficial wound moderate exudate 10 cm x 10 cm dressing, 5

4897R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	1	..	*81.74	6.10	DuoDERM CGF H7660 [CC]

dressings hydrocolloid superficial wound moderate exudate 20 cm x 20 cm dressing, 5

4920Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	1	..	*222.66	6.10	DuoDERM CGF H7662 [CC]

▪ DRESSING HYDROCOLLOID SUPERFICIAL WOUND MODERATE EXUDATE**Note**

This dressing should remain in place until saturated or strike through occurs for a maximum of 7 days.

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

dressings hydrocolloid superficial wound moderate exudate 10 cm x 10 cm dressing, 10

4921B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	89.94	6.10	Replicare Ultra 66000434 [SN]

▪ DRESSING HYDROCOLLOID SUPERFICIAL WOUND MODERATE EXUDATE**Note**

This dressing should remain in place until saturated or strike through occurs for a maximum of 7 days.

Hartmann wound dressings are available through HARTMANN and Independence Australia only. If you would like to order Hartmann Wound Care products, please call HARTMANN customer service on 1800 805 839 or Independence Australia on 1300 788 855.

dressings hydrocolloid superficial wound moderate exudate 10 cm x 10 cm dressing, 10

4945G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	48.49	6.10	Hydrocoll 900744 [HR]

dressings hydrocolloid superficial wound moderate exudate 15 cm x 15 cm dressing, 10

4946H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	90.25	6.10	Hydrocoll 900936 [HR]

▪ DRESSING HYDROCOLLOID SUPERFICIAL WOUND MODERATE EXUDATE**Note**

This dressing should remain in place until saturated or strike through occurs for a maximum of 7 days.

Coloplast dressings are available via a range of distributors. However, Coloplast's principal agreement to ensure correct RPBS Price to Pharmacy and ready supply has been secured with Independence Australia on 1300 788 855 and BrightSky on 1300 290 400. Please note that Coloplast is unable to guarantee ready supply or rebate for price differences on purchases outside these distributors.

DRESSING-HYDROCOLLOID (SUPERFICIAL WOUND-MODERATE EXUDATE) Dressings with alginate 10 cm x 10 cm, 10, 1

4923D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	82.34	6.10	Comfeel Plus Ulcer Dressing 3110 [CT]

dressings hydrocolloid superficial wound moderate exudate 10 cm (round) dressing, 1

4679G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	5	..	..	*59.96	6.10	Comfeel Plus Pressure Relieving 3353 [CT]

dressings hydrocolloid superficial wound moderate exudate 7 cm (butterfly shape) dressing, 1

4678F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	5	..	..	*55.51	6.10	Comfeel Plus Pressure Relieving 3350 [CT]

▪ DRESSING HYDROFIBRE ALTERNATE TO ALGINATES**dressings hydrofibre alternate to alginates 10 cm x 10 cm dressing, 10**

2797F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	101.32	6.10	Aquacel Extra 420672 [CC]

dressings hydrofibre alternate to alginates 15 cm x 15 cm dressing, 5

2803M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	1	..	*209.04	6.10	Aquacel Extra 420673 [CC]

dressings hydrofibre alternate to alginates 2 g (30 cm) rope, 5 x 2 g

4698G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	84.05	6.10	Aquacel 403770 [CC]

▪ DRESSING HYDROFIBRE GELLING FIBRE**Note**

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

dressings hydrofibre gelling fibre 10 cm x 10 cm dressing, 10

2486W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	100.19	6.10	Durafiber 66800560 [SN]

dressings hydrofibre gelling fibre 15 cm x 15 cm dressing, 5

2445Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡2	1	..	*208.14	6.10	Durafiber 66800561 [SN]

dressings hydrofibre gelling fibre 2 cm x 45 cm rope, 5

2462N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	83.65	6.10	Durafiber 66800563 [SN]

▪ DRESSING HYDROFIBRE WITH SILVER**Authority required**

Wound critical colonisation or chronic wounds that have not responded to conventional dressings

Clinical criteria:

Patient must have a wound where there is evidence of critical colonisation; OR

Patient must have a well-assessed chronic wound that has not responded to conventional dressings.

dressings hydrofibre with silver 10 cm x 10 cm dressing, 10

10097K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	262.40	6.10	Aquacel Ag 403708 [CC]

dressings hydrofibre with silver 15 cm x 15 cm dressing, 5

10098L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	279.45	6.10	Aquacel Ag 403710 [CC]

dressings hydrofibre with silver 2 cm x 45 cm rope, 5

10105W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	1	..	224.78	6.10	Aquacel Ag 403771 [CC]

▪ DRESSING HYDROGEL**dressings hydrogel 10 cm x 10 cm dressing, 20**

2471C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	114.38	6.10	Sorbact Absorption Dressing S98222 [QL]

▪ DRESSING HYDROGEL AMORPHOUS**Note**

This dressing should be applied to a thickness of 3 mm to 5 mm and remain in situ in infected wounds for 24 hours and in clean wounds for up to 3 days. It should be covered with a secondary dressing such as foam or film. It should not be covered with gauze or combine.

dressings hydrogel amorphous gel, 3 x 30 g tubes

4913N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	3	1	..	*97.45	6.10	DuoDERM Gel H7987 [CC]

dressings hydrogel amorphous gel, 50 g

4914P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	3	3	..	*33.46	6.10	Solugel 10336 [JJ]

▪ DRESSING HYDROGEL AMORPHOUS**Note**

This dressing should be applied to a thickness of 3 mm to 5 mm and remain in situ in infected wounds for 24 hours and in clean wounds for up to 3 days. It should be covered with a secondary dressing such as foam or film. It should not be covered with gauze or combine.

Coloplast dressings are available via a range of distributors. However, Coloplast's principal agreement to ensure correct RPBS Price to Pharmacy and ready supply has been secured with Independence Australia on 1300 788 855 and BrightSky on 1300 290 400. Please note that Coloplast is unable to guarantee ready supply or rebate for price differences on purchases outside these distributors.

dressing hydrogel amorphous gel, 10 x 15 g tubes

4912M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	1	..	64.82	6.10	DuoDERM Gel H7990 [CC]
			..	72.43	6.10	Comfeel Purilon Gel 3900 [CT]

▪ DRESSING HYDROGEL AMORPHOUS

Note

This dressing should be applied to a thickness of 3 mm to 5 mm and remain in situ in infected wounds for 24 hours and in clean wounds for up to 3 days. It should be covered with a secondary dressing such as foam or film. It should not be covered with gauze or combine.

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

dressing hydrogel amorphous gel, 25 g

4894N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	4	3	..	*69.52	6.10	Intrasite Gel 7313 [SN]

dressing hydrogel amorphous gel, 50 g

4599C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	3	3	..	*31.57	6.10	SoloSite Gel 36361338 [SN]

▪ DRESSING HYDROGEL FOAM

dressing hydrogel foam 10 cm x 10 cm dressing, 10

2533H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	79.79	6.10	Sorbact Foam Dressing S98310 [QL]

▪ DRESSING HYDROGEL RIBBON

dressing hydrogel ribbon 1 cm x 50 cm dressing, 20

2512F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	118.23	6.10	Sorbact Ribbon Gauze S98118 [QL]

dressing hydrogel ribbon 5 cm x 200 cm dressing, 10

2529D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	1	..	..	114.38	6.10	Sorbact Ribbon Gauze S98120 [QL]

▪ DRESSING HYDROGEL SHEET

Note

This dressing should be applied to a thickness of 3 mm to 5 mm and remain in situ in infected wounds for 24 hours and in clean wounds for up to 3 days. It should be covered with a secondary dressing such as foam or film. It should not be covered with gauze or combine.

dressing hydrogel sheet 9.5 cm x 10.2 cm dressing, 5

4911L	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*83.54	6.10	Nu-Gel 2497 [KI]

▪ DRESSING HYDROGEL SHEET

Note

This dressing should be applied to a thickness of 3 mm to 5 mm and remain in situ in infected wounds for 24 hours and in clean wounds for up to 3 days. It should be covered with a secondary dressing such as foam or film. It should not be covered with gauze or combine.

Hartmann wound dressings are available through HARTMANN and Independence Australia only. If you would like to order Hartmann Wound Care products, please call HARTMANN customer service on 1800 805 839 or Independence Australia on 1300 788 855.

dressings hydrogel sheet 10 cm x 10 cm dressing, 5

4806Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*53.62	6.10	Hydrosorb 900854 [HR]

▪ DRESSING NON ADHERENT**dressings non adherent 5 cm x 7.5 cm dressing, 10**

4755G	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	11.36	6.10	Telfa 1970C [KE]

dressings non adherent 7.5 cm x 10 cm self adhesive dressing, 6

4758K	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	11.57	6.10	Telfa 2140C [KE]

dressings non adherent 7.5 cm x 10 cm self adhesive dressing, 6

4844Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	2	..	12.36	6.10	Telfa 7650C [KE]

▪ DRESSING NON ADHERENT**Note**

Molnlycke Healthcare products are distributed through leading pharmacy distributors. To best ensure product availability at RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email customerservice@independenceaustralia.com. Molnlycke Healthcare are not able to ensure product availability or pricing on listed products beyond these two suppliers.

DRESSING SELF ADHESIVE NON-ADHERENT DRY ABSORBENT Dressings, non-woven, with silicone 5 cm x 7.5 cm, 10, 1

4243H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	63.96	6.10	Mepitel 290510 [MH]

DRESSING SELF ADHESIVE NON-ADHERENT DRY ABSORBENT Dressings, non-woven, with silicone 7.5 cm x 10 cm, 10, 1

4244J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	107.96	6.10	Mepitel 290710 [MH]

▪ DRESSING NON ADHERENT**Note**

Hartmann wound dressings are available through HARTMANN and Independence Australia only. If you would like to order Hartmann Wound Care products, please call HARTMANN customer service on 1800 805 839 or Independence Australia on 1300 788 855.

dressings non adherent 7.5 cm x 10 cm dressing, 10

4944F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	15.58	6.10	Atrauman 499513 [HR]

▪ DRESSING NON ADHERENT**Note**

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma & Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS pricing from distributors other than those aforementioned.

dressings non adherent 10 cm x 10 cm dressing, 10

4861W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	37.47	6.10	Melolin 66974933 [SN]

dressings non adherent 10 cm x 10 cm dressing, 5

4862X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*25.44	6.10	Cutilin Non-Stick Wound Pad 36361375 [SN]

dressings non adherent 5 cm x 5 cm dressing, 5

4819P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*15.96	6.10	Cutilin Non-Stick Wound Pad 36361374 [SN]

dressings non adherent 5 cm x 5 cm dressing, 5

4860T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	2	..	..	*17.24	6.10	Melolin 36361357 [SN]

▪ DRESSING TULLE NON GAUZE PARAFFIN**dressings tulle non gauze paraffin 7.6 cm x 7.6 cm dressing, 1**

4909J	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	10	1	..	*16.06	6.10	Adaptic 2012 [KI]

▪ DRESSING WITH SILVER**Authority required**

For wounds where there is evidence of critical colonisation and for well-assessed chronic wounds that have not responded to conventional dressings

Note

Coloplast dressings are available via a range of distributors. However, Coloplast's principal agreement to ensure correct RPBS Price to Pharmacy and ready supply has been secured with Independence Australia on 1300 788 855 and BrightSky on 1300 290 400. Please note that Coloplast is unable to guarantee ready supply or rebate for price differences on purchases outside these distributors.

dressings with silver 10 cm x 10 cm dressing: hydroactive, 5 dressings

4646M	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	176.22	6.10	Biatain Ag 9622 [CT]

dressings with silver 12.5 cm x 12.5 cm dressing: hydroactive, 5 dressings

4647N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	191.63	6.10	Biatain Ag 9632 [CT]

▪ DRESSING WITH SILVER**Authority required**

For wounds where there is evidence of critical colonisation and for well-assessed chronic wounds that have not responded to conventional dressings

Note

Hartmann wound dressings are available through HARTMANN and Independence Australia only. If you would like to order Hartmann Wound Care products, please call HARTMANN customer service on 1800 805 839 or Independence Australia on 1300 788 855.

dressings with silver 10 cm x 10 cm dressing: tulle, 3 dressings

4648P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	44.12	6.10	Atrauman Ag 499572 [HR]

▪ GAUZE AND COTTON TISSUE COMBINE ROLL**gauze and cotton tissue combine roll 10 cm x 10 m roll: wrapped pack, 1 pack**

4761N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	17.55	6.10	JJ 12010 [JJ]

▪ GAUZE AND COTTON TISSUE COMBINE ROLL**Note**

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

gauze and cotton tissue combine roll 9 cm x 10 m roll: wrapped pack, 1 pack

4767X	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	11.92	6.10	BSN 2902165 [BV]

▪ TAPE NON WOVEN RETENTION POLYACRYLATE**tape non woven retention polyacrylate 2.5 cm x 9.1 m tape, 1 roll**

4915Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	13.21	6.10	Medipore 2961 [MM]

▪ TAPE NON WOVEN RETENTION POLYACRYLATE**Note**

Molnlycke Healthcare products are distributed through leading pharmacy distributors. To best ensure product availability at RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email customerservice@independenceaustralia.com. Molnlycke Healthcare are not able to ensure product availability or pricing on listed products beyond these two suppliers.

tape non woven retention polyacrylate 2.5 cm x 10 m tape, 1 roll

4917T	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	..	..	11.38	6.10	Mefix 310250 [MH]

■ TAPE PLASTER ADHESIVE ELASTIC

Note

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

tape plaster adhesive elastic 2.5 cm x 2.5 m tape, 1 roll

4780N	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	..	..	13.95	6.10	Leukoplast 01071-00 [BV]

tape plaster adhesive elastic 5 cm x 2.5 m tape, 1 roll

4781P	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	..	..	20.50	6.10	Leukoplast 01072-00 [BV]

tape plaster adhesive elastic 7.5 cm x 2.5 m tape, 1 roll

4782Q	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	..	..	24.55	6.10	Leukoplast 01073-00 [BV]

■ TAPE PLASTER ADHESIVE HYPOALLERGENIC

tape plaster adhesive hypoallergenic 1.9 cm x 5.4 m dispenser tape, 1 roll

4848E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	..	..	11.39	6.10	Nexcare Durable Cloth First Aid Tape 799 [MM]

tape plaster adhesive hypoallergenic 1.9 cm x 7.3 m dispenser tape, 1 roll

4849F	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	..	..	11.39	6.10	Nexcare Gentle Paper First Aid Tape 789 [MM]

■ TAPE PLASTER ADHESIVE HYPOALLERGENIC

Note

Smith & Nephew products are distributed via the three major wholesalers, API, Sigma and Symbion. To best ensure product availability at RPBS agreed prices, please order from one of these suppliers. In the event that your preferred wholesaler cannot supply, please contact Smith & Nephew Customer Service on 13 13 60. Smith & Nephew cannot ensure RPBS agreed pricing from distributors other than those aforementioned.

tape plaster adhesive hypoallergenic 1.25 cm x 5 m tape, 1 roll

4783R	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	..	..	11.10	6.10	Leukopor 2471 [BV]

tape plaster adhesive hypoallergenic 1.25 cm x 5 m tape, 1 roll

4785W	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	..	..	11.42	6.10	Leukosilk 1021 [BV]

tape plaster adhesive hypoallergenic 2.5 cm x 5 m tape, 1 roll

4787Y	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	..	..	14.34	6.10	Leukosilk 1022 [BV]

tape plaster adhesive hypoallergenic 2.5 cm x 5 m tape, 1 roll

4794H	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	..	..	13.76	6.10	Leukopor 2472 [BV]

tape plaster adhesive hypoallergenic 5 cm x 5 m stretch tape, 1 roll

4788B	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	±1	..	..	17.55	6.10	Leukoflex 1124 [BV]

tape plaster adhesive hypoallergenic 5 cm x 5 m stretch tape, 1 roll

4789C	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	18.55	6.10	Leukosilk 1024 [BV]

tape plaster adhesive hypoallergenic 5 cm x 5 m stretch tape, 1 roll

4790D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	17.63	6.10	Leukopor 2474 [BV]

▪ TAPE PLASTER ADHESIVE WITH SILICONE**Note**

Molnlycke Healthcare products are distributed through leading pharmacy distributors. To best ensure product availability at RPBS agreed prices, special arrangements have been made with API and Independence Australia Health Solutions (IAHS). IAHS orders can be placed on: Tel: 1300 788 855; or Email customerservice@independenceaustralia.com. Molnlycke Healthcare are not able to ensure product availability or pricing on listed products beyond these two suppliers.

tape plaster adhesive with silicone 2 cm x 3 m tape, 1 roll

4239D	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	21.71	6.10	Mepitac 298300 [MH]

tape plaster adhesive with silicone 4 cm x 1.5 m tape, 1 roll

4240E	Max.Qty Packs	No. of Rpts	Premium \$	DPMQ \$	MRVSN \$	Brand Name and Manufacturer
	‡1	..	..	21.71	6.10	Mepitac 298400 [MH]

Index of Manufacturers' Code

Code	Manufacturer	Code	Manufacturer
AB	Abbott Australasia Pty Ltd	IA	iNova Pharmaceuticals (Australia) Pty Limited
AE	AFT Pharmaceuticals Pty Ltd	IB	Apotex Pty Ltd
AF	Alphapharm Pty Ltd	IF	Infopia Australia Pty Ltd
AG	Allergan Australia Pty Limited	IK	Medtronic Australasia Pty Ltd
AL	Alphapharm Pty Ltd	IQ	Alcon Laboratories (Australia) Pty Ltd
AN	Amgen Australia Pty Limited	IS	Ipsen Pty Ltd
AP	AstraZeneca Pty Ltd	IV	iNova Pharmaceuticals (Australia) Pty Limited
AQ	Alcon Laboratories (Australia) Pty Ltd	IX	Clinect Pty Ltd
AS	Aspen Pharmacare Australia Pty Limited	JC	Janssen-Cilag Pty Ltd
AT	Actelion Pharmaceuticals Australia Pty Ltd	JJ	Johnson & Johnson Medical Pty Ltd
AV	sanofi-aventis Australia Pty Ltd	JN	JNS Biomedical Pty Ltd
BB	Blackmores Limited	JT	Johnson & Johnson Pacific Pty Limited
BD	Biogen Australia Pty Ltd	KE	Kendall Australasia Pty Ltd
BE	Beiersdorf Australia Ltd	KI	KCI Medical Australia Pty Ltd
BG	Sandoz Pty Ltd	KP	Eli Lilly Australia Pty Ltd
BI	Biotech Pharmaceuticals Pty Ltd	KY	Key Pharmaceuticals Pty Ltd
BN	Bayer Australia Ltd	LL	Astellas Pharma Australia Pty Ltd
BQ	Bristol-Myers Squibb Australia Pty Ltd	LM	Link Medical Products Pty Ltd
BR	B. Braun Australia Pty Ltd	LN	Aspen Pharmacare Australia Pty Limited
BV	B.S.N.	LO	Leo Pharma Pty Ltd
BX	Baxter Healthcare Pty Limited	LS	Astellas Pharma Australia Pty Ltd
BY	Boehringer Ingelheim Pty Ltd	LU	Lundbeck Australia Pty Ltd
BZ	Boucher & Muir Pty Ltd	LY	Eli Lilly Australia Pty Ltd
CC	ConvaTec A Division of Bristol-Myers Squibb Australia Pty Ltd	MD	Roche Products Pty Ltd
CH	Apotex Pty Ltd	MF	Mundipharma Pty Limited
CJ	Celgene Pty Limited	MH	Molnlycke Health Care Pty Ltd
CR	Pharmacor Pty Limited	MK	Merck Sharp & Dohme (Australia) Pty Ltd
CS	bioCSL (Australia) Pty Ltd	MM	3M Pharmaceuticals Australia Pty Ltd
CT	Coloplast Pty Ltd	MQ	Alphapharm Pty Ltd
CU	Care Pharmaceuticals Pty Limited	MS	Abbott Australasia Pty Ltd
CX	Contact Lens Centre Australia Limited	MT	Mentholatum Australasia Pty Ltd
DO	Aurobindo Pharma (Australia) Pty Limited	MW	Biomed Aust Pty Limited
DQ	Church & Dwight (Australia) Pty Ltd	NA	National Diagnostic Products (Australia) Pty Limited
DV	Medical Developments International Limited	NC	Novartis Consumer Health Australasia Pty Ltd
EA	Amneal Pharmaceuticals Pty Ltd	NE	Norgine Pty Limited
EH	Entra Health Systems Pty Ltd	NF	Novo Nordisk Pharmaceuticals Pty Limited
EI	Eisai Australia Pty Ltd	NI	Novo Nordisk Pharmaceuticals Pty Limited
EL	Eli Lilly Australia Pty Ltd	NJ	Norac Pharma Australia Pty Ltd
EO	Ego Pharmaceuticals Proprietary Limited	NM	Novartis Pharmaceuticals Australia Pty Limited
ER	Eris Pharmaceuticals (Australia) Pty Ltd	NO	Novo Nordisk Pharmaceuticals Pty Limited
EU	Emerge Health Pty Ltd	NQ	Takeda Pharmaceuticals Australia Pty Ltd
EZ	Merz Australia Pty Ltd	NT	Nestle Australia Ltd
FB	Pierre Fabre Medicament Australia Pty Ltd	NU	Nutricia Australia Pty Limited
FI	Boehringer Ingelheim Pty Ltd	NV	Novartis Pharmaceuticals Australia Pty Limited
FK	A. Menarini Australia Pty Limited	NX	Nipro Australia Pty Ltd
FM	Fawns and McAllan Proprietary Limited	OA	Orphan Australia Pty Ltd
FN	Fresenius Medical Care Australia Pty Ltd	OB	Oral B Laboratories Pty Ltd
FO	For Benefit Medicines Pty Ltd	OE	Omegapharm Pty Ltd
FP	Ferring Pharmaceuticals Pty Limited	OI	Boian Surgical Pty Ltd
FR	Merck Sharp & Dohme (Australia) Pty Ltd	OL	Owen Laboratories Division of Galderma Australia Pty Ltd
FZ	Pfizer Australia Pty Ltd	OM	Colgate Oral Care
GA	Galderma Australia Pty Ltd	ON	Orion Laboratories Pty Ltd
GC	GlaxoSmithKline Australia Pty Ltd	OZ	Medical Specialties Australia Unit Trust
GH	Mercury Pharma (Australia) Pty Limited	PB	Pharmaco (Australia) Limited
GI	Gilead Sciences Pty Limited	PE	Allergan Australia Pty Limited
GK	GlaxoSmithKline Australia Pty Ltd	PF	Pfizer Australia Pty Ltd
GN	Actavis Pty Ltd	PK	Fresenius Kabi Australia Pty Limited
GO	BGP Products Pty Ltd	PL	The Trustee for Virgo Unit Trust (trading as Phebra)
GQ	Generic Health Pty Ltd	PM	Pharmaceutical Manufacturing Company Pty Limited
GT	BGP Products Pty Ltd	PP	Petrus Pharmaceuticals Pty Ltd
GX	Apotex Pty Ltd	PQ	PMIP Pty Ltd
GZ	sanofi-aventis Australia Pty Ltd	PX	Point of Care Diagnostics Australia Pty Ltd
HB	Besins Healthcare Australia Pty Ltd	PY	Procter & Gamble Pharmaceuticals Australia Pty Ltd
HH	Hospira Pty Limited	QA	Aspen Pharma Pty Ltd
HL	Helex-A Pty. Ltd.	QB	Bionime Australia Pty Limited
HM	Meda Pharmaceuticals Pty Ltd	QH	Cortex Health Pty Ltd
HR	Paul Hartmann Pty Ltd	QL	Amcla Pty Limited
HX	Sandoz Pty Ltd	RA	Ranbaxy Australia Pty Limited

Code	Manufacturer
RB	Bio Revive Pty Ltd
RC	Reckitt Benckiser (Australia) Pty Limited
RD	Roche Diagnostics Australia Pty Limited
RI	Dr Reddy's Laboratories (Australia) Pty Ltd
RO	Roche Products Pty Ltd
RX	Servier Laboratories (Aust.) Pty Ltd
RZ	Dr Reddy's Laboratories (Australia) Pty Ltd
SA	SciGen (Australia) Pty Limited
SB	Nutricia Australia Pty Limited
SE	Servier Laboratories (Aust.) Pty Ltd
SG	Merck Serono Australia Pty Ltd
SI	Sigma Company Limited
SJ	Sharpe Laboratories Pty Ltd
SN	Smith & Nephew Pty Limited
SS	SSL Australia Pty Ltd
SW	sanofi-aventis Australia Pty Ltd
SY	Bayer Australia Ltd
SZ	Sandoz Pty Ltd
TB	Teva Pharma Australia Pty Limited
TK	Takeda Pharmaceuticals Australia Pty Ltd
TL	Tolmar Australia Pty Ltd
TM	Technipro Marketing Pty Ltd
TS	Specialised Therapeutics Australia Pty Ltd
TW	Apotex Pty Ltd
TX	Apotex Pty Ltd
UA	Actavis Pty Ltd
UC	UCB Australia Proprietary Limited
UH	uHealth Australia Pty Limited
UM	Unomedical Pty Ltd
UN	Unilever Australia Limited
VE	AbbVie Pty Ltd
VF	Vitaflo Australia Pty Limited
VI	ViiV Healthcare Pty Ltd
VL	Vifor Pharma Pty Limited
VN	Actavis Pty Ltd
VR	Vertex Pharmaceuticals (Australia) Pty Ltd
WA	sanofi-aventis Australia Pty Ltd
WI	Wincot Pty Limited
XA	Pharmaxis Ltd
XH	MS Health Pty Ltd
XI	Alexion Pharmaceuticals Australasia Pty Ltd
XM	The Medicines Company (Australia) Pty Limited
YN	Mayne Pharma International Pty Ltd
YT	Mayne Products Pty Ltd
ZF	Sun Pharmaceutical Industries (Australia) Pty Ltd
ZI	Shire Australia Pty Limited
ZP	Medis Pharma Pty Ltd
ZX	Zenex Pharmaceuticals Pty Ltd

Generic/Proprietary Index

3TC(VI).....	659, 848
ABACAVIR.....	656, 845
ABACAVIR + LAMIVUDINE.....	663, 852
ABACAVIR + LAMIVUDINE + ZIDOVUDINE.....	663, 852
ABATACEPT.....	266, 269, 685, 876
Abbocillin-V(QA).....	193
Abbocillin-VK Filmstab(QA).....	193, 194
ABCIXIMAB.....	80
Abilify Maintena(LU).....	478
Abilify(BQ).....	478
ABIRATERONE.....	261
Abisart HCT 150/12.5(AF).....	123
Abisart HCT 300/12.5(AF).....	123
Abisart HCT 300/25(AF).....	123
Abisart(AF).....	120
ACAMPROSATE.....	509
ACARBOSE.....	67
Accomin Adult Tonic(PF).....	1017
Accu-Chek Active(RD).....	554, 557
Accu-Chek Advantage/Sensor Comfort(RD).....	554, 557
Accu-Chek Aviva(RD).....	555, 557
Accu-Chek Go(RD).....	555, 557
Accu-Chek Integra(RD).....	555, 558
Accu-Chek Mobile(RD).....	556
Accu-Chek Performa(RD).....	554, 557
Accupril(PF).....	113, 114
Accuretic 10/12.5mg(PF).....	117
Accuretic 20/12.5mg(PF).....	117
ACETAZOLAMIDE.....	531
Acetec(AL).....	111
ACETIC ACID + HYDROXYQUINOLINE + RICINOLEIC ACID.....	1026
ACICLOVIR.....	
. ANTIINFECTIVES FOR SYSTEMIC USE.....	217, 218
. SENSORY ORGANS.....	527, 528
Aciclovir 200(CR).....	217
Aciclovir 800(CR).....	218
Aciclovir GH (GQ).....	217
Aciclovir Sandoz(HX).....	217
Acihexal (SZ).....	217, 218
Acihexal(SZ).....	217
Aci-Jel(CU).....	1026
Acimax Tablets(AL).....	40
ACITRETIN.....	159
Acitretin Actavis(GN).....	159
Aclasta(NV).....	423
ACLIDINIUM.....	522
Aclor 125(QA).....	200
Aclor 250(QA).....	200
Acpio 15(QA).....	68
Acpio 30(QA).....	68
Acpio 45(QA).....	68
Acquin Aspen 10(AS).....	113
Acquin Aspen 20(AS).....	113
Acquin Aspen 5(AS).....	114
Acris Combi(AF).....	426, 1031
Acris Once-a-Month(AF).....	422
Acris Once-a-Week(AF).....	422, 1031
Actemra(RO).....	754, 758, 763, 768, 945, 949, 954, 959
Actilax(AF).....	49, 590
Actiq(OA).....	598, 599
Actisorb Plus MAP105(KI).....	1043
Actonel EC Combi D(UA).....	427, 1032
Actonel EC Combi(UA).....	426, 1031
Actonel EC(UA).....	422, 1031
Actonel Once-a-Month (UA).....	422
Actonel(UA).....	422, 1031
Actos (TK).....	68
Actrapid Penfill 3 mL(NO).....	59

Actrapid(NO).....	59
Acyclo-V 200 (AF).....	217
Acyclo-V 200(AF).....	217
Acyclo-V 800 (AF).....	217
Acyclo-V 800(AF).....	218
Adalat 10(BN).....	109
Adalat 20(BN).....	109
Adalat Oros 20mg(BN).....	109
Adalat Oros 30(BN).....	109
Adalat Oros 60(BN).....	109
ADALIMUMAB278, 280, 283, 286, 289, 291, 295, 297, 302, 304, 310, 315, 319, 322, 701, 892	
ADAPALENE + BENZOYL PEROXIDE.....	162, 163
Adaptic 2012(KI).....	1056
Adcirca(LY).....	647, 835
add-ins(SB).....	575
Addos XR 30(QA).....	109
Addos XR 60(QA).....	109
Adefin 10(AF).....	109
Adefin 20(AF).....	109
Adefin XL 30 (AF).....	109
Adefin XL 60 (AF).....	109
ADEFOVIR DIPIVOXIL.....	657, 845
Adesan HCT 16/12.5(AF).....	122
Adesan HCT 32/12.5(AF).....	122
Adesan HCT 32/25(AF).....	122
Adesan(AF).....	119
ADRENALINE.....	
. CARDIOVASCULAR SYSTEM.....	97
. Prescriber Bag.....	20
. RESPIRATORY SYSTEM.....	523
ADT Booster(CS).....	21, 221
Advantan(BN).....	161, 162
Aeron 250(QA).....	522
Aeron 500(QA).....	523
Afinitor(NV).....	232, 233, 234
AFLIBERCEPT.....	538
Aggrastat(AS).....	85
Airomir Autohaler(IA).....	516
Akamin 50(AF).....	190
Akineton(LM).....	461
Albalon Liquifilm(AG).....	1037
Albalon-A(AG).....	1037
ALBENDAZOLE.....	513
Albey Bee Venom(HL).....	549
Albey Paper Wasp Venom(HL).....	549
Albey Yellow Jacket Venom(HL).....	549
Aldactone(PF).....	104
Aldara Pump(IA).....	165, 1025
Aldara(IA).....	164, 1025
Aldiq (QA).....	164, 1025
Aldomet(AS).....	100
ALEMTUZUMAB.....	692, 883
Alendro Once Weekly(QA).....	420
Alendrobell 70mg(GQ).....	420
ALENDRONATE.....	419
ALENDRONATE + COLECALCIFEROL.....	423, 424, 1031
ALENDRONATE + COLECALCIFEROL (&) CALCIUM CARBONATE.....	425, 1031
Alendronate AN (EA).....	420
Alendronate D3 70 mg/140 microgram(UA).....	424
Alendronate D3 70 mg/70 microgram(UA).....	425
Alendronate Plus D3 and Calcium Sandoz(SZ).....	425
Alendronate Plus D3 Calcium Actavis (UA).....	425
Alendronate plus D3-DRLA (RZ).....	424, 425
Alendronate plus D3-DRLA(RZ).....	1031
Alendronate Sandoz (SZ).....	420
Alendronate-GA(GN).....	420
Alepam 15(AF).....	484, 485, 602, 603

<i>Alepam 30(AF)</i>	484, 485, 602, 603
<i>Alfamino(NT)</i>	566, 567
<i>Alfaré(NT)</i>	570
<i>ALFUZOSIN</i>	1027
<i>ALGINATE SODIUM + CALCIUM CARBONATE + BICARBONATE</i>	42
<i>Algisite M 66000519(SN)</i>	1044
<i>Algisite M 66000520(SN)</i>	1044
<i>Algisite M 66000521(SN)</i>	1044
<i>Alkeran(AS)</i>	222
<i>Allegron(AS)</i>	488
<i>Allereze(AF)</i>	1037
<i>Allevyn 66007637(SN)</i>	1045
<i>Allevyn Adhesive 66000044(SN)</i>	1046
<i>Allevyn Ag Adhesive 66800073(SN)</i>	1048
<i>Allevyn Ag Adhesive 66800075(SN)</i>	1047
<i>Allevyn Ag Adhesive 66800078(SN)</i>	1048
<i>Allevyn Ag Gentle Border 66800460(SN)</i>	1048
<i>Allevyn Ag Gentle Border 66800461(SN)</i>	1048
<i>Allevyn Ag Gentle Border 66800462(SN)</i>	1048
<i>Allevyn Ag Non-Adhesive 66800086(SN)</i>	1047
<i>Allevyn Gentle 66800248(SN)</i>	1046
<i>Allevyn Gentle Border 66800269(SN)</i>	1047
<i>Allevyn Gentle Border 66800270(SN)</i>	1046
<i>Allevyn Life 66801067(SN)</i>	1046
<i>Allevyn Life 66801068(SN)</i>	1046
<i>Allevyn Life 66801069(SN)</i>	1046
<i>Allevyn Life 66801070(SN)</i>	1046
<i>Allevyn Plus Cavity 66047571(SN)</i>	1049
<i>Allevyn Plus Cavity 66047573(SN)</i>	1049
<i>Allevyn Thin 66047576(SN)</i>	1050
<i>Allevyn Thin 66047578(SN)</i>	1050
<i>Allmercap(LM)</i>	224
<i>ALLOPURINOL</i>	419
<i>Allopurinol Sandoz(SZ)</i>	419
<i>Allosig (FM)</i>	419
<i>Alodorm(AF)</i>	
Palliative Care.....	603
<i>Alodorm(AF)</i>	
NERVOUS SYSTEM.....	450, 485, 486
<i>ALOGLIPTIN</i>	69
<i>ALOGLIPTIN + METFORMIN</i>	62
<i>Aloxi(TS)</i>	46
<i>Alpha Keri Bath Oil(MT)</i>	1022
<i>Alpha Keri Lotion(MT)</i>	1022
<i>Alphagan P 1.5(AG)</i>	530
<i>Alphagan(AG)</i>	530
<i>Alphamox 125(AF)</i>	190
<i>Alphamox 250(AF)</i>	191
<i>Alphamox 500(AF)</i>	191
<i>Alphapress 25(AF)</i>	101
<i>Alphapress 50(AF)</i>	101
<i>Alprax 0.25(QA)</i>	483
<i>Alprax 0.5(QA)</i>	483
<i>Alprax 1(QA)</i>	483
<i>Alprax 2(QA)</i>	483
<i>ALPRAZOLAM</i>	483
<i>Alprim(AF)</i>	203
<i>ALPROSTADIL</i>	1026
<i>Altven(FZ)</i>	495, 496
<i>ALUMINIUM HYDROXIDE + MAGNESIUM HYDROXIDE + MAGNESIUM TRISILICATE</i>	36
<i>ALUMINIUM HYDROXIDE WITH MAGNESIUM HYDROXIDE</i>	36
<i>ALUMINIUM HYDROXIDE WITH MAGNESIUM HYDROXIDE AND SIMETHICONE</i>	1015
<i>Alvesco 160(NQ)</i>	521
<i>Alvesco 80(NQ)</i>	522
<i>Alzene(AF)</i>	1036
<i>AMANTADINE</i>	463
<i>Amaryl(SW)</i>	61, 62
<i>AMBRISENTAN</i>	614, 802
<i>AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS AND TRACE ELEMENTS WITHOUT METHIONINE AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID</i>	573
<i>AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS AND TRACE ELEMENTS WITHOUT PHENYLALANINE AND TYROSINE, AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID</i>	573
<i>AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT LYSINE AND LOW IN TRYPTOPHAN</i>	573, 574
<i>AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT METHIONINE</i>	574
<i>AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT METHIONINE, THREONINE AND VALINE AND LOW IN ISOLEUCINE</i>	575
<i>AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT PHENYLALANINE</i>	575, 576
<i>AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT PHENYLALANINE AND TYROSINE</i>	576, 577
<i>AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT VALINE, LEUCINE AND ISOLEUCINE</i>	577, 578
<i>AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT VALINE, LEUCINE AND ISOLEUCINE WITH FAT, CARBOHYDRATE AND TRACE ELEMENTS AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID</i>	579
<i>AMINO ACID FORMULA WITH VITAMINS, MINERALS AND LONG CHAIN POLYUNSATURATED FATTY ACIDS WITHOUT PHENYLALANINE</i>	579
<i>AMINO ACID FORMULA WITHOUT PHENYLALANINE</i>	579
<i>AMINO ACID FORMULA WITHOUT VALINE, LEUCINE AND ISOLEUCINE</i>	579
<i>AMINO ACID SYNTHETIC FORMULA</i>	559, 560, 561
<i>AMINO ACID SYNTHETIC FORMULA SUPPLEMENTED WITH LONG CHAIN POLYUNSATURATED FATTY ACIDS</i>	562, 563
<i>AMINO ACID SYNTHETIC FORMULA SUPPLEMENTED WITH LONG CHAIN POLYUNSATURATED FATTY ACIDS AND MEDIUM CHAIN TRIGLYCERIDES</i>	564, 565, 566, 567
<i>AMIODARONE</i>	96
<i>Amiodarone Actavis(GN)</i>	97
<i>Amiodarone Sandoz (SZ)</i>	97
<i>Amipride 400(QA)</i>	478
<i>Amira 150(AF)</i>	492
<i>Amira 300(AF)</i>	492
<i>AMISULPRIDE</i>	477
<i>Amisulpride 100 Winthrop(WA)</i>	477
<i>Amisulpride 200 Winthrop(WA)</i>	477
<i>Amisulpride 400 Winthrop (WA)</i>	478
<i>Amisulpride Sandoz (SZ)</i>	477
<i>Amisulpride Sandoz(SZ)</i>	478
<i>AMITRIPTYLINE</i>	486
<i>Amlo 10(QA)</i>	108
<i>Amlo 5(QA)</i>	108
<i>AMLODIPINE</i>	108
<i>AMLODIPINE + ATORVASTATIN</i>	155
<i>AMLODIPINE + VALSARTAN</i>	125
<i>AMLODIPINE + VALSARTAN + HYDROCHLOROTHIAZIDE</i>	126
<i>Amlodipine AN (EA)</i>	108
<i>Amlodipine generichealth (GQ)</i>	108
<i>Amlodipine Sandoz(SZ)</i>	108
<i>Amlodipine-DRLA(RZ)</i>	108

AMMONIUM + SENEGA ROOT	1036	APIXABAN	87, 88
AMOROLFINE	1020	APO- Hydroxychloroquine(TX)	417
Amoxil Forte(AS)	191	APO- Paracetamol/Codeine 500/30(TX)	438, 439
Amoxil(AS)	190, 191, 192	APO-Adefovir(TX)	657, 846
AMOXYCILLIN	190, 192	APO-Alendronate (TX)	420
AMOXYCILLIN + CLAVULANIC ACID	195	APO-Alendronate Plus D3 70 mg/140 mcg(TX)	424
Amoxycillin AN (EA)	191	APO-Alendronate Plus D3 70 mg/70 mcg(TX)	425
Amoxycillin generichealth 500 (GQ)	191	APO-Allopurinol(TX)	419
Amoxycillin Ranbaxy (RA)	191	APO-Amisulpride (TX)	478
Amoxycillin Ranbaxy(SZ)	191	APO-Amisulpride(TX)	477
Amoxycillin Sandoz (SZ)	190, 191	APO-Amitriptyline 10(TX)	486
Amoxycillin Sandoz(BG)	192	APO-Amitriptyline 25(TX)	487
Amoxycillin Sandoz(SZ)	191	APO-Amitriptyline 50(TX)	487
Amoxycillin-GA(GN)	191	APO-Amlodipine (TX)	108
Amoxyclav AN 500/125(EA)	196	APO-Amlodipine/Atorvastatin 10/10(TX)	155
Amoxyclav AN 875/125(EA)	196	APO-Amlodipine/Atorvastatin 10/20(TX)	155
AmoxyClav GH 875/125 (GQ)	196	APO-Amlodipine/Atorvastatin 10/40(TX)	155
AmoxyClav RBX 875/125(RA)	196	APO-Amlodipine/Atorvastatin 10/80(TX)	155
AMPHOTERICIN B	36	APO-Amlodipine/Atorvastatin 5/10(TX)	155
AMPICILLIN	192	APO-Amlodipine/Atorvastatin 5/20(TX)	156
Ampicyn(AF)	192	APO-Amlodipine/Atorvastatin 5/40(TX)	156
AMYLOPECTIN MODIFIED LONG CHAIN	571	APO-Amlodipine/Atorvastatin 5/80(TX)	156
Anafranil 25(NV)	487	APO-Amoxycillin (TX)	191
ANAKINRA	748, 939	APO-Amoxycillin and Clavulanic Acid (TX)	196
Anamorph(FM)	434, 436	APO-Amoxycillin and Clavulanic Acid 125/31.25(TX)	195
Anandron(SW)	259	APO-Amoxycillin and Clavulanic Acid 400/57(TX)	196
Anapen Junior(LM)		APO-Amoxycillin(TX)	190, 191
.CARDIOVASCULAR SYSTEM	98	APO-Amoxycillin/ Clavulanic Acid 500/125 (TX)	196
.RESPIRATORY SYSTEM	524	APO-Anastrozole (TX)	259
Anapen(LM)		APO-Atenolol(TX)	105
.CARDIOVASCULAR SYSTEM	98	APO-Atorvastatin(TX)	127, 128, 129
.RESPIRATORY SYSTEM	524	APO-Azathioprine(TX)	411
Anaprox 550(RO)	416, 596, 597	APO-Azithromycin(TX)	
Anastrol(QA)	259	.Repatriation Pharmaceutical Benefits Scheme	1029
ANASTROZOLE	259	APO-Azithromycin(TX)	
Anastrozole AN (EA)	259	.ANTIINFECTIVES FOR SYSTEMIC USE	204
Anastrozole FBM (FO)	259	.SENSORY ORGANS	526
Anastrozole GH (GQ)	259	APO-Bicalutamide(TX)	258
Anastrozole RBX(RA)	259	APO-Bisoprolol(TX)	105, 106
Anastrozole Sandoz (SZ)	259	APO-Candesartan (TX)	119
Anastrozole-DRLA(RZ)	259	APO-Candesartan HCTZ 16/12.5 (TX)	122
Anastrozole-GA(GN)	259	APO-Candesartan HCTZ 32/12.5 (TX)	122
Andepra(EL)	493	APO-Candesartan HCTZ 32/25 (TX)	122
Andriol Testocaps(MK)	171	APO-Carvedilol(TX)	107, 108
Androcur(BN)		APO-Cefaclor (TX)	200
.ANTINEOPLASTIC AND IMMUNOMODULATING		APO-Cefaclor CD(TX)	200
AGENTS	258	APO-Celecoxib(TX)	417
.GENITO URINARY SYSTEM AND SEX HORMONES		APO-Cephalexin(TX)	197, 198
.....	176	APO-Citalopram(TX)	488
Androcur-100(BN)		APO-Clarithromycin(TX)	204
.ANTINEOPLASTIC AND IMMUNOMODULATING		APO-Clindamycin(TX)	206
AGENTS	258	APO-Clopidogrel(TX)	81, 82, 1019
.GENITO URINARY SYSTEM AND SEX HORMONES		APO-Clopidogrel/Aspirin 75/100(TX)	83
.....	176	APO-Clotrimazole 3 Day Cream(TX)	1026
Androderm(GN)	169	APO-Clotrimazole 6 Day Cream(TX)	1026
Anginine Stabilised(QA)	99	APO-Diazepam (TX)	484, 602
Angiomax(XM)	85	APO-Diclofenac(TX)	411, 412, 593, 594
Anoro Ellipta 62.5/25(GK)	521	APO-Dipyridamole/Aspirin 200/25(TX)	84
Anpec 40(AF)	110	APO-Donepezil(TX)	499, 500
Anpec 80(AF)	110	APO-Duloxetine (TX)	493
Antenex 2(AF)	484, 602	APO-Enalapril (TX)	111
Antenex 5(AF)	484, 602	APO-Escitalopram(TX)	489
Anthel 125(AF)	514	APO-Exemestane(TX)	260
Anthel 250(AF)	514	APO-Famciclovir(TX)	218, 219, 220
Antroquoril(FR)	161	APO-Finasteride(TX)	1029
Anusol(JT)	1019	APO-Fluconazole(TX)	212
Anzole(UA)	259	APO-Fluvoxamine(TX)	490, 491
Apidra SoloStar (SW)	58	APO-Fosinopril HCTZ 10/12.5(TX)	116
Apidra(AV)	58	APO-Fosinopril HCTZ 20/12.5(TX)	116
Apidra(SW)	58	APO-Fosinopril(TX)	112

APO-Frusemide(TX).....	102, 103	APO-Sildenafil(TX).....	1027
APO-Gabapentin(TX)		APO-Simvastatin(TX).....	134, 135, 136
Repatriation Pharmaceutical Benefits Scheme	1033	APO-Sotalol(TX).....	97
APO-Gabapentin(TX)		APO-Sumatriptan(TX).....	447, 448
NERVOUS SYSTEM.....	454	APO-Telmisartan HCTZ 40/12.5(TX).....	124
APO-Galantamine MR(TX).....	501, 502	APO-Telmisartan HCTZ 80/12.5(TX).....	124
APO-Gliclazide MR(TX).....	61	APO-Telmisartan HCTZ 80/25(TX).....	124
APO-Glimepiride(TX).....	61, 62	APO-Telmisartan(TX).....	121
APO-Imiquimod(TX).....	165, 1025	APO-Temazepam(TX).....	486, 603
APO-Indapamide SR(TX).....	102	APOTEX-MORPHINE MR(TX).....	435
APO-Ipratropium (TX).....	522, 523	APOTEX-Pioglitazone(TX).....	68
APO-Irbesartan (TX).....	120	APO-Topiramate(TX).....	459, 460
APO-Irbesartan HCTZ (TX).....	123	APO-Tramadol SR(TX).....	442, 443
APO-Isotretinoin(TX).....	163	APO-Tramadol(TX).....	443, 444
APO-Lamotrigine(TX).....	456, 457	APO-Trandolapril(TX).....	115, 116
APO-Lansoprazole ODT(TX).....	39	APO-Valaciclovir(TX).....	220, 221, 651, 839
APO-Lansoprazole(TX).....	39	APO-Valsartan HCTZ 160/12.5(TX).....	124
APO-Latanoprost(TX).....	535, 536	APO-Valsartan HCTZ 320/12.5(TX).....	125
APO-Latanoprost/Timolol 0.05/5(TX).....	536	APO-Valsartan HCTZ 320/25(TX).....	125
APO-Leflunomide(TX).....	276	APO-Valsartan(TX).....	121
APO-Lercanidipine(TX).....	109	APO-Venlafaxine XR (TX).....	495, 496
APO-Letrozole(TX).....	261	APO-Ziprasidone(TX).....	469
APO-Levetiracetam(TX).....	457	APO-Zolmitriptan(TX).....	448
APO-Lisinopril(TX).....	112	APO-Zopiclone(TX).....	1034
APO-MACROGOL plus ELECTROLYTES(TX).....	50, 591	APRACLOINIDINE	530
APO-Meloxicam(TX).....	413	APREPITANT.....	46
APO-Memantine(TX).....	505, 506	Aptivus(BY).....	656, 845
APO-Metformin 1000(TX).....	60	Aquacare H.P.(AG).....	1021
APO-Metformin 500(TX).....	60	Aquacel 403770(CC).....	1053
APO-Metformin 850(TX).....	61	Aquacel Ag 403708(CC).....	1053
APO-Metformin XR 1000(TX).....	60	Aquacel Ag 403710(CC).....	1053
APO-Metformin XR 500(TX).....	61	Aquacel Ag 403771(CC).....	1053
APO-Metoclopramide(TX).....	43	Aquacel Extra 420672(CC).....	1052
APO-Metoprolol(TX).....	106, 107	Aquacel Extra 420673(CC).....	1052
Apomine PFS(HH).....	780, 971	Aquasun Lotion SPF 18(PF).....	1022
Apomine(HH).....	780, 971	Aquinafil(GN).....	113, 114
APO-Mirtazapine(TX).....	495	Arabloc (AV).....	276
APO-Montelukast(TX).....	525	Arabloc(AV).....	276
APOMORPHINE.....	780, 971	ARACHIDONIC ACID AND DOCOSAHEXAENOIC ACID	
APO-Mycophenolate(TX).....	276, 277, 700, 701, 891	WITH CARBOHYDRATE.....	579
APO-Nifedipine XR(TX).....	109	Aranesp SureClick(AN).....	611, 799
APO-Olanzapine ODT(TX).....	471, 472	Aranesp(AN).....	610, 611, 798, 799
APO-Olanzapine(TX).....	472, 473	Aratac 100(AF).....	97
APO-Omeprazole(TX).....	40	Aratac 200(AF).....	97
APO-Ondansetron(TX).....	44, 45	Arava (SW).....	276
APO-Oxazepam (TX).....	484, 485, 602, 603	Arava(SW).....	276
APO-Pantoprazole(TX).....	41	Arazil (AF).....	499, 500
APO-Paracetamol(TX).....	444, 445	ARDIX GLICLAZIDE 60mg MR(RX).....	61
APO-Perindopril(TX).....	113	Aredia 30 mg(NV).....	421, 779, 970
APO-Pramipexole(TX).....	464	Aredia 90 mg(NV).....	779, 970
APO-Pravastatin(TX).....	129, 130, 131	Arginine 2000(VF).....	580
APO-Prazosin(TX).....	101	Arginine 500(VF).....	580
APO-Prochlorperazine(TX).....	47, 48	Arginine 5000(VF).....	580
APO-Quetiapine(TX).....	475, 476, 477	ARGININE WITH CARBOHYDRATE	579
APO-Quinapril (TX).....	113, 114	Arianna(AF).....	259
APO-Rabeprazole(TX).....	41, 42	Aricept(PF).....	499, 500
APO-Raloxifene(TX).....	429	Aridon 10 (QA).....	499, 500
APO-Ramipril(TX).....	114, 115	Aridon 5 (QA).....	499, 500
APO-Ranitidine(TX).....	37	Aridon APN 10(FM).....	499, 500
APO-Riluzole(TX).....	511	Aridon APN 5(FM).....	499, 500
APO-Risedronate (TX).....	422, 1031	Arimidex (AP).....	259
APO-Risedronate(TX).....	422	ARIPIRAZOLE	478
APO-Risperidone(TX).....	479, 480, 481, 482, 483	Aristocort 0.02%(QA).....	160, 161
APO-Rosuvastatin(TX).....	131, 132, 133, 134	Arixtra(AS).....	92
APO-Roxithromycin(TX).....	205, 206	Aromasin (PF).....	260
Aporyl(TX).....	1020	Aropax(AS).....	491
APO-Salbutamol Inhaler(TX).....	23, 515	Artane(QA).....	460
APO-Salbutamol(TX).....	23, 516	ARTEMETHER + LUMEFANTRINE	512, 513
APO-Sertraline(TX).....	491	Arthrexin(AF).....	412, 594
APO-Sildenafil PHT(TX).....	643, 831	Arthrotec 50(PF).....	1030

<i>Asasantin SR (BY)</i>	84	<i>Auro-Citalopram 20 (DO)</i>	488
<i>ASENAPINE</i>	469	<i>Auro-Citalopram 40 (DO)</i>	488
<i>Asmol 2.5 uni-dose (AF)</i>	23, 516	<i>Auro-Famciclovir 250 (DO)</i>	218, 219
<i>Asmol 5 uni-dose (AF)</i>	23, 516	<i>Auro-Famciclovir 500 (DO)</i>	220
<i>Asmol CFC-free (AL)</i>	23, 515	<i>Auro-Lisinopril 10 (DO)</i>	112
<i>Aspalgin 40(QA)</i>	1032	<i>Auro-Lisinopril 20 (DO)</i>	112
<i>Aspen Methadone Syrup(QA)</i>		<i>Auro-Lisinopril 5 (DO)</i>	112
<i>.Opiate Dependence Treatment Program</i>	1004	<i>Auro-Montelukast Tabs 4 (DO)</i>	525
<i>.Palliative Care</i>	600	<i>Auro-Montelukast Tabs 5 (DO)</i>	525
<i>Aspen Pharma Pty Ltd(QA)</i>		<i>Auro-Pravastatin 10 (DO)</i>	129, 130
<i>.NERVOUS SYSTEM</i>	449, 497	<i>Auro-Pravastatin 20 (DO)</i>	130
ASPIRIN		<i>Auro-Pravastatin 40 (DO)</i>	130
<i>.BLOOD AND BLOOD FORMING ORGANS</i>	81	<i>Auro-Pravastatin 80 (DO)</i>	130, 131
<i>.NERVOUS SYSTEM</i>	444	<i>Aurorix 300 mg(HM)</i>	492
<i>.Repatriation Pharmaceutical Benefits Scheme</i>	1018	<i>Aurorix(HM)</i>	492
ASPIRIN + CODEINE	1032	<i>Auro-Sertraline 100 (DO)</i>	491
<i>Astrix(YN)</i>	81, 1018	<i>Auro-Sertraline 100(DO)</i>	492
<i>Astromide(GN)</i>	222, 223	<i>Auro-Sertraline 50 (DO)</i>	491
<i>Atacand Plus 16/12.5(AP)</i>	122	<i>Auro-Sertraline 50(DO)</i>	492
<i>Atacand Plus 32/12.5(AP)</i>	122	<i>Auro-Simvastatin 10 (DO)</i>	134, 135
<i>Atacand Plus 32/25(AP)</i>	122	<i>Auro-Simvastatin 20 (DO)</i>	134, 135
<i>Atacand(AP)</i>	119	<i>Auro-Simvastatin 40 (DO)</i>	134, 135
ATAZANAVIR	651, 840	<i>Auro-Simvastatin 80 (DO)</i>	135, 136
ATENOLOL	105	AUROTHIOMALATE SODIUM	417
<i>Atenolol AN (EA)</i>	105	<i>Aurozapine 30 (DO)</i>	495
<i>Atenolol GH (GQ)</i>	105	<i>Aurozapine 45 (DO)</i>	495
<i>Atenolol RBX(RA)</i>	105	<i>Auscasp Aspen(QA)</i>	490
<i>Atenolol Sandoz (SZ)</i>	105	<i>Ausfam 20(QA)</i>	37
<i>Atenolol-AFT(AE)</i>	105	<i>Ausfam 40(QA)</i>	37
<i>Atenolol-GA(GN)</i>	105	<i>Ausgem(QA)</i>	136, 137
ATOMOXETINE	496	<i>Auspril(QA)</i>	111
<i>Atorvachol (GN)</i>	127, 128, 129	<i>Ausran (QA)</i>	37
ATORVASTATIN	127, 128	<i>Austrapen (AL)</i>	192
ATORVASTATIN (&) EZETIMIBE	140, 142	<i>Austrapen(AL)</i>	192
<i>Atorvastatin AN(EA)</i>	127, 128, 129	<i>Avandamet(GK)</i>	64
<i>Atorvastatin GH (GQ)</i>	127, 128, 129	<i>Avandia(GK)</i>	69
<i>Atorvastatin Pfizer(FZ)</i>	127, 128, 129	<i>Avanza SolTab(MK)</i>	494
<i>Atorvastatin Sandoz (SZ)</i>	127, 128, 129	<i>Avanza(MK)</i>	495
<i>Atorvastatin SCP 10(RZ)</i>	127, 128	<i>Avapro HCT 150/12.5(AV)</i>	123
<i>Atorvastatin SCP 20(RZ)</i>	127, 128	<i>Avapro HCT 300/12.5(AV)</i>	123
<i>Atorvastatin SCP 40(RZ)</i>	128	<i>Avapro HCT 300/25(AV)</i>	123
<i>Atorvastatin SCP 80(RZ)</i>	128, 129	<i>Avapro(AV)</i>	120
<i>Atorvastatin SZ (HX)</i>	127, 128, 129	<i>Avodart(GK)</i>	179, 1028
ATOVAQUONE	512	<i>Avonex(BD)</i>	263
ATOVAQUONE + PROGUANIL	512	<i>Axiron(LY)</i>	168
<i>Atozet Composite Pack(MK)</i>	142, 145	<i>Axit 15 (AF)</i>	495
<i>Atrauman 499513(HR)</i>	1055	<i>Axit 30(AF)</i>	495
<i>Atrauman Ag 499572(HR)</i>	1056	<i>Axit 45(AF)</i>	495
<i>Atripia(GI)</i>	665, 854	<i>Aylide 1 (AF)</i>	61
ATROPINE		<i>Aylide 2 (AF)</i>	62
<i>.ALIMENTARY TRACT AND METABOLISM</i>	43	<i>Aylide 3 (AF)</i>	62
<i>.Prescriber Bag</i>	20	<i>Aylide 4 (AF)</i>	62
<i>.SENSORY ORGANS</i>	537	AZACITIDINE	667, 668, 856, 857
<i>Atropt(QA)</i>	537	<i>Azamun (GN)</i>	411
<i>Atrovent Adult(BY)</i>	523	<i>Azapin(QA)</i>	411
<i>Atrovent Nasal Aqueous(BY)</i>	1035	<i>Azarga(AQ)</i>	532
<i>Atrovent Nasal Forte(BY)</i>	1036	<i>Azastrole(ER)</i>	259
<i>Atrovent(BY)</i>	522	AZATHIOPRINE	411
<i>Aubagio(GZ)</i>	278	<i>Azathioprine AN (EA)</i>	411
<i>Augmentin Duo 400(AS)</i>	196	<i>Azathioprine GH (GQ)</i>	411
<i>Augmentin Duo forte(AS)</i>	196	<i>Azathioprine GH(GQ)</i>	411
<i>Augmentin Duo(AS)</i>	196	<i>Azathioprine Sandoz (SZ)</i>	411
<i>Augmentin(AS)</i>	195	<i>Azathioprine Sandoz(SZ)</i>	411
AURANOFIN	417	<i>Azilect(LU)</i>	466
<i>Auro-Amlodipine 10(DO)</i>	108	AZITHROMYCIN	
<i>Auro-Amlodipine 5(DO)</i>	108	<i>.ANTIINFECTIVES FOR SYSTEMIC USE</i>	204
<i>Auro-Candesartan 16(DO)</i>	119	<i>.Highly Specialised Drugs Program (Private Hospital)</i> 650	
<i>Auro-Candesartan 32(DO)</i>	119	<i>.Highly Specialised Drugs Program (Public Hospital)</i> .838	
<i>Auro-Candesartan 4(DO)</i>	119	<i>.Repatriation Pharmaceutical Benefits Scheme</i>	1029
<i>Auro-Candesartan 8(DO)</i>	119	<i>.SENSORY ORGANS</i>	526

<i>Azithromycin Sandoz(SZ)</i>		<i>Betnovate(QA)</i>	1023
.Repatriation Pharmaceutical Benefits Scheme	1029	<i>Betoptic S(AQ)</i>	533
<i>Azithromycin Sandoz(SZ)</i>		<i>Betoptic(AQ)</i>	533
.ANTIINFECTIVES FOR SYSTEMIC USE	204	<i>BetoQuin(IQ)</i>	533
.SENSORY ORGANS	526	<i>Bgramin (GN)</i>	190, 191
<i>Azithromycin-GA (UA)</i>	204, 526, 1029	<i>BGStar(SW)</i>	554, 556
<i>Azol 100(AF)</i>	177	<i>Biatain Adhesive 3420(CT)</i>	1050
<i>Azol 200(AF)</i>	177	<i>Biatain Adhesive 3423(CT)</i>	1050
<i>Azopt(AQ)</i>	532	<i>Biatain Ag 9622(CT)</i>	1056
BACILLUS CALMETTE AND GUERIN-CONNAUGHT		<i>Biatain Ag 9632(CT)</i>	1056
STRAIN	265	<i>Biatain Non-adhesive 3410(CT)</i>	1050
BACILLUS CALMETTE AND GUERIN-TICE STRAIN	265	<i>Biatain Non-adhesive 3413(CT)</i>	1050
BACLOFEN	418, 778, 969	<i>Biassig (AV)</i>	205, 206
<i>Bactigras 7457(SN)</i>	1048	<i>Bicalox (ER)</i>	258
<i>Bactrim DS(RO)</i>	203	BICALUTAMIDE	258
<i>Bactrim(RO)</i>	204	<i>Bicalutamide AN(EA)</i>	258
<i>Bactroban(GK)</i>		<i>Bicalutamide-GA (GN)</i>	258
.Repatriation Pharmaceutical Benefits Scheme	1023	BICARBONATE	178
<i>Bactroban(GK)</i>		BICARBONATE + CITRATE + TARTARIC ACID	1027
.RESPIRATORY SYSTEM	515	<i>Bicard 10(QA)</i>	106
BALSALAZIDE	54	<i>Bicard 2.5(QA)</i>	106
BANDAGE ABSORBENT WOOL	1038	<i>Bicard 5(QA)</i>	106
BANDAGE CALICO	1038	<i>Bicillin L-A(PF)</i>	192
BANDAGE COMPRESSION	1038, 1039	<i>Bicor(AL)</i>	106
BANDAGE RETENTION COHESIVE HEAVY	1039	<i>Biltricide(BN)</i>	513
BANDAGE RETENTION COHESIVE LIGHT	1039	BIMATOPROST	534
BANDAGE RETENTION COTTON CREPE	1040	BIMATOPROST + TIMOLOL	535
BANDAGE TUBULAR	1040	<i>Biodone Forte (MW)</i>	1004
BANDAGE TUBULAR FINGER	1041	<i>Bion Tears(AQ)</i>	544
BANDAGE TUBULAR LIGHT WEIGHT	1041	<i>Bionime Rightest(QB)</i>	555, 558
BANDAGE TUBULAR LONG STOCKING	1041	BIPERIDEN	460
BANDAGE TUBULAR SHORT STOCKING	1041	BISACODYL	
BANDAGE ZINC PASTE	1042	.ALIMENTARY TRACT AND METABOLISM	48, 50
<i>Baraclude(BQ)</i>	658, 847	.Palliative Care	588, 589, 591
<i>Barbloc 5(AF)</i>	105	<i>Bisalax(AS)</i>	
<i>basecal 100(VF)</i>	580	.Palliative Care	589, 591
<i>basecal 200(VF)</i>	580	<i>Bisalax(AS)</i>	
<i>Baxter Healthcare Pty Ltd(BX)</i>		.ALIMENTARY TRACT AND METABOLISM	49, 51
.Repatriation Pharmaceutical Benefits Scheme	1019	<i>Biso 10 (GN)</i>	106
<i>Baxter Healthcare Pty Ltd(BX)</i>		<i>Biso 2.5 (GN)</i>	106
.BLOOD AND BLOOD FORMING ORGANS	94	<i>Biso 5 (GN)</i>	106
BECLOMETHASONE	521	BISOPROLOL	105
BEE VENOM	549	<i>Bisoprolol AN(EA)</i>	106
<i>BenPen(CS)</i>	20, 192, 193	<i>Bisoprolol GH (GQ)</i>	106
BENZATHINE BENZYL PENICILLIN	192	<i>Bisoprolol Sandoz(SZ)</i>	106
BENZHEXOL	460	<i>Bispro 10 (AF)</i>	106
<i>Benztrop(PL)</i>	461	<i>Bispro 2.5 (AF)</i>	106
BENZTROPINE	20, 461	<i>Bispro 5 (AF)</i>	106
BENZYDAMINE	36, 588	BIVALIRUDIN	85
BENZYL PENICILLIN	20, 192	<i>Blooms the Chemist Amlodipine/Atorvastatin 10/10 (IB)</i>	155
<i>Beprol 10 (DO)</i>	105	<i>Blooms the Chemist Amlodipine/Atorvastatin 10/20 (IB)</i>	155
<i>Beprol 2.5 (DO)</i>	106	<i>Blooms the Chemist Amlodipine/Atorvastatin 10/40 (IB)</i>	155
<i>Beprol 5 (DO)</i>	106	<i>Blooms the Chemist Amlodipine/Atorvastatin 10/80 (IB)</i>	155
<i>Betachek G5(NA)</i>	555, 558	<i>Blooms the Chemist Amlodipine/Atorvastatin 5/10 (IB)</i>	155
<i>Betachek(NA)</i>	555, 558	<i>Blooms the Chemist Amlodipine/Atorvastatin 5/20 (IB)</i>	156
<i>Betadine Antiseptic Liquid(SW)</i>	1024	<i>Blooms the Chemist Amlodipine/Atorvastatin 5/40 (IB)</i>	156
<i>Betaferon(BN)</i>	264	<i>Blooms the Chemist Amlodipine/Atorvastatin 5/80 (IB)</i>	156
BETAINE	77	<i>Blooms the Chemist Atorvastatin(IB)</i>	127, 128, 129
BETAINE + POLYAMINOPROPYL BIGUANIDE	1042	<i>Blooms the Chemist Celecoxib (IB)</i>	417
<i>Betaloc(AP)</i>	107	<i>Blooms the Chemist Perindopril (IB)</i>	113
BETAMETHASONE ACETATE + BETAMETHASONE		<i>Blooms the Chemist Rosuvastatin (IB)</i>	131, 132, 133, 134
SODIUM PHOSPHATE	181	<i>Blooms the Chemist Venlafaxine XR(IB)</i>	495, 496
BETAMETHASONE DIPROPIONATE	161	BOCEPREVIR	652, 840
BETAMETHASONE VALERATE	161, 1023	<i>Bondronat(RO)</i>	421, 778, 969
<i>betaquik(VF)</i>	559	<i>Bonefos 800 mg(BN)</i>	420
<i>Betavit(PP)</i>	75, 1017	<i>Bonefos(BN)</i>	420
BETAXOLOL	533	BOSENTAN	618, 622, 806, 811
BETHANECHOL	506	<i>Botox(AG)</i>	985
<i>Betnovate 1/2(QA)</i>	161	BOTULINUM TOXIN TYPE A	984
<i>Betnovate 1/5(QA)</i>	161	<i>Breo Ellipta 100/25(GK)</i>	520

<i>Breo Ellipta 200/25(GK)</i>	520
<i>Bretaris Genuair(FK)</i>	522
<i>Brevinor(PF)</i>	167
<i>Brevinor-1(PF)</i>	167
<i>Bricanyl Turbuhaler(AP)</i>	516
<i>Bricanyl(AP)</i>	524
<i>Brilinta(AP)</i>	84
BRIMONIDINE.....	530
BRIMONIDINE + TIMOLOL.....	530, 531
BRINZOLAMIDE.....	532
BRINZOLAMIDE + TIMOLOL.....	532
<i>BrinzoQuin(IQ)</i>	532
BROMAZEPAM.....	1033
BROMOCRIPTINE	
.GENITO URINARY SYSTEM AND SEX HORMONES	165
.NERVOUS SYSTEM.....	463
<i>bronchitol(XA)</i>	786, 978
<i>Brufen(GO)</i>	414, 595
<i>BSN 2902165(BV)</i>	1056
<i>Budamax Aqueous(PM)</i>	1035
<i>Budenofalk(OA)</i>	53
BUDESONIDE	
.ALIMENTARY TRACT AND METABOLISM.....	53
.Repatiation Pharmaceutical Benefits Scheme.....	1035
.RESPIRATORY SYSTEM.....	521
BUDESONIDE + EFORMOTEROL.....	516, 517
BUPRENORPHINE	
.NERVOUS SYSTEM.....	441
.Opiate Dependence Treatment Program.....	1003
BUPRENORPHINE + NALOXONE.....	1003
BUPROPION.....	506
<i>Buscopan(BY)</i>	21, 588, 1015
<i>Buspar(QA)</i>	1033
BUSPIRONE.....	1033
BUSULFAN.....	222
<i>Butamol 2.5(QA)</i>	23, 516
<i>Butamol 5(QA)</i>	23, 516
<i>Byetta 10 microgram(AP)</i>	75
<i>Byetta 5 microgram(AP)</i>	75
<i>Cabaser(PF)</i>	464
CABERGOLINE	
.GENITO URINARY SYSTEM AND SEX HORMONES	165, 166
.NERVOUS SYSTEM.....	463
<i>Cadatin 10/10(FZ)</i>	155
<i>Cadatin 10/20(FZ)</i>	155
<i>Cadatin 10/40(FZ)</i>	155
<i>Cadatin 10/80(FZ)</i>	155
<i>Cadatin 5/10(FZ)</i>	156
<i>Cadatin 5/20(FZ)</i>	156
<i>Cadatin 5/40(FZ)</i>	156
<i>Cadatin 5/80(FZ)</i>	156
CADEXOMER-IODINE.....	1042
<i>Cadivast 10/10 (AF)</i>	155
<i>Cadivast 10/20 (AF)</i>	155
<i>Cadivast 10/40 (AF)</i>	155
<i>Cadivast 10/80 (AF)</i>	155
<i>Cadivast 5/10 (AF)</i>	156
<i>Cadivast 5/20 (AF)</i>	156
<i>Cadivast 5/40 (AF)</i>	156
<i>Cadivast 5/80 (AF)</i>	156
<i>Caduet 10/10(PF)</i>	155
<i>Caduet 10/20(PF)</i>	155
<i>Caduet 10/40(PF)</i>	155
<i>Caduet 10/80(PF)</i>	155
<i>Caduet 5/10(PF)</i>	156
<i>Caduet 5/20(PF)</i>	156
<i>Caduet 5/40(PF)</i>	156
<i>Caduet 5/80(PF)</i>	156

<i>Caelyx(JC)</i>	668, 858
<i>Cal-500(PP)</i>	76, 1018
<i>CAL-600(PP)</i>	1018
CALCIPOTRIOL + BETAMETHASONE DIPROPIONATE	
.....	158, 159
<i>Calciprox(ER)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	75
.MUSCULO-SKELETAL SYSTEM.....	427
<i>Calci-Tab 600(AE)</i>	76
CALCITRIOL	
.ALIMENTARY TRACT AND METABOLISM.....	75
.MUSCULO-SKELETAL SYSTEM.....	427
<i>Calcitriol AN (EA)</i>	75, 427
<i>Calcitriol Sandoz (SZ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	75
.MUSCULO-SKELETAL SYSTEM.....	427
<i>Calcitriol-GA(UA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	75
.MUSCULO-SKELETAL SYSTEM.....	427
CALCIUM.....	75, 1018
CALCIUM CARBONATE + GLYCINE.....	1015
<i>Calcium Folate Ebewe(SZ)</i>	551
<i>Calmurid(OL)</i>	1021
<i>Cal-Sup (IA)</i>	76, 1018
<i>Calutex(QA)</i>	258
<i>Camino Pro Bettermilk(QH)</i>	582
<i>Camino Pro Complete(QH)</i>	581
<i>Camino Pro Restore(QH)</i>	581
<i>Campral(AF)</i>	509
CANAGLIFLOZIN.....	72
CANDESARTAN.....	119
CANDESARTAN + HYDROCHLOROTHIAZIDE.....	121
<i>Candesartan AN (EA)</i>	119
<i>Candesartan Aspen 16(QA)</i>	119
<i>Candesartan Aspen 32(QA)</i>	119
<i>Candesartan Aspen 4(QA)</i>	119
<i>Candesartan Aspen 8(QA)</i>	119
<i>Candesartan Combi Aspen 16/12.5(QA)</i>	122
<i>Candesartan Combi Aspen 32/12.5(QA)</i>	122
<i>Candesartan Combi Aspen 32/25(QA)</i>	122
<i>Candesartan GH(GQ)</i>	119
<i>Candesartan HCT GH 16/12.5 (GQ)</i>	122
<i>Candesartan HCT GH 32/12.5 (GQ)</i>	122
<i>Candesartan HCT GH 32/25 (GQ)</i>	122
<i>Candesartan HCTZ AN 16/12.5 (EA)</i>	122
<i>Candesartan HCTZ AN 32/12.5 (EA)</i>	122
<i>Candesartan HCTZ AN 32/25 (EA)</i>	122
<i>Candesartan HCTZ RBX 16/12.5 (RA)</i>	122
<i>Candesartan HCTZ RBX 32/12.5 (RA)</i>	122
<i>Candesartan HCTZ RBX 32/25 (RA)</i>	122
<i>Candesartan HCTZ-GA 16/12.5(GN)</i>	122
<i>Candesartan HCTZ-GA 32/12.5(GN)</i>	122
<i>Candesartan HCTZ-GA 32/25(GN)</i>	122
<i>Candesartan RBX (RA)</i>	119
<i>Candesartan Sandoz(SZ)</i>	119
<i>Candesartan/HCT Sandoz(SZ)</i>	122
<i>Candesartan-GA (GN)</i>	119
CAPECITABINE.....	224
<i>Capecitabine Actavis(GN)</i>	224, 225
<i>Capecitabine Alphapharm (AF)</i>	224, 225
<i>Capecitabine AN(EA)</i>	224, 225
<i>Capecitabine Apotex (TX)</i>	225
<i>Capecitabine GH (GQ)</i>	225
<i>Capecitabine Sandoz(SZ)</i>	224, 225
<i>Capecitabine-DRLA (RZ)</i>	224
<i>Capecitabine-DRLA(RZ)</i>	225
<i>Capoten(QA)</i>	111
CAPTOPRIL.....	111
<i>Captopril Sandoz(SZ)</i>	111
<i>Carafate(AS)</i>	42

CARBAMAZEPINE	451, 452	Celica (RA)	488
Carbamazepine Sandoz(SZ)	451, 452	CellCept (RO)	276, 277, 700, 701, 891
CARBAMIDE PEROXIDE	1037	CellCept(RO)	276, 700, 891
Carbimazol ARISTO(PQ)	186	Cellufresh(AG)	542
CARBIMAZOLE	186	Celluvisc(AG)	542
CarboFLEX 403202(CC)	1043	Celsentri(VI)	666, 855
CarboFLEX 403204(CC)	1043	Cephalex 250(CR)	197, 198
Carbohydrate Free Mixture(SB)	583	Cephalex 500(NJ)	198
CARBOHYDRATE, FAT, VITAMINS, MINERALS AND TRACE ELEMENTS	580	CEPHALEXIN	197, 198
CARBOHYDRATES, FAT, VITAMINS, MINERALS, TRACE ELEMENTS AND SUPPLEMENTED WITH ARACHIDONIC ACID AND DOCOSAHEXAENOIC ACID	580	Cephalexin AN (EA)	197, 198
CARBOMER-974	541	Cephalexin generichealth(GQ)	197, 198
CARBOMER-980	541	CEPHALOTHIN	198
carbzero(VF)	558	CEPHAZOLIN	199
Cardiprin 100(RC)	1018	Cephazolin Alphapharm (AF)	199
Cardizem CD(SW)	110	Ceptolate(AF)	276, 277, 700, 701, 891
Cardizem(SW)	110	Certican(NV)	275, 699, 700, 890
Cardol (AF)	97	CERTOLIZUMAB PEGOL	326, 331, 335
CareSens N(PB)	555, 557	Cerumol(UN)	1037
CareSens(PB)	555, 558	CETIRIZINE	1036
CARMELLOSE SODIUM	542	CETRORELIX	999
CARMELLOSE SODIUM + GELATIN + PECTIN	1021	Cetrotide(SG)	999
CARMELLOSE SODIUM + GLYCEROL	543	C-Flox 250(AL)	209
CARMUSTINE	222	C-Flox 500(AL)	208
Cartia(AS)	1019	C-Flox 750(AL)	208
CARVEDILOL	107	Champix(PF)	508, 509
Carvedilol AN (EA)	107, 108	Chem mart Aciclovir(CH)	217
Carvedilol generichealth(GQ)	107, 108	Chem mart Alendronate 70mg(CH)	420
Carvedilol Sandoz (SZ)	107, 108	Chem mart Allopurinol (CH)	419
Catapres 100(BY)	101	Chem mart Alprazolam (CH)	483
Catapres(BY)	101	Chem mart Amiodarone (CH)	97
Caverject(PF)	1026	Chem mart Amitriptyline (CH)	486, 487
Cavicare 4563(SN)	1045	Chem mart Amlodipine (CH)	108
Cavstat(AF)	131, 132, 133, 134	Chem mart Amlodipine/Atorvastatin 10/10 (CH)	155
Ceclor CD(AS)	200	Chem mart Amlodipine/Atorvastatin 10/20 (CH)	155
Ceclor(AS)	200	Chem mart Amlodipine/Atorvastatin 10/40 (CH)	155
CEFACTOR	200	Chem mart Amlodipine/Atorvastatin 10/80 (CH)	155
Cefaclor GH(GQ)	200	Chem mart Amlodipine/Atorvastatin 5/10 (CH)	156
Cefaclor-GA (GN)	200	Chem mart Amlodipine/Atorvastatin 5/20 (CH)	156
Cefalexin Sandoz (SZ)	197, 198	Chem mart Amlodipine/Atorvastatin 5/40 (CH)	156
Cefazolin Sandoz(SZ)	199, 200	Chem mart Amlodipine/Atorvastatin 5/80 (CH)	156
Cefazolin-AFT(AE)	199, 200	Chem mart Amoxycillin (CH)	191
CEFEPIME	203	Chem mart Amoxycillin and Clavulanic Acid(CH)	196
Cefepime Alphapharm (AF)	203	Chem mart Amoxycillin(CH)	190, 191
Cefepime Sandoz(SZ)	203	Chem mart Anastrozole (CH)	259
Cefepime-AFT(AE)	203	Chem mart Atenolol(CH)	105
CEFOTAXIME	201	Chem mart Atorvastatin (CH)	127, 128, 129
Cefotaxime Sandoz(SZ)	201, 202	Chem mart Azithromycin (CH) .Repatriation Pharmaceutical Benefits Scheme	1029
CEFTRIAZONE	202	Chem mart Azithromycin (CH) .ANTIINFECTIVES FOR SYSTEMIC USE	204
Ceftriaxone Alphapharm (AF)	202	.SENSORY ORGANS	526
Ceftriaxone Alphapharm(AF)	203	Chem mart Baclofen(CH)	418
Ceftriaxone ICP (PP)	202, 203	Chem mart Bisoprolol(CH)	106
Ceftriaxone Sandoz(SZ)	202, 203	Chem mart Candesartan (CH)	119
Ceftriaxone-AFT(AE)	202, 203	Chem mart Candesartan HCTZ 16/12.5(CH)	122
CEFUROXIME	200	Chem mart Candesartan HCTZ 32/12.5(CH)	122
Celapram(AF)	488	Chem mart Candesartan HCTZ 32/25(CH)	122
Celaxib(AF)	417	Chem mart Carvedilol 12.5 mg(CH)	107
Celebrex (PF)	417	Chem mart Carvedilol 25 mg(CH)	108
CELECOXIB	416	Chem mart Carvedilol 3.125 mg(CH)	108
Celecoxib Actavis(GN)	417	Chem mart Carvedilol 6.25 mg(CH)	108
Celecoxib AN (EA)	417	Chem mart Cefaclor CD (CH)	200
Celecoxib GH(GQ)	417	Chem mart Celecoxib(CH)	417
Celecoxib RBX (RA)	417	Chem mart Cephalexin (CH)	197, 198
Celecoxib Sandoz(SZ)	417	Chem mart Cephalexin(CH)	197, 198
Celestone Chronodose(MK)	181	Chem mart Citalopram(CH)	488
Celestone-M(MK)	161	Chem mart Clarithromycin (CH)	204
Cellexi (QA)	417	Chem mart Clindamycin (CH)	206
		Chem mart Clomipramine(CH)	487
		Chem mart Clopidogrel (CH)	82, 1019

Chem mart Clopidogrel/Aspirin 75/100 (CH).....	83
Chem mart Diclofenac (CH).....	411, 412, 593, 594
Chem mart Diltiazem CD (CH).....	110
Chem mart Donepezil (CH).....	499, 500
Chem mart Doxycycline(CH).....	188, 189, 190
Chem mart Duloxetine(CH).....	493
Chem mart Enalapril (CH).....	111
Chem mart Escitalopram (CH).....	489
Chem mart Famciclovir (CH).....	219
Chem mart Famciclovir(CH).....	220
Chem mart Famotidine (CH).....	37
Chem mart Fluoxetine (CH).....	490
Chem mart Frusemide (CH).....	102, 103
Chem mart Gemfibrozil (CH).....	136, 137
Chem mart Glimepiride MR (CH).....	61
Chem mart Glimepiride(CH).....	61
Chem mart Hydroxychloroquine (CH).....	417
Chem mart Indapamide SR (CH).....	102
Chem mart Indapamide(CH).....	102
Chem mart Irbesartan (CH).....	120
Chem mart Irbesartan HCTZ (CH).....	123
Chem mart Isosorbide Mononitrate(CH).....	99
Chem mart Latanoprost (CH).....	535, 536
Chem mart Lercanidipine (CH).....	109
Chem mart Letrozole (CH).....	261
Chem mart Levetiracetam (CH).....	457
Chem mart Lisinopril(CH).....	112
Chem mart Meloxicam (CH).....	413
Chem mart Meloxicam 15 mg (CH).....	413
Chem mart Meloxicam 7.5 mg (CH).....	413
Chem mart Metformin (CH).....	60, 61
Chem mart Metformin 1000 (CH).....	60
Chem mart Metformin XR 500 (CH).....	61
Chem mart Metoprolol (CH).....	106, 107
Chem mart Mirtazapine (CH).....	495
Chem mart Moclobemide (CH).....	492
Chem mart Montelukast(CH).....	525
Chem mart Olanzapine (CH).....	472, 473
Chem mart Olanzapine ODT (CH).....	471, 472
Chem mart Omeprazole (CH).....	40
Chem mart Pantoprazole (CH).....	41
Chem mart Paroxetine(CH).....	491
Chem mart Perindopril(CH).....	113
Chem mart Perindopril/ Indapamide 4/1.25(CH).....	117
Chem mart Pioglitazone (CH).....	68
Chem mart Piroxicam(CH).....	413, 414
Chem mart Pravastatin(CH).....	129, 130, 131
Chem mart Prazosin (CH).....	101
Chem mart Quetiapine (CH).....	475, 476, 477
Chem mart Rabeprazole (CH).....	41, 42
Chem mart Raloxifene (CH).....	429
Chem mart Ramipril (CH).....	114, 115
Chem mart Ranitidine(CH).....	37, 38
Chem mart Risedronate (CH).....	422
Chem mart Rosuvastatin (CH).....	131, 132, 133, 134
Chem mart Roxithromycin(CH).....	205, 206
Chem mart Sertraline(CH).....	491
Chem mart Sildenafil (CH).....	1027
Chem mart Simvastatin(CH).....	134, 135, 136
Chem mart Sotalol(CH).....	97
Chem mart Sumatriptan (CH).....	447, 448
Chem mart Telmisartan (CH).....	121
Chem mart Telmisartan HCTZ 40/12.5 (CH).....	124
Chem mart Telmisartan HCTZ 80/12.5 (CH).....	124
Chem mart Telmisartan HCTZ 80/25 (CH).....	124
Chem mart Tramadol (CH).....	443, 444
Chem mart Tramadol SR (CH).....	442, 443
Chem mart Valaciclovir (CH).....	220, 221
Chem mart Venlafaxine XR (CH).....	495, 496
Chem mart Zopiclone (CH).....	1034
Chemists' Own Laxative with Senna(AS).....	1016
CHLORAMBUCIL.....	222
CHLORAMPHENICOL.....	526
CHLORHEXIDINE.....	1015
CHLORPROMAZINE.....	20, 467
Chlorsig(QA).....	526, 527
CHLORTHALIDONE.....	102
Chlorvescent(AS).....	76
CHOLESTYRAMINE.....	137
Cholstat 10 (AF).....	129, 130
Cholstat 20 (AF).....	130
Cholstat 40 (AF).....	130
Cholvastin(RA).....	130, 131
CHORIOGONADOTROPIN ALFA.....	996
Cialis(LY).....	1027
Ciazil (UA).....	488
CICLESONIDE.....	521
CICLOPIROX.....	1020
Cifran (RA).....	208
Cilamox (QA).....	191
Cilamox(QA).....	191
Cilex (GN).....	197, 198
Cilex(GN).....	197, 198
Cilicaine V(FM).....	193
Cilicaine VK(FM).....	193, 194
Cilicaine(QA).....	20, 194
Cilopam-S(ER).....	489
Cilopen VK (GN).....	193, 194
CiloQuin(IQ).....	528
Ciloxan(AQ).....	
SENSORY ORGANS.....	528, 548
CIMETIDINE.....	36
Cimzia(UC).....	331, 335, 340
CINACALCET.....	187, 649, 837
Cipramil(LU).....	488
CIPROFLOXACIN.....	
ANTIINFECTIVES FOR SYSTEMIC USE.....	208, 209
SENSORY ORGANS.....	528, 548
Ciprofloxacin 500(CR).....	208
Ciprofloxacin 750(CR).....	208
Ciprofloxacin AN (EA).....	208
Ciprofloxacin Sandoz (SZ).....	208, 209
Ciprofloxacin Sandoz(SZ).....	209
Ciprofloxacin-BW(GQ).....	208
Ciprofloxacin-DRLA (RZ).....	208, 209
Ciprofloxacin-GA(GN).....	208, 209
Ciprol 250 (QA).....	209
Ciprol 500(QA).....	208
Ciprol 750(QA).....	209
Ciproxin 250(BN).....	209
Ciproxin 500(BN).....	208
CITALOPRAM.....	488
Citalopram Actavis (UA).....	488
Citalopram Actavis (VN).....	488
Citalopram Actavis(VN).....	488
Citalopram AN (EA).....	488
Citalopram AN(EA).....	489
Citalopram generichealth (GQ).....	488
Citalopram Sandoz(SZ).....	488, 489
Citalopram-GA (GN).....	489
Citalopram-GA(GN).....	488
Citrulline 1000(VF).....	580
CITRULLINE WITH CARBOHYDRATE.....	580
Clamoxyl (AL).....	195
Clamoxyl Duo 400 (AL).....	196
Clamoxyl Duo forte (AL).....	196
Clamoxyl Duo(AL).....	196
Clarac(GN).....	204
Claratyne(BN).....	1037
Clarithexal (HX).....	204

<i>Clarithro 250(QA)</i>	204	<i>Co-Diovan 160/12.5 (NV)</i>	124
CLARITHROMYCIN	204, 650, 838	<i>Co-Diovan 160/25(NV)</i>	124
<i>Clarithromycin AN (EA)</i>	204	<i>Co-Diovan 320/12.5 (NV)</i>	125
<i>Clarithromycin Sandoz(SZ)</i>	204	<i>Co-Diovan 320/25 (NV)</i>	125
<i>Clavam 875 mg/125 mg(NJ)</i>	196	<i>Co-Diovan 80/12.5(NV)</i>	125
<i>Cleocin(FZ)</i>	206	<i>Cogentin(FK)</i>	20, 461
<i>Clexane(SW)</i>	79, 80	<i>Colaxsen (QA)</i>	1016
<i>Climara 100(BN)</i>	171	<i>Colazide(PK)</i>	54
<i>Climara 25(BN)</i>	172	COLCHICINE	419
<i>Climara 50(BN)</i>	172	<i>Colese(AF)</i>	1015
<i>Climara 75(BN)</i>	172	<i>Colestid(PF)</i>	137
CLINDAMYCIN	206	COLESTIPOL HYDROCHLORIDE.....	137
<i>Clindamycin-Link (LM)</i>	206	<i>Colgout(AS)</i>	419
<i>Clobemix(GN)</i>	492	<i>Colifoam(HM)</i>	53
CLOBETASOL	162	<i>Colofac(GO)</i>	1015
<i>Clobex(GA)</i>	162	<i>Coloxyl 50(FM)</i>	1016
CLODRONATE	420	<i>Coloxyl with Senna(FM)</i>	1016
<i>Clofen 10 (AF)</i>	418	<i>CombiDERM 651027(CC)</i>	1049
<i>Clofen 25 (AF)</i>	418	<i>CombiDERM 651031(CC)</i>	1049
<i>Clomid(SW)</i>	176	<i>Combigan(AG)</i>	531
CLOMIPHENE	175	<i>Combivir(VI)</i>	664, 853
CLOMIPRAMINE	487	<i>Comfarol Forte (SZ)</i>	438, 439
<i>Clonac 25(QA)</i>	411, 412, 593, 594	<i>Comfeel Paste 4701(CT)</i>	1051
<i>Clonac 50(QA)</i>	412, 593, 594	<i>Comfeel Plus Pressure Relieving 3350(CT)</i>	1052
CLONAZEPAM	20, 450, 601	<i>Comfeel Plus Pressure Relieving 3353(CT)</i>	1052
<i>Clonea(AF)</i>	1020	<i>Comfeel Plus Transparent 3530(CT)</i>	1051
CLONIDINE	101	<i>Comfeel Plus Transparent 3533(CT)</i>	1051
CLOPIDOGREL	81, 82, 1019	<i>Comfeel Plus Transparent 3536(CT)</i>	1051
CLOPIDOGREL + ASPIRIN	83	<i>Comfeel Plus Ulcer Dressing 3110(CT)</i>	1052
<i>Clopidogrel Actavis(UA)</i>	83	<i>Comfeel Purilon Gel 3900(CT)</i>	1054
<i>Clopidogrel AN (EA)</i>	81	<i>Comfeel SeaSorb Dressing 3705(CT)</i>	1044
<i>Clopidogrel AN(EA)</i>	82	<i>Comfeel SeaSorb Dressing 3710(CT)</i>	1044
<i>Clopidogrel GH(GQ)</i>	83, 1019	<i>Comfeel SeaSorb Filler 3740(CT)</i>	1043
<i>Clopidogrel RBX (RA)</i>	82	<i>Comprilan 01027-00(BV)</i>	1038
<i>Clopidogrel Sandoz(SZ)</i>	82	<i>Comtan(NV)</i>	466
<i>Clopidogrel Winthrop (WA)</i>	82	<i>Concerta(JC)</i>	497
<i>Clopidogrel Winthrop plus aspirin (WA)</i>	83	<i>Condylone Paint(NQ)</i>	1023
<i>Clopidogrel Winthrop(WA)</i>	81	<i>Contour next(IK)</i>	554, 556
<i>Clopidogrel/Aspirin Actavis 75/100(GN)</i>	83	<i>Contour(IK)</i>	554, 556
<i>Clopidogrel-DRLA(RZ)</i>	82	<i>Copaxone(TB)</i>	266
<i>Clopidogrel-GA (GN)</i>	83	<i>Coperin (AF)</i>	493
<i>Clopidogrel-GA(GN)</i>	81	<i>CoPlavix(SW)</i>	83
<i>Clopine 100(HH)</i>	780, 972	<i>Coralan(SE)</i>	100
<i>Clopine 200(HH)</i>	780, 972	<i>Corbeton 40(AF)</i>	105
<i>Clopine 25(HH)</i>	780, 972	<i>Cordarone X 100 (SW)</i>	97
<i>Clopine 50(HH)</i>	781, 972	<i>Cordarone X 200(SW)</i>	97
<i>Clopine Suspension(HH)</i>	781, 972	<i>Cordilox 180 SR(GT)</i>	110
<i>Clopixel Depot(LU)</i>	469	<i>Cordilox SR(GT)</i>	110
CLOSTRIDIUM BOTULINUM TYPE A TOXIN- HAEMAGGLUTININ COMPLEX	985	CORIFOLLITROPIN ALFA	997
CLOTIRMAZOLE		<i>Cortate(AS)</i>	181
.Repatriation Pharmaceutical Benefits Scheme	1020, 1026	<i>Cortic-DS 1%(FM)</i>	160
<i>Clovix 75 (QA)</i>	81, 83	CORTISONE	181
CLOZAPINE	780, 971	<i>Cortival 1/2(FM)</i>	161
<i>Clozaril 100 (NV)</i>	780, 972	<i>Cortival 1/5 (FM)</i>	161
<i>Clozaril 25 (NV)</i>	780, 972	<i>Cosamide (AF)</i>	258
COAL TAR PREPARED	158	<i>Cosdor(QA)</i>	533
COAL TAR SOLUTION + PHENOL + SULFUR- PRECIPITATED	1022	<i>Co-Senna(PP)</i>	1016
COAL TAR SOLUTION + TAR + SALICYLIC ACID	1024	<i>Cosopt (MK)</i>	533
<i>Coban 1584(MM)</i>	1039	<i>Cosudex(AP)</i>	258
<i>Coban 2(MM)</i>	1039	<i>Coumadin(QA)</i>	78
<i>Cobasol (GN)</i>	464	<i>Coveram 10/10(SE)</i>	118
<i>Codalgin Forte (FM)</i>	438, 439	<i>Coveram 10/5(SE)</i>	118
<i>Codalgin(FM)</i>	1032	<i>Coveram 5/10(SE)</i>	118
<i>Codapane Forte(AL)</i>	438, 439	<i>Coveram 5/5(SE)</i>	118
CODEINE		<i>Coversyl 10mg(SE)</i>	113
.NERVOUS SYSTEM.....	430	<i>Coversyl 2.5mg(SE)</i>	112
.RESPIRATORY SYSTEM.....	526	<i>Coversyl 5mg(SE)</i>	113
		<i>Coversyl Plus 5mg/1.25mg(SE)</i>	117
		<i>Coversyl Plus LD 2.5mg/0.625mg(SE)</i>	116
		<i>Cozavan(AF)</i>	120

<i>Creon 10,000(GO)</i>	57, 58
<i>Creon 25,000(GO)</i>	57, 58
<i>Creon 40,000(GO)</i>	57, 58
<i>Creon Micro(GO)</i>	57, 58
<i>Crestor(AP)</i>	131, 132, 133, 134
<i>Crinone 8%(SG)</i>	996
<i>Crixivan 400 mg(MK)</i>	654, 842
CROMOGLYCATE	
.Repatriation Pharmaceutical Benefits Scheme	1035
.RESPIRATORY SYSTEM.....	523
.SENSORY ORGANS	537
<i>Crosuva 10 (ZP)</i>	131, 132, 133
<i>Crosuva 20 (ZP)</i>	131, 132, 133
<i>Crosuva 40 (ZP)</i>	131, 132, 133, 134
<i>Crosuva 5 (ZP)</i>	131, 132, 133, 134
<i>Crysanal(MD)</i>	416, 596, 597
<i>Curam Duo 500/125 (SZ)</i>	196
<i>Curam Duo Forte 875/125 (SZ)</i>	196
<i>Curam Duo(SZ)</i>	196
<i>Curam(SZ)</i>	195
<i>Curity 4112(KE)</i>	1048
<i>Cutifilm Plus 36361370(SN)</i>	1045
<i>Cutifilm Plus 36361371(SN)</i>	1045
<i>Cutilin Non-Stick Wound Pad 36361374(SN)</i>	1055
<i>Cutilin Non-Stick Wound Pad 36361375(SN)</i>	1055
<i>Cutinova Hydro 66047441(SN)</i>	1050
<i>Cutinova Hydro 66047443(SN)</i>	1050
CYANOCOBALAMIN + FERRIC PYROPHOSPHATE +	
LYSINE + PYRIDOXINE + THIAMINE	1017
<i>Cycloblastin(ZX)</i>	222
CYCLOPHOSPHAMIDE	222
CYCLOSPORIN.....	410, 768, 959
<i>Cyclosporin Sandoz(SZ)</i>	410, 769, 960
<i>Cyklokapron(PF)</i>	92
<i>Cymbalta(LY)</i>	493
<i>Cymevene(RO)</i>	651, 839
<i>Cyprocur 100(QA)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS.....	258
.GENITO URINARY SYSTEM AND SEX HORMONES	
.....	176
<i>Cyprocur 50(QA)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS.....	258
.GENITO URINARY SYSTEM AND SEX HORMONES	
.....	176
CYPROHEPTADINE	448
<i>Cyprone (AF)</i>	176, 258
<i>Cyprostat(SY)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS.....	258
.GENITO URINARY SYSTEM AND SEX HORMONES	
.....	176
<i>Cyprostat-100 (SY)</i>	176, 258
CYPROTERONE	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS.....	258
.GENITO URINARY SYSTEM AND SEX HORMONES	
.....	176
<i>Cyproterone AN (EA)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS.....	258
.GENITO URINARY SYSTEM AND SEX HORMONES	
.....	176
<i>Cyproterone AN(EA)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS.....	258
.GENITO URINARY SYSTEM AND SEX HORMONES	
.....	176
<i>Cyproterone Sandoz (HX)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	258
.GENITO URINARY SYSTEM AND SEX HORMONES	
.....	176
<i>Cyproterone Sandoz(HX)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	258
.GENITO URINARY SYSTEM AND SEX HORMONES	
.....	176
<i>Cyrotone (ER)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	258
.GENITO URINARY SYSTEM AND SEX HORMONES	
.....	176
<i>Cystadane(EU)</i>	77
<i>Cystine 500(VF)</i>	580
CYSTINE WITH CARBOHYDRATE	580
DABIGATRAN	85, 86, 87
DABRAFENIB	225, 226
<i>Daivobet 50/500 gel(LO)</i>	158, 159
<i>Daivobet(LO)</i>	159
<i>Daktarin Tincture(JT)</i>	157, 1020
<i>Daktarin(JT)</i>	157, 1020
<i>Dalacin C(PF)</i>	206
DALTEPARIN SODIUM.....	78, 79
DANAZOL	176
<i>Dantrium(PF)</i>	418, 419
DANTROLENE	418
<i>Daonil(SW)</i>	61
DAPAGLIFLOZIN	72
<i>Dapa-Tabs (AF)</i>	102
DAPSONE	
.ANTIINFECTIVES FOR SYSTEMIC USE	216
.DERMATOLOGICALS	164
<i>Daraprim(AS)</i>	512
DARBEPOETIN ALFA.....	610, 798
<i>Dario(UH)</i>	554, 556
DARUNAVIR	653, 841
DASATINIB	226, 228, 230
<i>DBL Cefepime (HH)</i>	203
<i>DBL Gabapentin(HH)</i>	1033
<i>DBL Metronidazole Intravenous Infusion(HH)</i>	211
<i>Deca-Durabolin(AS)</i>	77
DEFERASIROX.....	789, 980
DEFERIPRONE	789, 981
DEGARELIX.....	261
<i>Delucon 100(DO)</i>	475
<i>Delucon 200(DO)</i>	476
<i>Delucon 25(DO)</i>	477
<i>Delucon 300(DO)</i>	476
DENOSUMAB	427, 428
<i>Denpax(AF)</i>	439, 440
<i>Densate 70 (DO)</i>	420
<i>Deotine 30 (SZ)</i>	493
<i>Deotine 60 (SZ)</i>	493
<i>Depo-Medrol(PF)</i>	183
<i>Depo-Nisolone(FZ)</i>	183
<i>Depo-Provera(PF)</i>	167
<i>Depo-Ralovera(FZ)</i>	167
<i>Depreta 30(DO)</i>	493
<i>Depreta 60(DO)</i>	493
<i>Deptran 10(AF)</i>	487
<i>Deptran 25(AF)</i>	487
<i>Deptran 50(AF)</i>	488
<i>Deralin 10(AF)</i>	105
<i>Deralin 160(AF)</i>	105
<i>Deralin 40(AF)</i>	105
<i>Dermatane (ER)</i>	163
<i>Dermatane(ER)</i>	163
<i>Desfax(AF)</i>	493

<i>Desferal 2 g(NV)</i>	790, 981	<i>Dilart HCT 160/25 (AF)</i>	124
<i>Desferal 500 mg(NV)</i>	790, 981	<i>Dilart HCT 320/12.5(AF)</i>	125
DESFERIOXAMINE	790, 981	<i>Dilart HCT 320/25(AF)</i>	125
DESMOPRESSIN	179, 180	<i>Dilatrend 12.5(RO)</i>	107
DESVENLAFAXINE	492	<i>Dilatrend 25(RO)</i>	108
<i>Desvenlafaxine Actavis (GN)</i>	493	<i>Dilatrend 3.125 (RO)</i>	108
<i>Desvenlafaxine GH XR(GQ)</i>	493	<i>Dilatrend 6.25(RO)</i>	108
DEXAMETHASONE		<i>Dilaudid(MF)</i>	430, 431
.SENSORY ORGANS	528	<i>Dilaudid-HP(MF)</i>	430
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX		DILTIAZEM.....	110
HORMONES AND INSULINS	182	<i>Diltiazem Actavis (UA)</i>	110
DEXAMETHASONE + FRAMYCETIN SULFATE +		<i>Diltiazem AN(EA)</i>	110
GRAMICIDIN.....	549	<i>Diltiazem Sandoz (SZ)</i>	110
DEXAMETHASONE SODIUM PHOSPHATE	21, 182	<i>Diltiazem Sandoz CD (SZ)</i>	110
DEXAMPHETAMINE	497	<i>Diltiazem Sandoz CD(SZ)</i>	110
<i>Dexmethsone(AF)</i>	21, 182	<i>Dilzem 60 mg(GN)</i>	110
<i>Dexmethsone(AS)</i>	182	DIMETHICONE-350 + GLYCEROL.....	1021
DEXTRAN-70 + HYPROMELLOSE	543, 544	DIMETHYL FUMARATE.....	510
<i>Diabex 1000(AL)</i>	60	<i>Dimetriose(SW)</i>	177
<i>Diabex 850(AL)</i>	61	<i>Dimirel (AV)</i>	61, 62
<i>Diabex XR 1000(AL)</i>	60	<i>Diovan(NV)</i>	121
<i>Diabex XR(AL)</i>	61	<i>Dipentum(IX)</i>	56
<i>Diabex(AL)</i>	61	DIPHENOXYLATE + ATROPINE SULFATE	53
<i>Diaformin 1000(AF)</i>	60	<i>Diphereline(IS)</i>	257
<i>Diaformin 850(AF)</i>	61	DIPHThERIA TOXOID + TETANUS TOXOID.....	21, 221
<i>Diaformin XR 1000 (AF)</i>	60	<i>Diprosone(MK)</i>	161
<i>Diaformin XR(AF)</i>	61	DIPYRIDAMOLE	83
<i>Diaformin(AF)</i>	60	DIPYRIDAMOLE + ASPIRIN	83
<i>Dialamine(SB)</i>	581	DISOPYRAMIDE	96
<i>Diamicron 60mg MR(SE)</i>	61	<i>Distaph 250(AF)</i>	194
<i>Diamox(QA)</i>	532	<i>Distaph 500(AF)</i>	194
<i>Diapride 1(QA)</i>	61	<i>Dithiazide(PL)</i>	102
<i>Diapride 2(QA)</i>	62	<i>Ditropan(SW)</i>	177
<i>Diapride 3(QA)</i>	62	<i>Dizole 100 (AF)</i>	212
<i>Diapride 4(QA)</i>	62	<i>Dizole 200(AF)</i>	212
<i>Diasp SR(QA)</i>	84	<i>Dizole 50 (AF)</i>	212
<i>Diastix(BN)</i>	553	<i>docomega(VF)</i>	581
DIAZEPAM	21, 483, 484, 602	DOCOSAHEXAENOIC ACID WITH CARBOHYDRATE	580
<i>Diazepam Elixir(ON)</i>	484	DOCUSATE	
<i>Dibenyline(GH)</i>.....		.Repatriation Pharmaceutical Benefits Scheme	1016, 1037
.CARDIOVASCULAR SYSTEM	104	DOCUSATE + SENNOSIDE B.....	1016
.GENITO URINARY SYSTEM AND SEX HORMONES		DOCUSATE + SENNOSIDES	1016
.....	178	<i>Dolapril 0.5 (QA)</i>	116
<i>Dibenzyliline(BZ)</i>		<i>Dolapril 1 (QA)</i>	115
.CARDIOVASCULAR SYSTEM	104	<i>Dolapril 2 (QA)</i>	115
.GENITO URINARY SYSTEM AND SEX HORMONES		<i>Dolapril 4 (QA)</i>	116
.....	178	DOLUTEGRAVIR	665, 855
<i>Dicarz (AF)</i>	107, 108	DOLUTEGRAVIR + ABACAVIR + LAMIVUDINE ..	663, 853
DICHLOROBENZENE WITH CHLORBUTOL AND		DOMPERIDONE	43
ARACHIS OIL	1037	DONEPEZIL	499
DICLOFENAC		<i>Donepezil AN(EA)</i>	499, 500
.MUSCULO-SKELETAL SYSTEM	411	<i>Donepezil generichealth (GQ)</i>	499, 500
.Palliative Care	593, 594	<i>Donepezil RBX(RA)</i>	499, 500
.Repatriation Pharmaceutical Benefits Scheme	1024	<i>Donepezil Sandoz (SZ)</i>	499, 500
DICLOFENAC + MISOPROSTOL	1030	<i>Donepezil-DRLA (RZ)</i>	499, 500
<i>Diclofenac AN (EA)</i>	411, 412, 593, 594	<i>Donepezil-GA(GN)</i>	499, 500
<i>Diclofenac Sandoz (SZ)</i>	411, 412, 593, 594	DORNASE ALFA.....	784, 975
<i>Diclofenac-GA(GN)</i>	411, 412, 593, 594	<i>Doryx(YN)</i>	188, 189, 190
DICLOXACILLIN	194	DORZOLAMIDE	532
DIDANOSINE	657, 846	DORZOLAMIDE + TIMOLOL	533
<i>Diffiam(LA)</i>	36, 588	<i>Dorzolamide/Timolol Sandoz 20/5(SZ)</i>	533
<i>Diffucan (PF)</i>	212	<i>Dostan(GN)</i>	166
<i>Diffucan(PF)</i>	212, 213	<i>Dostinex (PF)</i>	166
<i>Digestelact(SJ)</i>	572, 573	<i>Dothep 25(AF)</i>	487
DIGOXIN.....	95	<i>Dothep 75(AF)</i>	487
<i>Dilantin Infatabs(PF)</i>	449	DOTHIEPIN	487
<i>Dilantin Sodium(PF)</i>	449	DOXEPIN	487
<i>Dilantin(PF)</i>	449	DOXORUBICIN HYDROCHLORIDE-PEGYLATED	
<i>Dilart (AF)</i>	121	LIPOSOMAL	668, 858
<i>Dilart HCT 160/12.5(AF)</i>	124		

<i>Doxsig(QA)</i>	188, 189	<i>Duloxetine-DRLA (RZ)</i>	493
<i>Doxy-100 (GN)</i>	188, 189	<i>Duocal(SB)</i>	584
<i>Doxy-50(GN)</i>	190	<i>DuoCover (AV)</i>	83
DOXYCYCLINE.....	188, 189	<i>Duodart 500ug/400ug(GK)</i>	178, 1028
<i>Doxycycline AN (EA)</i>	190	<i>DuoDERM CGF H7660(CC)</i>	1051
<i>Doxycycline AN(EA)</i>	188, 189	<i>DuoDERM CGF H7662(CC)</i>	1052
<i>Doxycycline Sandoz (HX)</i>	188, 189, 190	<i>DuoDERM Extra Thin H7955(CC)</i>	1051
<i>Doxylin 100 (AF)</i>	188, 189	<i>DuoDERM Gel H7987(CC)</i>	1053
<i>Doxylin 100(AF)</i>	189	<i>DuoDERM Gel H7990(CC)</i>	1054
<i>Doxylin 50(AF)</i>	190	<i>DuoDERM Paste H7930(CC)</i>	1050
<i>D-Penamine(AL)</i>	418	<i>Duodopa(VE)</i>	462, 780, 971
DRESSING ACTIVATED CHARCOAL MALODOROUS		<i>Duofilm Solution(GK)</i>	1024
WOUND.....	1043	<i>DuoPlidogrel(GZ)</i>	83
DRESSING ALGINATE CAVITY WOUND.....	1043	<i>Duotrav(AQ)</i>	537
DRESSING ALGINATE SUPERFICIAL WOUND.....	1043, 1044	<i>Durafiber 66800560(SN)</i>	1053
DRESSING FILM.....	1044	<i>Durafiber 66800561(SN)</i>	1053
DRESSING FILM ISLAND.....	1045	<i>Durafiber 66800563(SN)</i>	1053
DRESSING FOAM HEAVY EXUDATE.....	1045	<i>Duratears(AQ)</i>	545, 546
DRESSING FOAM MODERATE EXUDATE.....	1045	<i>Duride (AF)</i>	99
DRESSING FOAM WITH SILICONE.....	1046	<i>Durogesic 100(JC)</i>	440
DRESSING FOAM WITH SILICONE AND SILVER.....	1046	<i>Durogesic 12(JC)</i>	440
DRESSING FOAM WITH SILICONE HEAVY EXUDATE		<i>Durogesic 25(JC)</i>	440
.....	1046, 1047	<i>Durogesic 50(JC)</i>	440
DRESSING FOAM WITH SILICONE LIGHT EXUDATE		<i>Durogesic 75(JC)</i>	440
.....	1047	<i>Duro-K(NM)</i>	76
DRESSING FOAM WITH SILICONE MODERATE		<i>Duro-Tuss(IA)</i>	1036
EXUDATE.....	1047	DUTASTERIDE.....	178, 1028
DRESSING FOAM WITH SILVER.....	1047	DUTASTERIDE + TAMSULOSIN.....	178, 1028
DRESSING GAUZE ABSORBENT.....	1048	<i>Dutran 100(GN)</i>	439
DRESSING GAUZE EYE.....	1048	<i>Dutran 12(GN)</i>	440
DRESSING GAUZE PARAFFIN.....	1048	<i>Dutran 25(GN)</i>	440
DRESSING GAUZE PARAFFIN WITH CHLORHEXIDINE		<i>Dutran 50(GN)</i>	440
ACETATE.....	1048	<i>Dutran 75(GN)</i>	440
DRESSING HYDROACTIVE CAVITY WOUND.....	1049	<i>Dysport(IS)</i>	986
DRESSING HYDROACTIVE DEBRIDEMENT.....	1049	<i>E.E.S. 200(LM)</i>	205
DRESSING HYDROACTIVE SUPERFICIAL WOUND		<i>E.E.S. 400 Filmtab(LM)</i>	205
HIGH EXUDATE SEMI-PERMEABLE ABSORBENT		<i>E.E.S. Granules(LM)</i>	205
FOAM.....	1049	<i>EAA Supplement(VF)</i>	581
DRESSING HYDROACTIVE SUPERFICIAL WOUND		<i>Ear Clear for Ear Wax Removal(KY)</i>	1037
LIGHT EXUDATE.....	1050	<i>Easiphen(SB)</i>	575
DRESSING HYDROACTIVE SUPERFICIAL WOUND		<i>EasyMate II(WI)</i>	554, 556, 557
MODERATE EXUDATE.....	1050	<i>Ebixa (LU)</i>	505, 506
DRESSING HYDROCOLLOID CAVITY WOUND.....	1050	ECULIZUMAB.....	693, 695, 883, 884, 885
DRESSING HYDROCOLLOID SUPERFICIAL WOUND		<i>Edecrin(FK)</i>	103
LIGHT EXUDATE.....	1051	<i>Edronax(PF)</i>	495
DRESSING HYDROCOLLOID SUPERFICIAL WOUND		<i>Edurant(JC)</i>	663, 852
MODERATE EXUDATE.....	1051, 1052	EFAVIRENZ.....	661, 850
DRESSING HYDROFIBRE ALTERNATE TO ALGINATES		<i>Efexor-XR (PF)</i>	495
.....	1052	<i>Efexor-XR(PF)</i>	495, 496
DRESSING HYDROFIBRE GELLING FIBRE.....	1053	<i>Effient(LY)</i>	84
DRESSING HYDROFIBRE WITH SILVER.....	1053	EFORMOTEROL.....	515
DRESSING HYDROGEL.....	1053	<i>Efudix(IA)</i>	1029
DRESSING HYDROGEL AMORPHOUS.....	1053, 1054	<i>Egoderm Cream(EO)</i>	1025
DRESSING HYDROGEL FOAM.....	1054	<i>Egoderm Ointment(EO)</i>	1025
DRESSING HYDROGEL RIBBON.....	1054	<i>Egopsoryl-TA(EO)</i>	1022
DRESSING HYDROGEL SHEET.....	1054	<i>Elastoplast 2225(BE)</i>	1040
DRESSING NON ADHERENT.....	1055	<i>Elastoplast 2226(BE)</i>	1040
DRESSING TULLE NON GAUZE PARAFFIN.....	1056	<i>Elastoplast 2227(BE)</i>	1040
DRESSING WITH SILVER.....	1056	<i>Elaxine SR 150 (ZP)</i>	495
<i>Drixine(BN)</i>	1035	<i>Elaxine SR 37.5(ZP)</i>	495
<i>Dronalen Plus (GN)</i>	424	<i>Elaxine SR 75 (ZP)</i>	496
<i>Dronalen Plus D-Cal(FR)</i>	425	<i>Eldepryl(AS)</i>	466
<i>Drulox (GN)</i>	493	<i>Eleanor 150/30 ED(EA)</i>	166
<i>Dulcolax(BY)</i>	49, 589	<i>EleCare LCP(AB)</i>	563, 564
<i>Dulose (FM)</i>	49, 590	<i>EleCare(AB)</i>	560, 561, 562
DULOXETINE.....	493	ELETRIPTAN.....	445
<i>Duloxetine AN(EA)</i>	493	<i>Eleuphrat(FR)</i>	161
<i>Duloxetine GH(GQ)</i>	493	<i>Eleva 100 (AF)</i>	491, 492
<i>Duloxetine RBX (RA)</i>	493	<i>Eleva 50 (AF)</i>	491, 492
		<i>Elidel(HM)</i>	164

<i>Eligard 1 month(TL)</i>	256	EPROSARTAN.....	119
<i>Eligard 3 month(TL)</i>	256	EPROSARTAN + HYDROCHLOROTHIAZIDE	122
<i>Eligard 4 month(TL)</i>	256	EPTIFIBATIDE	84
<i>Eligard 6 month(TL)</i>	256	ERLOTINIB	231
<i>Eliquis(BQ)</i>	87, 88, 89	<i>Eryc(YN)</i>	205
<i>Elocon(MK)</i>	162, 1024	<i>Erythrocin-I.V.(LM)</i>	205
<i>Elonva(MK)</i>	997	ERYTHROMYCIN	205
ELTROMBOPAG	607, 795	ERYTHROMYCIN ETHYLSUCCINATE	205
<i>Emend(MK)</i>	47	ERYTHROMYCIN LACTOBIONATE	205
EMPAGLIFLOZIN	73	<i>Escicor 10 (RA)</i>	489
EMTRICITABINE	657, 846	<i>Escicor 20 (RA)</i>	489
EMTRICITABINE + RILPIVIRINE + TENOFOVIR .	664, 853	ESCITALOPRAM	489, 490
<i>Emtriva(GI)</i>	658, 846	<i>Escitalopram AN(EA)</i>	489
<i>E-Mycin 200(AF)</i>	205	<i>Escitalopram GA(GN)</i>	489
<i>E-Mycin 400(AF)</i>	205	<i>Escitalopram generichealth (GQ)</i>	489
<i>E-Mycin(AF)</i>	205	<i>Escitalopram-DRLA (RZ)</i>	489
ENALAPRIL	111	<i>Esipram(UA)</i>	489
ENALAPRIL + HYDROCHLOROTHIAZIDE	116	<i>Esitalo (SZ)</i>	489
<i>Enalapril Actavis(UA)</i>	111	<i>Eskazole(AS)</i>	513
<i>Enalapril AN (EA)</i>	111	ESOMEPRAZOLE	38
<i>Enalapril generichealth (GQ)</i>	111	ESOMEPRAZOLE (&) CLARITHROMYCIN (&)	
<i>Enalapril Sandoz(SZ)</i>	111	AMOXICILLIN.....	42
<i>Enalapril/HCT Sandoz(SZ)</i>	116	<i>Esomeprazole Apotex(TX)</i>	38
<i>Enalapril-GA(GN)</i>	111	<i>Esomeprazole GxP (AF)</i>	38
<i>Enbrel(PF)</i>	342, 345, 348, 352, 354, 359, 361, 366, 369, 373, 383, 710, 901	<i>Esomeprazole RBX(RA)</i>	38
<i>Endep 10(AF)</i>	487	<i>Essential Amino Acid Mix(SB)</i>	581
<i>Endep 25(AF)</i>	487	ESSENTIAL AMINO ACIDS FORMULA.....	581
<i>Endep 50(AF)</i>	487	ESSENTIAL AMINO ACIDS FORMULA WITH MINERALS	
<i>Endometrin(FP)</i>	996	AND VITAMIN C	581
<i>Endone(QA)</i>	436, 437	ESSENTIAL AMINO ACIDS FORMULA WITH VITAMINS	
<i>Endoxan(BX)</i>	222	AND MINERALS	581
<i>Energivit(SB)</i>	580	<i>Estalis continuous 50/140(NV)</i>	173
ENFUVIRTIDE	666, 855	<i>Estalis continuous 50/250(NV)</i>	173
<i>Enidin(PE)</i>	530	<i>Estalis sequi 50/140(NV)</i>	174
<i>Enlifax-XR(AF)</i>	495, 496	<i>Estalis sequi 50/250(NV)</i>	174
ENOXAPARIN SODIUM	79, 80	<i>Estraderm MX 100(NV)</i>	171
ENTACAPONE	466	<i>Estraderm MX 25(NV)</i>	172
ENTECAVIR	658, 847	<i>Estraderm MX 50(NV)</i>	172
ENZALUTAMIDE	258	<i>Estradot 100(NV)</i>	172
<i>Epiduo(GA)</i>	163	<i>Estradot 25(NV)</i>	172
<i>Epilim EC(SW)</i>	453	<i>Estradot 37.5(NV)</i>	172
<i>Epilim Liquid(SW)</i>	453	<i>Estradot 50(NV)</i>	172
<i>Epilim Syrup(SW)</i>	453	<i>Estradot 75(NV)</i>	172
<i>Epilim(SW)</i>	453	ETANERCEPT340, 342, 345, 348, 352, 354, 359, 361, 366, 369, 373, 706, 896	
<i>EpiPen Jr.(AL)</i>		ETHACRYNIC ACID.....	103
.CARDIOVASCULAR SYSTEM	98	ETHINYLOESTRADIOL + LEVONORGESTREL	
.RESPIRATORY SYSTEM.....	524	.GENITO URINARY SYSTEM AND SEX HORMONES	
<i>EpiPen(AL)</i>		.....	166, 167
.CARDIOVASCULAR SYSTEM	98	ETHINYLOESTRADIOL + NORETHISTERONE	167
.RESPIRATORY SYSTEM.....	524	ETHOSUXIMIDE	449
<i>Epiramax 100 (QA)</i>	459	ETONOGESTREL	167
<i>Epiramax 200 (QA)</i>	459	ETOPOSIDE	225
<i>Epiramax 25 (QA)</i>	460	ETRAVIRINE	661, 851
<i>Epiramax 50 (QA)</i>	460	<i>Eucerin(BE)</i>	1021
EPLERENONE	103	<i>Eutroxsig(FM)</i>	185
EPOETIN ALFA	611, 799	<i>Evelyn 150/30 ED (GQ)</i>	166
EPOETIN BETA.....	612, 800	EVEROLIMUS	
EPOETIN LAMBDA	613, 801	.ANTINEOPLASTIC AND IMMUNOMODULATING	
EPOPROSTENOL	627, 815	AGENTS	232, 233, 234, 275
<i>Eprex 1000(JC)</i>	612, 800	.Highly Specialised Drugs Program (Private Hospital) 699	
<i>Eprex 10000(JC)</i>	611, 800	.Highly Specialised Drugs Program (Public Hospital) . 890	
<i>Eprex 20,000(JC)</i>	612, 800	<i>Evifyne(EL)</i>	429
<i>Eprex 2000(JC)</i>	612, 800	<i>Eviplera(GI)</i>	664, 853
<i>Eprex 3000(JC)</i>	612, 800	<i>Evista (LY)</i>	429
<i>Eprex 40,000(JC)</i>	612, 800	<i>Exaccord(RA)</i>	260
<i>Eprex 4000(JC)</i>	612, 800	<i>Exelon Patch 10(NV)</i>	503, 504
<i>Eprex 5000(JC)</i>	612, 800	<i>Exelon Patch 5(NV)</i>	503, 504
<i>Eprex 6000(JC)</i>	612, 800	<i>Exelon(NV)</i>	503, 504
<i>Eprex 8000(JC)</i>	612, 800	EXEMESTANE	260

<i>Exemestane AN (EA)</i>	260	<i>Fendex ER (AF)</i>	109
<i>Exemestane GH (GQ)</i>	260	<i>Fendex ER(AF)</i>	109
<i>Exemestane Pfizer(FZ)</i>	260	<i>FENOFIBRATE</i>	136
<i>Exemestane Sandoz (SZ)</i>	260	<i>Fenpatch 100 (ZP)</i>	439
<i>Exemestane-GA(GN)</i>	260	<i>Fenpatch 12 (ZP)</i>	440
<i>EXENATIDE</i>	74	<i>Fenpatch 25 (ZP)</i>	440
<i>Exforge 10/160(NV)</i>	125	<i>Fenpatch 50 (ZP)</i>	440
<i>Exforge 10/320(NV)</i>	125	<i>Fenpatch 75 (ZP)</i>	440
<i>Exforge 5/160(NV)</i>	125	<i>FENTANYL</i>	439, 598, 599
<i>Exforge 5/320(NV)</i>	125	<i>Fentanyl Sandoz (SZ)</i>	440
<i>Exforge 5/80(NV)</i>	125	<i>Fera(QA)</i>	261
<i>Exforge HCT 10/160/12.5(NV)</i>	126	<i>ferinject(VL)</i>	92
<i>Exforge HCT 10/160/25(NV)</i>	126	<i>Ferriprox(TX)</i>	790, 981
<i>Exforge HCT 10/320/25(NV)</i>	126	<i>Ferro-f-tab(AE)</i>	93
<i>Exforge HCT 5/160/12.5(NV)</i>	126	<i>Ferro-Liquid(AE)</i>	92
<i>Exforge HCT 5/160/25(NV)</i>	126	<i>Ferrosig(SI)</i>	92, 93
<i>Exjade(NV)</i>	789, 981	<i>Ferro-tab(AE)</i>	92
<i>Exorex(GN)</i>	158	<i>FERROUS FUMARATE</i>	92
<i>Extine 20 (QA)</i>	491	<i>FERROUS FUMARATE + FOLIC ACID</i>	93
<i>Eylea(BN)</i>	539	<i>FERROUS SULFATE</i>	92
<i>EZETIMIBE</i>	137	<i>Ferrum H (AS)</i>	92, 93
<i>EZETIMIBE + SIMVASTATIN</i>	145, 147	<i>Fexal(SZ)</i>	1036
<i>Ezetrol(MK)</i>	140	<i>FEXOFENADINE</i>	1036
<i>Ezovir (AF)</i>	218, 220	<i>Fibre Health Natural Granular(PP)</i>	1016
<i>Ezovir(AF)</i>	218, 219	<i>Fibsol 10 (QA)</i>	112
<i>FAMCICLOVIR</i>	218, 219	<i>Fibsol 20 (QA)</i>	112
<i>Famciclovir AN (EA)</i>	218, 219	<i>Fibsol 5 (QA)</i>	112
<i>Famciclovir AN(EA)</i>	218, 219, 220	<i>FILGRASTIM</i>	669, 858
<i>Famciclovir generichealth 250 (GQ)</i>	218, 219	<i>Finasta (SZ)</i>	1029
<i>Famciclovir generichealth 500(GQ)</i>	220	<i>FINASTERIDE</i>	1028
<i>Famciclovir Sandoz (SZ)</i>	219, 220	<i>Finasteride Alphapharm(AF)</i>	1029
<i>Famciclovir Sandoz(SZ)</i>	218, 219	<i>Finasteride GH 5(GQ)</i>	1029
<i>Famciclovir SCP 250 (CR)</i>	218, 219	<i>Finasteride RBX(RA)</i>	1029
<i>Famciclovir-GA (GN)</i>	218, 220	<i>Finasteride-GA 5 (GN)</i>	1029
<i>Famciclovir-GA(GN)</i>	218, 219	<i>FINGOLIMOD</i>	275
<i>Famlo(RA)</i>	218, 219	<i>Finnacar (QA)</i>	1029
<i>FAMOTIDINE</i>	37	<i>Finpro(RZ)</i>	1028
<i>Famotidine AN(EA)</i>	37	<i>Firazyr(ZI)</i>	95
<i>Famotidine Sandoz (SZ)</i>	37	<i>Firmagon 120mg(FP)</i>	261
<i>Famvir (NV)</i>	218, 219	<i>Firmagon 80mg(FP)</i>	261
<i>Famvir(NV)</i>	218, 219, 220	<i>Flagyl S(SW)</i>	210
<i>Fareston(MK)</i>	258	<i>Flagyl(SW)</i>	210, 211
<i>Fasigyn(PF)</i>	211	<i>Flamazine(SN)</i>	160
<i>Faverin 100 (QA)</i>	490	<i>Flarex(AQ)</i>	529
<i>Faverin 50 (QA)</i>	491	<i>FLECAINIDE</i>	96
<i>Favic 125 (QA)</i>	218	<i>Flecatab(AF)</i>	96
<i>Favic 250(QA)</i>	218, 219	<i>Flexidress 650941(CC)</i>	1042
<i>Favic 500 (QA)</i>	219, 220	<i>Flixotide Accuhaler(GK)</i>	522
<i>Fawns and McAllan Proprietary Limited(FM)</i>		<i>Flixotide Junior Accuhaler(GK)</i>	522
.ANTIINFECTIVES FOR SYSTEMIC USE.....	216	<i>Flixotide Junior(GK)</i>	522
.NERVOUS SYSTEM.....	430, 449	<i>Flixotide(GK)</i>	522
.RESPIRATORY SYSTEM.....	526	<i>Flolan Kit(GK)</i>	630, 818
<i>Febridol (GN)</i>	444, 445	<i>Flomaxtra(LS)</i>	1028
<i>Feldene(PF)</i>	414	<i>Flopen(AS)</i>	195
<i>Feldene-D(PF)</i>	414	<i>Florinef(QA)</i>	181
<i>Felodil XR 10(QA)</i>	109	<i>Fluanxol Concentrated Depot(LU)</i>	469
<i>Felodil XR 5(QA)</i>	109	<i>Fluanxol Depot(LU)</i>	469
<i>FELODIPINE</i>	109	<i>Flubiclox(GN)</i>	194, 195
<i>Felodur ER 10 mg (TX)</i>	109	<i>Flucil (AS)</i>	194, 195
<i>Felodur ER 2.5 mg(TX)</i>	109	<i>Flucil(LN)</i>	195
<i>Felodur ER 5 mg (TX)</i>	109	<i>FLUCLOXACILLIN</i>	194, 195
<i>Femara 2.5 mg(NV)</i>	261	<i>Flucon(AQ)</i>	529
<i>Femme-Tab ED 20/100(AE)</i>	167	<i>FLUCONAZOLE</i>	212, 213
<i>Femme-Tab ED 30/150(AE)</i>	166	<i>Fluconazole Alphapharm(AF)</i>	212
<i>Femolet (AF)</i>	261	<i>Fluconazole Hexal (HX)</i>	212
<i>Femoston 1/10(GO)</i>	174	<i>Fluconazole Hexal(HX)</i>	212
<i>Femoston 2/10(GO)</i>	174	<i>Fluconazole Sandoz (SZ)</i>	212
<i>Femoston-Conti(GO)</i>	173	<i>Fluconazole Sandoz(SZ)</i>	212
<i>Fenac 25(AF)</i>	412, 593, 594	<i>Fludara(GZ)</i>	224
<i>Fenac(AF)</i>	412, 593, 594	<i>FLUDARABINE</i>	224

FLUDROCORTISONE ACETATE	180	<i>Fruzemide RBX(RA)</i>	103
FLUNITRAZEPAM.....	1034	<i>Fruzemide Sandoz (SZ)</i>	21, 102
FLUOROMETHOLONE	529	<i>Fruzemide Sandoz(SZ)</i>	102
FLUOROMETHOLONE ACETATE.....	529	<i>Fruzemide-Clarix(AE)</i>	21, 102
FLUOROURACIL.....	1029	<i>Frusid (GN)</i>	103
FLUOXETINE	490	<i>Frusid (UA)</i>	102
<i>Fluoxetine 20(CR)</i>	490	<i>Fucidin(CS)</i>	210
<i>Fluoxetine AN (EA)</i>	490	<i>Fungilin(QA)</i>	36
<i>Fluoxetine generichealth (GQ)</i>	490	FUSIDATE.....	210
<i>Fluoxetine RBX(RA)</i>	490	<i>Fuzeon(RO)</i>	666, 855
<i>Fluoxetine Sandoz (SZ)</i>	490	<i>Fybogel(RC)</i>	1016
<i>Fluoxetine-GA(GN)</i>	490	<i>Fycompa(EI)</i>	458
FLUPENTHIXOL DECANOATE	469	<i>GA express 15(VF)</i>	573
FLUPHENAZINE DECANOATE	467	<i>GA gel(VF)</i>	573
FLURBIPROFEN	530	<i>GA Tramadol 50mg(GN)</i>	443, 444
FLUTAMIDE	259	<i>GA Tramadol SR 100mg(GN)</i>	442
<i>Flutamin(AF)</i>	259	<i>GA Tramadol SR 150mg(GN)</i>	443
FLUTICASONE.....	522	<i>GA Tramadol SR 200mg(GN)</i>	443
FLUTICASONE + EFORMOTEROL	518	<i>GA1 Anamix infant(SB)</i>	574
FLUTICASONE + SALMETEROL.....	518, 519	<i>GA-Amclav 125/31.25 (GN)</i>	195
FLUTICASONE + VILANTEROL	519, 520	<i>GA-Amclav 500/125(GN)</i>	196
<i>flutiform 125/5(MF)</i>	518	<i>GA-Amclav Forte 400/57 (GN)</i>	196
<i>flutiform 250/10(MF)</i>	518	<i>GA-Amclav Forte 875/125(GN)</i>	196
<i>flutiform 50/5(MF)</i>	518	<i>Gabacor (NJ)</i>	454
FLUVASTATIN	129	<i>Gabacor(NJ)</i>	454
FLUVOXAMINE	490	GABAPENTIN	453
<i>Fluvoxamine GA(GN)</i>	490, 491	.NERVOUS SYSTEM	453
<i>Fluzole 200(QA)</i>	212	.Repatriation Pharmaceutical Benefits Scheme	1032
<i>FML Liquifilm (AG)</i>	529	<i>Gabapentin 300 (CR)</i>	454, 1033
FOLIC ACID.....	93, 94	<i>Gabapentin 400 (CR)</i>	454, 1033
FOLINIC ACID.....	551, 552	<i>Gabapentin AN(EA)</i>	454
FOLLITROPIN ALFA	174, 997	<i>Gabapentin Aspen 100 (FM)</i>	1033
FOLLITROPIN BETA.....	175, 997	<i>Gabapentin Aspen 100(FM)</i>	
<i>Foltabs 500(PP)</i>	93	.NERVOUS SYSTEM	454
<i>Fonat(AL)</i>	420	<i>Gabapentin Aspen 300(FM)</i>	
<i>FonatPLUS (AF)</i>	425, 1031	.Repatriation Pharmaceutical Benefits Scheme	1033
<i>FonatPLUS(AF)</i>	424	<i>Gabapentin Aspen 300(FM)</i>	
FONDAPARINUX	92	.NERVOUS SYSTEM	454
<i>Foradile(NV)</i>	515	<i>Gabapentin Aspen 400(FM)</i>	
<i>Formet 1000 (QA)</i>	60	.Repatriation Pharmaceutical Benefits Scheme	1033
<i>Formet Aspen 500 (AS)</i>	60	<i>Gabapentin Aspen 400(FM)</i>	
<i>Formet Aspen 850 (AS)</i>	61	.NERVOUS SYSTEM	454
<i>Forteo(LY)</i>		<i>Gabapentin Aspen 600 (FM)</i>	454
.MUSCULO-SKELETAL SYSTEM	430	<i>Gabapentin Aspen 600(FM)</i>	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX		.Repatriation Pharmaceutical Benefits Scheme	1033
HORMONES AND INSULINS	187	<i>Gabapentin Aspen 800 (FM)</i>	454
<i>Forxiga(AP)</i>	73	<i>Gabapentin Aspen 800(FM)</i>	
<i>Fosamax Plus 70 mg/140 mcg(MK)</i>	424, 1031	.Repatriation Pharmaceutical Benefits Scheme	1033
<i>Fosamax Plus D-Cal (MK)</i>	425	<i>Gabapentin GH (GQ)</i>	
<i>Fosamax Plus D-Cal(MK)</i>	1031	.NERVOUS SYSTEM	454
<i>Fosamax Plus(MK)</i>	425, 1031	<i>Gabapentin GH(GQ)</i>	454
FOSAMPRENAVIR.....	653, 842	<i>Gabapentin Sandoz (SZ)</i>	454
FOSCARNET.....	651, 839	<i>Gabapentin Sandoz(SZ)</i>	454
<i>Foscavir(IX)</i>	651, 840	<i>Gabapentin-GA (UA)</i>	
<i>Fosetic 20/12.5 (ZP)</i>	116	.NERVOUS SYSTEM	454
FOSINOPRIL	112	<i>Gabaran(RA)</i>	454
FOSINOPRIL + HYDROCHLOROTHIAZIDE	116	<i>Gabitril(OA)</i>	452, 453
<i>Fosinopril/HCT Actavis 20/12.5(UA)</i>	116	GALANTAMINE.....	501
<i>Fosipril 10 (QA)</i>	112	<i>Galantamine AN SR (EA)</i>	501, 502
<i>Fosipril 20 (QA)</i>	112	<i>Galantyl(AF)</i>	501, 502
<i>Fosrenol(ZI)</i>	550, 790, 981, 982	<i>Galvumet 50/1000(NV)</i>	66
<i>Fragmin(PF)</i>	78, 79	<i>Galvumet 50/500(NV)</i>	66
<i>Frakas(QA)</i>	190	<i>Galvumet 50/850(NV)</i>	66
FRAMYCETIN SULFATE	549	<i>Galvus(NV)</i>	72
<i>FreeStyle Lite(MS)</i>	554, 557	<i>Gamine XR (QA)</i>	501, 502
<i>FreeStyle Optium(MS)</i>	554, 557	GANCICLOVIR.....	650, 839
<i>Fruiti Vits(VF)</i>	585	<i>Ganfort 0.3/5(AG)</i>	535
<i>Frusax(ER)</i>	102	<i>GANfort PF 0.3/5(AG)</i>	535
FRUSEMIDE.....	21, 102, 103	GANIRELIX	999
<i>Fruzemide RBX (RA)</i>	102	<i>Gantin (GN)</i>	454, 1033

.Repatriation Pharmaceutical Benefits Scheme	1033
Gantin(GN)	
.NERVOUS SYSTEM.....	454
Gastrex(CR).....	53
Gastrogel(FM).....	36
Gastro-Stop Loperamide (AS)	53
GAUZE AND COTTON TISSUE COMBINE ROLL	1056
Gaviscon P(RC).....	42
GEFITINIB	234
GELATIN-SUCCINYLATED.....	94
Gelofusine(BR)	94
GEMFIBROZIL	136, 137
Gemfibrozil-GA(UA).....	136, 137
Gemhexal (SZ)	136, 137
Generic Health Pty Ltd(GQ).....	444, 445
Genlac(QA).....	49, 590
Genoptic(AG).....	527
Genotropin GoQuick(PF).....	990
Genotropin MiniQuick(PF)	990, 991, 992
Genotropin(PF).....	991
Genox 10(AF)	257
Genox 20(AF)	257
GenRx Aciclovir (GX).....	217, 218
GenRx Aciclovir(GX).....	217
GenRx Allopurinol(GX)	419
GenRx Alprazolam(GX)	483
GenRx Amiodarone (GX).....	97
GenRx Amoxycillin (GX).....	190
GenRx Amoxycillin(GX).....	191
GenRx Azathioprine(GX).....	411
GenRx Baclofen(GX).....	418
GenRx Calcitriol(GX)	
.ALIMENTARY TRACT AND METABOLISM	75
.MUSCULO-SKELETAL SYSTEM	427
GenRx Captopril (GX).....	111
GenRx Cefaclor CD(GX).....	200
GenRx Cefaclor(GX).....	200
GenRx Cephalixin (GX).....	197, 198
GenRx Ciprofloxacin (GX)	208, 209
GenRx Ciprofloxacin(GX)	209
GenRx Clomipramine (GX).....	487
GenRx Cyproterone Acetate (GX)	
.GENITO URINARY SYSTEM AND SEX HORMONES	176
GenRx Cyproterone Acetate(GX)	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS.....	258
.GENITO URINARY SYSTEM AND SEX HORMONES	176
GenRx Diltiazem CD (GX)	110
GenRx Doxycycline (GX).....	190
GenRx Doxycycline(GX).....	188, 189
GenRx Enalapril (GX).....	111
GenRx Famotidine(GX)	37
GenRx Fluoxetine(GX)	490
GenRx Fosinopril(GX)	112
GenRx Frusemide(GX).....	103
GenRx Gabapentin (GX).....	454, 1033
GenRx Gabapentin (GX)	
.NERVOUS SYSTEM.....	454
GenRx Gabapentin(GX)	
.Repatriation Pharmaceutical Benefits Scheme	1033
GenRx Gabapentin(GX)	
.NERVOUS SYSTEM.....	454
GenRx Gemfibrozil(GX).....	136, 137
GenRx Gliclazide (GX)	61
GenRx Indapamide(GX)	102
GenRx Isosorbide Mononitrate(GX).....	99
GenRx Lamotrigine (GX)	456, 457
GenRx Meloxicam(GX).....	413

GenRx Metoprolol(GX).....	106, 107
GenRx Mirtazapine(GX)	495
GenRx Moclobemide (GX)	492
GenRx Nifedipine (GX).....	109
GenRx Norfloxacin(GX).....	209
GenRx Paroxetine(GX).....	491
GenRx Perindopril/ Indapamide 4/1.25 (GX).....	117
GenRx Piroxicam (GX).....	413, 414
GenRx Ramipril(GX).....	114
GenRx Ranitidine (GX).....	37, 38
GenRx Salbutamol (GX).....	23, 516
GenRx Sertraline(GX)	491
GenRx Simvastatin (GX)	134, 135
GenRx Sotalol (GX).....	97
GenRx Tamoxifen (GX).....	257
GenRx Terbinafine(GX).....	158, 1021
GENTAMICIN	
.ANTIINFECTIVES FOR SYSTEMIC USE	207
.SENSORY ORGANS.....	527
Genteal gel(AQ)	545
Genteal(AQ)	544, 545
GESTRINONE.....	177
Gilenya(NV).....	276
GLATIRAMER ACETATE.....	265
Gliadel(OA).....	222
GLIBENCLAMIDE	61
GLICLAZIDE	61
Glimel(AF)	61
GLIMEPIRIDE	61
Glimepiride AN(EA).....	61, 62
Glimepiride GA 1 (GN)	61
Glimepiride GA 2 (GN)	62
Glimepiride GA 3 (GN)	62
Glimepiride GA 4 (GN)	62
Glimepiride Sandoz(SZ)	61, 62
GLIPIZIDE	62
Glivec(NV).....	236, 237, 238, 239, 240, 241, 242, 243
Glucagen Hypokit(NO).....	21, 186
GLUCAGON HYDROCHLORIDE.....	21, 186
Glucobay 100(BN).....	67
Glucobay 50(BN).....	67
Glucobete 1000(DO)	60
Glucobete 500(DO)	60
Glucobete 850(DO)	61
Glucodur(OZ).....	555, 557
Glucoflex-R(NA)	555, 558
Glucophage(MQ).....	61
GLUCOSE.....	94
GLUCOSE AND KETONE INDICATOR URINE	553
GLUCOSE INDICATOR BLOOD	553, 556
GLUCOSE INDICATOR URINE	553
Glucovance 250mg/1.25mg(AL).....	63
Glucovance 500mg/2.5mg(AL).....	64
Glucovance 500mg/5mg(AL).....	64
GluNEO(IF)	554, 557
Glyade MR(AF)	61
Glyade(AF)	61
GLYCEROL.....	51, 592, 593, 1017
GLYCERYL TRINITRATE	21, 98, 99
GLYCINE WITH CARBOHYDRATE	581
Glycine500(VF)	581
GLYCOMACROPEPTIDE AND ESSENTIAL AMINO ACIDS.....	581
GLYCOMACROPEPTIDE AND ESSENTIAL AMINO ACIDS WITH VITAMINS AND MINERALS	581
GLYCOPYRRONIUM	522
Glycosade(VF)	571
GN-Carvedilol (GN)	107, 108
GN-Carvedilol(GN)	108
Gold Cross(BI)	

.Repatriation Pharmaceutical Benefits Scheme	1030, 1036	.ANTIINFECTIVES FOR SYSTEMIC USE	198
GOLIMUMAB.....	383, 386, 389, 393, 396, 399	<i>Hospira Pty Limited(HH)</i>	
GONADOTROPHIN CHORIONIC HUMAN	175, 998	.ANTIINFECTIVES FOR SYSTEMIC USE	201
GONADOTROPHIN-MENOPAUSAL HUMAN.....	998	<i>Hospira Pty Limited(HH)</i>	
<i>Gonal-f Pen(SG)</i>	174, 175, 997	.ANTIINFECTIVES FOR SYSTEMIC USE	201
<i>GoodLife(JN)</i>	553, 556	<i>Hospira Pty Limited(HH)</i>	
<i>Gopten(GO)</i>	115, 116	.ANTIINFECTIVES FOR SYSTEMIC USE	201
GOSERELIN.....	255	<i>Hospira Pty Limited(HH)</i>	
GOSERELIN (&) BICALUTAMIDE.....	255	.ANTIINFECTIVES FOR SYSTEMIC USE	202
GRANISETRON	43, 44	<i>Hospira Pty Limited(HH)</i>	
<i>Granisetron Kabi (PK)</i>	43, 44	.ANTIINFECTIVES FOR SYSTEMIC USE	207
<i>Granisetron-AFT(AE)</i>	43, 44	<i>Hospira Pty Limited(HH)</i>	
<i>Granocyte 13(HH)</i>	671, 861	.ANTIINFECTIVES FOR SYSTEMIC USE	209
<i>Granocyte 34(HH)</i>	671, 861	<i>Hospira Pty Limited(HH)</i>	
GRISEOFULVIN.....	157	.ANTIINFECTIVES FOR SYSTEMIC USE	209
<i>Grisovin 500(QA)</i>	157	<i>Hospira Pty Limited(HH)</i>	
<i>Grisovin(QA)</i>	157	.ANTIINFECTIVES FOR SYSTEMIC USE	209
<i>Gynotril (ER)</i>	261	<i>Hospira Pty Limited(HH)</i>	
<i>Haldol decanoate(JC)</i>	468	.ANTIINFECTIVES FOR SYSTEMIC USE	210
HALOPERIDOL	20, 468	<i>Hospira Pty Limited(HH)</i>	
HALOPERIDOL DECANOATE	468	.ANTIINFECTIVES FOR SYSTEMIC USE	210
<i>Hamilton Skin Therapy Oil(KY)</i>	1022	<i>Hospira Pty Limited(HH)</i>	
<i>Hamilton Skin Therapy Wash(KY)</i>	1025	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>Handy 36361414(BV)</i>	1038	AGENTS	224
<i>Handy 71117-05(BV)</i>	1048	<i>Hospira Pty Limited(HH)</i>	
<i>Handy 71117-06(BV)</i>	1048	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>Handygauze Cohesive 8631(BV)</i>	1039	AGENTS	224
<i>Handygauze Cohesive 8633(BV)</i>	1040	<i>Hospira Pty Limited(HH)</i>	
<i>Handygauze Cohesive 8635(BV)</i>	1039	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>HCU Anamix infant(SB)</i>	574	AGENTS	224
<i>HCU Anamix junior LQ(SB)</i>	573	<i>Hospira Pty Limited(HH)</i>	
<i>HCU cooler 10(VF)</i>	574	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>HCU cooler 15(VF)</i>	574	AGENTS	411
<i>HCU cooler 20(VF)</i>	574	<i>Hospira Pty Limited(HH)</i>	
<i>HCU express 15(VF)</i>	574	.NERVOUS SYSTEM	432
<i>HCU gel(VF)</i>	574	<i>Hospira Pty Limited(HH)</i>	
<i>HCU Lophlex LQ 20(SB)</i>	574	.NERVOUS SYSTEM	432
<i>Healthpro(IF)</i>	554, 557	<i>Hospira Pty Limited(HH)</i>	
HEPARIN SODIUM	80	.NERVOUS SYSTEM	432
<i>Hepsera (GI)</i>	657, 846	<i>Hospira Pty Limited(HH)</i>	
<i>Herron ClearLax(ON)</i>	50, 590	.NERVOUS SYSTEM	432
HEXAMINE HIPPURATE.....	212	<i>Hospira Pty Limited(HH)</i>	
HIGH FAT FORMULA WITH VITAMINS, MINERALS AND		.NERVOUS SYSTEM	433
TRACE ELEMENTS AND LOW IN PROTEIN AND		<i>Hospira Pty Limited(HH)</i>	
CARBOHYDRATE	582	.NERVOUS SYSTEM	433
<i>Hiprex(IA)</i>	212	<i>Hospira Pty Limited(HH)</i>	
HOMATROPINE	537	.NERVOUS SYSTEM	433
<i>Hospira Cefazolin Sodium (HH)</i>	199, 200	<i>Hospira Pty Limited(HH)</i>	
<i>Hospira Ceftriaxone (HH)</i>	202, 203	.NERVOUS SYSTEM	483
<i>Hospira Pty Limited (HH)</i>	21, 182	<i>Hospira Pty Limited(HH)</i>	
<i>Hospira Pty Limited(HH)</i>		.NERVOUS SYSTEM	484
.Highly Specialised Drugs Program (Private Hospital) 648,	790	<i>Hospira Pty Limited(HH)</i>	
.Highly Specialised Drugs Program (Public Hospital) 836,	837, 981	.RESPIRATORY SYSTEM	526
.Prescriber Bag	21, 22	<i>HPMC PAA(IQ)</i>	545
<i>Hospira Pty Limited(HH)</i>		<i>Humalog KwikPen (KP)</i>	59
.ALIMENTARY TRACT AND METABOLISM	48	<i>Humalog Mix25 KwikPen (KP)</i>	60
<i>Hospira Pty Limited(HH)</i>		<i>Humalog Mix25(LY)</i>	60
.BLOOD AND BLOOD FORMING ORGANS	80	<i>Humalog Mix50 KwikPen (KP)</i>	60
<i>Hospira Pty Limited(HH)</i>		<i>Humalog Mix50(LY)</i>	60
.BLOOD AND BLOOD FORMING ORGANS	80	<i>Humalog(LY)</i>	59
<i>Hospira Pty Limited(HH)</i>		<i>Humatrope(LY)</i>	991, 992
.ANTIINFECTIVES FOR SYSTEMIC USE	194	<i>Humira(VE)</i>	280, 283, 285, 288, 291, 295, 297, 302, 304, 310, 315, 319, 322, 326, 705, 706, 896
<i>Hospira Pty Limited(HH)</i>		<i>Humulin 30/70(LY)</i>	59, 60
.ANTIINFECTIVES FOR SYSTEMIC USE	194	<i>Humulin NPH(LY)</i>	59
<i>Hospira Pty Limited(HH)</i>		<i>Humulin R (LY)</i>	59
.ANTIINFECTIVES FOR SYSTEMIC USE	198	<i>Hycor(QA)</i>	529
<i>Hospira Pty Limited(HH)</i>		<i>Hydopa(AF)</i>	100

HYDRALAZINE.....	101	<i>Imuran</i> (AS).....	411
<i>Hydrea</i> (BQ).....	254	<i>Imuran</i> (AS).....	411
<i>Hydrene 25/50</i> (AF).....	104	<i>In a Wink Moisturising</i> (IQ).....	544, 545
HYDROCHLOROTHIAZIDE.....	102	<i>Incivo</i> (JC).....	656, 845
HYDROCHLOROTHIAZIDE + AMILORIDE.....	104	INCOBOTULINUMTOXINA.....	986
HYDROCHLOROTHIAZIDE + TRIAMTERENE.....	104	<i>Incruse Ellipta</i> (GK).....	523
<i>Hydrocoll 900744</i> (HR).....	1052	INDACATEROL.....	515
<i>Hydrocoll 900936</i> (HR).....	1052	INDACATEROL + GLYCOPYRRONIUM.....	520
<i>Hydrocoll Thin 900758</i> (HR).....	1051	INDAPAMIDE.....	102
HYDROCORTISONE.....	182	<i>Indapamide AN</i> (EA).....	102
HYDROCORTISONE ACETATE.....		<i>Indapamide Sandoz</i> (SZ).....	102
. ALIMENTARY TRACT AND METABOLISM.....	53	<i>Indapamide-GA</i> (GN).....	102
. DERMATOLOGICALS.....	160	<i>Inderal</i> (AP).....	105
. SENSORY ORGANS.....	529	INDINAVIR.....	653, 842
HYDROCORTISONE SODIUM SUCCINATE.....	21, 182	<i>Indocid</i> (AS).....	412, 594, 595
HYDROMORPHONE.....	430, 431	INDOMETHACIN.....	412, 594
<i>Hydrosorb 900854</i> (HR).....	1055	<i>Indopril 2</i> (QA).....	113
<i>Hydroxo-B12</i> (AS).....	93	<i>Indopril 4</i> (QA).....	113
HYDROXOCOBALAMIN.....	93	<i>Indopril 8</i> (QA).....	113
HYDROXYCHLOROQUINE.....	417	<i>Indosyl Combi 4/1.25</i> (QA).....	117
<i>Hydroxychloroquine Actavis</i> (GN).....	417	<i>Indosyl Mono 2</i> (FM).....	113
<i>Hydroxychloroquine RBX</i> (RA).....	417	<i>Indosyl Mono 4</i> (FM).....	113
HYDROXYUREA.....	254	<i>Indosyl Mono 8</i> (FM).....	113
<i>Hygroton 25</i> (LM).....	102	INFLIXIMAB .. 710, 713, 716, 722, 725, 730, 734, 739, 901,	
<i>Hylo-Forte</i> (AE).....	548	904, 907, 913, 916, 920, 925, 934, 1029	
<i>Hylo-Fresh</i> (AE).....	548	INGENOL MEBUTATE.....	1023
HYOSCINE BUTYLBROMIDE.....	21, 588, 1015	<i>iNova Pharmaceuticals (Australia) Pty Ltd</i> (IA).....	511
<i>Hypnodorm</i> (AF).....	1034	<i>Insig</i> (QA).....	102
HYPROMELLOSE.....	544	<i>Inspra</i> (PF).....	103
HYPROMELLOSE + CARBOMER-980.....	545	INSULIN ASPART.....	58
<i>Hypurin Isophane</i> (AS).....	59	INSULIN ASPART + INSULIN ASPART PROTAMINE.....	59
<i>Hypurin Neutral</i> (AS).....	59	INSULIN DETEMIR.....	60
<i>Hysone 20</i> (AF).....	182	INSULIN GLARGINE.....	60
<i>Hysone 4</i> (AF).....	182	INSULIN GLULISINE.....	58
<i>Hytrin</i> (GO).....	1028	INSULIN ISOPHANE BOVINE.....	59
<i>Ialax</i> (LN).....	197, 198	INSULIN ISOPHANE HUMAN.....	59
IBANDRONIC ACID.....	421, 778, 969	INSULIN ISOPHANE HUMAN + INSULIN NEUTRAL	
<i>Ibilex 125</i> (AF).....	197	HUMAN.....	59
<i>Ibilex 250</i> (AF).....	197, 198	INSULIN LISPRO.....	59
<i>Ibilex 500</i> (AF).....	198	INSULIN LISPRO + INSULIN LISPRO PROTAMINE.....	60
<i>Ibimicyn</i> (GN).....	192	INSULIN NEUTRAL BOVINE.....	59
<i>Ibimicyn</i> (GN).....	192	INSULIN NEUTRAL HUMAN.....	59
IBUPROFEN.....	414, 595	<i>Intal CFC-Free</i> (SW).....	523
ICATIBANT.....	95	<i>Intal Forte CFC-Free</i> (SW).....	523
ICHTHAMMOL.....	1025	<i>Intal Spincaps</i> (GN).....	523
ICHTHAMMOL + ZINC OXIDE.....	1025	<i>Integrilin</i> (MK).....	84
<i>Idaprex 2</i> (SZ).....	113	<i>Intelence</i> (JC).....	662, 851
<i>Idaprex 4</i> (SZ).....	113	INTERFERON ALFA-2A.....	262, 672, 862
<i>Idaprex 8</i> (SZ).....	113	INTERFERON ALFA-2B.....	262, 263, 673, 863
<i>Idaprex Combi 4/1.25</i> (SZ).....	117	INTERFERON BETA-1A.....	263
IDARUBICIN.....	225	INTERFERON BETA-1B.....	264
<i>Ikorel</i> (SW).....	99, 100	INTERFERON GAMMA-1B.....	673, 864
<i>Ikotab</i> (QA).....	99, 100	<i>Intrasite Gel 7313</i> (SN).....	1054
ILOPROST.....	630, 818	<i>Intron A Redipen</i> (MK).....	263, 673, 863, 864
IMATINIB.....	235, 236, 237, 238, 239, 240, 241, 242	<i>Intron A</i> (MK).....	673, 863, 864
<i>Imazan</i> (ER).....	411	<i>Invega Sustenna</i> (JC).....	479
<i>Imdur 120 mg</i> (AP).....	99	<i>Invega</i> (JC).....	479
<i>Imdur Durule</i> (AP).....	99	<i>Invirase</i> (RO).....	654, 843
<i>Imigran FDT</i> (AS).....	447	<i>Invokana</i> (JC).....	72
<i>Imigran</i> (AS).....	447	<i>Inza 250</i> (AF).....	415, 595, 596
<i>Imigran</i> (LN).....	447	<i>Inza 500</i> (AF).....	415, 595, 596
IMIPRAMINE.....	488	<i>Iodosorb 66051330</i> (SN).....	1043
IMIQUIMOD.....	164, 1025	<i>Iodosorb 66051340</i> (SN).....	1043
<i>ImmuCyst</i> (SW).....	265	<i>Iodosorb 66051360</i> (SN).....	1042
<i>Imodium</i> (JT).....	53	<i>Iodosorb Ointment 66051230</i> (SN).....	1043
<i>Imovane</i> (SW).....	1034	<i>Iodosorb Ointment 66051240</i> (SN).....	1043
<i>Implanon NXT</i> (MK).....	167	<i>Iodosorb Powder 66051070</i> (SN).....	1043
<i>Imrest</i> (AF).....	1034	<i>Ionil-T</i> (GA).....	1024
<i>Imtrate 60 mg</i> (GN).....	99	<i>Iopidine 0.5%</i> (AQ).....	530
<i>Imukin</i> (BY).....	673, 864	<i>I-Pantoprazole</i> (CR).....	41

<i>Ipratrin Adult</i> (AF)	523	IVERMECTIN	514
<i>Ipratrin</i> (AF).....	522	<i>Janumet XR</i> (MK).....	65, 66
IPRATROPIUM		<i>Janumet</i> (MK).....	66
Repatriation Pharmaceutical Benefits Scheme	1035	<i>Januvia</i> (MK).....	71
RESPIRATORY SYSTEM.....	522	<i>Jardiance</i> (BY).....	74
<i>Iptam</i> (AL).....	447, 448	<i>Jelonet 7404</i> (SN)	1048
IRBESARTAN	120	<i>Jezil</i> (GN)	136, 137
IRBESARTAN + HYDROCHLOROTHIAZIDE	122	<i>JJ 12010</i> (JJ).....	1056
<i>Irbesartan Actavis 150</i> (UA).....	120	<i>Jurnista</i> (JC).....	432
<i>Irbesartan Actavis 300</i> (UA).....	120	<i>Kaletra</i> (VE).....	664, 665, 854
<i>Irbesartan Actavis 75</i> (UA).....	120	<i>Kalixocin</i> (AF).....	204
<i>Irbesartan AN</i> (EA).....	120	<i>Kalma 0.25</i> (AF).....	483
<i>Irbesartan GH</i> (GQ).....	120	<i>Kalma 0.5</i> (AF).....	483
<i>Irbesartan HCT Actavis 150/12.5</i> (UA)	123	<i>Kalma 1</i> (AF).....	483
<i>Irbesartan HCT Actavis 300/12.5</i> (UA)	123	<i>Kalma 2</i> (AF).....	483
<i>Irbesartan HCT Actavis 300/25</i> (UA)	123	<i>Kaltostat 168117</i> (CC).....	1043
<i>Irbesartan HCT GH 150/12.5</i> (GQ).....	123	<i>Kaltostat 168210</i> (CC).....	1044
<i>Irbesartan HCT GH 300/12.5</i> (GQ).....	123	<i>Kaltostat 168212</i> (CC).....	1044
<i>Irbesartan HCT GH 300/25</i> (GQ).....	123	<i>Kalydeco</i> (VR).....	789, 980
<i>Irbesartan HCT Winthrop 150/12.5</i> (WA).....	123	<i>Kapanol</i> (YN).....	434
<i>Irbesartan HCT Winthrop 300/12.5</i> (WA).....	123	<i>Kaptan</i> (ER).....	475, 476, 477
<i>Irbesartan HCT Winthrop 300/25</i> (WA).....	123	<i>Karbesat 150</i> (QA).....	120
<i>Irbesartan HCTZ AN 150/12.5</i> (EA).....	123	<i>Karbesat 300</i> (QA).....	120
<i>Irbesartan HCTZ AN 300/12.5</i> (EA).....	123	<i>Karbesat 75</i> (QA).....	120
<i>Irbesartan HCTZ AN 300/25</i> (EA).....	123	<i>Karicare Aptamil Gold De-Lact</i> (NU).....	572
<i>Irbesartan HCTZ-GA 150/12.5</i> (GN).....	123	<i>Karicare Aptamil Pepti-Junior Gold</i> (NU).....	569
<i>Irbesartan HCTZ-GA 300/12.5</i> (GN).....	123	<i>Karlor CD</i> (LN).....	200
<i>Irbesartan HCTZ-GA 300/25</i> (GN).....	123	<i>Karvea</i> (SW).....	120
<i>Irbesartan RBX</i> (RA).....	120	<i>Karvezide 150/12.5</i> (SW)	123
<i>Irbesartan Sandoz</i> (SZ)	120	<i>Karvezide 300/12.5</i> (SW)	123
<i>Irbesartan Winthrop</i> (WA).....	120	<i>Karvezide 300/25</i> (SW)	123
<i>Irbesartan/HCT Sandoz</i> (SZ)	123	<i>Keflex</i> (AS).....	197, 198
<i>Irbesartan/HCTZ RBX 150/12.5</i> (RA)	123	<i>Keflor</i> (AF).....	200
<i>Irbesartan/HCTZ RBX 300/12.5</i> (RA)	123	<i>Keflor CD</i> (AF).....	200
<i>Irbesartan/HCTZ RBX 300/25</i> (RA)	123	<i>Kenacomb Otic</i> (QA)	549
<i>Irbesartan-DRLA</i> (RZ).....	120	<i>Kenacort-A 10</i> (QA).....	184, 185
<i>Irbesartan-GA</i> (GN).....	120	<i>Kepcet</i> (GN)	457
<i>Ircal</i> (PE).....	545, 546	<i>Keppra</i> (UC)	457
<i>Iressa</i> (AP).....	235	<i>Keppra</i> (UC).....	458
IRON.....	92	<i>Kerron 1000</i> (DO).....	457
IRON POLYMALTOSE	92	<i>Kerron 250</i> (DO).....	457
IRON SUCROSE	93	<i>Kerron 500</i> (DO).....	457
<i>Irprestan 150</i> (ZP).....	120	<i>KetoCal 3</i>	
<i>Irprestan 300</i> (ZP).....	120	1(SB).....	582
<i>Irprestan 75</i> (ZP).....	120	<i>KetoCal 4</i>	
<i>Iscover</i> (AV).....	81	1 LQ(SB).....	582
<i>Iscover</i> (AV).....	82, 1019	1(SB).....	582
<i>Isentress</i> (MK)	666, 667, 856	KETOCONAZOLE	156, 1020
<i>Isoleucine 1000</i> (VF).....	583	<i>Keto-Diabur- Test 5000</i> (RD).....	553
<i>Isoleucine 50</i> (VF).....	583	<i>Keto-Diastix</i> (BN).....	553
ISOLEUCINE WITH CARBOHYDRATE	582	KETOPROFEN.....	415
<i>Isomonit</i> (SZ)	99	<i>Kevtam</i> (AF).....	457
ISONIAZID	216	<i>keyomega</i> (VF).....	579
<i>Isoptin 180 SR</i> (GO)	110	<i>Kindergen</i> (SB).....	585
<i>Isoptin SR</i> (GO)	110	<i>Kineret</i> (FK).....	748, 939
<i>Isoptin</i> (GO)	110	<i>Kinson</i> (AF)	462
<i>Isopto Carpine</i> (AQ).....	531	<i>Kivexa</i> (VI).....	663, 852
<i>Isopto Homatropine</i> (AQ).....	537	<i>Klacid</i> (GO).....	204, 205, 650, 838
<i>Isordil Sublingual</i> (QA).....	99	<i>Kombiglyze XR 2.5/1000</i> (AP).....	65
<i>Isosorbide AN</i> (EA).....	99	<i>Kombiglyze XR 5/1000</i> (AP).....	65
ISOSORBIDE DINITRATE.....	99	<i>Kombiglyze XR 5/500</i> (AP).....	65
ISOSORBIDE MONONITRATE	99	<i>Konakion MM</i> (RO).....	22
ISOTRETINOIN	163	<i>Kosteo</i> (QA)	
<i>Isotretinoin AN</i> (EA).....	163	ALIMENTARY TRACT AND METABOLISM	75
<i>Isotretinoin SCP 10</i> (CR)	163	MUSCULO-SKELETAL SYSTEM.....	427
<i>Isotretinoin SCP 20</i> (CR)	163	<i>Krypton 2.5</i> (AF).....	
ISPAGHULA HUSK DRY.....	1016	GENITO URINARY SYSTEM AND SEX HORMONES	165
ITRACONAZOLE	213	NERVOUS SYSTEM	463
IVABRADINE	100	<i>KSART HCT 150/12.5</i> (QA).....	123
IVACAFTOR	786, 978		

KSART HCT 300/12.5(QA).....	123	Leflunomide Sandoz(SZ).....	276
KSART HCT 300/25(QA).....	123	Leflunomide-GA(GN).....	276
Kudeq (FZ).....	417	Lemtrada(GZ).....	692, 693, 883
Kuvan(SG).....	77, 78	LENALIDOMIDE.....	770, 771, 961, 962
Kytril(RO).....	43, 44	Lengout(LN).....	419
LABETALOL.....	108	LENOGRASTIM.....	670, 860
LACOSAMIDE.....	454, 455	Lercadip (GN).....	109
LACTATE + SODIUM CHLORIDE + POTASSIUM CHLORIDE + CALCIUM CHLORIDE DIHYDRATE.....	94	Lercan(QA).....	109
LACTIC ACID + SALICYLIC ACID.....	1024	LERCANIDIPINE.....	109
LACTULOSE.....	49, 589, 590	LERCANIDIPINE + ENALAPRIL.....	117
Lamictal(AS).....	456, 457	Lercanidipine GH (GQ).....	109
Lamidus(RA).....	456, 457	Lercanidipine Sandoz(SZ).....	109
Lamisil (Novartis Pharmaceuticals Australia Pty Limited) (NV).....	158, 1021	Lescol XL(NV).....	129
Lamisil DermGel(NC).....	1020	Lescol(NV).....	129
Lamisil(NC).....	157, 1020	LETROZOLE.....	260
LAMIVUDINE.....	658, 659, 847, 848	Letrozole Actavis(VN).....	261
LAMIVUDINE + ZIDOVUDINE.....	664, 853	Letrozole AN (EA).....	261
Lamivudine 150 mg + Zidovudine 300 mg Alphapharm (AF)	664, 853	Letrozole FBM (FO).....	261
Lamivudine Alphapharm (AF).....	659, 848	Letrozole generichealth (GQ).....	261
Lamivudine RBX(RA).....	659, 848	Letrozole RBX(RA).....	261
Lamogine (AF).....	456, 457	Letrozole Sandoz (SZ).....	261
Lamogine(AF).....	456	Letrozole-DRLA(RZ).....	261
LAMOTRIGINE.....	456	Letrozole-GA(GN).....	261
Lamotrigine AN(EA).....	456, 457	Leucovorin Calcium (Hospira Pty Limited) (HH).....	551
Lamotrigine Aspen 100 (FM).....	456	Leucovorin Calcium (Hospira Pty Limited)(HH).....	551, 552
Lamotrigine Aspen 200 (FM).....	456	Leucovorin Calcium (Pfizer Australia Pty Ltd)(PF).....	551, 552
Lamotrigine Aspen 25 (FM).....	456	Leukeran(AS).....	222
Lamotrigine Aspen 5 (FM).....	456	Leukoflex 1124(BV).....	1057
Lamotrigine Aspen 50 (FM).....	457	Leukoplast 01071-00(BV).....	1057
Lamotrigine generichealth (GQ).....	456, 457	Leukoplast 01072-00(BV).....	1057
Lamotrigine Sandoz(SZ).....	456, 457	Leukoplast 01073-00(BV).....	1057
Lamotrigine-GA(GN).....	456, 457	Leukopor 2471(BV).....	1057
Lamotrust 100 (CR).....	456	Leukopor 2472(BV).....	1057
Lamotrust 200 (CR).....	456	Leukopor 2474(BV).....	1058
Lamotrust 25 (CR).....	456	Leukosilk 1021(BV).....	1057
Lamotrust 50 (CR).....	457	Leukosilk 1022(BV).....	1057
Lanoxin(QA).....	95	Leukosilk 1024(BV).....	1058
Lanoxin-PG(QA).....	96	LEUPRORELIN.....	256
LANREOTIDE.....	647, 835, 836	Levactam(ER).....	457
LANSOPRAZOLE.....	38, 39	Levecetam 1000 (RZ).....	457
Lansoprazole ODT GH (GQ).....	39	Levecetam 250 (RZ).....	457
LANTHANUM.....	550, 790, 981	Levecetam 500 (RZ).....	457
Lantus SoloStar (AV).....	60	Levemir FlexPen(NF).....	60
Lantus(SW).....	60	Levemir Penfill (NO).....	60
Lanvis(AS).....	224	LEVETIRACETAM.....	457
Lanzek Zydis(EL).....	474	Levetiracetam AN(EA).....	457
Lanzek(EL).....	472, 473	Levetiracetam generichealth (GQ).....	457
Lanzopran (RA).....	39	Levetiracetam SZ(SZ).....	457
LAPATINIB.....	243	Levi 1000 (FM).....	457
Largactil(SW).....	20, 467	Levi 250 (FM).....	457
Lasix(SW).....	21, 102, 103	Levi 500 (FM).....	457
Lasix-M(SW).....	103	Levitaccord(RA).....	457
Latanocom (FZ).....	536	Levitam 1000 (QA).....	457
LATANOPROST.....	535	Levitam 250 (QA).....	457
LATANOPROST + TIMOLOL.....	536	Levitam 500 (QA).....	457
Latanoprost Actavis(GN).....	535, 536	Levitra(BN).....	1027
Latanoprost GH (GQ).....	535, 536	Levlen ED (SY).....	166
Latanoprost Pfizer(FZ).....	535, 536	LEVOCABASTINE.....	
Latanoprost Sandoz (SZ).....	535, 536	Repatriation Pharmaceutical Benefits Scheme.....	1035, 1037
Latanoprost/Timolol Sandoz 50/5(SZ).....	536	LEVODOPA + BENSERAZIDE.....	461
LaxaCon (GN).....	50, 591	LEVODOPA + CARBIDOPA ANHYDROUS...462, 779, 971	
lax-sachets(AE).....	50, 591	LEVODOPA + CARBIDOPA ANHYDROUS + ENTACAPONE.....	462
Lax-Tab (AE).....	49, 589	LEVONORGESTREL.....	
Ledip(RA).....	109	.GENITO URINARY SYSTEM AND SEX HORMONES.....	165, 167
LEFLUNOMIDE.....	276	Lexam 10(QA).....	489
Leflunomide AN (EA).....	276	Lexam 20(QA).....	489
Leflunomide GH (GQ).....	276	Lexapro(LU).....	489, 490

<i>Lexotan(RO)</i>	1033
<i>Lezole(UA)</i>	261
<i>Lifeline Attest(OL)</i>	555, 558
LIGNOCAINE	
.CARDIOVASCULAR SYSTEM	96
.Prescriber Bag	22
.Repatriation Pharmaceutical Benefits Scheme	1022
<i>LINAGLIPTIN</i>	69
<i>LINAGLIPTIN + METFORMIN</i>	63
<i>Lincocin(PF)</i>	207
<i>LINCOMYCIN</i>	207
<i>Link Medical Products Pty Ltd(LM)</i>	
.Prescriber Bag	20
<i>Link Medical Products Pty Ltd(LM)</i>	
.CARDIOVASCULAR SYSTEM	97
<i>Link Medical Products Pty Ltd(LM)</i>	
.CARDIOVASCULAR SYSTEM	97
<i>Link Medical Products Pty Ltd(LM)</i>	
.DERMATOLOGICALS	164
<i>Link Medical Products Pty Ltd(LM)</i>	
.DERMATOLOGICALS	164
<i>Link Medical Products Pty Ltd(LM)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	216
<i>Link Medical Products Pty Ltd(LM)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	216
<i>Link Medical Products Pty Ltd(LM)</i>	
.RESPIRATORY SYSTEM	523
<i>Link Medical Products Pty Ltd(LM)</i>	
.RESPIRATORY SYSTEM	523
<i>Lioresal 10 (NV)</i>	418
<i>Lioresal 25 (NV)</i>	418
<i>Lioresal Intrathecal(NV)</i>	778, 969
LIOTHYRONINE	185
<i>Lipex 10(FR)</i>	134, 135
<i>Lipex 20(FR)</i>	134, 135
<i>Lipex 40(FR)</i>	134, 135
<i>Lipex 80(FR)</i>	135, 136
<i>Lipidil(GO)</i>	136
<i>Lipigem(AF)</i>	137
<i>Lipistart(VF)</i>	571
<i>Lipitor(PF)</i>	127, 128, 129
<i>Liposomal Doxorubicin SUN (ZF)</i>	668, 858
<i>Lipostat 10(QA)</i>	129, 130
<i>Lipostat 20 (QA)</i>	130
<i>Lipostat 40 (QA)</i>	130, 131
<i>Lipostat 80 (QA)</i>	130, 131
<i>Liquifilm Tears(AG)</i>	547
<i>Liquigen(SB)</i>	559
LISINOPRIL	112
<i>Lisinopril AN(EA)</i>	112
<i>Lisinopril generichealth (GQ)</i>	112
<i>Lisinopril Sandoz(SZ)</i>	112
<i>Lisinopril-DRLA (RZ)</i>	112
<i>Lisinopril-GA(GN)</i>	112
<i>Lithicarb(AS)</i>	494
LITHIUM CARBONATE	494
<i>Livostin(JT)</i>	
.Repatriation Pharmaceutical Benefits Scheme	1035, 1037
<i>Locasol(SB)</i>	573
<i>Loceryl(GA)</i>	1020
<i>Lodam SR 100 (ZP)</i>	442
<i>Lodam SR 150 (ZP)</i>	443
<i>Lofenoxal(IA)</i>	53
<i>Logem(AL)</i>	456, 457
<i>Logicin Rapid Relief(QA)</i>	1035
<i>Logicin Sinus(QA)</i>	1036
<i>Logynon ED(SY)</i>	167
<i>Lomotil(IV)</i>	53
<i>Loniten(PF)</i>	102

LOPERAMIDE	53
<i>Lophlex(SB)</i>	576
LOPINAVIR + RITONAVIR	664, 853
<i>Lopresor 100(NV)</i>	107
<i>Lopresor 50(NV)</i>	107
<i>Lorano(SZ)</i>	1037
LORATADINE	1037
<i>Lorstat 10 (AF)</i>	127, 128
<i>Lorstat 20 (AF)</i>	127, 128
<i>Lorstat 40 (AF)</i>	128
<i>Lorstat 80 (AF)</i>	128, 129
LOSARTAN	120
<i>Losec Tablets(AP)</i>	39, 40
<i>Lovan (AL)</i>	490
<i>Lovan 20 Tab(AL)</i>	490
<i>Lovir (GN)</i>	217
<i>Lovir(GN)</i>	217
<i>LoxaLate (AF)</i>	489
<i>Loxip 500(DO)</i>	208
<i>Loxip 750(DO)</i>	209
<i>LPV(IA)</i>	193, 194
LUBRICATING AGENT	1038
<i>Lubri-Gel(PP)</i>	1038
<i>Lucentis(NV)</i>	539
<i>Lucrin Depot 3 Month PDS(VE)</i>	256
<i>Lucrin Depot 4 Month PDS(VE)</i>	256
<i>Lucrin Depot 7.5mg PDS(VE)</i>	257
<i>Lucrin Depot Paediatric 30 mg PDS(VE)</i>	256
<i>Lukair (FR)</i>	525
<i>Lumigan PF(AG)</i>	534, 535
<i>Lumigan(AG)</i>	534
<i>Lumin 10(AF)</i>	494
<i>Lumin 20(AF)</i>	494
<i>Lunava 10 (ZP)</i>	276
<i>Lunava 20 (ZP)</i>	276
<i>Luvov(GO)</i>	491
<i>Lycinate(FM)</i>	99
<i>Lyclear(JT)</i>	514
<i>Lyrica(PF)</i>	445
<i>Mabthera(RO)</i>	
.Highly Specialised Drugs Program (Private Hospital)	777
.Highly Specialised Drugs Program (Public Hospital)	968
MACITENTAN	635, 823
<i>Macrochantin(PF)</i>	211
MACROGOL-3350	49, 590
MACROGOL-3350 + SODIUM CHLORIDE + POTASSIUM CHLORIDE + BICARBONATE	50, 590, 591
<i>Macrovic (QA)</i>	50, 591
<i>Madopar 125(RO)</i>	461
<i>Madopar 62.5(RO)</i>	461
<i>Madopar HBS(RO)</i>	461
<i>Madopar Rapid 125(RO)</i>	461
<i>Madopar Rapid 62.5(RO)</i>	461
<i>Madopar(RO)</i>	461
<i>Magicul 400(AF)</i>	37
<i>MagMin (PBS)(BB)</i>	76
<i>Magmin(BB)</i>	1018
MAGNESIUM ASPARTATE DIHYDRATE	76, 1018
<i>Mag-Sup (PP)</i>	76
<i>Mag-Sup(PP)</i>	1018
<i>Malarone(GK)</i>	512
<i>Malean(FM)</i>	111
MANNITOL	785, 977
MARAVIROC	666, 855
<i>Marevan (FM)</i>	78
<i>Marevan(FM)</i>	78
<i>MassBiologics tetanus and diphtheria toxoids adsorbed(CS)</i>	21, 221
<i>Max Pharma Ceftriaxone (GQ)</i>	203
<i>Maxalt(MK)</i>	447

<i>Maxamox</i> (SZ)	191, 192	<i>Metformin 850</i> (CR).....	61
<i>Maxidex</i> (AQ).....	528, 529	<i>Metformin AN</i> (EA)	60
<i>Maxolon</i> (IA)	22, 43	<i>Metformin AN</i> (EA)	60, 61
<i>Maxor</i> (AF).....	40	<i>Metformin generichealth 1000</i> (GQ)	60
<i>Mayne Pharma Aspirin</i> (YT).....	81	<i>Metformin generichealth</i> (GQ)	60, 61
<i>Mayne Pharma Doxycycline</i> (YT)	188, 189, 190	<i>Metformin Ranbaxy</i> (RA).....	60, 61
<i>Mayne Pharma Erythromycin</i> (YT).....	205	<i>Metformin Ranbaxy 1000</i> (RA)	60
<i>MCT Oil</i> (SB).....	559	<i>Metformin Sandoz</i> (SZ)	60
<i>MCT Pro-Cal</i> (VF).....	584	<i>Metformin Sandoz</i> (SZ)	61
<i>MEBENDAZOLE</i>	1035	<i>Metformin-GA</i> (GN)	60, 61
<i>MEBEVERINE</i>	1015	<i>Metformin-GA</i> (GN)	60
<i>Medipore 2961</i> (MM)	1056	<i>Methaccord</i> (GN).....	224
MEDROXYPROGESTERONE		METHADONE	
.ANTINEOPLASTIC AND IMMUNOMODULATING		.NERVOUS SYSTEM	440
AGENTS	254	.Opiate Dependence Treatment Program	1003
.GENITO URINARY SYSTEM AND SEX HORMONES		.Palliative Care.....	599, 600
.....	167, 172, 173	<i>Methoblastin</i> (PF)	
<i>MEFENAMIC ACID</i>	416	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>Mefix 310250</i> (MH)	1057	AGENTS	224, 411
<i>Megace</i> (QA)	254	<i>Methoblastin</i> (PF)	
<i>Megafof 0.5</i> (AF).....	93	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>Megafof 5</i> (AF).....	94	AGENTS	224, 411
<i>MEGESTROL</i>	254	<i>Methopt</i> (QA).....	544, 545
<i>Melizide</i> (AF).....	62	METHOTREXATE	
<i>Melolin 36361357</i> (SN).....	1056	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>Melolin 66974933</i> (SN).....	1055	AGENTS	224, 411
<i>Melox 15</i> (GN)	413	<i>Methotrexate MYX</i> (YN)	224
<i>Melox 7.5</i> (GN)	413	METHOXY POLYETHYLENE GLYCOL-EPOETIN BETA	
<i>Meloxiauro 15</i> (DO)	413	.....	613, 801
<i>Meloxiauro 7.5</i> (DO)	413	METHOXYFLURANE	22
<i>Meloxibell</i> (GQ).....	413	METHYL SALICYLATE	1030
<i>MELOXICAM</i>	412, 413	METHYL SALICYLATE + MENTHOL + EUCALYPTUS OIL	
<i>Meloxicam AN</i> (EA)	413	.....	1030
<i>Meloxicam Ranbaxy</i> (RA).....	413	METHYLDOPA	100
<i>Meloxicam Sandoz</i> (SZ).....	413	METHYLNALTREXONE	592
<i>Meloxicam-GA</i> (GN)	413	METHYLPHENIDATE	497, 498
<i>MELPHALAN</i>	222	<i>Methylpred</i> (AL).....	183
<i>MEMANTINE</i>	504, 505	METHYLPREDNISOLONE	
<i>Memantine generichealth</i> (GQ).....	505, 506	.DERMATOLOGICALS	161, 162
<i>Memantine RBX</i> (RA)	505, 506	.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
<i>Memaxa</i> (QA)	505	HORMONES AND INSULINS	183
<i>Menopur 1200</i> (FP).....	998	<i>Methylprednisolone Alphapharm</i> (AF)	183
<i>Menopur 600</i> (FP).....	998	METOCLOPRAMIDE	22, 43
<i>Mepilex 294100</i> (MH)	1047	<i>Metoclopramide Actavis</i> (GN).....	43
<i>Mepilex Ag</i> (MH).....	1046	<i>Metoclopramide AN</i> (EA).....	43
<i>Mepilex Border 295200</i> (MH).....	1047	<i>Metoclopramide RBX</i> (RA)	43
<i>Mepilex Border 295300</i> (MH).....	1047	<i>Metoprolol Actavis</i> (GN)	106, 107
<i>Mepilex Border Ag</i> (MH)	1046	<i>Metoprolol AN</i> (EA).....	106, 107
<i>Mepilex Lite 284000</i> (MH).....	1047	<i>Metoprolol RBX</i> (RA).....	106, 107
<i>Mepilex Lite 284100</i> (MH).....	1047	<i>Metoprolol Sandoz</i> (SZ).....	106, 107
<i>Mepitac 298300</i> (MH)	1058	METOPROLOL SUCCINATE	106
<i>Mepitac 298400</i> (MH)	1058	METOPROLOL TARTRATE	106
<i>Mepitel 290510</i> (MH)	1055	<i>Metrogyl 200</i> (AF).....	210
<i>Mepitel 290710</i> (MH)	1055	<i>Metrogyl 400</i> (AF).....	210, 211
<i>Meprazol</i> (SZ).....	40	<i>Metrol 100</i> (QA).....	106
MERCAPTOPURINE	224	<i>Metrol 50</i> (QA).....	107
MESALAZINE	54, 55, 56	<i>Metrol-XL 190</i> (QA)	106
<i>Mesasal</i> (AS)	55	<i>Metrol-XL 23.75</i> (QA)	106
MESNA	552	<i>Metrol-XL 47.5</i> (QA)	106
<i>Mestinon Timespan</i> (IA).....	506	<i>Metrol-XL 95</i> (QA)	106
<i>Mestinon</i> (IA)	506	METRONIDAZOLE	210, 211
MESTRANOL + NORETHISTERONE	167	<i>Metronidazole Sandoz IV</i> (SZ)	211
<i>Metalyse</i> (BY).....	85	<i>Metronidazole-Claris</i> (AE)	211
<i>Metamucil Natural Granular</i> (PY).....	1016	<i>Metronide 200</i> (AV)	210
<i>Metamucil Orange Smooth</i> (PY).....	1016	<i>Metronide 400</i> (AV)	210, 211
<i>Metatar</i> (FM).....	106, 107	<i>Mezavant</i> (ZI)	54
<i>Metex XR</i> (QA)	61	<i>Miacalcic 100</i> (NV)	187
METFORMIN	60	MIANSERIN	494
METFORMIN + GLIBENCLAMIDE	63	<i>Micardis Plus 40/12.5 mg</i> (BY).....	124
<i>Metformin 500</i> (CR).....	60	<i>Micardis Plus 80/12.5 mg</i> (BY).....	124

Micardis Plus 80/25 mg(BY)	124	Mobilis D-20(AF)	414
Micardis(BY)	121	MOCLOBEMIDE	492
Micolette(AE)	51, 592, 1016	Moclobemide AN(EA).....	492
MICONAZOLE	157, 1020	Moclobemide Sandoz (SZ)	492
Microgynon 30 ED(BN).....	166	MODAFINIL.....	498
Microgynon 50 ED(BN).....	166	Modavigil(CS).....	499
Microlax (JT).....	51, 592, 1016	Modecate(BQ)	467
Microlut 28(BN).....	167	Moduretic(AS)	104
Micronelle 30 ED(TX)	166	Mogadon(IA)	
Micronor(JC).....	167	Palliative Care.....	603
MIDAZOLAM	22	Mogadon(IA)	
MIFEPRISTONE (&) MISOPROSTOL	177	NERVOUS SYSTEM	451, 485, 486
Milivin OD 15(DO).....	494	Mohexal(HX)	492
Milivin OD 30(DO).....	494	Molaxole(HM).....	50, 591
Milivin OD 45(DO).....	494	Momasone(QA)	162
MILK POWDER LACTOSE FREE FORMULA.....	571	MOMETASONE	162, 1023
MILK POWDER LACTOSE FREE FORMULA		Momex SR 10(QA)	435
PREDIGESTED	572	Momex SR 100 (QA)	435
MILK POWDER LACTOSE MODIFIED PREDIGESTED	572,	Momex SR 30(QA)	435
573		Momex SR 60(QA)	435
MILK POWDER SYNTHETIC LOW CALCIUM.....	573	Monace 10 (AF).....	112
MILK PROTEIN AND FAT FORMULA WITH VITAMINS		Monace 20 (AF).....	112
AND MINERALS CARBOHYDRATE FREE	583	Monodur 120 mg(PM).....	99
Minax 100 (AF)	106	Monodur 60 mg(PM).....	99
Minax 50 (AF)	107	Monofeme 28 (FZ).....	166
Minax XL (AF).....	106	Monogen(SB)	571
Minidiab(PF)	62	Monoplus 10/12.5 (BQ)	116
Minipress(PF)	101	Monoplus 20/12.5 (BQ)	116
Minirin Melt(FP)	180	Monopril(BQ)	112
Minirin Nasal Spray(FP).....	179	Montair 4(GN).....	525
Minirin(FP)	179, 180	Montair 5(GN).....	525
Minitran 10(IA)	98	MONTELUKAST	525
Minitran 15(IA)	98	Montelukast AN (EA)	525
Minitran 5(IA).....	99	Montelukast GH(GQ).....	525
MINOCYCLINE	190	Montelukast RBX (RA)	525
Minomycin-50(QA).....	190	Montelukast Sandoz 4(SZ)	525
MINOXIDIL	101	Montelukast Sandoz 5(SZ)	525
Mircera(RO).....	613, 614, 801, 802	MORPHINE	22, 432, 433, 434, 435, 597, 598, 1032
Mirena(BN)	165	MORPHINE MR APOTEX (TX)	435
MIRTAZAPINE	494	Motilium(JC)	43
Mirtazapine AN (EA).....	495	Movalis 15 (QA).....	413
Mirtazapine AN ODT (EA).....	494	Movalis 7.5 (QA).....	413
Mirtazapine AN(EA).....	495	Movicol (NE).....	50, 591
Mirtazapine GH (GQ).....	495	Movicol Liquid(NE)	50, 591
Mirtazapine GH(GQ).....	495	Movox 100 (AF).....	490
Mirtazapine Sandoz (SZ)	495	Movox 50 (AL).....	491
Mirtazapine Sandoz ODT 15(SZ).....	494	Moxicam 15(AF).....	413
Mirtazapine Sandoz ODT 30(SZ).....	494	Moxicam 7.5(AF).....	413
Mirtazapine Sandoz ODT 45(SZ).....	494	Moxiclav Duo 500/125 (QA)	196
Mirtazapine Sandoz(SZ)	495	Moxiclav Duo Forte 875/125 (QA)	196
Mirtazapine-GA (GN).....	495	MOXONIDINE	101
Mirtazapine-GA(GN).....	495	Mozobil(GZ).....	685, 875
Mirtazon (QA)	495	MS Contin Suspension 100 mg(MF).....	435
Mirtazon(QA)	495	MS Contin Suspension 20 mg(MF).....	435
Mistrom(ER).....	106, 107	MS Contin Suspension 200 mg(MF).....	433
Mixtard 30/70 InnoLet (NI)	59	MS Contin Suspension 30 mg(MF).....	434
Mixtard 30/70 Penfill 3 mL(NO).....	59	MS Contin Suspension 60 mg(MF).....	434
Mixtard 50/50 Penfill 3 mL(NO).....	60	MS Contin(MF)	433, 435, 597, 598, 1032
Mizart (AF)	121	MS Mono(MF)	435
Mizart HCT 40/12.5 mg (AF).....	124	MS-2 Step(XH).....	177
Mizart HCT 80/12.5 mg (AF).....	124	MSUD AID III(SB).....	578
Mizart HCT 80/25 mg (AF).....	124	MSUD amino5(VF)	579
MMA/PA Anamix infant(SB).....	575	MSUD Anamix infant(SB).....	578
MMA/PA cooler 15(VF).....	575	MSUD Anamix Junior LQ(SB)	579
MMA/PA express 15(VF).....	575	MSUD Anamix Junior(SB).....	578, 579
MMA/PA gel(VF).....	575	MSUD cooler 10(VF)	578
Mobic(BY).....	413	MSUD cooler 15(VF)	578
Mobilis 10(AF).....	414	MSUD cooler 20(VF)	578
Mobilis 20(AF).....	414	MSUD express 15(VF)	578
Mobilis D-10(AF).....	414	MSUD express 20(VF)	578

MSUD gel(VF)	578	.NERVOUS SYSTEM	454
MSUD Lophlex LQ 20(SB).....	578	Neurontin(PF)	
MSUD Maxamaid(SB)	578	.Repatriation Pharmaceutical Benefits Scheme	1033
MSUD Maxamum(SB)	578	Neurontin(PF)	
MUPIROICIN		.NERVOUS SYSTEM	454
.Repatriation Pharmaceutical Benefits Scheme	1022	Nevipin(GN).....	662, 851
.RESPIRATORY SYSTEM.....	515	NEVIRAPINE.....	662, 851
Murelax(FM)	484, 485, 602, 603	Nevirapine Alphapharm (AF).....	662, 851
Mycobutin(PF)	650, 839	Nevirapine RBX(RA).....	662, 851
MYCOPHENOLATE	276, 277, 700, 890, 891	Nexavar(BN).....	250, 251
Mycophenolate Sandoz (SZ)	276, 700, 891	Nexcare Durable Cloth First Aid Tape 799(MM).....	1057
Mycophenolate Sandoz(SZ)	277, 701, 891	Nexcare Gentle Paper First Aid Tape 789(MM)	1057
Mycostatin(FM)		Nexcare Tegaderm Transparent H1624(MM).....	1044
.Repatriation Pharmaceutical Benefits Scheme	1019	Nexcare Tegaderm Transparent H1626(MM).....	1044
Mycostatin(FM)		Nexium (AP).....	38
.ALIMENTARY TRACT AND METABOLISM	36	Nexium Hp7(AP)	42
.DERMATOLOGICALS	156	Nicabate CQ 14(GC).....	1034
Myfortic(NV).....	276, 700, 891	Nicabate CQ 21(GC)	1034
MyGlucoHealth(EH).....	555, 558	Nicabate P(GC).....	508
Mylanta Double Strength(JT).....	1015	NICORANDIL	99
Mylanta P(JT)	36	nicorette 16hr Invisipatch(JT)	508
Myleran(AS).....	222	Nicorette Patch(JT).....	1034
Myocrisin(SW)	418	NICOTINE	507, 1034
Mysoline(LM)	449	Nicotinell Step 1(NC).....	507
NAFARELIN.....	180, 998	Nicotinell Step 2(NC).....	507
NALOXONE.....	22, 550	Nicotinell Step 3(NC).....	507
Naloxone minijet(UC).....	22, 550	Nidem (QA)	61
NALTREXONE	509	NIFEDIPINE	109
Naltrexone GH(GQ).....	510	NILOTINIB.....	244, 245
NANDROLONE DECANOATE	76	Nilstat(QA)	
NAPHAZOLINE	1037	.Repatriation Pharmaceutical Benefits Scheme	1026
NAPHAZOLINE + ANTAZOLINE	1037	Nilstat(QA)	
Naprosyn SR1000(RO).....	415, 595, 596	.ALIMENTARY TRACT AND METABOLISM	36, 52
Naprosyn SR750(RO).....	415, 416, 596	NILUTAMIDE.....	259
Naprosyn(RO).....	415, 595, 596	NITRAZEPAM	
NAPROXEN.....	415, 416, 595, 596	.NERVOUS SYSTEM	450, 485
Naramig(AS).....	446, 447	.Palliative Care.....	603
NARATRIPTAN	446	Nitro-Dur 10(MK).....	98
Nardil(LM).....	492	Nitro-Dur 15(MK).....	98
NATALIZUMAB.....	701, 891	Nitro-Dur 5(MK).....	99
Natrilix SR(SE).....	102	NITROFURANTOIN	211
Natrilix(SE).....	102	Nitrolingual Pumpspray(SW)	21, 99
Navelbine(FB).....	225	Nivestim(HH)	670, 860
Nebilet(FK).....	107	Nizac(LN)	37
NEBIVOLOL	107	NIZATIDINE	37
NEDOCROMIL	523	Nizoral 1%(JT).....	156
Neo-B12 (HH).....	93	Nizoral 2% Cream(JT).....	157
Neocate Advance Vanilla(SB).....	560, 561, 562	Nizoral 2%(JT).....	157, 1020
Neocate Advance(SB)	561, 562	Nolvadex-D(AP)	257
Neocate Gold(SB).....	565, 567, 568	Nordette 28(PF).....	166
Neocate LCP(SB)	563, 564	Nordip(AF).....	108
Neo-Mercazole (LM)	186	Norditropin FlexPro(NO).....	993
Neoral 10(NV).....	410, 769, 960	Norditropin SimpleXx(NO).....	990, 991, 992
Neoral 100 (NV).....	410, 769, 960	NORETHISTERONE	
Neoral 25 (NV).....	410, 769, 960	.GENITO URINARY SYSTEM AND SEX HORMONES	
Neoral 50 (NV).....	410, 769, 960	.....	167, 173
Neoral(NV).....	410, 769, 960	NORETHISTERONE ACETATE + OESTRADIOL	173
NeoRecormon(RO).....	612, 800, 801	NORETHISTERONE ACETATE + OESTRADIOL (&)	
Neotigason (UA).....	159	OESTRADIOL.....	173
Nesina Met 12.5/1000(TK).....	63	NORFLOXACIN	209
Nesina Met 12.5/500(TK).....	63	Norfloxacin AN (EA)	209
Nesina Met 12.5/850(TK).....	63	Norfloxacin Sandoz (SZ)	209
Nesina(TK).....	69	Norfloxacin-GA(GN)	209
Neulactil(SW).....	468	Noriday 28 Day (PF).....	167
Neulasta(AN)	672, 862	Norimin 28 Day(FZ).....	167
Neupogen(AN).....	670, 860	Norimin-1 28 Day(FZ).....	167
Neupro(UC)	466	Norinyl-1/28(PF).....	167
Neurontin (PF)		Normacol Plus(NE).....	49, 589, 1016
.Repatriation Pharmaceutical Benefits Scheme	1033	Normison(QA)	486, 603
Neurontin (PF)		Norprolac(FP).....	166

Norspan(MF).....	441	Olanzapine generichealth 2.5(GQ).....	470
NORTRIPTYLINE	488	Olanzapine generichealth 5(GQ).....	470
Norvapine (GN).....	108	Olanzapine generichealth 7.5(GQ).....	470
Norvasc(PF).....	108	Olanzapine GH(GQ).....	473
Norvir(VE).....	654, 843	Olanzapine ODT generichealth 10 (GQ)	471
Noten (AF).....	105	Olanzapine ODT generichealth 5 (GQ)	471
Novasone (FR).....	162	Olanzapine ODT-DRLA(RZ).....	471
Novasone(FR).....	162	Olanzapine RBX (RA).....	473
Novatin(TX).....	159	Olanzapine RBX ODT(RA).....	471
Novicrit(SZ).....	613, 801	Olanzapine RBX(RA).....	472
NovoMix 30 FlexPen(NF).....	59	Olanzapine Sandoz (SZ).....	472
NovoMix 30 Penfill 3 mL (NO)	59	Olanzapine Sandoz ODT 10 (SZ).....	471
NovoRapid FlexPen(NF).....	58	Olanzapine Sandoz ODT 5 (SZ).....	471
NovoRapid Penfill 3 mL (NO).....	58	Olanzapine Sandoz(SZ).....	473
NovoRapid(NO).....	58	Olanzapine-DRLA(RZ).....	472, 473
Noxafil(MK).....	214	Olanzapine-GA (GN).....	472, 473
Nplate(AN).....	610, 798	Olanzapine-GA ODT (GN).....	471
Nuelin(IA).....	525	OLMESARTAN + AMLODIPINE +	
Nuelin-SR 200(IA).....	525	HYDROCHLOROTHIAZIDE	127
Nuelin-SR 250(IA).....	525	OLMESARTAN MEDOXOMIL.....	120
Nuelin-SR 300(IA).....	525	OLMESARTAN MEDOXOMIL + AMLODIPINE	125
Nufloxib(AF).....	209	OLMESARTAN MEDOXOMIL +	
Nu-Gel 2497(KI).....	1054	HYDROCHLOROTHIAZIDE	123
Nupentin 100 (AF)		Olmetec Plus(MK).....	123, 124
.Repatriation Pharmaceutical Benefits Scheme	1033	Olmetec(MK).....	120, 121
Nupentin 100(AF)		OLSALAZINE	56
.NERVOUS SYSTEM.....	454	Olysio(JC).....	655, 844
Nupentin 300 (AF)		OMALIZUMAB.....	781, 972
.NERVOUS SYSTEM.....	454	Omegapharm Pty Ltd(OE).....	203
Nupentin 300(AF)		Omepral (TX).....	40
.Repatriation Pharmaceutical Benefits Scheme	1033	OMEPRAZOLE	39, 40
Nupentin 400(AF)		Omeprazole AN (EA).....	40
.Repatriation Pharmaceutical Benefits Scheme	1033	Omeprazole generichealth (GQ)	40
Nupentin 400(AF)		Omeprazole RBX(RA).....	40
.NERVOUS SYSTEM.....	454	Omeprazole Sandoz(HX).....	40
Nupentin Tabs (AF)		Omeprazole Sandoz(SZ).....	40
.Repatriation Pharmaceutical Benefits Scheme	1033	Omeprazole-GA(GN).....	40
Nupentin Tabs (AF)		Omepro-GA (GN).....	40
.NERVOUS SYSTEM.....	454	Omnitrope(SZ).....	991
Nupentin Tabs(AF)		Onbrez(NV).....	515
.Repatriation Pharmaceutical Benefits Scheme	1033	OncoTICE(MK).....	265
Nupentin Tabs(AF)		ONDANSETRON.....	44, 45, 46
.NERVOUS SYSTEM.....	454	Ondansetron Alphapharm(AF).....	44, 45
NutropinAq(IS).....	991	Ondansetron AN (EA).....	44, 45
Nyogel(AS).....	534	Ondansetron AN ODT(EA).....	45, 46
NYSTATIN		Ondansetron Kabi(PK).....	44, 45
.ALIMENTARY TRACT AND METABOLISM	36, 52	Ondansetron ODT-DRLA (RZ)	45, 46
.DERMATOLOGICALS	156	Ondansetron SZ (HX).....	44, 45
.Repatriation Pharmaceutical Benefits Scheme	1019,	Ondansetron SZ ODT(HX).....	45, 46
1026		Ondansetron-Claris (AE).....	44, 45
O.R.S.(AS).....	53	Ondansetron-DRLA(RZ).....	44, 45
OCTREOTIDE	648, 649, 836, 837	Ondaz Zydis(SZ).....	45, 46
Octreotide (SUN)(ZF).....	648, 837	Ondaz(SZ).....	44, 45
Octreotide MaxRx (GQ)		OneTouch Select(JJ).....	555, 557
.Highly Specialised Drugs Program (Private Hospital) 648		OneTouch Verio(JJ).....	555, 557
.Highly Specialised Drugs Program (Public Hospital) 836,		Onglyza(AP).....	70
837		Onsetron (ZP).....	44, 45
Ocufen(AG).....	530	Onsetron 4 (ZP).....	44, 45
Ocuflox(AG).....	528	Onsetron 8 (ZP).....	44, 45
Odaplix SR (AF).....	102	Onsetron ODT 4 (GN).....	45, 46
OESTRADIOL.....	171	Onsetron ODT 8 (GN).....	45, 46
OESTRADIOL (&) OESTRADIOL + DYDROGESTERONE		Op-Site Flexigrid 4629(SN)	1045
.....	174	Opsumit(AT).....	639, 827
OESTRADIOL + DYDROGESTERONE	173	Opticrom(SW).....	538
OESTRIOL.....	172	Optifresh eye gel(PP).....	541
OFLOXACIN.....	528	Optifresh Plus(PP).....	542
OLANZAPINE.....	470, 471, 472, 473, 474, 475	Optifresh Tears(PP).....	542
Olanzapine AN (EA).....	472, 473	Optium Omega(MS).....	555, 557
Olanzapine AN ODT(EA).....	471, 472	Optive(AG).....	543
Olanzapine generichealth 10(GQ).....	471	Orabase(QA).....	1021

Oratane (GN).....	163	Panamax 240 Elixir(SW)	444
Oratane(GN).....	163	Panamax Co. 40(SW).....	1032
Ordine 10(MF)	434, 436	Panamax(SW).....	444
Ordine 2(MF)	434, 436	PANCREATIC EXTRACT.....	57
Ordine 5(MF)	434, 436	PANCRELIPASE	58
Orencia(BQ).....	269, 275, 692, 883	PANTHENOL	1025
Orgalutran(MK).....	999	Panthron(ER)	41
Orion Temozolomide (ON).....	222, 223	Panto (TK).....	41
Oripro(ON).....	996	Pantofast 20(RZ).....	41
ORLISTAT	1017	Pantofast 40(RZ).....	41
Oroxine(QA).....	185	PANTOPRAZOLE	40, 41
Orudis SR 200(SW).....	415	Pantoprazole Actavis (GN)	41
Orudis(SW).....	415	Pantoprazole AN (EA)	41
Oruvail SR(AV)	415	Pantoprazole AN(EA)	41
OsmoLax(KY)	50, 590	Pantoprazole generichealth (GQ).....	41
Ospolot(PL).....	459	Pantoprazole generichealth(GQ).....	41
Ossmax 70mg (RA).....	420	Pantoprazole Sandoz (SZ)	41
Osteomol 665 Paracetamol(CR).....	445, 600, 601	Pantoprazole Sandoz(SZ)	41
Otocomb Otic(FM)	549	Pantoprazole-GA (UA).....	41
Otodex(AV).....	549	Pantoprazole-GA(GN).....	41
Ovestin Ovula(AS).....	172	Panzytrat 25000(TM).....	58
Ovestin(AS).....	172	PAPER WASP VENOM.....	549
Ovidrel(SG).....	997	PARACETAMOL	444, 445, 600
OXAZEPAM.....	484, 485, 602	Paracetamol (Sandoz)(SZ).....	444, 445
OXCARBAZEPINE	452	PARACETAMOL + CODEINE	
Oxis Turbuhaler(AP).....	515	.NERVOUS SYSTEM	438, 439
OXPRENOLOL	105	.Repatriation Pharmaceutical Benefits Scheme	1032
OXYBUTYNIN	177	Paracetamol/Codeine GH 500/30(GQ).....	438, 439
Oxybutynin Sandoz (SZ).....	177	PARAFFIN.....	545, 546
Oxybutynin Winthrop(WA)	177	PARAFFIN LIGHT LIQUID + COCOAMPHODIACETATE	
OXYCODONE	436, 437	DISODIUM.....	1025
OXYCODONE + NALOXONE	438	Paralgin (FM).....	444, 445
Oxycodone Sandoz(SZ).....	437, 438	Parapane(AF).....	444, 445
OxyContin (MF)	437, 438	Pariet(JC)	41, 42
OxyContin(MF)	437, 438	Parlodel (NV).....	165
OXYMETAZOLINE	1035	Parlodel(NV)	
OxyNorm Liquid 5mg/5mL(MF).....	436, 437	.GENITO URINARY SYSTEM AND SEX HORMONES	
OxyNorm(MF).....	436, 437	.....	165
OXYTOCIN	22	.NERVOUS SYSTEM	463
Oxytocin Sandoz(SZ).....	22	Parnate(GH)	492
Oxytrol(GN).....	177	PAROXETINE	491
Ozapace(RA).....	113	Paroxetine Actavis (UA)	491
Ozcef (RA).....	200	Paroxetine AN(EA)	491
Oziclide MR (RA).....	61	Paroxetine generichealth(GQ).....	491
Ozidal (RA)	479, 480, 481, 482	Paroxetine GH(GQ).....	491
Ozidal(RA)	482, 483	Paroxetine Sandoz (SZ)	491
Ozin 10 (DO).....	473	Paroxetine-GA (GN)	491
Ozin 2.5(DO).....	472	Parzol 10 (ZP)	41
Ozin 5 (DO).....	473	Parzol 20 (ZP)	42
Ozin 7.5 (DO).....	473	Paxam 0.5(AF)	450, 601
Ozlodip(RA)	108	Paxam 2(AF)	450, 601
Ozmep (ZP).....	40	Paxtine(AF)	491
Ozole (RA).....	212	PAZOPANIB.....	247, 248, 249
Ozpan (RA).....	41	Peg 7420(MM).....	1039
Ozvir (RA).....	217	Peg 7422(MM).....	1039
PAA (IQ)	541	Peg 7423(MM).....	1039
Paediatric Seravit(SB)	585	Peg 7425(MM).....	1039
Palaxia SR(CS).....	442	Pegasys RBV(RO).....	677, 867, 868
PALIPERIDONE	478	Pegasys(RO).....	674, 865
PALONOSETRON.....	46	Pegatron(MK).....	680, 684, 870, 871, 875
Pamacid 20 (AF).....	37	PEGFILGRASTIM	671, 861
Pamacid 40 (AF).....	37	PEGINTERFERON ALFA-2A	674, 864
PAMIDRONATE DISODIUM.....	421, 778, 779, 969, 970	PEGINTERFERON ALFA-2A (&) RIBAVIRIN	674, 865
Pamisol(HH)	421, 778, 779, 969, 970	PEGINTERFERON ALFA-2B (&) RIBAVIRIN.....	677, 680, 868, 871
Panadeine Forte(SW).....	438, 439	PEGINTERFERON BETA-1A.....	264, 265
Panadol Osteo(GC).....	445, 600, 601	Pemzo(QA).....	40
Panadol(GC).....	600, 601	PENICILLAMINE	418
Panafcort(AS)	184	Pentasa(FP).....	55, 56
Panafcortelone(AS)	183, 184	PENTASTARCH + SODIUM CHLORIDE	94
Panamax (SW)	444, 445		

<i>Penthrox(DV)</i>	22	<i>Pharmacor Olanzapine 5(CR)</i>	473
<i>Peptamen Junior(NT)</i>	571	<i>Pharmacor Olanzapine 7.5(CR)</i>	473
<i>Pepzan(GN)</i>	37	<i>Pharmacor Omeprazole 20 (CR)</i>	40
PERAMPANEL.....	458	<i>Pharmacor Pioglitazone 15(CR)</i>	68
PERHEXILINE.....	100	<i>Pharmacor Pioglitazone 30(CR)</i>	68
<i>Periactin(AS)</i>	448	<i>Pharmacor Pioglitazone 45(CR)</i>	68
PERICYAZINE.....	468	<i>Pharmacor Pravastat 10 (CR)</i>	129, 130
<i>Perindo (AF)</i>	113	<i>Pharmacor Pravastat 20(CR)</i>	130
<i>Perindo Combi 4/1.25(AF)</i>	117	<i>Pharmacor Pravastat 40(CR)</i>	130, 131
PERINDOPRIL.....	112, 113	<i>Pharmacor Prozine 5 (CR)</i>	47, 48
PERINDOPRIL + AMLODIPINE.....	117	<i>Pharmacor Quetiapine 100(CR)</i>	476
PERINDOPRIL + INDAPAMIDE.....	116	<i>Pharmacor Quetiapine 200(CR)</i>	476
<i>Perindopril Actavis 2(UA)</i>	113	<i>Pharmacor Quetiapine 25(CR)</i>	477
<i>Perindopril Actavis 4(UA)</i>	113	<i>Pharmacor Quetiapine 300(CR)</i>	476
<i>Perindopril Actavis 8(UA)</i>	113	<i>Pharmacor Ramipril 10 (CR)</i>	114
<i>Perindopril and Indapamide CH 4/1.25 (EA)</i>	117	<i>Pharmacor Ramipril 5(CR)</i>	115
<i>Perindopril CH (EA)</i>	113	<i>Pharmacor Riluzole (CR)</i>	511
<i>Perindopril Combi Actavis 4/1.25(GN)</i>	117	<i>Pharmacor Salbutamol 2.5(CR)</i>	23, 516
<i>Perindopril generichealth(GQ)</i>	113	<i>Pharmacor Salbutamol 5(CR)</i>	23, 516
<i>Perindopril/ Indapamide GH 4/1.25 (GQ)</i>	117	<i>Pharmacor Sumatriptan 50 (CR)</i>	448
PERMETHRIN.....	514	<i>Pharmacor Tacrolimus 0.5(CR)</i>	410, 769, 960
<i>Persantin SR(BY)</i>	83	<i>Pharmacor Tacrolimus 1(CR)</i>	410, 769, 960
<i>Petrus Bisacodyl Suppositories(PP)</i>	49, 589	<i>Pharmacor Tacrolimus 5(CR)</i>	410, 769, 960
<i>Petrus Pharmaceuticals Pty Ltd(PP)</i>	51, 52, 592, 593, 1017	<i>Pharmacor Telmisartan 40(CR)</i>	121
<i>Pexsig(QA)</i>	100	<i>Pharmacor Telmisartan 80(CR)</i>	121
<i>Pfizer Australia Pty Ltd(PF)</i>		<i>Pharmacy Action Anti-Fungal Cream(GQ)</i>	1020
<i>.Prescriber Bag</i>	20, 22	<i>Pharmacy Action Cetrelief(GQ)</i>	1036
<i>Pfizer Australia Pty Ltd(PF)</i>		<i>Pharmacy Action FemCream(GQ)</i>	1026
<i>.ALIMENTARY TRACT AND METABOLISM</i>	43	<i>Pharmacy Action Laxative with Senna(GQ)</i>	1016
<i>Pfizer Australia Pty Ltd(PF)</i>		<i>Pharmacy Action Lorastyne(GQ)</i>	1037
<i>.ALIMENTARY TRACT AND METABOLISM</i>	43	<i>Pharmacy Action Low Dose Aspirin (GQ)</i>	1019
<i>Pfizer Australia Pty Ltd(PF)</i>		<i>Pharmacy Action Paracetamol Plus Codeine(GQ)</i>	1032
<i>.BLOOD AND BLOOD FORMING ORGANS</i>	80	<i>Pharmacy Action Sinus & Nasal Decongestant Relief(GQ)</i>	
<i>Pfizer Australia Pty Ltd(PF)</i>		.....	1036
<i>.ANTIINFECTIVES FOR SYSTEMIC USE</i>	207	<i>Pharmacy Choice Anastrozole (RI)</i>	260
<i>Pfizer Australia Pty Ltd(PF)</i>		<i>Pharmacy Choice Finasteride (RI)</i>	1028
<i>.ANTIINFECTIVES FOR SYSTEMIC USE</i>	207	<i>Pharmacy Choice Letrozole(RI)</i>	261
<i>Pharmacor Amlodipine (CR)</i>	108	<i>Pharmacy Choice Olanzapine (RI)</i>	473, 474
<i>Pharmacor AmoxyClav 500/125(CR)</i>	196	<i>Pharmacy Choice Olanzapine ODT(RI)</i>	471
<i>Pharmacor AmoxyClav 875/125(CR)</i>	196	<i>Pharmacy Choice Olanzapine(RI)</i>	472
<i>Pharmacor Anastrozole 1(CR)</i>	260	<i>Pharmacy Choice Quetiapine (RI)</i>	476, 477
<i>Pharmacor Candesartan 16(CR)</i>	119	<i>Pharmacy Choice Terbinafine(RI)</i>	158
<i>Pharmacor Candesartan 32(CR)</i>	119	<i>Phebra Naproxen Suspension(PL)</i>	416, 595, 596
<i>Pharmacor Candesartan 4(CR)</i>	119	PHENELZINE.....	492
<i>Pharmacor Candesartan 8(CR)</i>	119	PHENOBARBITONE.....	449
<i>Pharmacor Candesartan HCT 16/12.5 (CR)</i>	122	PHENOXYBENZAMINE	
<i>Pharmacor Candesartan HCT 32/12.5 (CR)</i>	122	<i>.CARDIOVASCULAR SYSTEM</i>	104
<i>Pharmacor Candesartan HCT 32/25 (CR)</i>	122	<i>.GENITO URINARY SYSTEM AND SEX HORMONES</i>	
<i>Pharmacor Cephalexin 500(CR)</i>	198	.....	178
<i>Pharmacor Citalo 20 (CR)</i>	488	PHENOXYMETHYLPENICILLIN.....	193, 194
<i>Pharmacor Donepezil 10(CR)</i>	499, 500	<i>Phenoxymethylpenicillin-AFT(AE)</i>	193
<i>Pharmacor Donepezil 5(CR)</i>	499, 500	<i>Phenylalanine 50(VF)</i>	583
<i>Pharmacor Duloxetine 30(CR)</i>	493	PHENYLALANINE WITH CARBOHYDRATE.....	583
<i>Pharmacor Duloxetine 60(CR)</i>	493	PHENYLEPHRINE + PREDNISOLONE ACETATE.....	529
<i>Pharmacor Escitalopram 10(CR)</i>	489	PHENYTOIN.....	449
<i>Pharmacor Escitalopram 20(CR)</i>	489	<i>Phlexy-10 Drink Mix(SB)</i>	579
<i>Pharmacor Finasteride 5(CR)</i>	1029	<i>Phlexy-10(SB)</i>	579
<i>Pharmacor Gabapentin 600(CR)</i>	454	PHOLCODINE.....	1036
<i>Pharmacor Gabapentin 800 (CR)</i>		<i>Phosphate Sandoz(NV)</i>	552
<i>.NERVOUS SYSTEM</i>	454	PHOSPHORUS.....	552
<i>Pharmacor Letrozole 2.5 (CR)</i>	261	<i>Physeptone(QA)</i>	441
<i>Pharmacor Meloxicam 15 (CR)</i>	413	<i>Physiotens(GO)</i>	101
<i>Pharmacor Meloxicam 7.5 (CR)</i>	413	PHYTOMENADIONE.....	22
<i>Pharmacor Metformin 1000(CR)</i>	60	<i>Piax (AF)</i>	82, 1019
<i>Pharmacor Montelukast 4 (CR)</i>	525	<i>Piax Plus Aspirin (AF)</i>	83
<i>Pharmacor Montelukast 5 (CR)</i>	525	<i>Piax(AF)</i>	81
<i>Pharmacor Mycophenolate 250 (CR)</i>	277, 701, 891	<i>Picato(LO)</i>	1023
<i>Pharmacor Mycophenolate 500(CR)</i>	276, 700, 891	PILOCARPINE.....	531
<i>Pharmacor Olanzapine 10(CR)</i>	474	PIMECROLIMUS.....	163
<i>Pharmacor Olanzapine 2.5 (CR)</i>	472	PINDOLOL.....	105

PINE TAR WITH TRIETHANOLAMINE LAURYL SULFATE		
.....	1022	
<i>Pinetarsol</i> (EO)	1022	
PIOGLITAZONE	67	
<i>Pioglitazone AN</i> (EA)	68	
<i>Pioglitazone generichealth 15</i> (GQ)	68	
<i>Pioglitazone generichealth 30</i> (GQ)	68	
<i>Pioglitazone generichealth 45</i> (GQ)	68	
<i>Pioglitazone Sandoz</i> (SZ)	68	
<i>Pioglitazone-GA</i> (GN)	68	
PIROXICAM	413	
<i>Pizaccord</i> (RA)	68	
PIZOTIFEN	448	
<i>PKU Anamix infant</i> (SB)	579	
<i>PKU Anamix Junior LQ</i> (SB)	576	
<i>PKU Anamix Junior</i> (SB)	576	
<i>PKU Cooler 10</i> (VF)	576	
<i>PKU Cooler 15</i> (VF)	575	
<i>PKU Cooler 20</i> (VF)	575	
<i>PKU express 15</i> (VF)	576	
<i>PKU express 20</i> (VF)	575	
<i>PKU gel</i> (VF)	576	
<i>PKU Lophlex LQ 10</i> (SB)	576	
<i>PKU Lophlex LQ 20</i> (SB)	575	
<i>PKU Lophlex Sensation 20</i> (SB)	576	
<i>PKU squeeze</i> (VF)	576	
<i>Placil</i> (AF)	487	
<i>Plaqacide</i> (OB)	1015	
<i>Plaquenil</i> (SW)	417	
<i>Plasma-Lyte 148</i> (BX)	95	
<i>Plavacor 75</i> (CR)	82	
<i>Plavix</i> (SW)	81, 82	
<i>Plavix</i> (SW)	1019	
<i>Plegrixy</i> (BD)	264, 265	
<i>Plendil ER</i> (GX)	109	
PLERIXAFOR	685, 875	
<i>Plidogrel</i> (FM)	81, 83	
PNEUMOCOCCAL PURIFIED CAPSULAR		
POLYSACCHARIDES	221	
<i>Pneumovax 23</i> (CS)	221	
PODOPHYLLOTOXIN	1023	
<i>Poly Gel</i> (AQ)	541	
<i>Poly Visc</i> (IQ)	545, 546	
POLYETHYLENE GLYCOL-400 + PROPYLENE GLYCOL		
.....	546, 547	
POLYLACTIC ACID	552	
POLYSTYRENE SULFONATE SODIUM	1038	
<i>Polytar</i> (GK)	1024	
<i>Poly-Tears</i> (IQ)	543, 544	
POLYVINYL ALCOHOL	547	
<i>Ponstan</i> (PF)	416	
POSACONAZOLE	213	
POTASSIUM CHLORIDE	76	
POTASSIUM CHLORIDE + POTASSIUM BICARBONATE		
+ POTASSIUM CARBONATE	76	
POVIDONE-IODINE	1024	
<i>Prabez</i> (AF)	42	
<i>Pradaxa</i> (BY)	86, 87	
<i>Pramin</i> (AF)	43	
PRAMIPEXOLE	464, 465	
<i>Pramipexole AN</i> (EA)	464	
<i>Pramipexole GH</i> (GQ)	464	
PRASUGREL	84	
<i>Pravachol</i> (FM)	129, 130, 131	
PRAVASTATIN	129, 130	
<i>Pravastatin Actavis 10</i> (UA)	129, 130	
<i>Pravastatin Actavis 20</i> (UA)	130	
<i>Pravastatin Actavis 40</i> (UA)	130, 131	
<i>Pravastatin AN</i> (EA)	129, 130	
<i>Pravastatin AN</i> (EA)	130, 131	
<i>Pravastatin generichealth</i> (GQ)	129, 130	
<i>Pravastatin generichealth</i> (GQ)	130, 131	
<i>Pravastatin Sandoz</i> (SZ)	130, 131	
<i>Pravastatin Sandoz</i> (SZ)	129, 130	
<i>Pravastatin-GA 10</i> (GN)	129, 130	
<i>Pravastatin-GA 20</i> (GN)	130	
<i>Pravastatin-GA 40</i> (GN)	130, 131	
<i>Pravastatin-GA 80</i> (GN)	130, 131	
PRAZICUANTEL	513	
PRazosin	101	
<i>PredMix</i> (LN)	184	
<i>Prednephin Forte</i> (AG)	529, 530	
PREDNISOLONE	183	
PREDNISOLONE SODIUM PHOSPHATE		
ALIMENTARY TRACT AND METABOLISM	53, 54	
SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX		
HORMONES AND INSULINS	184	
PREDNISONE	184	
<i>Predsol</i> (QA)	54	
<i>Predsolone</i> (LN)	183	
<i>Predsone</i> (LN)	184	
PREGABALIN	445	
<i>Pregnyl</i> (MK)	175, 998	
<i>Presolol 100</i> (AF)	108	
<i>Presolol 200</i> (AF)	108	
<i>Prexaton</i> (GN)	506, 507	
PREXUM 10 (RX)	113	
PREXUM 2.5 (RX)	112	
PREXUM 5 (RX)	113	
<i>Prexum Combi 5/1.25</i> (RX)	117	
<i>Prezista</i> (JC)	653, 841, 842	
<i>Prilace 10</i> (QA)	114	
<i>Prilace 2.5</i> (QA)	115	
<i>Prilace 5</i> (QA)	115	
PRIMIDONE	449	
<i>Primolut N</i> (BN)	173	
<i>Primoteston Depot</i> (BN)	170	
<i>Prinivil 10</i> (MK)	112	
<i>Prinivil 20</i> (MK)	112	
<i>Prioten 15</i> (DO)	68	
<i>Prioten 30</i> (DO)	68	
<i>Prioten 45</i> (DO)	68	
<i>Pristiq</i> (PF)	493	
<i>Pritor Plus 40/12.5 mg</i> (FI)	124	
<i>Pritor Plus 80/12.5 mg</i> (FI)	124	
<i>Pritor Plus 80/25 mg</i> (FI)	124	
<i>Pritor/Amlodipine</i> (FI)	126	
<i>Pro-Banthine</i> (QA)	178	
PROBENECID	419	
<i>Probitor</i> (SZ)	40	
PROCAINE PENICILLIN	20, 194	
<i>ProCalm</i> (QA)	47, 48	
PROCHLORPERAZINE	22, 47	
<i>Prochlorperazine AN</i> (EA)	47, 48	
<i>Prochlorperazine GH</i> (GQ)	47, 48	
<i>Prochlorperazine-GA</i> (GN)	47, 48	
<i>Pro-Cid</i> (PL)	419	
Procur (GN)		
ANTINEOPLASTIC AND IMMUNOMODULATING		
AGENTS	258	
GENITO URINARY SYSTEM AND SEX HORMONES		
.....	176	
<i>Procur 100</i> (GN)		
ANTINEOPLASTIC AND IMMUNOMODULATING		
AGENTS	258	
GENITO URINARY SYSTEM AND SEX HORMONES		
.....	176	
<i>Procur</i> (GN)		
GENITO URINARY SYSTEM AND SEX HORMONES		
.....	176	

<i>Prodeine 15(SW)</i>	1032	<i>Quetiapine GH 300(GQ)</i>	476
<i>Prodeine Forte (AV)</i>	438, 439	<i>Quetiapine RBX (RA)</i>	476, 477
<i>Profore 66050016(SN)</i>	1038	<i>Quetiapine Sandoz(SZ)</i>	476, 477
<i>Profore Lite 66050415(SN)</i>	1038	<i>Quetiapine-DRLA(RZ)</i>	476, 477
PROGESTERONE	996	<i>Quetiapine-GA (GN)</i>	476, 477
<i>Progout 100(AF)</i>	419	<i>Quilonum SR(AS)</i>	494
<i>Progout 300 (AF)</i>	419	QUINAGOLIDE	166
<i>Prograf (LL)</i>	410, 769, 960	QUINAPRIL	113
<i>Prograf XL(LL)</i>	410, 769, 770, 960, 961	QUINAPRIL + HYDROCHLOROTHIAZIDE	117
<i>Prodynova(BN)</i>	171	<i>Quinapril generichealth (GQ)</i>	114
<i>Proladone(PL)</i>	436, 437	<i>Quinapril-GA(UA)</i>	114
<i>Prolia(AN)</i>	428	<i>Quinate(AS)</i>	512
PROMETHAZINE		QUININE	512
.ALIMENTARY TRACT AND METABOLISM	48	<i>QuitX(AF)</i>	1034, 1035
.Prescriber Bag	22	<i>QV Bath Oil(EO)</i>	1022
.RESPIRATORY SYSTEM	526	<i>Qvar 100 Autohaler(IA)</i>	521
<i>Prontosan Wound Irrigation Solution(BR)</i>	1042	<i>Qvar 100(IA)</i>	521
PROPANTHELINE	177	<i>Qvar 50 Autohaler(IA)</i>	521
PROPRANOLOL	105	<i>Qvar 50(IA)</i>	521
PROPYLTHIOURACIL	185	RABEPRAZOLE	41, 42
<i>Proscar (MK)</i>	1029	<i>Rabeprazole Actavis 20 (UA)</i>	42
<i>Protaphane (NO)</i>	59	<i>Rabeprazole AN (EA)</i>	42
<i>Protaphane InnoLet (NI)</i>	59	<i>Rabeprazole AN(EA)</i>	42
<i>Protaphane Penfill 3 mL(NO)</i>	59	<i>Rabeprazole generichealth(GQ)</i>	42
PROTEIN HYDROLYSATE FORMULA WITH MEDIUM		<i>Rabeprazole RBX (RA)</i>	42
CHAIN TRIGLYCERIDES	568, 569	<i>Rabeprazole Sandoz (SZ)</i>	42
<i>Protos 2 g(SE)</i>	429	<i>Rabeprazole Sandoz(SZ)</i>	42
<i>Provera(PF)</i>		<i>Rabeprazole-DRLA (RZ)</i>	42
.ANTINEOPLASTIC AND IMMUNOMODULATING		<i>Rabeprazole-DRLA(RZ)</i>	42
AGENTS	254	<i>Rabeprazole-GA (GN)</i>	42
.GENITO URINARY SYSTEM AND SEX HORMONES		<i>Ralovera(FZ)</i>	173
.....	173	RALOXIFENE	428
<i>Proxen SR 1000(MD)</i>	415, 595, 596	<i>Raloxifene AN(EA)</i>	429
<i>Proxen SR 750(MD)</i>	415, 596	RALTEGRAVIR	666, 856
<i>Prozac 20(LY)</i>	490	<i>Ramace 1.25 mg(AV)</i>	114
<i>Prozac Tab(LY)</i>	490	<i>Ramace 10 mg (AV)</i>	114
<i>ProZero(VF)</i>	583, 584	<i>Ramace 2.5 mg (AV)</i>	115
PSEUDOEPHEDRINE	1036	<i>Ramace 5 mg (AV)</i>	115
PSYLLIUM HUSK POWDER	1016	RAMIPRIL	114, 115
<i>PTU(PL)</i>	186	RAMIPRIL + FELODIPINE	118
<i>Pulmicort Respules(AP)</i>	521	<i>Ramipril AN (EA)</i>	114
<i>Pulmicort Turbuhaler(AP)</i>	521	<i>Ramipril AN(EA)</i>	114, 115
<i>Pulmozyme(RO)</i>	785, 977	<i>Ramipril CH(EA)</i>	114
<i>Puregon 300 IU/0.36 mL(MK)</i>	175, 997	<i>Ramipril generichealth (GQ)</i>	115
<i>Puregon 600 IU/0.72 mL(MK)</i>	175, 998	<i>Ramipril generichealth(GQ)</i>	114, 115
<i>Puregon 900 IU/1.08 mL(MK)</i>	175, 998	<i>Ramipril RBX Tabs (RA)</i>	114, 115
<i>Purinethol(AS)</i>	224	<i>Ramipril Sandoz (SZ)</i>	114
<i>PVA Tears(PE)</i>	547	<i>Ramipril Sandoz(SZ)</i>	114, 115
<i>Pyralin EN(FZ)</i>	57	<i>Ramipril Winthrop (WA)</i>	114, 115
PYRANTEL	514	<i>Ramipril Winthrop(WA)</i>	114
PYRIDOSTIGMINE	506	<i>Ramipril-GA (GN)</i>	114, 115
PYRIMETHAMINE	512	<i>Ramipril-GA(GN)</i>	114, 115
<i>Qpril 10 (AF)</i>	113	<i>Rancef (RA)</i>	198
<i>Qpril 20 (AF)</i>	113	<i>Rancef(RA)</i>	197, 198
<i>Qpril 5 (AF)</i>	114	<i>Rani 2(AF)</i>	37, 38
<i>Questran Lite(QA)</i>	137	RANIBIZUMAB	539
<i>Quetia 100(FM)</i>	476	RANITIDINE	37
<i>Quetia 200(FM)</i>	476	<i>Ranitidine AN (EA)</i>	37
<i>Quetia 25(FM)</i>	477	<i>Ranitidine GH (GQ)</i>	38
<i>Quetia 300(FM)</i>	476	<i>Ranitidine GH(GQ)</i>	37
<i>Quetiaccord (UA)</i>	476, 477	<i>Ranitidine Sandoz (SZ)</i>	37
QUETIAPINE	475, 476	<i>Ranitidine Sandoz(SZ)</i>	38
<i>Quetiapine Actavis 100(VN)</i>	476	<i>Ranmoxy (RA)</i>	191
<i>Quetiapine Actavis 200(VN)</i>	476	<i>Ranmoxy(RA)</i>	190
<i>Quetiapine Actavis 25(VN)</i>	477	<i>Ranoxyl (GN)</i>	38
<i>Quetiapine Actavis 300(VN)</i>	476	<i>Ranoxyl(GN)</i>	37
<i>Quetiapine AN (EA)</i>	476, 477	<i>Ransim (RA)</i>	134, 135, 136
<i>Quetiapine GH 100(GQ)</i>	476	<i>Ransim(RA)</i>	134, 135
<i>Quetiapine GH 200(GQ)</i>	476	<i>Ranzepam(RA)</i>	484, 602
<i>Quetiapine GH 25(GQ)</i>	477	<i>Rapamune(PF)</i>	277, 701, 892

<i>Rapilysin 10 U(GN)</i>	85	<i>Risedronate AN(EA)</i>	422
<i>RASAGILINE</i>	466	<i>Risedronate Sandoz (SZ)</i>	1031
<i>Razit 10(DO)</i>	42	<i>Risedronate Sandoz(SZ)</i>	422
<i>Razit 20 (DO)</i>	42	<i>Risedronate-GA (GN)</i>	422
<i>RBX Topiramate(RA)</i>	459, 460	<i>Risedronate-GA(GN)</i>	1031
<i>RCF(AB)</i>	583	<i>Rispa (QA)</i>	482, 483
<i>Reandron 1000(BN)</i>	171	<i>Rispa(QA)</i>	479, 480, 481, 482
<i>Reaptan 10/10 (RX)</i>	118	<i>Risperdal (JC)</i>	479, 480, 481, 482, 483
<i>Reaptan 10/5 (RX)</i>	118	<i>Risperdal Consta(JC)</i>	481
<i>Reaptan 5/10 (RX)</i>	118	<i>Risperdal Quicklet(JC)</i>	479, 480, 481, 482
<i>Reaptan 5/5 (RX)</i>	118	<i>Risperdal(JC)</i>	480, 482
<i>Rebif 44(SG)</i>	263, 264	<i>Rispericor 0.5(CR)</i>	482, 483
<i>REBOXETINE</i>	495	<i>Rispericor 1(CR)</i>	480, 482
<i>ReddyMax Plus D-Cal(RZ)</i>	425	<i>Rispericor 2(CR)</i>	479, 480
<i>Redipred(AS)</i>	184	<i>Rispericor 3(CR)</i>	480
<i>Reedos 100 (DO)</i>	456	<i>Rispericor 4(CR)</i>	481
<i>Reedos 200 (DO)</i>	456	<i>RISPERIDONE</i>	479, 480, 481, 482
<i>Reedos 25 (DO)</i>	456	<i>Risperidone Actavis 0.5 (UA)</i>	482, 483
<i>Reedos 50 (DO)</i>	457	<i>Risperidone Actavis 1 (UA)</i>	480, 482
<i>Refresh Liquigel(AG)</i>	542, 543	<i>Risperidone Actavis 2 (UA)</i>	479, 480
<i>Refresh Night Time(AG)</i>	545, 546	<i>Risperidone Actavis 3 (UA)</i>	480
<i>Refresh Tears Plus(AG)</i>	542, 543	<i>Risperidone AN (EA)</i>	481
<i>Relistor(LM)</i>	592	<i>Risperidone AN(EA)</i>	479, 480, 482, 483
<i>Relpax(PF)</i>	446	<i>Risperidone generichealth (GQ)</i>	479, 480, 481, 482
<i>Remeron SolTab (FR)</i>	494	<i>Risperidone generichealth(GQ)</i>	481
<i>Remicade(JC) 710, 713, 716, 722, 725, 730, 734, 739, 748, 901, 904, 907, 913, 916, 920, 925, 934, 939, 1030</i>		<i>Risperidone GH (GQ)</i>	482, 483
<i>Reminyl(JC)</i>	501, 502	<i>Risperidone Sandoz (SZ)</i>	481
<i>Renagel(GZ)</i>	551, 790, 982	<i>Risperidone Sandoz(SZ)</i>	479, 480, 481, 482, 483
<i>Renastart(VF)</i>	585	<i>Risperidone-DRLA (RZ)</i>	479, 480, 482, 483
<i>RenaStart(VF)</i>	585	<i>Risperidone-DRLA(RZ)</i>	481
<i>Renitec 20(MK)</i>	111	<i>Risperidone-GA (GN)</i>	481
<i>Renitec Plus 20/6 (MK)</i>	116	<i>Risperidone-GA(GN)</i>	479, 480, 481, 482, 483
<i>Renitec(MK)</i>	111	<i>Rispermia (ER)</i>	479, 480, 481, 482, 483
<i>ReoPro(LY)</i>	81	<i>Rispermia(ER)</i>	481
<i>Repalyte New Formulation (SW)</i>	53	<i>Ritalin 10(NV)</i>	498
<i>Replicare Ultra 66000434(SN)</i>	1052	<i>Ritalin LA(NV)</i>	498
<i>Resolve Thrush(EO)</i>	1020	<i>Rithmik 200(QA)</i>	97
<i>Resonium-A(SW)</i>	1038	<i>RITONAVIR</i>	654, 842
<i>Respikast 4(QA)</i>	525	RITUXIMAB	
<i>Respikast 5(QA)</i>	525	.Highly Specialised Drugs Program (Private Hospital) 773	
<i>Resprim Forte (AF)</i>	203	.Highly Specialised Drugs Program (Public Hospital) .964	
<i>restore O.R.S.(GN)</i>	53	RIVAROXABAN	89, 90, 91
RETEPLASE	85	RIVASTIGMINE	502, 503
<i>Retrovir(VI)</i>	661, 850	<i>Rivotril(RO)</i>	20, 450, 601
<i>Revatio (PF)</i>	643, 831	<i>Rixadone (AF)</i>	481
<i>ReVia (BQ)</i>	510	<i>Rixadone(AF)</i>	479, 480, 481, 482, 483
<i>Revlimid(CJ)</i>	771, 773, 962, 964	RIZATRIPTAN	447
<i>Revolade(GK)</i>	608, 796	<i>Roaccutane (RO)</i>	163
<i>Reyataz(BQ)</i>	651, 652, 840	<i>Rocaltrol(RO)</i>	
RHAMNUS FRANGULA + STERCULIA	49, 589, 1016	.ALIMENTARY TRACT AND METABOLISM.....	75
<i>Riamet 20mg/120mg Dispersible(NV)</i>	513	.MUSCULO-SKELETAL SYSTEM.....	427
<i>Riamet(NV)</i>	513	<i>Rocta 10(QA)</i>	163
<i>Ridaura(GH)</i>	417	<i>Rocta 20(QA)</i>	163
RIFABUTIN	650, 839	<i>Roferon-A(RO)</i>	262, 672, 673, 863
<i>Rifadin(SW)</i>	217	ROMIPLOSTIM	608, 796
RIFAMPICIN	216	ROSIGLITAZONE	68
RIFAXIMIN	52	ROSIGLITAZONE + METFORMIN	64
RILPIVIRINE	662, 851	<i>Rostor 10(DO)</i>	132, 133
<i>Rilutek(SW)</i>	511	<i>Rostor 20(DO)</i>	132, 133
RILUZOLE	511	<i>Rostor 40(DO)</i>	132, 134
<i>Riluzole Sandoz (SZ)</i>	511	<i>Rostor 5(DO)</i>	132, 134
<i>Rimycin 150(AF)</i>	216, 217	ROSUVASTATIN	131, 132, 133
<i>Rimycin 300(AF)</i>	216, 217	ROSUVASTATIN (&) EZETIMIBE	150, 152
<i>Risedro once a week (QA)</i>	422	<i>Rosuvastatin Actavis 10 (GN)</i>	132, 133
<i>Risedro once a week(QA)</i>	1031	<i>Rosuvastatin Actavis 10(GN)</i>	131, 132
RISEDRONATE	421, 422, 1030	<i>Rosuvastatin Actavis 20 (GN)</i>	132, 133
RISEDRONATE (&) CALCIUM CARBONATE	426, 1031	<i>Rosuvastatin Actavis 20(GN)</i>	131, 133
RISEDRONATE (&) CALCIUM CARBONATE + COLECALCIFEROL	426, 1031	<i>Rosuvastatin Actavis 40 (GN)</i>	132, 134
		<i>Rosuvastatin Actavis 40(GN)</i>	131, 133
		<i>Rosuvastatin Actavis 5 (GN)</i>	132, 134

<i>Rosuvastatin Actavis 5(GN)</i>	131, 133	<i>seebri breezhaler(NV)</i>	522
<i>Rosuvastatin AN(EA)</i>	132, 133, 134	SELEGILINE	466
<i>Rosuvastatin GH(GQ)</i>	131, 132, 133, 134	SELENIUM SULFIDE	1024
<i>Rosuvastatin RBX (RA)</i>	132, 133, 134	Selgene (AF)	466
<i>Rosuvastatin Sandoz(SZ)</i>	132, 133, 134	Selsun(DQ).....	1024
<i>Rosuvastatin-DRLA (RI)</i>	131, 132, 133, 134	Senna-Gen(PP).....	1016
<i>Rosuzet Composite Pack(MK)</i>	152, 154	SENNOSIDE B.....	1016
ROTIGOTINE	465, 466	<i>Senokot(RC)</i>	1016
<i>Roxar 150 (QA)</i>	205, 206	<i>Sensipar(AN)</i>	188, 650, 838
<i>Roxar 300 (QA)</i>	206	<i>SensoCard(PX)</i>	555, 558
<i>Roxet 20 (DO)</i>	491	<i>Septrin Forte(QA)</i>	203
<i>Roximycin(AF)</i>	205, 206	<i>Septrin(QA)</i>	204
<i>Roxin (QA)</i>	209	<i>Serenace(QA)</i>	20, 468
ROXITHROMYCIN	205	<i>Serepax(QA)</i>	484, 485, 602, 603
<i>Roxithromycin AN (EA)</i>	205, 206	<i>Seretide Accuhaler 100/50(GK)</i>	519
<i>Roxithromycin GH (GQ)</i>	205, 206	<i>Seretide Accuhaler 250/50(GK)</i>	519
<i>Roxithromycin Sandoz(SZ)</i>	206	<i>Seretide Accuhaler 500/50(GK)</i>	519
<i>Roxithromycin SCP 150 (CR)</i>	206	<i>Seretide MDI 125/25(GK)</i>	519
<i>Roxithromycin SCP 300 (CR)</i>	206	<i>Seretide MDI 250/25(GK)</i>	519
<i>Roxithromycin-GA(GN)</i>	205, 206	<i>Seretide MDI 50/25(GK)</i>	519
<i>Rulide D(SW)</i>	206	<i>Serevent Accuhaler(GK)</i>	516
<i>Rulide(SW)</i>	206	<i>Seronia 100 (QA)</i>	476
<i>Rynacrom(SW)</i>	1035	<i>Seronia 200 (QA)</i>	476
<i>Rythmodan(SW)</i>	96	<i>Seronia 25 (QA)</i>	477
<i>S-26 LF(AS)</i>	571, 572	<i>Seronia 300 (QA)</i>	476
<i>Sabril(SW)</i>	453	<i>Serophene (SG)</i>	176
<i>Saflutan(MK)</i>	536	<i>Seroquel XR(AP)</i>	476
<i>Saizen 8 mg click.easy(SG)</i>	990	<i>Seroquel(AP)</i>	476, 477
<i>Saizen(SG)</i>	991, 992	<i>Sertra 100 (QA)</i>	491
<i>Salazopyrin(PF)</i>	57	<i>Sertra 50 (QA)</i>	491
<i>Salazopyrin-EN(PF)</i>	57	<i>Sertracor 100(CR)</i>	491
SALBUTAMOL		<i>Sertracor 50(CR)</i>	491
Prescriber Bag	23	SERTRALINE	491
RESPIRATORY SYSTEM.....	515, 516, 524	<i>Sertraline Actavis (UA)</i>	491
<i>Salbutamol Actavis (UA)</i>	23, 516	<i>Sertraline Actavis(UA)</i>	492
<i>Salbutamol Sandoz (SZ)</i>	23, 516	<i>Sertraline AN (EA)</i>	492
<i>Salbutamol-GA(GN)</i>	23, 516	<i>Sertraline AN(EA)</i>	491
SALCATIONIN	187	<i>Sertraline generichealth(GQ)</i>	491
SALICYLIC ACID + BENZALKONIUM CHLORIDE +		<i>Sertraline Sandoz (SZ)</i>	491
ALCOHOL + COAL TAR SOLUTION +		<i>Sertraline-DRLA (RZ)</i>	491
POLYOXYETHYLENE ETHERS.....	1024	<i>Setopress 3505(MH)</i>	1039
SALMETEROL.....	516	<i>Setrona(RA)</i>	491
<i>Salofalk(OA)</i>	54, 55, 56	SEVELAMER	550, 790, 982
<i>Salpraz (AF)</i>	41	<i>Sevikar 20/5(MK)</i>	126
<i>Salpraz(AF)</i>	41	<i>Sevikar 40/10(MK)</i>	126
<i>Sandimmun(NV)</i>	768, 959	<i>Sevikar 40/5(MK)</i>	126
<i>Sandomigran 0.5(NV)</i>	448	<i>Sevikar HCT 20/5/12.5(MK)</i>	127
<i>Sandostatin 0.05 (NV)</i>	648, 837	<i>Sevikar HCT 40/10/12.5(MK)</i>	127
<i>Sandostatin 0.1 (NV)</i>	648, 837	<i>Sevikar HCT 40/10/25(MK)</i>	127
<i>Sandostatin 0.5 (NV)</i>	648, 837	<i>Sevikar HCT 40/5/12.5(MK)</i>	127
<i>Sandostatin LAR(NV)</i>	649, 837	<i>Sevikar HCT 40/5/25(MK)</i>	127
<i>Sandrena(AS)</i>	171	<i>Sevredol(MF)</i>	433, 597, 598
<i>Saphris(LU)</i>	470	<i>Shilova 500(DO)</i>	220
SAPROPTERIN	77	Sical (AF)	
SAQUINAVIR.....	654, 843	ALIMENTARY TRACT AND METABOLISM	75
<i>Savacol Mouth and Throat Rinse(OM)</i>	1015	MUSCULO-SKELETAL SYSTEM	427
SAXAGLIPTIN	70	<i>Sifrol (BY)</i>	464
SAXAGLIPTIN + METFORMIN.....	64	<i>Sifrol ER(BY)</i>	464, 465
<i>Sculptra(GA)</i>	552, 553	<i>Sifrol(BY)</i>	465
<i>Scytera(RZ)</i>	158	<i>Sigmacort(QA)</i>	160
<i>Seaze 100(QA)</i>	456	<i>Sigmaxin(FM)</i>	95
<i>Seaze 200(QA)</i>	456	<i>Sigmaxin-PG(FM)</i>	96
<i>Seaze 25(QA)</i>	456	<i>Silaran(RA)</i>	1027
<i>Seaze 5(QA)</i>	456	SILDENAFIL	
<i>Seaze 50(QA)</i>	457	Highly Specialised Drugs Program (Private Hospital) 639	
<i>Sebifin 250 (RA)</i>	158	Highly Specialised Drugs Program (Public Hospital) .827	
<i>SebiRinse(EO)</i>	1025	Repatriation Pharmaceutical Benefits Scheme	1026
<i>Sebitar(EO)</i>	1024	<i>Sildenafil Actavis (UA)</i>	1027
<i>Sebivo(NV)</i>	660, 849	<i>Sildenafil Actavis(UA)</i>	1027
<i>Sebizole(GN)</i>	1020	<i>Sildenafil AN PHT 20(EA)</i>	643, 831

Sildenafil GH (GQ).....	1027
Sildenafil Sandoz PHT 20(SZ).....	643, 831
SILDENAFIL-DRx (RZ).....	643, 831
Silic 15(EQ).....	1021
SIMEPREVIR.....	654, 843
Simipex 0.125(QA).....	464
Simipex 0.25(QA).....	464
Simipex 1(QA).....	464
Simplotan(FZ).....	211
Simponi(JC).....	386, 389, 393, 396, 399, 402
Simpral (AF).....	464
Simvacor 10 (CR).....	134, 135
Simvacor 20(CR).....	134, 135
Simvacor 40(CR).....	134, 135
Simvacor 80(CR).....	135, 136
Simvar 10(QA).....	134, 135
Simvar 20 (QA).....	134, 135
Simvar 40 (QA).....	134, 135
Simvar 80 (QA).....	135, 136
SIMVASTATIN.....	134, 135
Simvastatin AN (EA).....	134, 135
Simvastatin AN(EA).....	134, 135, 136
Simvastatin generichealth (GQ).....	134, 135
Simvastatin generichealth(GQ).....	134, 135, 136
Simvastatin Sandoz (SZ).....	134, 135, 136
Simvastatin Sandoz(SZ).....	134, 135
Simvastatin-DP (UA).....	134, 135, 136
Simvastatin-DP(UA).....	134, 135
Simvastatin-DRLA (RZ).....	134, 135
Simvastatin-DRLA(RZ).....	134, 135, 136
Simvastatin-GA 10(GN).....	134, 135
Simvastatin-GA 20 (GN).....	134, 135
Simvastatin-GA 40 (GN).....	134, 135
Simvastatin-GA 80 (GN).....	135, 136
Sinemet 100/25(MK).....	462
Sinemet CR(MK).....	462
Sinemet(MK).....	462
Sinequan(PF).....	487
Singular (MK).....	525
SIROLIMUS.....	277, 701, 892
SITAGLIPTIN.....	71
SITAGLIPTIN + METFORMIN.....	65
Skelid(SW).....	423
SKIN EMOLLIENT.....	1022
Slow-K(NV).....	76
Sno-Pro(SB).....	583
Sodibic(AS).....	178
SODIUM CHLORIDE	
BLOOD AND BLOOD FORMING ORGANS.....	94
Repatriation Pharmaceutical Benefits Scheme.....	1019
SODIUM CHLORIDE + GLUCOSE.....	94
SODIUM CHLORIDE + POTASSIUM CHLORIDE +	
GLUCOSE MONOHYDRATE + CITRATE.....	53
SODIUM GLUCONATE + SODIUM CHLORIDE +	
POTASSIUM CHLORIDE + MAGNESIUM CHLORIDE +	
SODIUM ACETATE TRIHYDRATE + GLUCOSE.....	95
SODIUM HYALURONATE.....	547, 548
Sodium Valproate Sandoz(SZ).....	453
Soflax(GN).....	1016
Sofradex(SW).....	549
Soframycin(SW).....	549
Solaraze 3% Gel(CS).....	1025
Solavert(QA).....	97
Solian 100 (SW).....	477
Solian 200 (SW).....	477
Solian 400(SW).....	478
Solian Solution(SW).....	477
Soliris(XI).....	693, 695, 699, 884, 885, 890
Solone (IA).....	184
SoloSite Gel 36361338(SN).....	1054

Solprin(RC)	
BLOOD AND BLOOD FORMING ORGANS.....	81
NERVOUS SYSTEM.....	444
Solu-Cortef(PF).....	21, 182, 183
Solugel 10336(JJ).....	1053
Solu-Medrol(PF).....	183
Somac (NQ).....	41
Somac(NQ).....	41
SOMATROPIN.....	990, 992
Somatuline Autogel(IS).....	648, 836
Somatuline LA(IS).....	647, 835
Sone (IA).....	184
SORAFENIB.....	250, 251
Sorbact Absorption Dressing S98222(QL).....	1053
Sorbact Foam Dressing S98310(QL).....	1054
Sorbact Ribbon Gauze S98118(QL).....	1054
Sorbact Ribbon Gauze S98120(QL).....	1054
SORBITOL + CITRATE + LAURYL SULFOACETATE	
SODIUM.....	51, 591, 592, 1016
Sorbsan 1410(UM).....	1044
Sorbsan 1411(UM).....	1043
Sotacor(FM).....	97
SOTALOL.....	97
Sotalol Sandoz (SZ).....	97
SOY LECITHIN + TOCOPHEROLS + VITAMIN A.....	548
SOY PROTEIN AND FAT FORMULA WITH VITAMINS	
AND MINERALS CARBOHYDRATE FREE.....	583
Sozol (QA).....	41
Sozol(QA).....	41
Span-K(AS).....	76
Spiractin 100(AF).....	104
Spiractin 25(AF).....	104
Spiriva(BY).....	523
SPIRONOLACTONE.....	103
Sporanox(JC).....	213
Spren 100 (QA).....	81
Sprycel(BQ).....	228, 230, 231
Stalevo 100/25/200mg(NV).....	462
Stalevo 125/31.25/200mg(NV).....	463
Stalevo 150/37.5/200mg(NV).....	463
Stalevo 200/50/200mg(NV).....	463
Stalevo 50/12.5/200mg(NV).....	463
Stalevo 75/18.75/200mg(NV).....	463
Staphylex 250 (AF).....	195
Staphylex 500 (AF).....	195
STAVUDINE.....	659, 848
Stelara(JC).....	405, 410
Stelax 10(QA).....	418
Stelax 25(QA).....	418
Stelazine(GH).....	467, 468
Sternetil(SW).....	22, 47, 48
Stemzine(AV).....	47, 48
Steripaste 3610(MH).....	1042
Stieprox Liquid(GK).....	1020
Stocrin(MK).....	661, 850, 851
Strattera(LY).....	496, 497
Stribild(GI).....	665, 855
Stromectol(MK).....	514
STRONTIUM.....	429
Suboxone Film 2/0.5(RC).....	1003
Suboxone Film 8/2(RC).....	1003
Subutex(RC).....	1003
SUCRALFATE.....	42
SUCROFERRIC OXYHYDROXIDE.....	551, 791, 982
SULFADIAZINE SILVER.....	159
SULFASALAZINE.....	56, 57
Sulprix (AF).....	478
Sulprix(AF).....	477
SULTHIAME.....	458
Sumagran Aspen 50 (AS).....	447

Sumatab(AF).....	447	Tegaderm Transparent Island 3586(MM).....	1045
Sumatran (QA).....	447	Tegretol 100(NV).....	451
Sumatran(QA).....	448	Tegretol 200(NV).....	451, 452
SUMATRIPTAN.....	447	Tegretol CR 200(NV).....	451
Sumatriptan AN (EA).....	448	Tegretol CR 400(NV).....	451
Sumatriptan generichealth (GQ).....	448	Tegretol Liquid(NV).....	451
Sumatriptan RBX(RA).....	448	TELAPREVIR.....	655, 844
Sumatriptan Sandoz (SZ).....	448	TELBIVUDINE.....	659, 848
Sumatriptan Sandoz(SZ).....	447	Telfa 1970C(KE).....	1055
Sumatriptan-GA(GN).....	448	Telfa 2140C(KE).....	1055
SUNITINIB.....	251, 252, 253	Telfa 7650C(KE).....	1055
SUNSCREENS.....	1022	Telfa 8252F(KE).....	1040
Sunsense Sensitive SPF 50+(EO).....	1022	Telfa 8253F(KE).....	1040
Sunsense Ultra SPF 50+(EO).....	1022	Telfa 8254F(KE).....	1040
Surepress 650947(CC).....	1038	Telfast 120(SW).....	1036
Surepress 650948(CC).....	1038	Telfast(SW).....	1036
Sutent(PF).....	252, 253, 254	Telmigen (GN).....	121
Symbicort Rapihaler 100/3(AP).....	517	Telmigen HCT 40/12.5 (GN).....	124
Symbicort Rapihaler 200/6(AP).....	518	Telmigen HCT 80/12.5 (GN).....	124
Symbicort Rapihaler 50/3(AP).....	517	Telmigen HCT 80/25 (GN).....	124
Symbicort Turbuhaler 100/6(AP).....	517	TELMISARTAN.....	121
Symbicort Turbuhaler 200/6(AP).....	517	TELMISARTAN + AMLODIPINE.....	126
Symbicort Turbuhaler 400/12(AP).....	517	TELMISARTAN + HYDROCHLOROTHIAZIDE.....	124
Symmetrel 100(NV).....	463	Telmisartan AN(EA).....	121
Synacthen Depot 1 mg/1 mL(NV).....	179	Telmisartan GH(GQ).....	121
Synarel(PF).....	180, 998	Telmisartan HCT GH 40/12.5(GQ).....	124
Syquet (AF).....	476, 477	Telmisartan HCT GH 80/12.5(GQ).....	124
Systane(AQ).....	546, 547	Telmisartan HCT GH 80/25(GQ).....	124
T Lukast (AF).....	525, 526	Telmisartan HCTZ AN 40/12.5(EA).....	124
Tacidine (AF).....	37	Telmisartan HCTZ AN 80/12.5(EA).....	124
TACROLIMUS.....	410, 769, 960	Telmisartan HCTZ AN 80/25(EA).....	124
Tacrolimus Sandoz(SZ).....	410, 769, 960	Telmisartan RBX (RA).....	121
TADALAFIL.....		Telmisartan Sandoz(SZ).....	121
.Highly Specialised Drugs Program (Private Hospital).....	643	Telmisartan/HCT Sandoz (SZ).....	124
.Highly Specialised Drugs Program (Public Hospital).....	831	Telmisartan-DRLA (RZ).....	121
.Repatriation Pharmaceutical Benefits Scheme.....	1027	Teltartan (QA).....	121
Tafinlar(GK).....	226	Teltartan HCT 40/12.5 (QA).....	124
TAFLUPROST.....	536	Teltartan HCT 80/12.5 (QA).....	124
Talam(QA).....	488	Teltartan HCT 80/25 (QA).....	124
Tamate (AF).....	459, 460	Telzir(VI).....	653, 842
Tambocor (IA).....	96	Temaze (AF).....	486, 603
Tambocor(IA).....	96	TEMAZEPAM.....	486, 603
Tamosin(QA).....	257	Temizole 100(QA).....	222, 223
Tamoxen 20 mg (GN).....	257	Temizole 140(QA).....	222, 223
TAMOXIFEN.....	257	Temizole 20(QA).....	223
Tamoxifen Sandoz(SZ).....	257	Temizole 250(QA).....	223
Tamsil(QA).....	158, 1021	Temizole 5(QA).....	223
TAMSULOSIN.....	1028	Temodal (MK).....	222, 223
Tamsulosin Sandoz SR (SZ).....	1028	Temodal(MK).....	222, 223
TAPE NON WOVEN RETENTION POLYACRYLATE.....	1056	TEMOZOLOMIDE.....	222, 223
TAPE PLASTER ADHESIVE ELASTIC.....	1057	Temozolomide Alphapharm(AF).....	222, 223
TAPE PLASTER ADHESIVE HYPOALLERGENIC.....	1057	Temozolomide AN (EA).....	222, 223
TAPE PLASTER ADHESIVE WITH SILICONE.....	1058	Temtabs(FM).....	486, 603
TAPENTADOL.....	441	Tenaxil SR(QA).....	102
TAR + CADE OIL + COAL TAR + ARACHIS OIL EXTRACT OF COAL TAR.....	1024	TenderWet 24 Active 609210(HR).....	1049
Tarceva(RO).....	231, 232	TenderWet 24 Active 609213(HR).....	1049
Targin 10/5mg(MF).....	438	TenderWet Active Cavity 609272(HR).....	1049
Targin 20/10mg(MF).....	438	TENECTEPLASE.....	85
Targin 40/20mg(MF).....	438	TENOFOVIR.....	660, 849
Targin 5/2.5mg(MF).....	438	TENOFOVIR + EMTRICITABINE.....	665, 854
Tarka 2/180(GO).....	118	TENOFOVIR + EMTRICITABINE + EFAVIRENZ.....	665, 854
Tarka 4/240(GO).....	118	TENOFOVIR + EMTRICITABINE + ELVITEGRAVIR + COBICISTAT.....	665, 854
Tasigna(NV).....	245, 247	Tenolten 50(DO).....	105
Tazac(AS).....	37	Tenopt(QA).....	534
Tears Naturale(AQ).....	543, 544	Tenormin(AP).....	105
tearsagain(RB).....	548	Tensig (QA).....	105
Tecfidera(BD).....	510, 511	Tensocrepe 36300501(BV).....	1040
Tegaderm Transparent 1628(MM).....	1044	Tensocrepe 36301001(BV).....	1040
Tegaderm Transparent Island 3582(MM).....	1045	Tensocrepe 36307501(BV).....	1040

Tenosopress 71723-00(BV).....	1038
TERAZOSIN	1028
TERBINAFINE	
.DERMATOLOGICALS	157, 158
.Repatriation Pharmaceutical Benefits Scheme	1020, 1021
Terbinafine Actavis (VN).....	158
Terbinafine AN(EA).....	158
Terbinafine GH (GQ)	1021
Terbinafine GH(GQ)	158
Terbinafine Sandoz (SZ).....	158
Terbinafine Sandoz(SZ).....	1021
Terbinafine-DRLA (RZ).....	158
TERBUTALINE	
.RESPIRATORY SYSTEM.....	516, 524
TERIFLUNOMIDE	277
Teril(AF).....	451, 452
TERIPARATIDE	
.MUSCULO-SKELETAL SYSTEM	429
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS	186
Terry White Chemists Aciclovir(TW)	217
Terry White Chemists Alendronate 70mg(TW)	420
Terry White Chemists Allopurinol (TW).....	419
Terry White Chemists Allopurinol(TW).....	419
Terry White Chemists Alprazolam(TW)	483
Terry White Chemists Amiodarone (TW)	97
Terry White Chemists Amitriptyline (TW).....	487
Terry White Chemists Amlodipine(TW).....	108
Terry White Chemists Amlodipine/Atorvastatin 10/10(TW)	155
Terry White Chemists Amlodipine/Atorvastatin 10/20(TW)	155
Terry White Chemists Amlodipine/Atorvastatin 10/40(TW)	155
Terry White Chemists Amlodipine/Atorvastatin 10/80(TW)	155
Terry White Chemists Amlodipine/Atorvastatin 5/10(TW)	156
Terry White Chemists Amlodipine/Atorvastatin 5/20(TW)	156
Terry White Chemists Amlodipine/Atorvastatin 5/40(TW)	156
Terry White Chemists Amlodipine/Atorvastatin 5/80(TW)	156
Terry White Chemists Amoxycillin (TW)	190, 191
Terry White Chemists Amoxycillin and Clavulanic Acid (TW)	196
Terry White Chemists Amoxycillin(TW)	191
Terry White Chemists Anastrozole(TW).....	260
Terry White Chemists Atenolol(TW)	105
Terry White Chemists Atorvastatin(TW).....	127, 128, 129
Terry White Chemists Azithromycin(TW)	1029
.Repatriation Pharmaceutical Benefits Scheme	1029
Terry White Chemists Azithromycin(TW)	204
.ANTIINFECTIVES FOR SYSTEMIC USE	526
.SENSORY ORGANS	418
Terry White Chemists Baclofen (TW)	106
Terry White Chemists Bisoprolol (TW).....	119
Terry White Chemists Candesartan (TW).....	122
Terry White Chemists Candesartan HCTZ 16/12.5(TW)	122
Terry White Chemists Candesartan HCTZ 32/12.5(TW)	122
Terry White Chemists Candesartan HCTZ 32/25(TW)	107
Terry White Chemists Carvedilol 12.5 mg(TW).....	108
Terry White Chemists Carvedilol 25 mg(TW).....	108
Terry White Chemists Carvedilol 3.125 mg (TW).....	108
Terry White Chemists Carvedilol 6.25 mg(TW).....	200
Terry White Chemists Cefaclor CD(TW).....	417
Terry White Chemists Celecoxib(TW).....	197, 198

Terry White Chemists Cephalixin(TW)	197, 198
Terry White Chemists Citalopram (TW).....	488
Terry White Chemists Clarithromycin(TW)	204
Terry White Chemists Clindamycin(TW).....	487
Terry White Chemists Clomipramine (TW)	1019
Terry White Chemists Clopidogrel (TW).....	82
Terry White Chemists Clopidogrel(TW).....	83
Terry White Chemists Clopidogrel/Aspirin 75/100(TW)	412, 593, 594
Terry White Chemists Diclofenac (TW)	110
Terry White Chemists Diltiazem CD(TW)	499, 500
Terry White Chemists Donepezil (TW)	188, 189
Terry White Chemists Doxycycline (TW).....	189, 190
Terry White Chemists Doxycycline(TW).....	493
Terry White Chemists Duloxetine (TW)	111
Terry White Chemists Enalapril (TW)	489
Terry White Chemists Escitalopram (TW)	219, 220
Terry White Chemists Famciclovir(TW).....	37
Terry White Chemists Famotidine (TW)	490
Terry White Chemists Fluoxetine(TW).....	103
Terry White Chemists Frusemide (TW)	137
Terry White Chemists Gemfibrozil (TW).....	61
Terry White Chemists Gliclazide MR(TW)	61
Terry White Chemists Gliclazide(TW).....	417
Terry White Chemists Hydroxychloroquine (TW)	102
Terry White Chemists Indapamide (TW)	102
Terry White Chemists Indapamide SR (TW)	120
Terry White Chemists Irbesartan (TW).....	123
Terry White Chemists Irbesartan HCTZ (TW)	99
Terry White Chemists Isosorbide Mononitrate(TW).....	535, 536
Terry White Chemists Latanoprost(TW).....	109
Terry White Chemists Lercanidipine (TW).....	261
Terry White Chemists Letrozole (TW)	457
Terry White Chemists Levetiracetam(TW).....	112
Terry White Chemists Lisinopril (TW).....	413
Terry White Chemists Meloxicam 15 mg(TW).....	413
Terry White Chemists Meloxicam 7.5 mg(TW)	413
Terry White Chemists Meloxicam(TW).....	61
Terry White Chemists Metformin (TW)	60
Terry White Chemists Metformin 1000 (TW)	61
Terry White Chemists Metformin XR 500(TW)	106, 107
Terry White Chemists Metoprolol (TW)	495
Terry White Chemists Mirtazapine (TW).....	495
Terry White Chemists Mirtazapine(TW).....	492
Terry White Chemists Moclobemide (TW).....	492
Terry White Chemists Moclobemide(TW).....	525, 526
Terry White Chemists Montelukast(TW).....	472
Terry White Chemists Olanzapine (TW)	471, 472
Terry White Chemists Olanzapine ODT (TW)	473, 474
Terry White Chemists Olanzapine(TW).....	40
Terry White Chemists Omeprazole(TW).....	41
Terry White Chemists Pantoprazole (TW).....	41
Terry White Chemists Pantoprazole(TW).....	491
Terry White Chemists Paroxetine(TW).....	113
Terry White Chemists Perindopril (TW).....	117
Terry White Chemists Perindopril/ Indapamide 4/1.25(TW)	68
Terry White Chemists Pioglitazone (TW).....	414
Terry White Chemists Piroxicam (TW)	129, 130
Terry White Chemists Pravastatin (TW)	130, 131
Terry White Chemists Pravastatin(TW).....	101
Terry White Chemists Prazosin (TW)	476, 477
Terry White Chemists Quetiapine(TW).....	42
Terry White Chemists Rabeprazole (TW).....	42
Terry White Chemists Rabeprazole(TW).....	429
Terry White Chemists Raloxifene (TW)	114, 115
Terry White Chemists Ramipril (TW).....	114, 115
Terry White Chemists Ramipril(TW).....	37
Terry White Chemists Ranitidine (TW)	38
Terry White Chemists Ranitidine(TW).....	422

Terry White Chemists Rosuvastatin (TW).....	131, 132, 133, 134
Terry White Chemists Roxithromycin(TW).....	206
Terry White Chemists Sertraline (TW).....	491
Terry White Chemists Sildenafil(TW).....	1027
Terry White Chemists Simvastatin (TW).....	134, 135
Terry White Chemists Simvastatin(TW).....	134, 135, 136
Terry White Chemists Sotalol(TW).....	97
Terry White Chemists Sumatriptan (TW).....	447
Terry White Chemists Sumatriptan(TW).....	448
Terry White Chemists Telmisartan HCTZ 40/12.5(TW) .	124
Terry White Chemists Telmisartan HCTZ 80/12.5(TW) .	124
Terry White Chemists Telmisartan HCTZ 80/25(TW)	124
Terry White Chemists Telmisartan(TW).....	121
Terry White Chemists Tramadol (TW).....	443, 444
Terry White Chemists Tramadol SR (TW).....	443
Terry White Chemists Tramadol SR(TW).....	442, 443
Terry White Chemists Valaciclovir (TW).....	220
Terry White Chemists Valaciclovir(TW).....	220, 221
Terry White Chemists Venlafaxine XR (TW).....	495, 496
Terry White Chemists Zopiclone (TW).....	1034
Tertroxin(QA).....	185
Testogel(HB).....	168
TESTOSTERONE.....	167
TESTOSTERONE ENANTHATE.....	169
TESTOSTERONE UNDECANOATE.....	170
TETRABENAZINE.....	511
TETRACOSACTRIN.....	179
TevaGrastim(AS).....	670, 860
Teveten Plus 600/12.5(GO).....	122
Teveten(GO).....	119, 120
THALIDOMIDE.....	777, 968
Thalomid(CJ).....	778, 969
THEOPHYLLINE.....	524
TheraTears(CX).....	542
THIAMINE.....	75, 1017
THIOGUANINE.....	224
Thioprine 50 (AF).....	411
Thyrogen(GZ).....	179
THYROTROPIN ALFA.....	179
THYROXINE.....	185
TIAGABINE.....	452
TICAGRELOR.....	84
TICARCILLIN + CLAVULANIC ACID.....	196, 197
Tielle MT2442(KI).....	1049
Tielle MTL101E(KI).....	1049
Tilade CFC-Free(SW).....	523
TILUDRONATE.....	422
Timentin(AS).....	197
TIMOLOL.....	534
TIMOLOL + TRAVOPROST.....	536, 537
Timoptol XE(MK).....	534
Timoptol(FR).....	534
Tinaderm(BN).....	1021
Tinasil (AF).....	1021
Tinasil(AF).....	158
TINIDAZOLE.....	211
TIOTROPIUM.....	523
TIPRANAVIR.....	656, 845
TIROFIBAN.....	84
Tirofiban AC (GN).....	85
Titralac(MM).....	1015
Tivicay(VI).....	666, 855
TOBI podhaler(NV).....	208
Tobi(NV).....	207
Tobra-Day(PL).....	207
TOBRAMYCIN	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	207, 208
.SENSORY ORGANS.....	527
Tobrex(AQ).....	527
TOCILIZUMAB.....	748, 754, 758, 763, 939, 945, 949, 954
Tofranil 10(LM).....	488
Tofranil 25(LM).....	488
Tolerade 10(PQ).....	488
Tolerade 25(PQ).....	488
TOLNAFTATE.....	1021
Topamax Sprinkle(JC).....	459
Topamax(JC).....	459, 460
TOPIRAMATE.....	459
Topiramate AN (EA).....	459, 460
Topiramate GH(GQ).....	459, 460
Topiramate Sandoz (SZ).....	459, 460
Topra 40(DO).....	41
Toprol-XL 190(AP).....	106
Toprol-XL 23.75(AP).....	106
Toprol-XL 47.5(AP).....	106
Toprol-XL 95(AP).....	106
TOREMIFENE.....	258
Torlemo DT 100 (UA).....	456
Torlemo DT 200 (UA).....	456
Torlemo DT 25 (UA).....	456
Torlemo DT 50 (UA).....	457
Torvastat 10 (QA).....	127, 128
Torvastat 20 (QA).....	127, 128
Torvastat 40 (QA).....	128
Torvastat 80 (QA).....	128, 129
Torzole 20 (VN).....	41
Torzole 40 (VN).....	41
Tracleer(AT).....	622, 627, 811, 815
Trajenta(BY).....	70
Trajentamet(BY).....	63
TRAMADOL.....	23, 442, 443, 444
Tramadol ACT(GN).....	23, 442, 444
Tramadol Actavis(UA).....	443, 444
Tramadol AN (EA).....	443, 444
Tramadol AN SR (EA).....	442, 443
Tramadol AN SR(EA).....	443
Tramadol Sandoz (SZ).....	23, 442, 444
Tramadol Sandoz SR (SZ).....	443
Tramadol Sandoz SR(SZ).....	442, 443
Tramadol Sandoz(SZ).....	443, 444
Tramadol SCP (CR).....	443, 444
Tramadol SR generichealth (GQ).....	442, 443
Tramadol SR generichealth(GQ).....	443
Tramal 100(CS).....	23, 442, 444
Tramal SR 100(CS).....	443
Tramal SR 150(CS).....	443
Tramal SR 200(CS).....	443
Tramal SR 50(CS).....	443
Tramal(CS).....	442, 443, 444
Tramedo SR 100(AF).....	443
Tramedo SR 150(AF).....	443
Tramedo SR 200 (AF).....	443
Tramedo(AF).....	443, 444
Tranalpha(AF).....	115, 116
Trandate(QA).....	108
TRANDOLAPRIL.....	115
TRANDOLAPRIL + VERAPAMIL.....	118
Trandolapril-DP (GN).....	115, 116
TRANEXAMIC ACID.....	92
Transiderm-Nitro 25(NV).....	99
Transiderm-Nitro 50(NV).....	98
TRANLYCYPROMINE.....	492
Travatan(AQ).....	537
TRAVOPROST.....	537
TRIAMCINOLONE	
.DERMATOLOGICALS.....	160
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
HORMONES AND INSULINS.....	184

TRIAMCINOLONE + NEOMYCIN SULFATE + GRAMICIDIN + NYSTATIN	549	TYR cooler 20(VF).....	577
Triasyn 2.5/2.5(SW).....	118	TYR express 15(VF).....	577
Triasyn 5.0/5.0(SW).....	118	TYR gel(VF).....	577
Tricortone(FM).....	160, 161	TYR Lophlex LQ 20(SB).....	577
Trifeme 28 (FZ).....	167	Tyrosine 1000(VF).....	584
TRIFLUOPERAZINE	467	TYROSINE WITH CARBOHYDRATE	584
TRIGLYCERIDES LONG CHAIN.....	558	Tysabri(BD)	701, 892
TRIGLYCERIDES LONG CHAIN WITH GLUCOSE POLYMER	583	Ulcacid(RA).....	37
TRIGLYCERIDES MEDIUM CHAIN	558, 559	Ulcaye(AF)	42
TRIGLYCERIDES MEDIUM CHAIN AND LONG CHAIN WITH GLUCOSE POLYMER	584	ultibro breezhaler 110/50(NV)	520
TRIGLYCERIDES MEDIUM CHAIN FORMULA VARIOUS	570, 571, 584	UMECLIDINIUM	523
Trileptal(NV).....	452	UMECLIDINIUM + VILANTEROL	520
TRIMETHOPRIM	203	Uracol(GN)	1027
TRIMETHOPRIM + SULFAMETHOXAZOLE	203	Ural Sachets (QA)	1027
Triphasil 28(PF)	167	UREA	1021
Triprim(QA).....	203	Urederm(IA).....	1021
TRIPTORELIN	257	Uremide(AF).....	103
Triquilar ED(BN)	167	Urex(FM)	102
Tritace (SW).....	114	Urex-Forte(FM).....	103
Tritace 1.25 mg (SW).....	114	Urex-M(FM)	103
Tritace 10 mg(SW).....	114	Uro-Carb(YN)	506
Tritace 2.5 mg (SW).....	115	Uromitexan(BX)	552
Tritace 5 mg (SW).....	115	URSODEOXYCHOLIC ACID	48
Tritace Titration Pack(SW).....	114	Ursofalk(OA).....	48
Triumeq(VI).....	664, 853	Ursosan (BZ).....	48
Trizivir(VI)	663, 852	USTEKINUMAB	402, 405
TROPISETRON	46	Vaclovir (AF).....	220, 221
Tropisetron-AFT(AE)	46	Vaclovir(AF).....	220
Trovas(RA)	127, 128, 129	Vagifem Low(NO).....	171
TRUEbalance(NX).....	554, 556	VALACICLOVIR	220, 221, 651, 839
TRUEresult(NX).....	554, 556	Valaciclovir Actavis (VN)	220
TRUEtrack(NX).....	554, 557	Valaciclovir Actavis(VN)	220, 221
Trusamide(QA)	532, 533	Valaciclovir AN (EA)	220, 221
Trusopt (MK).....	532, 533	Valaciclovir AN(EA)	220
Truvada(GI)	665, 854	Valaciclovir GA (GN)	220
Tryzan Caps 1.25(AF)	114	Valaciclovir GA(GN)	220, 221
Tryzan Caps 10 (AF)	114	Valaciclovir generichealth (GQ).....	221
Tryzan Caps 2.5 (AF)	115	Valaciclovir generichealth(GQ).....	220
Tryzan Caps 5(AF)	115	Valaciclovir RBX (RA).....	220, 651, 839
Tryzan Tabs 1.25(AF).....	114	Valaciclovir RBX(RA).....	221
Tryzan Tabs 10(AF).....	114	Valaciclovir Sandoz (SZ)	220, 221
Tryzan Tabs 2.5(AF).....	115	Valaciclovir Sandoz(SZ)	220
Tryzan Tabs 5(AF).....	115	Valaciclovir SZ (HX)	220
Tubegauz 0501633(SS).....	1041	Valaciclovir SZ(HX)	220
Tubifast 2434(MH)	1041	Valacor 500 (CR).....	220
Tubifast 2436(MH)	1041	Valacor 500(CR).....	220, 221
Tubifast 2438(MH)	1041	Valcyte(RO).....	651, 839
Tubigrip 1479(MH).....	1042	VALGANCICLOVIR	651, 839
Tubigrip 1480(MH).....	1042	Valine 1000(VF)	584
Tubigrip 1481(MH).....	1041	Valine 50(VF)	584
Tubigrip 1482(MH).....	1041	VALINE WITH CARBOHYDRATE	584
Tubigrip 1483(MH).....	1041	Valium(RO).....	484, 602
Tubigrip 1484(MH).....	1041	Valnir (QA).....	220, 221
Tubigrip 1486(MH).....	1041	Valnir(QA).....	220
Tubigrip B 1520(MH)	1040	Valpam 2 (QA).....	484, 602
Tubigrip C 1545(MH).....	1040	Valpam 5 (QA).....	484, 602
Tubigrip D 1546(MH)	1040	Valprease 200 (QA).....	453
Tubigrip E 1547(MH)	1041	Valprease 500 (QA).....	453
Tubigrip F 1548(MH).....	1040	Valpro 200(AF).....	453
Twynsta (BY)	126	Valpro 500(AF).....	453
Tykerb(GK)	244	VALPROATE	453
TYR Anamix infant(SB).....	577	Valproate Winthrop EC 200 (WA).....	453
TYR Anamix junior LQ(SB).....	573	Valproate Winthrop EC 500 (WA).....	453
TYR Anamix Junior(SB).....	577	VALSARTAN	121
TYR cooler 10(VF).....	577	VALSARTAN + HYDROCHLOROTHIAZIDE	124, 125
TYR cooler 15(VF).....	577	Valsartan/Amlodipine Sandoz 80/5 (NM).....	125
		Valsartan/Amlodipine/HCT Sandoz 160/5/12.5 (NM)	126
		Valtrex (AS)	220
		Valtrex(AS)	220, 221, 651, 839
		Vancocin CP (AS)	

.ANTIINFECTIVES FOR SYSTEMIC USE.....	209, 210	<i>Viramune (BY)</i>	662, 851
<i>Vancocin(AS)</i>	52	<i>Viramune XR(BY)</i>	662, 851
VANCOMYCIN		<i>Viramune(BY)</i>	662, 851
.ALIMENTARY TRACT AND METABOLISM	52	<i>Viread(GI)</i>	661, 850
.ANTIINFECTIVES FOR SYSTEMIC USE	209	<i>Viscopaste 4948(SN)</i>	1042
<i>Vancomycin Alphapharm (AF)</i>		<i>Viscotears Gel PF(AQ)</i>	541
.ANTIINFECTIVES FOR SYSTEMIC USE.....	209, 210	<i>Viscotears(AQ)</i>	541
<i>Vancomycin Alphapharm(AF)</i>	209, 210	<i>Visken 15(NV)</i>	105
<i>Vancomycin Sandoz (SZ)</i>	209, 210	<i>Vistil Forte(AE)</i>	547
<i>Vancomycin Sandoz(SZ)</i>	209, 210	<i>Vistil(AE)</i>	547
VARDENAFIL	1027	<i>Visudyne(NV)</i>	541
VARENICLINE	508, 509	<i>Vita-B12(GH)</i>	93
<i>Vasafil 100 (QA)</i>	1027	VITAMINS, MINERALS AND TRACE ELEMENTS WITH	
<i>Vasafil 25 (QA)</i>	1027	CARBOHYDRATE	584, 585
<i>Vasafil 50(QA)</i>	1027	<i>VitA-POS(AE)</i>	546
<i>Vascalace 1.25 (DO)</i>	114	<i>Volibris(GK)</i>	618, 806
<i>Vascalace 10 (DO)</i>	114	<i>Volirop 12.5(DO)</i>	107
<i>Vascalace 2.5 (DO)</i>	115	<i>Volirop 25(DO)</i>	108
<i>Vascalace 5 (DO)</i>	115	<i>Volirop 3.125 (DO)</i>	108
<i>Vascalace Caps 1.25 (DO)</i>	114	<i>Volirop 6.25(DO)</i>	108
<i>Vascalace Caps 10(DO)</i>	114	<i>Voltaren 100(NV)</i>	411, 593, 594
<i>Vascalace Caps 2.5(DO)</i>	115	<i>Voltaren 25(NV)</i>	412, 593, 594
<i>Vascalace Caps 5 (DO)</i>	115	<i>Voltaren 50(NV)</i>	412, 593, 594
<i>Vasocardol (AV)</i>	110	<i>Volunen 6%(PK)</i>	94
<i>Vasocardol CD (AV)</i>	110	VORICONAZOLE	214, 215
<i>Vasocardol CD(AV)</i>	110	<i>Votrient(GK)</i>	248, 249, 250
<i>Vastin(NM)</i>	129	<i>Voxam(SZ)</i>	491
<i>Vedafil (AF)</i>	1027	<i>Vycin IV (GN)</i>	209, 210
<i>Vedafil(AF)</i>	1027	<i>Vytorin(MK)</i>	147, 149, 150
<i>Vedilol 12.5 (QA)</i>	107	WARFARIN	78
<i>Vedilol 25 (QA)</i>	108	<i>Wartec Cream(GK)</i>	1023
<i>Vedilol 3.125(QA)</i>	108	<i>Waxsol(HM)</i>	1037
<i>Vedilol 6.25 (QA)</i>	108	<i>Wellvone(AS)</i>	512
<i>Velettri(AT)</i>	630, 818	WHEY PROTEIN FORMULA SUPPLEMENTED WITH	
<i>Velphoro(FN)</i>	551, 791, 982	AMINO ACIDS, LONG CHAIN POLYUNSATURATED	
<i>Venla RBX (RA)</i>	495, 496	FATTY ACIDS, VITAMINS AND MINERALS, LOW IN	
VENLAFAXINE	495	PROTEIN, PHOSPHATE, POTASSIUM AND LACTOSE	
<i>Venlafaxine Actavis XR (UA)</i>	495	.....	585
<i>Venlafaxine Actavis XR(UA)</i>	495, 496	WHEY PROTEIN FORMULA SUPPLEMENTED WITH	
<i>Venlafaxine AN SR (EA)</i>	495, 496	AMINO ACIDS, VITAMINS AND MINERALS, AND LOW	
<i>Venlafaxine AN SR(EA)</i>	495	IN PROTEIN, PHOSPHATE, POTASSIUM AND	
<i>Venlafaxine generichealth XR(GQ)</i>	495, 496	LACTOSE	585
<i>Venlafaxine Sandoz XR (SZ)</i>	495, 496	WOOL ALCOHOLS	1021
<i>Venlafaxine SR SCP 150(CR)</i>	495	<i>Xalacom (PF)</i>	536
<i>Venlafaxine SR SCP 75(CR)</i>	496	<i>Xalamol 50/5(QA)</i>	536
<i>Venlexor XR(GN)</i>	495, 496	<i>Xalaprost (QA)</i>	535, 536
<i>Venofer(AS)</i>	93	<i>Xalatan(PF)</i>	535, 536
<i>Ventavis(BN)</i>	634, 823	<i>Xarelto(BN)</i>	89, 90, 91
<i>Ventolin CFC-free(GK)</i>	23, 515	<i>Xatral SR(SW)</i>	1028
<i>Ventolin Nebules(GK)</i>	23, 516	<i>Xelabine (QA)</i>	224, 225
<i>Ventolin Rotacaps(GK)</i>	515	<i>Xeloda(RO)</i>	224, 225
<i>Ventolin(GK)</i>	524	<i>Xenical(RO)</i>	1017
<i>Vepesid(BQ)</i>	225	<i>Xeomin(EZ)</i>	987
<i>Veracaps SR(QA)</i>	110	<i>Xergic(AF)</i>	1036
VERAPAMIL	110	<i>Xgeva(AN)</i>	428
<i>Vermox(IA)</i>	1035	<i>Xifaxan(NE)</i>	52
VERTEPORFIN	540	<i>XLYS, LOW TRY Maxamaid(SB)</i>	574
VESPULA SPP VENOM.....	549	<i>XMET Maxamaid(SB)</i>	574
<i>Vexazone(AF)</i>	68	<i>XMET Maxamum(SB)</i>	574
<i>Vfend(PF)</i>	214, 215	<i>XMTVI Maxamaid(SB)</i>	575
<i>Viagra (PF)</i>	1027	<i>XMTVI Maxamum(SB)</i>	575
<i>Viagra(PF)</i>	1027	<i>Xolair(NV)</i>	784, 975
<i>Victrilis(MK)</i>	653, 841	<i>XP Maxamaid(SB)</i>	576
<i>Vidaza(CJ)</i>	668, 857, 858	<i>XP Maxamum(SB)</i>	576
<i>Videx EC(BQ)</i>	657, 846	<i>XPhen, Tyr Maxamaid(SB)</i>	577
VIGABATRIN	453	<i>XPhen, Tyr Maxamum(SB)</i>	577
VILDAGLIPTIN	71	<i>Xtandi(LL)</i>	259
VILDAGLIPTIN + METFORMIN.....	66	<i>Xydep 100(GN)</i>	491, 492
<i>Vimpat(UC)</i>	455, 456	<i>Xydep 50(GN)</i>	491, 492
VINORELBINE.....	225	<i>Xylocaine Viscous(AP)</i>	1022

<i>Xylocard 500(AP)</i>	96	.ANTIINFECTIVES FOR SYSTEMIC USE	204
<i>Yomax 250 (DO)</i>	191	.SENSORY ORGANS	526
<i>Yomax 500(DO)</i>	191	<i>Zitrocin(GN)</i>	
<i>Z.S.C.(QA)</i>	1026	.Repatriation Pharmaceutical Benefits Scheme	1029
<i>Zabep (AL)</i>	42	<i>Zitrocin(GN)</i>	
<i>Zactin (AF)</i>	490	.ANTIINFECTIVES FOR SYSTEMIC USE	204
<i>Zactin Tablet (AF)</i>	490	.SENSORY ORGANS	526
<i>Zan-Extra 10/10(GO)</i>	117	<i>Zocor (MK)</i>	134, 135, 136
<i>Zan-Extra 10/20(GO)</i>	117	<i>Zofran (AS)</i>	44
<i>Zanidip(GO)</i>	109	<i>Zofran syrup 50 mL(AS)</i>	44, 45
<i>Zantac Syrup(AS)</i>	37	<i>Zofran Zydys (AS)</i>	45, 46
<i>Zantac(AS)</i>	37, 38	<i>Zofran(AS)</i>	45
<i>Zarontin(PF)</i>	449, 450	<i>ZolaCos CP 10.8/50(28)(AP)</i>	255
<i>Zarzio(SZ)</i>	670, 860	<i>ZolaCos CP 10.8/50(84)(AP)</i>	255
<i>Zatamil (EO)</i>	162	<i>ZolaCos CP 3.6/50(AP)</i>	255
<i>Zavedos(PF)</i>	225	<i>Zoladex 10.8 Implant(AP)</i>	255
<i>Zedace(AF)</i>	111	<i>Zoladex Implant(AP)</i>	255
<i>Zedd 500(QA)</i>	1029	<i>ZOLEDRONIC ACID</i>	423, 779, 970
<i>Zeffix(AS)</i>	659, 847	<i>ZOLMITRIPTAN</i>	448
<i>Zeldox (PF)</i>	469	<i>Zoloft(PF)</i>	491, 492
<i>Zelitrex (UA)</i>	220, 221, 651, 839	<i>Zoltrip (QA)</i>	448
<i>Zelitrex(UA)</i>	220, 221	<i>Zomacton(FP)</i>	990, 991
<i>Zentel(AS)</i>	513	<i>Zometa(NV)</i>	779, 971
<i>Zerit(BQ)</i>	659, 848	<i>Zomig(AP)</i>	448
<i>Zestril(AP)</i>	112	<i>Zonegran(SA)</i>	460
<i>Zetlam (AF)</i>	659, 847	<i>ZONISAMIDE</i>	460
<i>Ziagen(VI)</i>	657, 845	<i>ZOPICLONE</i>	1034
<i>ZIDOVUDINE</i>	661, 850	<i>Zopral ODT (AF)</i>	39
<i>Zilarex(SZ)</i>	1036	<i>Zopral ODT(AF)</i>	39
<i>Zilfojim 4(DO)</i>	44	<i>Zopral(AF)</i>	39
<i>Zilfojim 8(DO)</i>	44	<i>Zoton FasTabs (PF)</i>	39
<i>Zilfojim ODT 4(DO)</i>	46	<i>Zoton FasTabs(PF)</i>	39
<i>Zilfojim ODT 8(DO)</i>	46	<i>Zovirax 200 mg(GK)</i>	217
<i>Zimstat (AF)</i>	134, 135, 136	<i>Zovirax 800 mg(GK)</i>	218
<i>Zimstat(AF)</i>	134, 135	<i>Zovirax(GK)</i>	527, 528
<i>ZINC OXIDE + MAIZE STARCH + CHLORPHENESIN +</i>		<i>ZUCLOPENTHIXOL DECANOATE</i>	469
<i>TALC-PURIFIED</i>	1026	<i>Zumenon(GO)</i>	171
<i>ZINC OXIDE + PERU BALSAM + BENZYL BENZOATE</i>		<i>Zyban(AS)</i>	506, 507
.....	1019	<i>Zydol (QA)</i>	443, 444
<i>Zinnat(AS)</i>	200, 201	<i>Zydol SR 100 (QA)</i>	443
<i>Zinopril 10(AL)</i>	112	<i>Zydol SR 150 (QA)</i>	443
<i>Zinopril 20(AL)</i>	112	<i>Zydol SR 200(QA)</i>	443
<i>Zinopril 5(AL)</i>	112	<i>Zyloprim(QA)</i>	419
<i>ZIPRASIDONE</i>	469	<i>Zypine (AF)</i>	473, 474
<i>ZipZoc 66000747(SN)</i>	1042	<i>Zypine ODT (AF)</i>	474
<i>Zircol(AF)</i>	109	<i>Zypine ODT(AF)</i>	474, 475
<i>Zithromax (PF)</i>		<i>Zypine(AF)</i>	472
.Repatriation Pharmaceutical Benefits Scheme	1029	<i>Zyprexa (LY)</i>	472
<i>Zithromax (PF)</i>		<i>Zyprexa Relprevv(LY)</i>	475
.ANTIINFECTIVES FOR SYSTEMIC USE	204	<i>Zyprexa Zydys (LY)</i>	474, 475
.SENSORY ORGANS	526	<i>Zyprexa Zydys(LY)</i>	474
<i>Zithromax(PF)</i>		<i>Zyprexa(LY)</i>	473, 474
.Highly Specialised Drugs Program (Private Hospital) 650		<i>Zyrtec(JT)</i>	1036
.Highly Specialised Drugs Program (Public Hospital) . 838		<i>Zytiga(JC)</i>	261
<i>Zithromax(PF)</i>			