



Australian Government

Department of Health

SCHEDULE OF PHARMACEUTICAL BENEFITS

This Schedule is also available on the internet at
www.pbs.gov.au

EFFECTIVE

1 December 2014 – 31 December 2014

(ALL PREVIOUS EDITIONS CANCELLED)

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

PHARMACEUTICAL BENEFITS.....	6	SECTION 100 – HIGHLY SPECIALISED DRUGS PROGRAM	
SUMMARY OF CHANGES	7	(PRIVATE HOSPITAL)	16
GENERAL PHARMACEUTICAL BENEFITS	7	<i>Additions</i>	16
<i>Additions</i>	7	Addition – Item	16
Addition – Item.....	7	Addition – Brand.....	16
Addition – Brand	7	Addition – Equivalence Indicator.....	16
Addition – Equivalence Indicator	8	Addition – Note	16
Addition – Note	9	<i>Deletions</i>	16
<i>Deletions</i>	9	Deletion – Item	16
Deletion – Brand	9	<i>Alterations</i>	16
Deletion – Note	9	Alteration – Restriction.....	16
<i>Alterations</i>	9	Alteration – Manufacturer Code	17
Alteration – Brand Name.....	9	<i>Advanced Notices</i>	17
Alteration – Restriction	10	1 February 2015.....	17
Alteration – Restriction Level	10		
Alteration – Manufacturer Code	10	ADDRESSES — DEPARTMENT OF HUMAN	
<i>Advanced Notices</i>	11	SERVICES	18
1 January 2015	11	AUTHORITY PRESCRIPTION APPLICATIONS	19
1 February 2015	11	REQUESTS FOR DRUGS VIA THE SPECIAL ACCESS	
1 March 2015	11	SCHEME (SAS)	19
1 April 2015	11	POISONS INFORMATION CENTRES	20
PREScriBER BAG.....	12	DRUG INFORMATION CENTRES	20
<i>Additions</i>	12	LIST OF CONTACT OFFICERS FOR RECALLS OF	
Addition – Item.....	12	THERAPEUTIC GOODS	21
<i>Alterations</i>	12	INDEX OF MANUFACTURERS' CODE.....	22
Alteration – Manufacturer Code	12	SECTION 1 — EXPLANATORY NOTES.....	30
PALLIATIVE CARE.....	13	INTRODUCTION	30
<i>Additions</i>	13	1. THE SCHEDULE — WHERE TO FIND WHAT	30
Addition – Brand	13	<i>Section 1</i>	30
Addition – Equivalence Indicator	13	<i>Section 2</i>	30
<i>Deletions</i>	13	<i>Section 3</i>	30
Deletion – Brand	13	<i>Section 4</i>	31
<i>Alterations</i>	13	<i>Repatriation Schedule of Pharmaceutical</i>	
Alteration – Manufacturer Code	13	<i>Benefits</i>	31
SECTION 100 – HIGHLY SPECIALISED DRUGS PROGRAM		2. PRESCRIBING MEDICINES – INFORMATION FOR PBS	
(PUBLIC HOSPITAL).....	14	PREScriBERS.....	31
<i>Additions</i>	14	<i>PBS prescribers</i>	31
Addition – Item.....	14	<i>PBS Prescription forms</i>	31
Addition – Brand	14	PBS stationery order forms.....	31
Addition – Equivalence Indicator	14	<i>Preparing general PBS prescriptions</i>	32
Addition – Note	14	Do's and Don't's.....	32
<i>Deletions</i>	14	Writing the PBS prescription	32
Deletion – Item.....	14	<i>Restrictions</i>	33
<i>Alterations</i>	14	<i>Authority PBS prescriptions</i>	33
Alteration – Restriction	14	Authority required PBS Prescriptions	33
Alteration – Manufacturer Code	15		
<i>Advanced Notices</i>	15		
1 February 2015	15		

Authority required (STREAMLINED) PBS Prescriptions.....	33	Hospital prescription record forms	43
Writing authority PBS prescriptions	34	Multi-item prescription forms	43
Maximum quantities and repeats.....	34	Qualifying PBS prescriptions.....	43
Regulation 24.....	34	Lost prescription record forms.....	43
Urgent cases	34	Retrospective entitlement and patient refunds	43
Drugs of addiction.....	35	Applying for a Safety Net Entitlement/Concession Card	44
Prescriber bag supplies	35	Issuing a Safety Net Entitlement/Concession Card	44
Improving the capacity of the PBS to meet particular Aboriginal and Torres Strait Islander health needs.....	35	Issuing supplementary cards	44
How to prescribe these items?.....	35	Notification to the Department of Human Services and claim for payment.....	44
Aboriginal and Torres Strait Islander identification	35	Lost Safety Net Entitlement/Concession Cards	44
Asking about Aboriginal and/or Torres Strait Islander identification	36	Pharmacy record of issued cards.....	44
Aboriginal and Torres Strait Islander health... ..	36		
Communication and cultural issues	36	6. DEPARTMENT OF HUMAN SERVICES ENTITLEMENT CHECKS.....	45
3. SUPPLYING MEDICINES — WHAT PHARMACISTS NEED TO KNOW	37	General Patients	45
Eligible suppliers	37	Concessional Patients	45
Approval conditions for pharmacists	37	Entitlement checking procedures	45
Before supplying pharmaceutical benefits..	37	General Patients	45
Supplying pharmaceutical benefits.....	37	Concessional Patients	45
Do's and Don'ts	37	Step by step	45
What to do if the Schedule changes.....	38	7. HOW PHARMACISTS CLAIM REIMBURSEMENT: INFORMATION REQUIRED	45
Suspected forgery	38	PBS Prescription identification	45
Regulation 24.....	38	Serial numbers.....	46
Repeat authorisations.....	38	Repeat authorisations for authority PBS prescriptions.....	46
Preparing Repeat Authorisation Forms	38	Repeat authorisations for deferred supply.....	46
Repeat authorisations for deferred supply	39	Dropper containers.....	46
Authority PBS prescriptions.....	39	Extemporaneously-prepared pharmaceutical benefits not listed in the Standard Formulae List	46
Urgent cases	39	PBS prescriptions paid on an average price basis.....	46
Receipts.....	39	Pricing non-pre-priced extemporaneous preparations	47
Prescriber bag supplies	39	RPBS prescriptions for items not included in either the PBS or RPBS Schedule.....	47
4. PATIENT CHARGES	40	Payment to Pharmacists for Dispensing Premium-free Substitutable Medicines	47
Type of patient.....	40	8. HOW PHARMACISTS CLAIM REIMBURSEMENT: DOCUMENTS TO BE SUBMITTED.....	47
Establishing entitlement	40	Completing the claim form.....	47
What to charge	40	Lodging claims.....	47
Patient contribution	40	Reconciliation statements	48
Patient contributions for early supply of some PBS medicines	41	9. PRICING PBS PRESCRIPTIONS	48
Special patient contributions, brand premiums and therapeutic group premiums	41	Pricing principles	48
Increased quantities	41	Pricing dates.....	48
Regulation 24	41		
After hours	41		
Delivery	41		
5. THE SAFETY NET SCHEME	41		
Safety net thresholds	42		
Safety net cross-over arrangements	42		
Recording PBS prescriptions.....	42		

<i>Pricing ready-prepared items</i>	48	RPBS EXPLANATORY NOTES	1189
For maximum quantities	48	<i>Introduction</i>	1189
For lesser quantities	48	The Australian Repatriation System	1189
Wastage table percentage	49	<i>RPBS prescribing provisions</i>	1189
<i>Pricing extemporaneously-prepared items</i> .	49	Prior Approval Arrangements.....	1189
General.....	49	Palliative Care Drugs.....	1190
Pricing of ingredients	49	Dental Prescribing	1190
Pricing PBS prescriptions where extra		Prescribing by optometrists.....	1190
ingredients are added to a formula.....	50	<i>Provisions governing pricing and payment for</i>	
Containers	50	<i>RPBS benefits</i>	1191
Special provisions for extemporaneous PBS		Introduction.....	1191
prescriptions outside the Standard Formulae		Pricing of Schedule Items	1191
List	50	Pricing of Non-Schedule Ready Prepared Items	
10. MISCELLANEOUS.....	50		1191
<i>References</i>	50	Pricing of Non-Schedule Extemporaneously	
<i>Standards</i>	50	Prepared Items	1191
<i>Legislation</i>	50	Miscellaneous Pricing Rules.....	1191
NURSE PRACTITIONER PBS PRESCRIBING.....	50	<i>General</i>	1191
MIDWIFE PBS PRESCRIBING	51	Packaging Material, Postage or Freight	1191
OPTOMETRIST PBS PRESCRIBING.....	52	Payment for Items Supplied at Short Intervals	
THERAPEUTIC INDEX	54		1191
SECTION 2 – READY-PREPARED		Receipts for Patient Charges	1192
PHARMACEUTICAL BENEFITS.....	59	Special Patient Contributions	1192
<i>SYMBOLS USED IN THE SCHEDULE</i>	59	Therapeutic Group Premiums — Authority	
<i>RESTRICTED BENEFITS</i>	59	Processing.....	1192
<i>BRAND EQUIVALENCE</i>	59	DEPARTMENT OF VETERANS' AFFAIRS.....	1192
<i>BRAND PREMIUM POLICY</i>	59	SUMMARY OF CHANGES	1193
<i>THERAPEUTIC GROUP PREMIUM POLICY</i>	60	REPATRIATION PHARMACEUTICAL BENEFITS.....	1193
PRESCRIBER BAG	61	<i>Additions</i>	1193
GENERAL PHARMACEUTICAL BENEFITS	65	Addition – Item.....	1193
PHARMACEUTICAL BENEFITS FOR PALLIATIVE CARE ...	631	Addition – Brand.....	1193
ITEMS AVAILABLE UNDER SPECIAL		Addition – Equivalence Indicator.....	1193
ARRANGEMENTS(SECTION 100)	648	Addition – Note	1193
SECTION 3 – CONTAINER PRICES, FEES,		<i>Alterations</i>	1193
STANDARD PACKS AND PRICES FOR READY		Alteration – Restriction.....	1193
PREPARED PHARMACEUTICAL BENEFITS.....	1162	Alteration – Manufacturer Code	1193
SECTION 4.....	1178	<i>Deletions</i>	1193
DRUG TARIFF	1179	Deletion – Brand.....	1193
CONTAINER PRICES	1183	THERAPEUTIC INDEX FOR RPBS	1194
STANDARD FORMULA PREPARATIONS.....	1184	SECTION 1.....	1196
TABLE OF CODES, MAXIMUM QUANTITIES, AND NUMBER		SECTION 2.....	1241
OF REPEATS FOR EXTEMPORANEOUSLY PREPARED		GENERIC/PROPRIETARY INDEX.....	1244
BENEFITS	1186	THERAPEUTIC GROUP PREMIUM POLICY	1337
REPATRIATION SCHEDULE OF PHARMACEUTICAL		BRAND PREMIUM POLICY	1339
BENEFITS	1187		
BENEFICIARIES' ENTITLEMENT CARDS AND			
ELIGIBILITY FOR REPATRIATION			
PHARMACEUTICAL BENEFITS	1188		

PHARMACEUTICAL BENEFITS

These changes to the Schedule of Pharmaceutical Benefits are effective from 1 December 2014. The Schedule is updated on the first day of each month and is available on the Internet at www.pbs.gov.au.

Fees, Patient Contributions and Safety Net Thresholds

The following fees, patient contributions and safety net thresholds apply as at 1 December 2014 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*	\$4.19
Additional Fees (for safety net prices):	Ready-prepared	\$1.15
	Extemporaneously-prepared	\$1.50
Patient Co-payments:	General	\$36.90
	Concessional	\$6.00
Safety Net Thresholds:	General	\$1421.20
	Concessional	\$360.00
Safety Net Card Issue Fee:		\$9.26

*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

General Pharmaceutical Benefits

Additions

Addition – Item

10176N	DOXYCYCLINE , doxycycline 100 mg tablet, 21 (<i>Doxycycline AN</i>)
10174L	ENZALUTAMIDE , enzalutamide 40 mg capsule, 112 (<i>Xtandi</i>)
10181W	ESCITALOPRAM , escitalopram 20 mg/mL oral liquid, 15 mL (<i>Lexapro</i>)
10199T	FLUTICASONE + VILANTEROL , fluticasone furoate 100 microgram/actuation + vilanterol 25 microgram/actuation inhalation: powder for, 30 actuations (<i>Breo Ellipta 100/25</i>)
10167D	FLUTICASONE + VILANTEROL , fluticasone furoate 200 microgram/actuation + vilanterol 25 microgram/actuation inhalation: powder for, 30 actuations (<i>Breo Ellipta 200/25</i>)
10195N	GLYCINE WITH CARBOHYDRATE , glycine with carbohydrate containing 500 mg of glycine oral liquid: powder for, 30 x 4 g sachets (<i>Glycine500</i>)
10185C	HIGH FAT FORMULA WITH VITAMINS, MINERALS AND TRACE ELEMENTS AND LOW IN PROTEIN AND CARBOHYDRATE , 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 (<i>KetoCal 4:1 LQ</i>)
10189G	TRIGLYCERIDES LONG CHAIN WITH GLUCOSE POLYMER , triglycerides long chain with glucose polymer oral liquid, 27 x 200 mL cartons (<i>Sno-Pro</i>)
10187E	UMECLIDINIUM , umeclidinium 62.5 microgram/actuation inhalation: powder for, 30 actuations (<i>Incruse Ellipta</i>)
10188F	UMECLIDINIUM + VILANTEROL , umeclidinium 62.5 microgram/actuation + vilanterol 25 microgram/actuation inhalation: powder for, 30 actuations (<i>Anoro Ellipta 62.5/25</i>)
10168E	VORICONAZOLE , voriconazole 40 mg/mL oral liquid: powder for, 70 mL (<i>Vfend</i>)
10173K	VORICONAZOLE , voriconazole 50 mg tablet, 56 (<i>Vfend</i>)
10198R	VORICONAZOLE , voriconazole 200 mg tablet, 56 (<i>Vfend</i>)

Addition – Brand

8439E	<i>APO-Celecoxib, TX – CELECOXIB</i> , celecoxib 100 mg capsule, 60
8439E	<i>Blooms the Chemist Celecoxib, IB – CELECOXIB</i> , celecoxib 100 mg capsule, 60
8439E	<i>Celaxib, AF – CELECOXIB</i> , celecoxib 100 mg capsule, 60
8439E	<i>Celecoxib AN, EA – CELECOXIB</i> , celecoxib 100 mg capsule, 60
8439E	<i>Celecoxib Actavis, GN – CELECOXIB</i> , celecoxib 100 mg capsule, 60
8439E	<i>Celecoxib GH, GQ – CELECOXIB</i> , celecoxib 100 mg capsule, 60
8439E	<i>Celecoxib RBX, RA – CELECOXIB</i> , celecoxib 100 mg capsule, 60
8439E	<i>Celecoxib Sandoz, SZ – CELECOXIB</i> , celecoxib 100 mg capsule, 60
8439E	<i>Celexi, QA – CELECOXIB</i> , celecoxib 100 mg capsule, 60
8439E	<i>Chem mart Celecoxib, CH – CELECOXIB</i> , celecoxib 100 mg capsule, 60
8439E	<i>Kudeq, FZ – CELECOXIB</i> , celecoxib 100 mg capsule, 60
8439E	<i>Terry White Chemists Celecoxib, TW – CELECOXIB</i> , celecoxib 100 mg capsule, 60
8440F	<i>APO-Celecoxib, TX – CELECOXIB</i> , celecoxib 200 mg capsule, 30
8440F	<i>Blooms the Chemist Celecoxib, IB – CELECOXIB</i> , celecoxib 200 mg capsule, 30
8440F	<i>Celaxib, AF – CELECOXIB</i> , celecoxib 200 mg capsule, 30
8440F	<i>Celecoxib AN, EA – CELECOXIB</i> , celecoxib 200 mg capsule, 30
8440F	<i>Celecoxib Actavis, GN – CELECOXIB</i> , celecoxib 200 mg capsule, 30
8440F	<i>Celecoxib GH, GQ – CELECOXIB</i> , celecoxib 200 mg capsule, 30
8440F	<i>Celecoxib RBX, RA – CELECOXIB</i> , celecoxib 200 mg capsule, 30
8440F	<i>Celecoxib Sandoz, SZ – CELECOXIB</i> , celecoxib 200 mg capsule, 30
8440F	<i>Celexi, QA – CELECOXIB</i> , celecoxib 200 mg capsule, 30
8440F	<i>Chem mart Celecoxib, CH – CELECOXIB</i> , celecoxib 200 mg capsule, 30
8440F	<i>Kudeq, FZ – CELECOXIB</i> , celecoxib 200 mg capsule, 30
8440F	<i>Terry White Chemists Celecoxib, TW – CELECOXIB</i> , celecoxib 200 mg capsule, 30
3138E	<i>APO-Clindamycin, TX – CLINDAMYCIN</i> , clindamycin 150 mg capsule, 24
5057E	<i>APO-Clindamycin, TX – CLINDAMYCIN</i> , clindamycin 150 mg capsule, 24 (Dental)
3138E	<i>Chem mart Clindamycin, CH – CLINDAMYCIN</i> , clindamycin 150 mg capsule, 24
5057E	<i>Chem mart Clindamycin, CH – CLINDAMYCIN</i> , clindamycin 150 mg capsule, 24 (Dental)
3138E	<i>Terry White Chemists Clindamycin, TW – CLINDAMYCIN</i> , clindamycin 150 mg capsule, 24
5057E	<i>Terry White Chemists Clindamycin, TW – CLINDAMYCIN</i> , clindamycin 150 mg capsule, 24 (Dental)
9296G	<i>DuoPlidogrel, GZ – CLOPIDOGREL + ASPIRIN</i> , clopidogrel 75 mg + aspirin 100 mg tablet, 30
8382E	<i>APO-Dipyridamole/Aspirin 200/25, TX – DIPYRIDAMOLE + ASPIRIN</i> , dipyridamole 200 mg + aspirin 25 mg capsule: modified release, 60 capsules
5542Q	<i>Dorzolamide/Timolol Sandoz 20/5, SZ – DORZOLAMIDE + TIMOLOL</i> , dorzolamide 2% + timolol 0.5% eye drops, 5 mL

(Optometrical)

8567X	<i>Dorzolamide/Timolol Sandoz 20/5, SZ – DORZOLAMIDE + TIMOLOL</i> , dorzolamide 2% + timolol 0.5% eye drops, 5 mL
2463P	<i>Galantamine AN SR, EA – GALANTAMINE</i> , galantamine 8 mg capsule: modified release, 28 capsules
8770N	<i>Galantamine AN SR, EA – GALANTAMINE</i> , galantamine 8 mg capsule: modified release, 28 capsules
2537M	<i>Galantamine AN SR, EA – GALANTAMINE</i> , galantamine 16 mg capsule: modified release, 28 capsules
8771P	<i>Galantamine AN SR, EA – GALANTAMINE</i> , galantamine 16 mg capsule: modified release, 28 capsules
2531F	<i>Galantamine AN SR, EA – GALANTAMINE</i> , galantamine 24 mg capsule: modified release, 28 capsules
8772Q	<i>Galantamine AN SR, EA – GALANTAMINE</i> , galantamine 24 mg capsule: modified release, 28 capsules
9302N	<i>ARDIX GLICLAZIDE 60mg MR, RX – GLICLAZIDE</i> , gliclazide 60 mg tablet: modified release, 60 tablets
8532C	<i>Tenaxil SR, QA – INDAPAMIDE</i> , indapamide hemihydrate 1.5 mg tablet: modified release, 90 tablets
8374R	<i>Leflunomide AN, EA – LEFLUNOMIDE</i> , leflunomide 10 mg tablet, 30
5449T	<i>Leflunomide Sandoz, SZ – LEFLUNOMIDE</i> , leflunomide 10 mg tablet, 30
8374R	<i>Leflunomide Sandoz, SZ – LEFLUNOMIDE</i> , leflunomide 10 mg tablet, 30
8375T	<i>Leflunomide AN, EA – LEFLUNOMIDE</i> , leflunomide 20 mg tablet, 30
5450W	<i>Leflunomide Sandoz, SZ – LEFLUNOMIDE</i> , leflunomide 20 mg tablet, 30
8375T	<i>Leflunomide Sandoz, SZ – LEFLUNOMIDE</i> , leflunomide 20 mg tablet, 30
8385H	<i>Oxycodone Sandoz, SZ – OXYCODONE</i> , oxycodone hydrochloride 10 mg tablet: modified release, 28 tablets
8386J	<i>Oxycodone Sandoz, SZ – OXYCODONE</i> , oxycodone hydrochloride 20 mg tablet: modified release, 28 tablets
8387K	<i>Oxycodone Sandoz, SZ – OXYCODONE</i> , oxycodone hydrochloride 40 mg tablet: modified release, 28 tablets
8388L	<i>Oxycodone Sandoz, SZ – OXYCODONE</i> , oxycodone hydrochloride 80 mg tablet: modified release, 28 tablets
1746X	<i>Parapane, AF – PARACETAMOL</i> , paracetamol 500 mg tablet, 100
5196L	<i>Parapane, AF – PARACETAMOL</i> , paracetamol 500 mg tablet, 100 (Dental)
5224Y	<i>Parapane, AF – PARACETAMOL</i> , paracetamol 500 mg tablet, 100 (Dental)
8784H	<i>Parapane, AF – PARACETAMOL</i> , paracetamol 500 mg tablet, 100
8814X	<i>APO-Osteo Paracetamol 665 mg, TX – PARACETAMOL</i> , paracetamol 665 mg tablet: modified release, 96 tablets
8814X	<i>Blooms the Chemist Osteo Pain Relief Paracetamol 665 mg, IB – PARACETAMOL</i> , paracetamol 665 mg tablet: modified release, 96 tablets
8814X	<i>Chem mart Pharmacy Osteo Relief Paracetamol 665 mg, CH – PARACETAMOL</i> , paracetamol 665 mg tablet: modified release, 96 tablets
8814X	<i>Osteomol 665 Paracetamol, CR – PARACETAMOL</i> , paracetamol 665 mg tablet: modified release, 96 tablets
8814X	<i>Terry White Chemists Osteo Relief Paracetamol 665 mg, TW – PARACETAMOL</i> , paracetamol 665 mg tablet: modified release, 96 tablets
3051N	<i>Perindopril CH, EA – PERINDOPRIL</i> , perindopril erbumine 4 mg tablet, 30
8704D	<i>Perindopril CH, EA – PERINDOPRIL</i> , perindopril erbumine 8 mg tablet, 30
8449Q	<i>Perindopril and Indapamide CH 4/1.25, EA – PERINDOPRIL + INDAPAMIDE</i> , perindopril erbumine 4 mg + indapamide hemihydrate 1.25 mg tablet, 30
9151P	<i>Simpral, AF – PRAMIPEXOLE</i> , pramipexole hydrochloride monohydrate 125 microgram tablet, 30
9393J	<i>Simpral, AF – PRAMIPEXOLE</i> , pramipexole hydrochloride monohydrate 125 microgram tablet, 30
9152Q	<i>Simpral, AF – PRAMIPEXOLE</i> , pramipexole hydrochloride monohydrate 250 microgram tablet, 100
9394K	<i>Simpral, AF – PRAMIPEXOLE</i> , pramipexole hydrochloride monohydrate 250 microgram tablet, 100
9153R	<i>Simpral, AF – PRAMIPEXOLE</i> , pramipexole hydrochloride monohydrate 1 mg tablet, 100
8363E	<i>APO-Raloxifene, TX – RALOXIFENE</i> , raloxifene hydrochloride 60 mg tablet, 28
8363E	<i>Chem mart Raloxifene, CH – RALOXIFENE</i> , raloxifene hydrochloride 60 mg tablet, 28
8363E	<i>Evifyne, EL – RALOXIFENE</i> , raloxifene hydrochloride 60 mg tablet, 28
8363E	<i>Raloxifene AN, EA – RALOXIFENE</i> , raloxifene hydrochloride 60 mg tablet, 28
8363E	<i>Terry White Chemists Raloxifene, TW – RALOXIFENE</i> , raloxifene hydrochloride 60 mg tablet, 28
1945J	<i>Ramipril RBX Tabs, RA – RAMIPRIL</i> , ramipril 2.5 mg tablet, 30
1946K	<i>Ramipril RBX Tabs, RA – RAMIPRIL</i> , ramipril 5 mg tablet, 30
1316G	<i>Ramipril RBX Tabs, RA – RAMIPRIL</i> , ramipril 10 mg tablet, 30
1978D	<i>Ranitidine AN, EA – RANITIDINE</i> , ranitidine 150 mg tablet, 60
8622T	<i>Telmisartan HCT GH 40/12.5, GQ – TELMISARTAN + HYDROCHLOROTHIAZIDE</i> , telmisartan 40 mg + hydrochlorothiazide 12.5 mg tablet, 28
8623W	<i>Telmisartan HCT GH 80/12.5, GQ – TELMISARTAN + HYDROCHLOROTHIAZIDE</i> , telmisartan 80 mg + hydrochlorothiazide 12.5 mg tablet, 28
9381R	<i>Telmisartan HCT GH 80/25, GQ – TELMISARTAN + HYDROCHLOROTHIAZIDE</i> , telmisartan 80 mg + hydrochlorothiazide 25 mg tablet, 28
9373H	<i>APO-Valsartan HCTZ 160/12.5, TX – VALSARTAN + HYDROCHLOROTHIAZIDE</i> , valsartan 160 mg + hydrochlorothiazide 12.5 mg tablet, 28
9481B	<i>APO-Valsartan HCTZ 320/12.5, TX – VALSARTAN + HYDROCHLOROTHIAZIDE</i> , valsartan 320 mg + hydrochlorothiazide 12.5 mg tablet, 28
9482C	<i>APO-Valsartan HCTZ 320/25, TX – VALSARTAN + HYDROCHLOROTHIAZIDE</i> , valsartan 320 mg + hydrochlorothiazide 25 mg tablet, 28

Addition – Equivalence Indicator

8439E	<i>Celebrex, PF – CELECOXIB</i> , celecoxib 100 mg capsule, 60
8440F	<i>Celebrex, PF – CELECOXIB</i> , celecoxib 200 mg capsule, 30
8382E	<i>Asasantin SR, BY – DIPYRIDAMOLE + ASPIRIN</i> , dipyridamole 200 mg + aspirin 25 mg capsule: modified release, 60 capsules

5542Q	<i>Cosopt, MK</i> – DORZOLAMIDE + TIMOLOL , dorzolamide 2% + timolol 0.5% eye drops, 5 mL (Optometrical)
8567X	<i>Cosopt, MK</i> – DORZOLAMIDE + TIMOLOL , dorzolamide 2% + timolol 0.5% eye drops, 5 mL
9302N	<i>Diamicron 60mg MR, SE</i> – GLICLAZIDE , gliclazide 60 mg tablet: modified release, 60 tablets
8385H	<i>OxyContin, MF</i> – OXYCODONE , oxycodone hydrochloride 10 mg tablet: modified release, 28 tablets
8386J	<i>OxyContin, MF</i> – OXYCODONE , oxycodone hydrochloride 20 mg tablet: modified release, 28 tablets
8387K	<i>OxyContin, MF</i> – OXYCODONE , oxycodone hydrochloride 40 mg tablet: modified release, 28 tablets
8388L	<i>OxyContin, MF</i> – OXYCODONE , oxycodone hydrochloride 80 mg tablet: modified release, 28 tablets
8814X	<i>Panadol Osteo, GC</i> – PARACETAMOL , paracetamol 665 mg tablet: modified release, 96 tablets
9393J	<i>Sifrol, BY</i> – PRAMIPEXOLE , pramipexole hydrochloride monohydrate 125 microgram tablet, 30
9394K	<i>Sifrol, BY</i> – PRAMIPEXOLE , pramipexole hydrochloride monohydrate 250 microgram tablet, 100
8363E	<i>Evista, LY</i> – RALOXIFENE , raloxifene hydrochloride 60 mg tablet, 28
9373H	<i>Co-Diovan 160/12.5, NV</i> – VALSARTAN + HYDROCHLOROTHIAZIDE , valsartan 160 mg + hydrochlorothiazide 12.5 mg tablet, 28
9481B	<i>Co-Diovan 320/12.5, NV</i> – VALSARTAN + HYDROCHLOROTHIAZIDE , valsartan 320 mg + hydrochlorothiazide 12.5 mg tablet, 28
9482C	<i>Co-Diovan 320/25, NV</i> – VALSARTAN + HYDROCHLOROTHIAZIDE , valsartan 320 mg + hydrochlorothiazide 25 mg tablet, 28

Addition – Note

1220F	ABATACEPT , abatacept 125 mg/mL injection, 4 x 1 mL syringes (<i>Orencia</i>)
10018G	BUDESONIDE + EFORMOTEROL , budesonide 200 microgram/actuation + eformoterol fumarate dihydrate 6 microgram/actuation inhalation: pressurised, 120 actuations (<i>Symbicort Rapihaler 200/6</i>)
8750M	BUDESONIDE + EFORMOTEROL , budesonide 400 microgram/actuation + eformoterol fumarate dihydrate 12 microgram/actuation inhalation: powder for, 120 actuations (<i>Symbicort Turbuhaler 400/12</i>)
3425G	CERTOLIZUMAB PEGOL , certolizumab pegol 200 mg/mL injection, 2 x 1 mL syringes (<i>Cimzia</i>)
8432T	FLUTICASONE + SALMETEROL , fluticasone propionate 500 microgram/actuation + salmeterol 50 microgram/actuation inhalation: powder for, 60 actuations (<i>Seretide Accuhaler 500/50</i>)
8519J	FLUTICASONE + SALMETEROL , fluticasone propionate 250 microgram/actuation + salmeterol 25 microgram/actuation inhalation: pressurised, 120 actuations (<i>Seretide MDI 250/25</i>)
3426H	GOLIMUMAB , golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe (<i>Simponi</i>)
3427J	GOLIMUMAB , golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe (<i>Simponi</i>)
3428K	GOLIMUMAB , golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe (<i>Simponi</i>)
3429L	GOLIMUMAB , golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe (<i>Simponi</i>)
8385H	OXYCODONE , oxycodone hydrochloride 10 mg tablet: modified release, 28 tablets (<i>OxyContin, Oxycodone Sandoz</i>)
8386J	OXYCODONE , oxycodone hydrochloride 20 mg tablet: modified release, 28 tablets (<i>OxyContin, Oxycodone Sandoz</i>)
8387K	OXYCODONE , oxycodone hydrochloride 40 mg tablet: modified release, 28 tablets (<i>OxyContin, Oxycodone Sandoz</i>)
8388L	OXYCODONE , oxycodone hydrochloride 80 mg tablet: modified release, 28 tablets (<i>OxyContin, Oxycodone Sandoz</i>)
9399Q	OXYCODONE , oxycodone hydrochloride 15 mg tablet: modified release, 28 tablets (<i>OxyContin</i>)
9400R	OXYCODONE , oxycodone hydrochloride 30 mg tablet: modified release, 28 tablets (<i>OxyContin</i>)

Deletions

Deletion – Brand

8114C	<i>Tinexa, QA</i> – CABERGOLINE , cabergoline 500 microgram tablet, 8
8393R	<i>Bergoline 1, QA</i> – CABERGOLINE , cabergoline 1 mg tablet, 30
8394T	<i>Bergoline 2, QA</i> – CABERGOLINE , cabergoline 2 mg tablet, 30
1784X	<i>Rocephin, RO</i> – CEFTRIAXONE , ceftriaxone 1 g injection, 1 x 1 g vial
1785Y	<i>Rocephin, RO</i> – CEFTRIAXONE , ceftriaxone 2 g injection, 1 x 2 g vial
3161J	<i>Valium, RO</i> – DIAZEPAM , diazepam 2 mg tablet, 50
5071X	<i>Valium, RO</i> – DIAZEPAM , diazepam 2 mg tablet, 50 (Dental)
1370D	<i>Renitec M, MK</i> – ENALAPRIL , enalapril maleate 5 mg tablet, 30
1944H	<i>Prilace 1.25, QA</i> – RAMIPRIL , ramipril 1.25 mg tablet, 30
2013Y	<i>Zocor, MK</i> – SIMVASTATIN , simvastatin 5 mg tablet, 30
9241J	<i>Zocor, MK</i> – SIMVASTATIN , simvastatin 5 mg tablet, 30

Deletion – Note

1221G	ABATACEPT , abatacept 125 mg/mL injection, 4 x 1 mL syringes (<i>Orencia</i>)
8741C	ADALIMUMAB , adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes (<i>Humira</i>)
9100Y	ADALIMUMAB , adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges (<i>Humira</i>)

Alterations

Alteration – Brand Name

<i>From</i>	
1653B	<i>APOTEX-MORPHINE MR, TX</i> – MORPHINE , morphine sulfate 10 mg tablet: modified release, 28 tablets
<i>To</i>	
1653B	<i>MORPHINE MR APOTEX, TX</i> – MORPHINE , morphine sulfate 10 mg tablet: modified release, 28 tablets
<i>From</i>	
1654C	<i>APOTEX-MORPHINE MR, TX</i> – MORPHINE , morphine sulfate 30 mg tablet: modified release, 28 tablets

To
1654C *MORPHINE MR APOTEX, TX – MORPHINE*, morphine sulfate 30 mg tablet: modified release, 28 tablets

Alteration – Restriction

1220F	ABATACEPT , abatacept 125 mg/mL injection, 4 x 1 mL syringes (Orencia)
1221G	ABATACEPT , abatacept 125 mg/mL injection, 4 x 1 mL syringes (Orencia)
2698B	ABIRATERONE , abiraterone acetate 250 mg tablet, 120 (Zytiga)
8737W	ADALIMUMAB , adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes (Humira)
8741C	ADALIMUMAB , adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes (Humira)
9099X	ADALIMUMAB , adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges (Humira)
9100Y	ADALIMUMAB , adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges (Humira)
10018G	BUDESONIDE + EFORMOTEROL , budesonide 200 microgram/actuation + eformoterol fumarate dihydrate 6 microgram/actuation inhalation: pressurised, 120 actuations (Symbicort Rapihaler 200/6)
8750M	BUDESONIDE + EFORMOTEROL , budesonide 400 microgram/actuation + eformoterol fumarate dihydrate 12 microgram/actuation inhalation: powder for, 120 actuations (Symbicort Turbuhaler 400/12)
3425G	CERTOLIZUMAB PEGOL , certolizumab pegol 200 mg/mL injection, 2 x 1 mL syringes (Cimzia)
10011X	DAPAGLIFLOZIN , dapagliflozin 10 mg tablet, 28 (Forxiga)
8700X	ESCITALOPRAM , escitalopram 10 mg tablet, 28 (APO-Escitalopram, Chem mart Escitalopram, Cilopam-S, Escicor 10, Escitalopram AN, Escitalopram GA, Escitalopram generichealth, Escitalopram-DRLA, Esipram, Esitalo, Lexam 10, Lexapro, LoxaLate, Pharmacor Escitalopram 10, Terry White Chemists Escitalopram)
8701Y	ESCITALOPRAM , escitalopram 20 mg tablet, 28 (APO-Escitalopram, Chem mart Escitalopram, Cilopam-S, Escicor 20, Escitalopram AN, Escitalopram GA, Escitalopram generichealth, Escitalopram-DRLA, Esipram, Esitalo, Lexam 20, Lexapro, LoxaLate, Pharmacor Escitalopram 20, Terry White Chemists Escitalopram)
8849R	ESCITALOPRAM , escitalopram 10 mg/mL oral liquid, 28 mL (Lexapro)
9432K	ESCITALOPRAM , escitalopram 10 mg tablet, 28 (Esipram, Lexapro)
9433L	ESCITALOPRAM , escitalopram 20 mg tablet, 28 (Esipram, Lexapro)
8432T	FLUTICASONE + SALMETEROL , fluticasone propionate 500 microgram/actuation + salmeterol 50 microgram/actuation inhalation: powder for, 60 actuations (Seretide Accuhaler 500/50)
8519J	FLUTICASONE + SALMETEROL , fluticasone propionate 250 microgram/actuation + salmeterol 25 microgram/actuation inhalation: pressurised, 120 actuations (Seretide MDI 250/25)
3426H	GOLIMUMAB , golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe (Simponi)
3427J	GOLIMUMAB , golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe (Simponi)
3428K	GOLIMUMAB , golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe (Simponi)
3429L	GOLIMUMAB , golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe (Simponi)
8385H	OXYCODONE , oxycodone hydrochloride 10 mg tablet: modified release, 28 tablets (OxyContin, Oxycodone Sandoz)
8386J	OXYCODONE , oxycodone hydrochloride 20 mg tablet: modified release, 28 tablets (OxyContin, Oxycodone Sandoz)
8387K	OXYCODONE , oxycodone hydrochloride 40 mg tablet: modified release, 28 tablets (OxyContin, Oxycodone Sandoz)
8388L	OXYCODONE , oxycodone hydrochloride 80 mg tablet: modified release, 28 tablets (OxyContin, Oxycodone Sandoz)
9399Q	OXYCODONE , oxycodone hydrochloride 15 mg tablet: modified release, 28 tablets (OxyContin)
9400R	OXYCODONE , oxycodone hydrochloride 30 mg tablet: modified release, 28 tablets (OxyContin)
9363T	VORICONAZOLE , voriconazole 50 mg tablet, 56 (Vfend)
9364W	VORICONAZOLE , voriconazole 200 mg tablet, 56 (Vfend)
9452L	VORICONAZOLE , voriconazole 40 mg/mL oral liquid: powder for, 70 mL (Vfend)

Alteration – Restriction Level

10011X	DAPAGLIFLOZIN , dapagliflozin 10 mg tablet, 28 (Forxiga)	From authority-required	To streamlined

Alteration – Manufacturer Code

		From	To
2390T	<i>Austrapen – AMPICILLIN</i> , ampicillin 500 mg injection, 5 x 500 mg vials	LN	AL
3313J	<i>Austrapen – AMPICILLIN</i> , ampicillin 500 mg injection, 5 x 500 mg vials (Dental)	LN	AL
2977Q	<i>Aspen Ampicyn – AMPICILLIN</i> , ampicillin 1 g injection, 5 x 1 g vials	AS	AF
3314K	<i>Aspen Ampicyn – AMPICILLIN</i> , ampicillin 1 g injection, 5 x 1 g vials (Dental)	AS	AF
2977Q	<i>Austrapen – AMPICILLIN</i> , ampicillin 1 g injection, 5 x 1 g vials	LN	AL
3314K	<i>Austrapen – AMPICILLIN</i> , ampicillin 1 g injection, 5 x 1 g vials (Dental)	LN	AL
2509C	<i>Dexamethasone – DEXAMETHASONE SODIUM PHOSPHATE</i> , DEXAMETHASONE SODIUM PHOSPHATE Injection equivalent to 4 mg dexamethasone phosphate in 1 mL, 5	AS	AF
1291Y	<i>Dexamethasone – DEXAMETHASONE SODIUM PHOSPHATE</i> , DEXAMETHASONE SODIUM PHOSPHATE Injection equivalent to 8 mg dexamethasone phosphate in 2 mL, 5	AS	AF
5263B	<i>Methylpred – METHYLPREDNISOLONE</i> , methylprednisolone Powder for injection 40 mg (as sodium succinate), 5	AS	AL
5264C	<i>Methylpred – METHYLPREDNISOLONE</i> , methylprednisolone Powder for injection 1 g (as sodium succinate), 1	AS	AL
1206L	<i>Maxolon – METOCLOPRAMIDE</i> , metoclopramide hydrochloride 10 mg/2 mL injection, 10 x 2 mL ampoules	VT	IA
5153F	<i>Maxolon – METOCLOPRAMIDE</i> , metoclopramide hydrochloride 10 mg/2 mL injection, 10 x 2 mL ampoules (Dental)	VT	IA
1207M	<i>Maxolon – METOCLOPRAMIDE</i> , metoclopramide hydrochloride 10 mg tablet, 25	VT	IA
5151D	<i>Maxolon – METOCLOPRAMIDE</i> , metoclopramide hydrochloride 10 mg tablet, 25 (Dental)	VT	IA
2723H	<i>Mogadon – NITRAZEPAM</i> , nitrazepam 5 mg tablet, 25	VT	IA

2732T	<i>Mogadon</i> – NITRAZEPAM , nitrazepam 5 mg tablet, 25	VT	IA
5189D	<i>Mogadon</i> – NITRAZEPAM , nitrazepam 5 mg tablet, 25 (Dental)	VT	IA
1728Y	<i>Dipentum</i> – OLSALAZINE , olsalazine sodium 250 mg capsule, 100	UC	IX
8086N	<i>Dipentum</i> – OLSALAZINE , olsalazine sodium 500 mg tablet, 100	UC	IX
1705R	<i>LPV</i> – PHENOXYMETHYLPENICILLIN , phenoxymethylpenicillin 250 mg capsule, 50	VT	IA
1789E	<i>LPV</i> – PHENOXYMETHYLPENICILLIN , phenoxymethylpenicillin 250 mg capsule, 50	VT	IA
3363B	<i>LPV</i> – PHENOXYMETHYLPENICILLIN , phenoxymethylpenicillin 250 mg capsule, 50 (Dental)	VT	IA
2965C	<i>LPV</i> – PHENOXYMETHYLPENICILLIN , phenoxymethylpenicillin 500 mg capsule, 50	VT	IA
3364C	<i>LPV</i> – PHENOXYMETHYLPENICILLIN , phenoxymethylpenicillin 500 mg capsule, 50 (Dental)	VT	IA
8694N	<i>Actos</i> – PIOGLITAZONE , pioglitazone 15 mg tablet, 28	LY	TK
8695P	<i>Actos</i> – PIOGLITAZONE , pioglitazone 30 mg tablet, 28	LY	TK
8696Q	<i>Actos</i> – PIOGLITAZONE , pioglitazone 45 mg tablet, 28	LY	TK
1917X	<i>Solone</i> – PREDNISOLONE , prednisolone 5 mg tablet, 60	VT	IA
1916W	<i>Solone</i> – PREDNISOLONE , prednisolone 25 mg tablet, 30	VT	IA
1935W	<i>Sone</i> – PREDNISONE , prednisone 5 mg tablet, 60	VT	IA
1936X	<i>Sone</i> – PREDNISONE , prednisone 25 mg tablet, 30	VT	IA
2724J	<i>Mestinon</i> – PYRIDOSTIGMINE , PYRIDOSTIGMINE BROMIDE Tablet 10 mg, 50	VT	IA
1959D	<i>Mestinon</i> – PYRIDOSTIGMINE , pyridostigmine bromide 60 mg tablet, 150	VT	IA
2608G	<i>Mestinon Timespan</i> – PYRIDOSTIGMINE , pyridostigmine bromide 180 mg tablet: modified release, 50 tablets	VT	IA

Advanced Notices

1 January 2015

Deletion – Item

5213J	SODIUM CHLORIDE , sodium chloride 3% (30 g/1000 mL) injection, 1 x 1000 mL bag (<i>Baxter Healthcare Pty Ltd</i>)(Dental)
2260Y	SODIUM CHLORIDE , sodium chloride 3% (30 g/1000 mL) injection, 1 x 1000 mL bag (<i>Baxter Healthcare Pty Ltd</i>)
5215L	SODIUM CHLORIDE + GLUCOSE , sodium chloride 0.225% (1.125 g/500 mL) + glucose 3.75% (18.75 g/500 mL) injection, 1 x 500 mL bag (<i>Baxter Healthcare Pty Ltd</i>)(Dental)
2279Y	SODIUM CHLORIDE + GLUCOSE , sodium chloride 0.225% (1.125 g/500 mL) + glucose 3.75% (18.75 g/500 mL) injection, 1 x 500 mL bag (<i>Baxter Healthcare Pty Ltd</i>)
5216M	SODIUM CHLORIDE + GLUCOSE , sodium chloride 0.45% (2.25 g/500 mL) + glucose 2.5% (12.5 g/500 mL) injection, 1 x 500 mL bag (<i>Baxter Healthcare Pty Ltd</i>)(Dental)
2278X	SODIUM CHLORIDE + GLUCOSE , sodium chloride 0.45% (2.25 g/500 mL) + glucose 2.5% (12.5 g/500 mL) injection, 1 x 500 mL bag (<i>Baxter Healthcare Pty Ltd</i>)
2266G	SODIUM CHLORIDE + POTASSIUM CHLORIDE + CALCIUM CHLORIDE DIHYDRATE , sodium chloride 8.6 g/1000 mL + potassium chloride 300 mg/1000 mL + calcium chloride dihydrate 330 mg/1000 mL injection, 1 x 1000 mL bag (<i>Baxter Healthcare Pty Ltd</i>)

Deletion – Brand

5529B	<i>Cromolux</i> , AE – CROMOGLYCATE , cromoglycate sodium 2% eye drops, 10 mL (Optometrical)
1127H	<i>Cromolux</i> , AE – CROMOGLYCATE , cromoglycate sodium 2% eye drops, 10 mL
8973G	<i>Risedronate Winthrop EC Combi</i> , WA – RISEDRONATE (&) CALCIUM CARBONATE , 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
8974H	<i>Risedronate Winthrop EC Combi D</i> , WA – RISEDRONATE (&) CALCIUM CARBONATE + COLECALCIFEROL , 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

1 February 2015

Deletion – Item

2095G	TICLOPIDINE , ticlopidine hydrochloride 250 mg tablet, 60 (<i>Tilodene</i>)

1 March 2015

Deletion – Item

8849R	ESCITALOPRAM , escitalopram 10 mg/mL oral liquid, 28 mL (<i>Lexapro</i>)

1 April 2015

Deletion – Item

8216K	TOREMIFENE , toremifene 60 mg tablet, 30 (<i>Fareston</i>)

Prescriber Bag

Additions

Addition – Item

10178Q **MIDAZOLAM**, midazolam 5 mg/mL injection, 10 x 1 mL ampoules (*Pfizer Australia Pty Ltd*)

Alterations

Alteration – Manufacturer Code

		<i>From</i>	<i>To</i>
3472R	<i>Dexamethsone</i> – DEXAMETHASONE SODIUM PHOSPHATE , DEXAMETHASONE SODIUM PHOSPHATE Injection equivalent to 4 mg dexamethasone phosphate in 1 mL, 5	AS	AF
3476Y	<i>Maxolon</i> – METOCLOPRAMIDE , metoclopramide hydrochloride 10 mg/2 mL injection, 10 x 2 mL ampoules	VT	IA

Palliative Care

Additions

Addition – Brand

5343F	<i>APO-Osteo Paracetamol 665 mg, TX</i> – PARACETAMOL , paracetamol 665 mg tablet: modified release, 96 tablets
5344G	<i>APO-Osteo Paracetamol 665 mg, TX</i> – PARACETAMOL , paracetamol 665 mg tablet: modified release, 96 tablets
5343F	<i>Blooms the Chemist Osteo Pain Relief Paracetamol 665 mg, IB</i> – PARACETAMOL , paracetamol 665 mg tablet: modified release, 96 tablets
5344G	<i>Blooms the Chemist Osteo Pain Relief Paracetamol 665 mg, IB</i> – PARACETAMOL , paracetamol 665 mg tablet: modified release, 96 tablets
5343F	<i>Chem mart Pharmacy Osteo Relief Paracetamol 665 mg, CH</i> – PARACETAMOL , paracetamol 665 mg tablet: modified release, 96 tablets
5344G	<i>Chem mart Pharmacy Osteo Relief Paracetamol 665 mg, CH</i> – PARACETAMOL , paracetamol 665 mg tablet: modified release, 96 tablets
5343F	<i>Osteomol 665 Paracetamol, CR</i> – PARACETAMOL , paracetamol 665 mg tablet: modified release, 96 tablets
5344G	<i>Osteomol 665 Paracetamol, CR</i> – PARACETAMOL , paracetamol 665 mg tablet: modified release, 96 tablets
5343F	<i>Terry White Chemists Osteo Relief Paracetamol 665 mg, TW</i> – PARACETAMOL , paracetamol 665 mg tablet: modified release, 96 tablets
5344G	<i>Terry White Chemists Osteo Relief Paracetamol 665 mg, TW</i> – PARACETAMOL , paracetamol 665 mg tablet: modified release, 96 tablets

Addition – Equivalence Indicator

5343F	<i>Panadol Osteo, GC</i> – PARACETAMOL , paracetamol 665 mg tablet: modified release, 96 tablets
5344G	<i>Panadol Osteo, GC</i> – PARACETAMOL , paracetamol 665 mg tablet: modified release, 96 tablets

Deletions

Deletion – Brand

5355W	<i>Valium, RO</i> – DIAZEPAM , diazepam 2 mg tablet, 50
5357Y	<i>Valium, RO</i> – DIAZEPAM , diazepam 2 mg tablet, 50

Alterations

Alteration – Manufacturer Code

		<i>From</i>	<i>To</i>
5333Q	<i>Aquae</i> – CARMELLOSE SODIUM , carmellose sodium 10 mg/mL oral spray, 25 mL	VT	IA
5335T	<i>Aquae</i> – CARMELLOSE SODIUM , carmellose sodium 10 mg/mL oral spray, 25 mL	VT	IA
5334R	<i>Aquae</i> – CARMELLOSE SODIUM , carmellose sodium 10 mg/mL oral spray, 100 mL	VT	IA
5336W	<i>Aquae</i> – CARMELLOSE SODIUM , carmellose sodium 10 mg/mL oral spray, 100 mL	VT	IA
5421H	<i>Aquae Gel</i> – HYPROMELLOSE , HYPROMELLOSE Oral gel 20 mg per g, 100 g, 1	VT	IA
5422J	<i>Aquae Gel</i> – HYPROMELLOSE , HYPROMELLOSE Oral gel 20 mg per g, 100 g, 1	VT	IA
5359C	<i>Mogadon</i> – NITRAZEPAM , nitrazepam 5 mg tablet, 25	VT	IA
5360D	<i>Mogadon</i> – NITRAZEPAM , nitrazepam 5 mg tablet, 25	VT	IA

Section 100 – Highly Specialised Drugs Program (Public Hospital)

Additions

Addition – Item

10183Y	ECULIZUMAB , eculizumab 300 mg/30 mL injection, 1 x 30 mL vial (<i>Soliris</i>)
10190H	ECULIZUMAB , eculizumab 300 mg/30 mL injection, 1 x 30 mL vial (<i>Soliris</i>)
10191J	ECULIZUMAB , eculizumab 300 mg/30 mL injection, 1 x 30 mL vial (<i>Soliris</i>)
10196P	INFLIXIMAB , infliximab 100 mg injection, 1 x 100 mg vial (<i>Remicade</i>)
10170G	IVACAFTOR , ivacaftor 150 mg tablet, 56 (<i>Kalydeco</i>)
10200W	SIMEPREVIR , simeprevir sodium 150 mg capsule, 7 (<i>Olysio</i>)

Addition – Brand

5606C	<i>APO-Adefovir, TX</i> – ADEFOVIR DIPIVOXIL , adefovir dipivoxil 10 mg tablet, 30

Addition – Equivalence Indicator

5606C	<i>Hepsera, GI</i> – ADEFOVIR DIPIVOXIL , adefovir dipivoxil 10 mg tablet, 30

Addition – Note

5605B	ABATACEPT , abatacept 250 mg injection, 1 x 250 mg vial (<i>Orencia</i>)
5733R	ETANERCEPT , ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1 (<i>Enbrel</i>)
5735W	ETANERCEPT , ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1 (<i>Enbrel</i>)
5757B	INFLIXIMAB , infliximab 100 mg injection, 1 x 100 mg vial (<i>Remicade</i>)
9657G	TOCILIZUMAB , tocilizumab 80 mg/4 mL injection, 1 x 4 mL vial (<i>Actemra</i>)
9658H	TOCILIZUMAB , tocilizumab 200 mg/10 mL injection, 1 x 10 mL vial (<i>Actemra</i>)
9659J	TOCILIZUMAB , tocilizumab 400 mg/20 mL injection, 1 x 20 mL vial (<i>Actemra</i>)

Deletions

Deletion – Item

9745X	OMALIZUMAB , omalizumab 150 mg injection [1 x 150 mg vial] (&) inert substance diluent [1 x 1.2 mL ampoule], 1 pack (<i>Xolair</i>)

Alterations

Alteration – Restriction

5605B	ABATACEPT, abatacept 250 mg injection, 1 x 250 mg vial (<i>Orencia</i>)
5733R	ETANERCEPT, ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1 (<i>Enbrel</i>)
5735W	ETANERCEPT, ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1 (<i>Enbrel</i>)
5757B	INFLIXIMAB, infliximab 100 mg injection, 1 x 100 mg vial (<i>Remicade</i>)
9524G	PEGINTERFERON ALFA-2A (&) RIBAVIRIN, peginterferon alfa-2a 135 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [168 tablets], 1 pack
9525H	PEGINTERFERON ALFA-2A (&) RIBAVIRIN, peginterferon alfa-2a 180 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [112 tablets], 1 pack
9526J	PEGINTERFERON ALFA-2A (&) RIBAVIRIN, peginterferon alfa-2a 180 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [140 tablets], 1 pack
9527K	PEGINTERFERON ALFA-2A (&) RIBAVIRIN, peginterferon alfa-2a 180 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [168 tablets], 1 pack
9529M	PEGINTERFERON ALFA-2B (&) RIBAVIRIN, 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
9530N	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
9531P	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
9534T	PEGINTERFERON ALFA-2B (&) RIBAVIRIN, 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
9536X	PEGINTERFERON ALFA-2B (&) RIBAVIRIN, 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
9538B	PEGINTERFERON ALFA-2B (&) RIBAVIRIN, 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
9539C	PEGINTERFERON ALFA-2B (&) RIBAVIRIN, 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
9540D	PEGINTERFERON ALFA-2B (&) RIBAVIRIN, 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
9544H	RITUXIMAB, rituximab 500 mg/50 mL injection, 1 x 50 mL vial (<i>Mabthera</i>)
9657G	TOCILIZUMAB, tocilizumab 80 mg/4 mL injection, 1 x 4 mL vial (<i>Actemra</i>)

9658H TOCILIZUMAB, tocilizumab 200 mg/10 mL injection, 1 x 10 mL vial (Actemra)
 9659J TOCILIZUMAB, tocilizumab 400 mg/20 mL injection, 1 x 20 mL vial (Actemra)

Alteration – Manufacturer Code

		<i>From</i>	<i>To</i>
5658T	<i>Ferriprox</i> – DEFERIPRONE , deferiprone 100 mg/mL oral liquid, 250 mL	OA	TX
5657R	<i>Ferriprox</i> – DEFERIPRONE , deferiprone 500 mg tablet, 100	OA	TX

Advanced Notices

1 February 2015

Deletion – Item

5620T **CIDOFOVIR**, cidofovir 375 mg/5 mL injection, 1 x 5 mL vial (*Vistide*)

Section 100 – Highly Specialised Drugs Program (Private Hospital)

Additions

Addition – Item

10182X	ECULIZUMAB , eculizumab 300 mg/30 mL injection, 1 x 30 mL vial (<i>Soliris</i>)
10192K	ECULIZUMAB , eculizumab 300 mg/30 mL injection, 1 x 30 mL vial (<i>Soliris</i>)
10194M	ECULIZUMAB , eculizumab 300 mg/30 mL injection, 1 x 30 mL vial (<i>Soliris</i>)
10184B	INFLIXIMAB , infliximab 100 mg injection, 1 x 100 mg vial (<i>Remicade</i>)
10175M	IVACAFTOR , ivacaftor 150 mg tablet, 56 (<i>Kalydeco</i>)
10197Q	SIMEPREVIR , simeprevir sodium 150 mg capsule, 7 (<i>Olysio</i>)

Addition – Brand

6450L	<i>APO-Adefovir, TX</i> – ADEFOVIR DIPIVOXIL , adefovir dipivoxil 10 mg tablet, 30

Addition – Equivalence Indicator

6450L	<i>Hepsera, GI</i> – ADEFOVIR DIPIVOXIL , adefovir dipivoxil 10 mg tablet, 30

Addition – Note

9621J	ABATACEPT , abatacept 250 mg injection, 1 x 250 mg vial (<i>Orencia</i>)
9615C	ETANERCEPT , ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1 (<i>Enbrel</i>)
9641K	ETANERCEPT , ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1 (<i>Enbrel</i>)
6397Q	INFLIXIMAB , infliximab 100 mg injection, 1 x 100 mg vial (<i>Remicade</i>)
9671B	TOCILIZUMAB , tocilizumab 80 mg/4 mL injection, 1 x 4 mL vial (<i>Actemra</i>)
9672C	TOCILIZUMAB , tocilizumab 200 mg/10 mL injection, 1 x 10 mL vial (<i>Actemra</i>)
9673D	TOCILIZUMAB , tocilizumab 400 mg/20 mL injection, 1 x 20 mL vial (<i>Actemra</i>)

Deletions

Deletion – Item

9746Y	OMALIZUMAB , omalizumab 150 mg injection [1 x 150 mg vial] (&) inert substance diluent [1 x 1.2 mL ampoule], 1 pack (<i>Xolair</i>)

Alterations

Alteration – Restriction

9621J	ABATACEPT, abatacept 250 mg injection, 1 x 250 mg vial (<i>Orencia</i>)
9615C	ETANERCEPT, ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1 (<i>Enbrel</i>)
9641K	ETANERCEPT, ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1 (<i>Enbrel</i>)
6397Q	INFLIXIMAB, infliximab 100 mg injection, 1 x 100 mg vial (<i>Remicade</i>)
6392K	PEGINTERFERON ALFA-2A (&) RIBAVIRIN, peginterferon alfa-2a 135 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [168 tablets], 1 pack
6394M	PEGINTERFERON ALFA-2A (&) RIBAVIRIN, peginterferon alfa-2a 180 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [112 tablets], 1 pack
6395N	PEGINTERFERON ALFA-2A (&) RIBAVIRIN, peginterferon alfa-2a 180 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [140 tablets], 1 pack
6396P	PEGINTERFERON ALFA-2A (&) RIBAVIRIN, peginterferon alfa-2a 180 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [168 tablets], 1 pack
6400W	PEGINTERFERON ALFA-2B (&) RIBAVIRIN, 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
6401X	PEGINTERFERON ALFA-2B (&) RIBAVIRIN, 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
6402Y	PEGINTERFERON ALFA-2B (&) RIBAVIRIN, 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
6405D	PEGINTERFERON ALFA-2B (&) RIBAVIRIN, 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
6407F	PEGINTERFERON ALFA-2B (&) RIBAVIRIN, 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
6409H	PEGINTERFERON ALFA-2B (&) RIBAVIRIN, 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
6410J	PEGINTERFERON ALFA-2B (&) RIBAVIRIN, 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
9634C	PEGINTERFERON ALFA-2B (&) RIBAVIRIN, 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
9611W	RITUXIMAB, rituximab 500 mg/50 mL injection, 1 x 50 mL vial (<i>Mabthera</i>)
9671B	TOCILIZUMAB, tocilizumab 80 mg/4 mL injection, 1 x 4 mL vial (<i>Actemra</i>)

9672C TOCILIZUMAB, tocilizumab 200 mg/10 mL injection, 1 x 10 mL vial (Actemra)
 9673D TOCILIZUMAB, tocilizumab 400 mg/20 mL injection, 1 x 20 mL vial (Actemra)

Alteration – Manufacturer Code

		<i>From</i>	<i>To</i>
9638G	<i>Ferriprox</i> – DEFERIPRONE , deferiprone 100 mg/mL oral liquid, 250 mL	OA	TX
6416Q	<i>Ferriprox</i> – DEFERIPRONE , deferiprone 500 mg tablet, 100	OA	TX

Advanced Notices

1 February 2015

Deletion – Item

6247T **CIDOFOVIR**, cidofovir 375 mg/5 mL injection, 1 x 5 mL vial (*Vistide*)

Addresses — Department of Human Services

The Department of Human Services has responsibility for the operational aspects of the Pharmaceutical Benefits Scheme (PBS). This responsibility covers the processing of pharmaceutical benefit and safety net claims, authority applications and supply of PBS stationery used by medical practitioners, participating dental practitioners and approved pharmacists.

Procedures for ordering prescription forms are set out in the Introduction of this Schedule.

New South Wales and Australian Capital Territory

Pharmaceutical Benefits Branch
130 George Street
Parramatta NSW 2150

General and IME enquiries — Tel: 132 290

Orange Service Centre
189 Anson Street
Orange NSW 2800

General and IME enquiries — Tel: 132 290

Victoria

Pharmaceutical Branch
Level 10
595 Collins Street
Melbourne Vic 3000

General and IME enquiries — Tel: 132 290

Queensland

Pharmaceutical Services Branch
143 Turbot Street
Brisbane Qld 4000

General and IME enquiries — Tel: 132 290

Western Australia

Pharmaceutical Benefits Branch
Level 5, Work Distribution Centre,
(Reception on Level 4)
130 Stirling Street
Northbridge WA 6003

General and IME enquiries — Tel: 132 290

South Australia and Northern Territory

Pharmaceutical Services Branch
209 Greenhill Road
Eastwood SA 5063

General and IME enquiries — Tel: 132 290

Tasmania

Pharmaceutical Branch
199 Collins Street
Hobart Tas 7000

General and IME enquiries — Tel: 132 290

National Program Management

Pharmaceutical Benefits Branch
Department of Human Services
134 Reed Street
Greenway ACT 2900
Telephone — (02) 6124 6333
Website — www.humanservices.gov.au Email — pbs@humanservices.gov.au

Authority Prescription Applications

Authority required benefits fall into two categories – *Authority required* and *Authority required (STREAMLINED)*. The process in which an authority PBS prescription can be prescribed will depend on the type of Authority required benefit.

Prior approval is required for Authority required items as well as all requests for increased quantities and/or repeats for any category of PBS item.

Prior approval is not required for Authority required (STREAMLINED) items except if increased quantities and/or repeats are required (see Explanatory Notes for details).

Mail Applications:

REPLY PAID No. 9857
PBS Authorities Section
Department of Human Services
GPO Box 9857
In your Capital City

Telephone Applications:

Free call 1800 888 333
Australia-wide 24 hour service PBS Authorities Section

For telephone applications please have the following information available:

Patient:

Medicare Number
Surname
First name
Full residential address (including post code)

PBS Authority Prescription Number:

Top right hand side of the handwritten PBS Authority Form

Your Prescriber Number:

Located below your address block on the personalised forms

Drug Information:

PBS item
Quantity required and number of repeats
Daily dose
Disease or purpose information

Requests for Drugs via the Special Access Scheme (SAS)

Requests for individual patient approval to obtain drugs that are available only through the SAS may be directed to a delegate within the Drug Safety and Evaluation Branch, Therapeutic Goods Administration, telephone (02) 6232 8111, facsimile (02) 6232 8112, or by mail to PO Box 100 Woden ACT 2606.

Department of Veterans' Affairs

Details of the approving authority for the Department of Veterans' Affairs are listed at the front of the Repatriation Schedule of Pharmaceutical Benefits.

Telephone Interpreter Service

A 24-hour, seven days a week telephone service is available by contacting 131 450.

The translating service (TIS) can provide immediate assistance over the telephone or arrange for an interpreter to go to a location specified in either city or country areas. The TIS service has access to 2000 professional interpreters, covering over 100 languages and dialects.

Poisons Information Centres

Phone 131 126 from anywhere in Australia — 24 hours — form information and advice on the treatment of poisoning, bites and stings

NSW

The New Children's Hospital
Hawkesbury Road
Westmead NSW 2148
Tel: (02) 9845 3111

VIC

Austin Hospital
Studley Road
Heidelberg VIC 3084
Tel: (03) 9496 4410
www.austin.org.au/poisons

QLD

Pharmacy Department
Royal Children's Hospital
Herston QLD 4029
Tel: 131 126

WA

Sir Charles Gairdner Hospital
Hospital Avenue
Nedlands WA 6009
Tel: 131 126

TAS

Tel: 131 126

NT

Tel: 131 126

ACT

Tel: 131 126

Drug Information Centres

NSW

Drug Information Pharmacist
New South Wales Medicines Information
Centre
PO Box 766
Darlinghurst NSW 2010
Tel: (02) 8382 2136

OR

Drug Information Pharmacist
Hunter Drug Information Service
Newcastle Mater Misericordiae Hospital
Locked Bag 7
Hunter Regional Mail Centre NSW 2310
Tel: (02) 4921 1278
Tel: (02) 4921 1328

VIC

Drug Information Pharmacist
Austin & Repatriation Medical Centre
Studley Road
Heidelberg Vic 3084
Tel: (03) 9496 5668

OR

Drug Information Pharmacist
Drug Information Centre
Southern Health Care Network
Monash Medical Centre
246 Clayton Road
Clayton Vic 3168
Tel:(03) 9594 2361

QLD

Assistant Director of Pharmacy
Queensland Drug Information Ctr
Royal Brisbane Hospital
E Floor, Block 7
Herston Road
Herston Qld 4029
Tel: (07) 3636 7098
(07) 3636 7599

SA

Drug Information Pharmacist
Royal Adelaide Hospital
North Terrace
Adelaide SA 5000
Tel: (08) 8222 5546

OR

Drug Information Pharmacist
Flinders Medical Centre
Bedford Park SA 5042
Tel: (08) 8204 5301

OR

Drug Information Pharmacist
Queen Elizabeth Hospital
Woodville Road
Woodville SA 5011
Tel: (08) 8222 6777

WA

Drug Information Pharmacist
Sir Charles Gairdner Hospital
Hospital Avenue
Nedlands WA 6009
Tel: (08) 9346 2923

TAS

Drug Information Pharmacist
Royal Hobart Hospital
GPO Box 1061L
Hobart Tas 7001
Tel: (03) 6222 8737

NT

Drug Information Pharmacist
Royal Darwin Hospital
PO Box 41326
Casuarina NT 0811
Tel: (08) 8922 8424

ACT

Drug Information Pharmacist
Canberra Hospital
Yamba Drive
Garran ACT 2605
Tel: (02) 6244 3333

List of Contact Officers for Recalls of Therapeutic Goods

For details of consumer level recalls only — telephone 1800 020 512

These officers may be contacted —

- to obtain information about current recalls
- to report suspected problems relating to the quality, safety or efficacy of a therapeutic good

Australian Recall Coordinator

Mr Mick O'Connor

Bh 02 6232 8197
Mobile 0421 583 361
Fax 02 6203 1451
E-mail recalls@tga.gov.au

Australian Capital Territory

Mr Michael Conroy

Bh 02 6207 3974
Mobile 0418 182 375
Fax 02 6205 0997
E-mail pharmaceuticalservices@act.gov.au
 MichaelJ.Conroy@act.gov.au

New South Wales

Mr B. Batty

Bh 02 9879 3214
Mobile 0401 712 050
Fax 02 9859 5165
E-mail bruce.batty@doh.health.nsw.gov.au

Ms J. Mackson

Bh 02 9879 3214
Mobile 0411 145 562
Fax 02 9859 5165
E-mail jmack@doh.health.nsw.gov.au

Victoria

Ms M. Smith

Bh 03 9096 5355
Bh 1300 364 545
Mobile 0408 598 663
Fax 1300 360 830
E-mail megan.l.smith@health.vic.gov.au

Mr M. McCrone

Bh 03 9096 5066
Bh 1300 364 545
Mobile 0408 581 312
Fax 1300 360 830
E-mail matthew.mccrone@health.vic.gov.au

Queensland

Mr C.J. Healey

Bh 07 3328 9310
Mobile 0403 053 090
Fax 07 3328 9354
E-mail chris_healey@health.qld.gov.au

Mr A. Hawkins

Bh 07 3328 9310
Mobile 0449 267 625
Fax 07 3228 9354
E-mail andrew_hawkins@health.qld.gov.au

South Australia

Mr S. Morris

Bh 08 8204 1940
Mobile 0431 657 090
Fax 08 8226 9837
E-mail steve.morris@health.sa.gov.au

Ms E. Hender

Bh 0418 747 833
Mobile 0431 657 090
Fax 08 8226 9837
E-mail elizabeth.hender@health.sa.gov.au

Western Australia

Mr Neil Keen

Bh 08 9222 6883
Mobile 0419 944 801
Fax 08 9222 2463
E-mail neil.keen@health.wa.gov.au
 poisons@health.wa.gov.au

Tasmania

Ms M. Sharpe

Bh 03 6233 3766
Ah 03 6223 3476
Fax 03 6233 3904
E-mail mary.sharpe@dhhs.tas.gov.au

Mr J. Galloway

Bh 03 6233 2064
Ah 03 6223 7074
Fax 03 6233 3904
E-mail james.galloway@dhhs.tas.gov.au

Northern Territory

Ms Helgi Stone

Bh 08 8922 7035
Mobile 0429 091 636
Fax 08 8922 7200
E-mail Helgi.stone@nt.gov.au

Mr T. DeSilva

Bh 08 8922 7340
Mobile 0400 251 419
Fax 08 8922 7200
E-mail tyronne.dezilva@nt.gov.au

Index of Manufacturers' codes

Code	Manufacturer
AB	Abbott Australasia Pty Ltd Sir Joseph Banks Corporate Park 32-34 Lord Street BOTANY NSW 2019 Tel: 1800 801 478
AE	AFT Pharmaceuticals Pty Ltd Level 1 296 Burns Bay Road LANE COVE NSW 2066 Tel: 1800 097 639
AF	Alphapharm Pty Ltd Level 1 30 The Bond, 30-34 Hickson Rd MILLERS POINT NSW 2000 Tel: 1800 028 365
AG	Allergan Australia Pty Limited Level 4 810 Pacific Highway Gordon NSW 2072 Tel: 1800 252 224
AL	Alphapharm Pty Ltd Level 1 30 The Bond, 30-34 Hickson Rd MILLERS POINT NSW 2000 Tel: 1800 028 365
AN	Amgen Australia Pty Limited Avaya House Level 7, 123 Epping Road NORTH RYDE NSW 2113 Tel: 1800 803 638
AP	AstraZeneca Pty Ltd Alma Road NORTH RYDE NSW 2113 Tel: 1800 805 342
AQ	Alcon Laboratories (Australia) Pty Ltd 10/25 Frenchs Forest Road East FRENCHS FOREST NSW 2086 Tel: 1800 025 032
AS	Aspen Pharmacare Australia Pty Limited 34-36 Chandos Street ST LEONARDS NSW 2065 Tel: (02) 8436 8300
AT	Actelion Pharmaceuticals Australia Pty Ltd Suite 6 13b Narabang Way Belrose NSW 2085 Tel: (02) 9486 4600
AV	sanofi-aventis Australia Pty Ltd Building D, Talavera Corporate Centre 12-24 Talavera Road MACQUARIE PARK NSW 2113 Tel: +61 (0)2 8666 2000
BB	Blackmores Limited 20 Jubilee Avenue Warriewood NSW 2102 Tel: +61 (0)2 9910 5000 Fax: +61 (0)2 9910 5555

Code	Manufacturer
BD	Biogen Idec Australia Pty Ltd Suite 1, Level 5 123 Epping Road North Ryde NSW 2113 Tel: +61 (0)2 8875 3900
BE	Beiersdorf Australia Ltd 4 Khartoum Road North Ryde NSW 2113 Tel: +61 (0)2 9888 0977 Fax: +61 (0)2 9887 3487
BG	Sandoz Pty Ltd Suite 201, Level 2 19 Harris Street Pymont NSW 2009 Tel: 1800 726 369
BI	Biotech Pharmaceuticals Pty Ltd 83 Cherry Lane LAVERTON NORTH VIC 3026 Tel: (03) 9278 7555
BN	Bayer Australia Ltd 875 Pacific Highway PYMBLE NSW 2073 Tel: 1800 673 270
BQ	Bristol-Myers Squibb Australia Pty Ltd Level 2 4 Nexus Court Mulgrave VIC 3170 Tel: 1800 067 567
BR	B. Braun Australia Pty Ltd Norwest Business Park 17 Lexington Drive BELLA VISTA NSW 2153 Tel: +61 (0)2 9629 0200
BU	Bausch & Lomb (Australia) Pty Ltd Ground Floor 16 Giffnock Avenue MACQUARIE PARK NSW 2113 Tel: (02) 9887 1444
BV	B.S.N. 315 Ferntree Gully Road Mount Waverley VIC 3149 Tel: +61 (0)3 8540 6777
BX	Baxter Healthcare Pty Limited 1 Baxter Drive OLD TOONGABBIE NSW 2146 Tel: 1300 789 646
BY	Boehringer Ingelheim Pty Ltd 78 Waterloo Road NORTH RYDE NSW 2113 Tel: (02) 8875 8600
BZ	Boucher & Muir Pty Ltd Level 1, 134 Willoughby Road Crows Nest NSW 2065 Tel: 1800 627 680

Index of Manufacturers' codes

Code	Manufacturer
CC	ConvaTec A Division of Bristol-Myers Squibb Australia Pty Ltd 606 Hawthorn Road East Brighton VIC 3187 Tel: 1800 335 276
CH	Apotex Pty Ltd 16 Giffnock Avenue MACQUARIE PARK NSW 2113 Tel: 1800 276 839
CJ	Celgene Pty Limited Level 7 607 St Kilda Road MELBOURNE VIC 3044 Tel: (03) 9539 5500
CR	Pharmacor Pty Limited Suite 401 7 Oaks Avenue DeeWhy NSW 2099 Tel: 1300 138 805
CS	bioCSL (Australia) Pty Ltd 63 Poplar Road PARKVILLE VIC 3052 Tel: 1800 008 275
CT	Coloplast Pty Ltd 33 Gilby Road Mount Waverley VIC 3149 Tel: 1800 673 317
CU	Care Pharmaceuticals Pty Limited Suite 303, Level 3, 59-75 Grafton Street Bondi Junction NSW 2022 Tel: 1800 788 870
CX	Contact Lens Centre Australia Limited Unit D6, Hallmarc Business Park Cnr Westall and Centre Roads CLAYTON VIC 3168 Tel: (03) 9543 1811
DO	Aurobindo Pharma (Australia) Pty Limited Unit 3 North RydeLink Business Park 277-283 Lane Cove Road Macquarie Park NSW 2113 Tel: +61 (0)2 9805 6000
DQ	Church & Dwight (Australia) Pty Ltd Unit 1/108 Old Pittwater Road Brookvale NSW 2100 Tel: 1800 222 099
DV	Medical Developments International Limited 6/56 Smith Road SPRINGVALE VIC 3171 Tel: (03) 9547 1888
EA	Amneal Pharmaceuticals Pty Ltd 12 River Street South Yarra VIC 3141 Tel: +61 (0)3 8849 1200 Fax: +61 (0)3 8849 1299
EH	Entra Health Systems Pty Ltd 12/60 Castlereagh Street SYDNEY NSW 2000 Tel: (02) 9846 6642

Code	Manufacturer
EI	Eisai Australia Pty Ltd Level 2, 437 St Kilda Road Melbourne VIC 3004 Tel: +61 (0)3 9832 9100
EL	Eli Lilly Australia Pty Ltd 112 Wharf Road West Ryde NSW 2114 Tel: (02) 9325 4444
EO	Ego Pharmaceuticals Proprietary Limited 21-31 Malcolm Road Braeside VIC 3195 Tel: (03) 9587 1088
ER	Eris Pharmaceuticals (Australia) Pty Ltd 6 Eastern Road South Melbourne VIC 3205 Tel: +61 (0)3 9690 8473 Fax: +61 (0)3 9690 8479
EU	Emerge Health Pty Ltd Suite 3, Level 1 2 Theatre Place Canterbury VIC 3126 Tel: +61 (0)3 9077 4486 Fax: +61 (0)3 8672 0792
FB	Pierre Fabre Medicament Australia Pty Ltd Unit 3B 1 Richardson Place NORTH RYDE NSW 2113 Tel: +61 (0)2 8662 9800
FI	Boehringer Ingelheim Pty Ltd 78 Waterloo Road NORTH RYDE NSW 2113 Tel: (02) 8875 8600
FK	A. Menarini Australia Pty Limited Level 8 67 Albert Avenue Chatswood NSW 2067 Tel: +61 (0)2 9080 7200
FM	Fawns and McAllan Proprietary Limited 34-36 Chandos Street ST LEONARDS NSW 2065 Tel: +61 (0)2 8436 8300
FP	Ferring Pharmaceuticals Pty Limited Suite 2, Level 1, Building 1 Pymble Corporate Centre PYMBLE NSW 2073 Tel: +61 (0)2 9497 2300 Fax: +61 (0)2 9497 2399
FR	Merck Sharp & Dohme (Australia) Pty Ltd Level 1, Building A 26 Talavera Road MACQUARIE PARK NSW 2113 Tel: +61 (0)2 8988 8000
FZ	Pfizer Australia Pty Ltd 38-42 Wharf Road WEST RYDE NSW 2114 Tel: +61 (0)2 9850 3333

Index of Manufacturers' codes

Code	Manufacturer
GA	Galderma Australia Pty Ltd Suite 4 13B Narabang Way BELROSE NSW 2085 Tel: (02) 9479 0600
GC	GlaxoSmithKline Australia Pty Ltd Level 4, 436-438 Johnston Street Abbotsford VIC 3067 Tel: +61 (0)3 9721 8600
GH	Mercury Pharma (Australia) Pty Limited Level 1, 134 Willoughby Road Crows Nest NSW 2065 Tel: +61 (0)2 9431 6333
GI	Gilead Sciences Pty Limited Level 1, 128 Jolimont Road EAST MELBOURNE VIC 3002 Tel: (03) 9272 4400
GK	GlaxoSmithKline Australia Pty Ltd Level 4, 436-438 Johnston Street Abbotsford VIC 3067 Tel: +61 (0)3 9721 8600
GN	Actavis Pty Ltd Level 5 117 Harrington Street The Rocks NSW 2000 Tel: 1800 678 302
GQ	Generic Health Pty Ltd Level 1, 1100-1102 Toorak Road CAMBERWELL VIC 3124 Tel: +61 (0)3 9809 7900 Fax: +61 (0)3 9809 7999
GX	Apotex Pty Ltd 16 Giffnock Avenue MACQUARIE PARK NSW 2113 Tel: 1800 276 839
GZ	sanofi-aventis Australia Pty Ltd Building D, Talavera Corporate Centre 12-24 Talavera Road MACQUARIE PARK NSW 2113 Tel: +61 (0)2 8666 2000
HB	Besins Healthcare Australia Pty Ltd Level 20, Tower A, The Zenith 821 Pacific Highway Chatswood NSW 2067 Tel: +61 (0)2 9418 8343
HH	Hospira Pty Limited Level 3 500 Collins Street Melbourne VIC 3000 Tel: 1300 046 774
HL	Helex-A Pty. Ltd. 9/7 Anella Avenue CASTLE HILL NSW 2154 Tel: 1800 824 166

Code	Manufacturer
HM	Meda Pharmaceuticals Pty Ltd Suite 1, Level 3 110 Pacific Highway St Leonards NSW 2065 Tel: +61 (0)2 8209 3422 Fax: +61 (0)2 9436 4489
HR	Paul Hartmann Pty Ltd 27-28/11-21 Underwood Road Homebush NSW 2140 Tel: 1800 805 839
HX	Sandoz Pty Ltd Suite 201, Level 2 19 Harris Street Pyrmont NSW 2009 Tel: 1800 726 369
IA	iNova Pharmaceuticals (Australia) Pty Limited Po Box 5033 WEST CHATSWOOD NSW 2067 Tel: +61 (0)2 8918 6322 Fax: +61 (0)2 8918 6415
IB	Apotex Pty Ltd 16 Giffnock Avenue MACQUARIE PARK NSW 2113 Tel: 1800 276 839
IK	Medtronic Australasia Pty Ltd 97 Waterloo Road North Ryde NSW 2113 Tel: 1800 777 808
IQ	Alcon Laboratories (Australia) Pty Ltd 10/25 Frenchs Forest Road East FRENCHS FOREST NSW 2086 Tel: 1800 025 032
IS	Ipsen Pty Ltd Level 2, Building 4 Brandon Office Park GLEN WAVERLEY VIC 3150 Tel: +61 (0)3 8544 8100
IV	iNova Pharmaceuticals (Australia) Pty Limited Po Box 5033 WEST CHATSWOOD NSW 2067 Tel: +61 (0)2 8918 6322 Fax: +61 (0)2 8918 6415
IX	Clinect Pty Ltd Level 3, 484 St Kilda Road Melbourne VIC 3004 Tel: (03) 9918 5555
JC	Janssen-Cilag Pty Ltd 1-5 Khartoum Road North Ryde NSW 2113 Tel: +61 (0)2 8875 3333 Fax: +61 (0)2 8875 3300
JJ	Johnson & Johnson Medical Pty Ltd 1-5 Khartoum Road North Ryde NSW 2113 Tel: +61 (0)2 9815 4276

Index of Manufacturers' codes

Code	Manufacturer
JN	JNS Biomedical Pty Ltd 99 Finlayson Street Rosanna VIC 3084 Tel: +61 (0)3 9913 4660
JT	Johnson & Johnson Pacific Pty Limited 45 Jones street Ultimo NSW 2007 Tel: 1800 029 979
KE	Kendall Australasia Pty Ltd 22 Giffnock Avenue North Ryde NSW 2113 Tel: 1800 252 467
KN	Abbott Australasia Pty Ltd Sir Joseph Banks Corporate Park 32-34 Lord Street BOTANY NSW 2019 Tel: 1800 801 478
KP	Eli Lilly Australia Pty Ltd 112 Wharf Road West Ryde NSW 2114 Tel: (02) 9325 4444
KY	Key Pharmaceuticals Pty Ltd 12 Lyon Park Road MACQUARIE PARK NSW 2113 Tel: (02) 8113 6200
LB	Life Bioscience Pty Ltd 10 Atherton Road OAKLEIGH VIC 3166 Tel: 1800 114 610
LL	Astellas Pharma Australia Pty Ltd Level 4, 6 Eden Park Drive Macquarie Park NSW 2113 Tel: 1800 751 755
LM	Link Medical Products Pty Ltd Unit 1 5 Apollo Street WARRIEWOOD NSW 2102 Tel: +61 (0)2 8401 9777
LN	Aspen Pharmacare Australia Pty Limited 34-36 Chandos Street ST LEONARDS NSW 2065 Tel: (02) 8436 8300
LO	Leo Pharma Pty Ltd Level 3, Tower 1 25 Montpelier Road Bowen Hills QLD 4006 Tel: (07) 32501200
LU	Lundbeck Australia Pty Ltd Ground Floor 1 Innovation Road NORTH RYDE NSW 2113 Tel: (02) 88691000
LY	Eli Lilly Australia Pty Ltd 112 Wharf Road West Ryde NSW 2114 Tel: (02) 9325 4444

Code	Manufacturer
MD	Roche Products Pty Ltd 4-10 Inman Road DEE WHY NSW 2099 Tel: +61 (0)2 9454 9000 Fax: +61 (0)2 9971 7401
MF	Mundipharma Pty Limited 50 Bridge Street SYDNEY NSW 2000 Tel: 02 9231 7200
MH	Molnlycke Health Care Pty Ltd Building 1, Ground Floor 14 Aquatic Drive Frenchs Forest NSW 2086 Tel: +61 (0)2 9453 1144 Fax: +61 (0)2 9453 1155
MK	Merck Sharp & Dohme (Australia) Pty Ltd Level 1, Building A 26 Talavera Road MACQUARIE PARK NSW 2113 Tel: +61 (0)2 8988 8000
MM	3M Pharmaceuticals Australia Pty Ltd 9-15 Chilvers Road Thornleigh NSW 2120 Tel: (02) 9875 6333
MQ	Alphapharm Pty Ltd Level 1 30 The Bond, 30-34 Hickson Rd MILLERS POINT NSW 2000 Tel: 1800 028 365
MS	Abbott Australasia Pty Ltd Sir Joseph Banks Corporate Park 32-34 Lord Street BOTANY NSW 2019 Tel: 1800 801 478
MT	Mentholatum Australasia Pty Ltd 12-16 Janine Street Scoresby VIC 3179 Tel: (03) 9763 0322
MW	Biomed Aust Pty Limited C/o Robinson Legal Level 4, 350 Kent Street SYDNEY NSW 2000 Tel: +61 (0)2 9815 5405
NA	National Diagnostic Products (Australia) Pty Limited 7-9 Merriwa Street GORDON NSW 2072 Tel: +61 (0)2 9418 4777 Fax: +61 (0)2 9418 4747
NC	Novartis Consumer Health Australasia Pty Ltd 327-333 Police Road Mulgrave VIC 3170 Tel: 1800 069 643
NE	Norgine Pty Limited Unit 3, 14 Rodborough Road FRENCHS FOREST NSW 2086 Tel: 1800 636 000

Index of Manufacturers' codes

Code	Manufacturer
NF	Novo Nordisk Pharmaceuticals Pty Limited Level 3, 21 Solent Circuit Baulkham Hills NSW 2153 Tel: (02) 8858 3600
NI	Novo Nordisk Pharmaceuticals Pty Limited Level 3, 21 Solent Circuit Baulkham Hills NSW 2153 Tel: (02) 8858 3600
NJ	Norac Pharma Australia Pty Ltd Suite 401 7 Oaks Avenue DeeWhy NSW 2099 Tel: +61 (0)2 9981 4470
NM	Novartis Pharmaceuticals Australia Pty Limited 54 Waterloo Road North Ryde NSW 2113 Tel: 1800 671 203
NO	Novo Nordisk Pharmaceuticals Pty Limited Level 3, 21 Solent Circuit Baulkham Hills NSW 2153 Tel: (02) 8858 3600
NQ	Takeda Pharmaceuticals Australia Pty Ltd Ground Floor, 2-4 Lyonpark Road MACQUARIE PARK NSW 2113 Tel: +61 (0)2 9859 6900 Fax: +61 (0)2 9859 6950
NT	Nestle Australia Ltd 20-24 Howleys Road Notting Hill VIC 3168 Tel: 1800 025 361
NU	Nutricia Australia Pty Limited Level 4, Building D 12-24 Talavera Road Macquarie Park NSW 2113 Tel: +61 (0)2 8875 0300
NV	Novartis Pharmaceuticals Australia Pty Limited 54 Waterloo Road North Ryde NSW 2113 Tel: 1800 671 203
NX	Nipro Australia Pty Ltd Suite 3, 500 Pacific Hwy ST LEONARDS NSW 2065 Tel: 1800 451 737
OA	Orphan Australia Pty Ltd First Floor 34-36 Chandos Street ST LEONARDS NSW 2065 Tel: (02) 8436 8300
OB	Oral B Laboratories Pty Ltd Level 3, 90 Mount Street North Sydney NSW 2060 Tel: (02) 9957 6499
OE	Omegapharm Pty Ltd 21 Queen Street ORMOND VIC 3204 Tel: +61 (0)418 351 065

Code	Manufacturer
OI	Boian Surgical Pty Ltd 486 King Georges Road BEVERLY HILLS NSW 2209 Tel: (02) 9580 7447
OL	Owen Laboratories Division of Galderma Australia Pty Ltd 9 Rodborough Road Frenchs Forest NSW 2086 Tel: 1800 800 765
OM	Colgate Oral Care 345 George Street Sydney NSW 2000 Tel: (02) 9229 5600
ON	Orion Laboratories Pty Ltd 25-29 Delawney Street Balcatta WA 6021 Tel: 1800 004 110
OZ	Medical Specialties Australia Unit Trust 54 Gibbes Street Chatswood NSW 2067 Tel: (02) 9417 7955
PE	Allergan Australia Pty Limited Level 4 810 Pacific Highway Gordon NSW 2072 Tel: 1800 252 224
PF	Pfizer Australia Pty Ltd 38-42 Wharf Road WEST RYDE NSW 2114 Tel: +61 (0)2 9850 3333
PK	Fresenius Kabi Australia Pty Limited 964 Pacific Highway Pymble NSW 2073 Tel: 1800 181 537
PL	The Trustee for Virgo Unit Trust (trading as Phebra) 19 Orion Road Lane Cove West NSW 2066 Tel: 1800 720 020
PM	Pharmaceutical Manufacturing Company Pty Limited 5 Alma Road NORTH RYDE NSW 2113 Tel: (02) 9978 3500
PP	Petrus Pharmaceuticals Pty Ltd PO Box 1808 WEST PERTH WA 6872 Tel: +61 (0)8 9368 5954
PQ	PMIP Pty Ltd Unit 1 5 Apollo Street WARRIEWOOD NSW 2102 Tel: +61 (0)2 8401 9777
PX	Point of Care Diagnostics Australia Pty Ltd Unit 14 76 Reserve Road ARTARMON NSW 2064 Tel: (02) 9437 1355

Index of Manufacturers' codes

Code	Manufacturer
PY	Procter & Gamble Pharmaceuticals Australia Pty Ltd 99 Phillip Street Parramatta NSW 2150 Tel: (02) 9685 4500
QA	Aspen Pharma Pty Ltd 34-36 Chandos Street ST LEONARDS NSW 2065 Tel: (02) 8436 8300
QB	Bionime Australia Pty Limited 75/359 Pitt Street SYDNEY NSW 2000 Tel: (02) 9262 6900
QH	Cortex Health Pty Ltd Suite 3 309 Hampton Street Hampton VIC 3188 Tel: 1800 367 758 Fax: +61 (0)3 8677 7663
QL	Amcla Pty Limited Unit 4/490 Frankston Dandenong Road CARRUM DOWNS VIC 3201 Tel: +61 (0)3 9782 4777
RA	Ranbaxy Australia Pty Limited Ground Floor 9-13 Waterloo Road NORTH RYDE NSW 2113 Tel: +61 (0)2 9887 2600
RB	Bio Revive Pty Ltd 182-184 Stawell St Burnley VIC 3121 Tel: +61 (0)3 8416 0399
RC	Reckitt Benckiser (Australia) Pty Limited 44 Wharf Road WEST RYDE NSW 2114 Tel: 1800226766
RD	Roche Diagnostics Australia Pty Limited 31 Victoria Avenue CASTLE HILL NSW 2154 Tel: 1800 251 816
RI	Dr Reddy's Laboratories (Australia) Pty Ltd Level 1 181 Bay Street BRIGHTON VIC 3186 Tel: +61 (0)3 9595 3812 Fax: +61 (0)3 9595 3800
RO	Roche Products Pty Ltd 4-10 Inman Road DEE WHY NSW 2099 Tel: +61 (0)2 9454 9000 Fax: +61 (0)2 9971 7401
RX	Servier Laboratories (Aust.) Pty Ltd 8 Cato Street HAWTHORN VIC 3122 Tel: (03) 8823 7333

Code	Manufacturer
RZ	Dr Reddy's Laboratories (Australia) Pty Ltd Level 1 181 Bay Street BRIGHTON VIC 3186 Tel: +61 (0)3 9595 3812 Fax: +61 (0)3 9595 3800
SA	SciGen (Australia) Pty Limited Suite 1 13B Narabang Way BELROSE NSW 2085 Tel: 1800 966 303
SB	Nutricia Australia Pty Limited Level 4, Building D 12-24 Talavera Road Macquarie Park NSW 2113 Tel: +61 (0)2 8875 0300
SE	Servier Laboratories (Aust.) Pty Ltd 8 Cato Street HAWTHORN VIC 3122 Tel: (03) 8823 7333
SG	Merck Serono Australia Pty Ltd Unit 3-4, 25 Frenchs Forest Road East Frenchs Forest NSW 2086 Tel: +61 (0)2 8977 4100
SI	Sigma Company Limited 3 Myer Place ROWVILLE VIC 3178 Tel: 03 9215 9215
SJ	Sharpe Laboratories Pty Ltd 12 Hope Street Melrose Park NSW 2114 Tel: +61 (0)2 9858 5622
SN	Smith & Nephew Pty Limited 315 Ferntree Gully Road Mount Waverley VIC 3149 Tel: 13 13 60
SS	SSL Australia Pty Ltd 225 Beach Road Mordialloc VIC 3195 Tel: 1800 999 155
SW	sanofi-aventis Australia Pty Ltd Building D, Talavera Corporate Centre 12-24 Talavera Road MACQUARIE PARK NSW 2113 Tel: +61 (0)2 8666 2000
SY	Bayer Australia Ltd 875 Pacific Highway PYMBLE NSW 2073 Tel: 1800 673 270
SZ	Sandoz Pty Ltd Suite 201, Level 2 19 Harris Street Pyrmont NSW 2009 Tel: 1800 726 369

Index of Manufacturers' codes

Code	Manufacturer
TK	Takeda Pharmaceuticals Australia Pty Ltd Ground Floor, 2-4 Lyonpark Road MACQUARIE PARK NSW 2113 Tel: +61 (0)2 9859 6900 Fax: +61 (0)2 9859 6950
TL	Tolmar Australia Pty Ltd Building 2, Level 2, Suite 4 20 Bridge Street Pymble NSW 2073 Tel: +61 (0)2 9440 6700
TM	Technipro Marketing Pty Ltd PO Box 38 OATLANDS NSW 2117 Tel: +61 (0)2 9897 5899
TS	Specialised Therapeutics Australia Pty Ltd PO Box 250 EAST KEW VIC 3102 Tel: 1300 798 820
TW	Apotex Pty Ltd 16 Giffnock Avenue MACQUARIE PARK NSW 2113 Tel: 1800 276 839
TX	Apotex Pty Ltd 16 Giffnock Avenue MACQUARIE PARK NSW 2113 Tel: 1800 276 839
UA	Actavis Pty Ltd Level 5 117 Harrington Street The Rocks NSW 2000 Tel: 1800 678 302
UC	UCB Australia Proprietary Limited Level 1 1155 Malvern Road Malvern VIC 3144 Tel: +61 (0)3 9828 1800
UM	Unomedical Pty Ltd 11-17 Wilmette Place Mona Vale NSW 2103 Tel: (02) 9997 8033
UN	Unilever Australia Limited 20-22 Cambridge Street Epping NSW 2121 Tel: 1800 888 449
VE	AbbVie Pty Ltd 32-34 Lord Street BOTANY NSW 2019 Tel: 1800 043 460
VF	VitaFlo Australia Pty Limited 110 Fyans Street SOUTH GEELONG VIC 3220 Tel: (03) 5229 8222
VI	ViiV Healthcare Pty Ltd Level 4 436 Johnston Street Abbotsford VIC 3067 Tel: +61 (0)3 9721 6000

Code	Manufacturer
VL	Vifor Pharma Pty Limited Level 8 80 Dorcas Street Southbank VIC 3006 Tel: +61 (0)3 9686 0111 Fax: +61 (0)3 9686 0333
VN	Actavis Pty Ltd Level 5 117 Harrington Street The Rocks NSW 2000 Tel: 1800 678 302
VR	Vertex Pharmaceuticals (Australia) Pty Ltd Level 32 101 Miller Street North Sydney NSW 2060 Tel: 1800 179 987
VT	Valeant Pharmaceuticals Australasia Pty Limited level 10, 12 Help street CHATSWOOD NSW 2067 Tel: +61 (0)2 8918 6322 Fax: +61 (0)2 8918 6416
WA	sanofi-aventis Australia Pty Ltd Building D, Talavera Corporate Centre 12-24 Talavera Road MACQUARIE PARK NSW 2113 Tel: +61 (0)2 8666 2000
WI	Wincot Pty Limited 74 Balgownie Drive Armidale NSW 2350 Tel: +61 (0)2 6772 5855
XA	Pharmaxis Ltd 20 Rodborough Road FRENCHS FOREST NSW 2086 Tel: (02) 9454 7200
XH	MS Health Pty Ltd Suite 129 135 Cardigan Street Carlton VIC 3053 Tel: 1300 515 883 Fax: +61 (0)3 9658 7449
XI	Alexion Pharmaceuticals Australasia Pty Ltd Suite 226-227 117 Old Pittwater Road Brookvale NSW 2100 Tel: +61 (0)2 9091 0500 Fax: +61 (0)2 9091 0511
XM	The Medicines Company (Australia) Pty Limited Suite 1 Level 8, North Tower, 1-5 Railway Street CHATSWOOD NSW 2067 Tel: 1800 755 459
YN	Mayne Pharma International Pty Ltd Level 14 474 Flinders Street MELBOURNE VIC 3000 Tel: 1300 081 849

Index of Manufacturers' codes

Code	Manufacturer
YT	Mayne Products Pty Ltd Level 14 474 Flinders Street MELBOURNE VIC 3000 Tel: 1300 081 849
ZF	Sun Pharmaceutical Industries (Australia) Pty Ltd 1053 Burwood Highway FERNTREE GULLY VIC 3156 Tel: (03) 95686102

Code	Manufacturer
ZI	Shire Australia Pty Limited Avaya House Level 6, 123 Epping Road North Ryde NSW 2113 Tel: 1800 012 612
ZP	Medis Pharma Pty Ltd L3, 5 Essex St, The Rocks Sydney NSW 2000 Tel: +61 (0)2 8220 4650 Fax: +61 (0)2 9251 1099

Section 1 — Explanatory Notes

Introduction

These Explanatory Notes are provided to help PBS prescribers and pharmacists work within the Australian Government's Pharmaceutical Benefits Scheme (PBS).

The PBS is a system of subsidising the cost of most prescription medicines. The subsidies are available to all Australian residents and eligible foreign visitors, i.e., people from countries which have Reciprocal Health Care Agreements with Australia. These countries are the United Kingdom, Ireland, New Zealand, Malta, Italy, Sweden, the Netherlands, Finland, Norway, Belgium and Slovenia.

The aim of the PBS, which has been in operation since 1948, is to provide reliable and affordable access to a wide range of necessary medicines.

The Schedule of Pharmaceutical Benefits referred to throughout as the 'Schedule' – lists all the medicinal products available under the PBS, and explains the uses for which they can be subsidised.

The Schedule is produced monthly by the Australian Department of Health (effective on the first day of each month).

It is vital therefore that PBS prescribers and pharmacists remain up to date with information on which medicines are included in or excluded from the Schedule, which PBS prescribers may prescribe certain medicines, whether restrictions apply to the medicines, and how much patients should pay.

Queries relating to the PBS can be made to the Pharmaceutical Benefits Branch of the Department of Human Services (telephone 132 290 open 24 hours a day, 7 days a week). Queries relating to the Repatriation Pharmaceutical Benefits Scheme (RPBS) can be made to the State offices of the Department of Veterans' Affairs (DVA) (telephone 1800 552 580).

1. The Schedule — Where to Find What

The Schedule of Pharmaceutical Benefits is divided into sections. At the start of the Schedule, immediately after the table of contents, is a summary of any changes to listed items. This is followed by a list of important information sources, contacts and addresses, then an index of manufacturers' codes.

The last pages of the Schedule provide a generic/proprietary index of PBS and RPBS ready-prepared items.

Section 1

Section 1 is what you are reading, the Explanatory Notes. It outlines the correct way to prescribe and supply pharmaceutical benefits; patient charges; who qualifies for concessions; how the Safety Net system works; and, for pharmacists, how to claim reimbursement for PBS items.

Please note that except where indicated, the term '**prescriber**' is used in this section to cover doctors, dentists, optometrists, midwives and nurse practitioners who are approved to prescribe PBS medicines under the National Health Act 1953.

And except where stated otherwise, the term '**pharmacist**' means a pharmacist approved to supply medicines under the PBS.

Section 2

This section lists ready-prepared items, and includes the form, manner of administration, brand and brand equivalents which may be prescribed, and the maximum quantity and number of repeats for each item.

Prescriber bag supplies are also listed at the beginning of this section.

Medicines that have restrictions on how they can be prescribed are printed in ***bold italics***. Items appearing in more than one therapeutic group are cross-referenced.

The second page of Section 2 explains symbols used throughout the Schedule.

The use of 'NOTE' in this section is used to clarify how some pharmaceutical benefits should be prescribed.

The use of 'CAUTION' is to warn of known adverse reactions from, or precautions to be taken with, a particular pharmaceutical benefit. (The absence of a cautionary note does not imply reactions may not happen.)

Separate lists at the end of Section 2 relate to items that can be prescribed by dentists and optometrists who work within the PBS. These are followed by a list of items that are made available under special arrangements for doctors to prescribe.

Section 3

This section lists container prices, fees related to dispensing, standard packs and prices for ready-prepared preparations.

Section 4

This section deals with extemporaneous preparations. It lists the ingredients which can be used, a table of maximum quantities and number of repeats, container prices, and a list of standard formula preparations and prices (based on formularies in common use and referred to in the Schedule as the Standard Formulae List).

Restrictions applying to the use of a pharmaceutical benefit are indicated against the item.

Repatriation Schedule of Pharmaceutical Benefits

After Section 4, the Schedule provides information about pharmaceutical benefits under the RPBS. These may only be prescribed to DVA beneficiaries holding one of the repatriation health cards (see details under '4. Patient Charges').

2. Prescribing Medicines – Information for PBS Prescribers

PBS prescribers

Pharmaceutical benefits can only be prescribed by doctors, dentists, optometrists, midwives and nurse practitioners who are approved to prescribe PBS medicines under the *National Health Act 1953*.

There are separate arrangements for PBS prescriptions in certain public hospitals. To gain access to pharmaceutical benefits under this arrangement a patient must attend a participating public hospital and be a discharge patient or non-admitted patient. Only a medical practitioner providing medical treatment or a midwife providing midwifery treatment or a nurse practitioner providing nurse practitioner treatment within a participating public hospital may prescribe PBS subsidised medication from a hospital. The States of Victoria, Queensland, South Australia, Western Australia and Tasmania, and the Northern Territory have agreed to implement these arrangements.

PBS Prescription forms

Standard PBS prescription forms are available from the Department of Human Services for prescribing pharmaceutical benefits.

For doctors:

- *Personalised forms* — are printed with the doctor's name, qualifications, practice address/es, telephone number and prescriber number (which relates to pharmaceutical benefits). They are only provided to doctors who have a Medicare provider number.
- *Non-personalised (blank) forms* — are distributed as an emergency supply (usually when a doctor has temporarily run out of personalised forms).
- *Locum forms* — have the doctor's name, prescriber number and telephone number (if available) and a space to record the practice where the doctor is working.
- *PBS/RPBS Authority Prescription Forms* — can be in personalised, non-personalised or locum format.
- *Computer PBS prescription forms* — are either continuous or single sheet. On the reverse side they list the name, address and telephone number of the practice, and in the case of a sole doctor practice, the doctor's name.

For dentists:

- *Personalised forms* — have the dentist's name, qualifications, practice address/es, telephone number and prescriber number.
- *Non-personalised (blank) forms* — are distributed for emergency supply only.

For optometrists:

- *Personalised forms* — have the optometrist's name, qualifications, practice address/es, telephone number and prescriber number. These forms can be also be used to prescribe authority-required PBS/RPBS items.

For midwives:

- *Personalised forms* — have the midwife's name, qualifications, practice address/es, telephone number and prescriber number.
- *Non-personalised (blank) forms* — are distributed for emergency supply only.

For nurse practitioners:

- *Personalised forms* — have the nurse practitioner's name, qualifications, practice address/es, telephone number and prescriber number.
- *Non-personalised (blank) forms* — are distributed for emergency supply only.

PBS prescription forms for PBS prescribers are supplied free of charge.

The inclusion of the prescriber number on a PBS prescription enables the pharmacist to be sure the prescription is from a legitimate prescriber and satisfies State/Territory legislation. A PBS prescription written by a dentist, an optometrist, a midwife or a nurse practitioner must include the person's approval number as a PBS prescriber.

PBS prescriptions should be provided to the patient in duplicate, as both parts make up a valid PBS prescription. The patient should be reminded to present both the original and the duplicate copy to the pharmacist.

PBS stationery order forms

Prescribers are asked not to over order. Getting the right amount of forms helps to reduce the cost to taxpayers and helps to reduce paper wastage. Also, the pads may deteriorate if stored over time.

Prescribers can gain access to order forms for standard and authority prescription forms as well as computer prescription forms by

downloading the required order form from the Department of Human Services website at www.humanservices.gov.au.

The completed order form should be posted to:

Prescription Pad Order Clerk
Pharmaceutical Branch
Department of Human Services
GPO Box 9826
Sydney NSW 2001
Telephone (02) 9895 3295

Preparing general PBS prescriptions

Do's and Don't's

A PBS prescription is only valid when it is written by a doctor, a dentist, an optometrist, a midwife or a nurse practitioner.

The PBS prescription must be for the treatment of the person named on the PBS prescription. A PBS prescription may only be written for the treatment of one person.

A prescriber cannot write more than one PBS prescription for the same pharmaceutical benefit for the same person on the same day.

Up to **three** pharmaceutical benefit items may be included on a single PBS prescription form except for Authority required, Authority required (STREAMLINED) items and optometrist items. These items must be written on individual forms. Pharmaceutical benefits and non-pharmaceutical benefits should not be listed together on the one PBS prescription form.

If an item has a particular manner of administration it may not, as a pharmaceutical benefit, be administered in any other way, e.g., an ophthalmic preparation may not be prescribed for topical use.

If an item is restricted, and the use for the patient is different from the use specified in the restriction, it cannot be prescribed as a pharmaceutical benefit. The prescriber should write the prescription as a non-PBS private prescription. If a standard PBS prescription form is used for this purpose the 'PBS/RPBS' text must be clearly struck out. It should also be endorsed 'non-PBS'.

Prescribers must heed State/Territory laws when prescribing drugs listed as narcotic, specified or restricted in the poisons legislation of the particular State or Territory. Legislative requirements in some States/Territories are such that prescribers may be required to prescribe a drug of addiction on a separate PBS prescription. Prescribers must ensure that prescriptions written under the PBS fall within the limits of the prescribing approval granted to the person under State or Territory requirements. It is the prescriber's responsibility to ensure that PBS prescriptions comply with all aspects of his/her prescriber approval. Inclusion of a PBS medicine for prescribing does NOT confer approval for a particular prescriber to prescribe that medicine if it is not authorised to be prescribed in a particular State or Territory.

A PBS prescriber cannot prescribe a narcotic drug for him/herself.

Prescribers are issued with individual PBS prescription pads by the Department of Human Services for their own use — these pads should not be used by other prescribers.

Doctors should, and dentists and optometrists, midwives and nurse practitioners are required to, include their prescriber number on non-personalised PBS prescriptions.

The following admixtures are not pharmaceutical benefits:

- the admixture of two or more ready-prepared items listed in the Schedule; or
- the admixture of a ready-prepared item and one or more extemporaneous drugs listed in Section 4 of the Schedule; or
- the admixture of a non-pharmaceutical benefit item with a pharmaceutical benefit item.

Writing the PBS prescription

The following rules apply for writing PBS prescriptions:

- they must be written in indelible form (i.e., ink or ball-point pen) in the prescriber's own handwriting (exceptions must be approved by Chief Executive Medicare) either on the standard PBS prescription, or on paper approximately 18 cm x 12 cm, or they can be generated by computer on a form approved by the Department of Human Services. For patient safety reasons, both the original and the duplicate must be legible;
- they must record the prescriber's name and address (and, in the case of dentists, optometrists, midwives and nurse practitioners, the prescriber number), the patient's name, address and entitlement status, and whether the prescription is under the PBS or RPBS;
- they should completely identify the pharmaceutical benefit by detailing the item, dose, form, strength, quantity and instructions for use;
- they should indicate where brand substitution is not permitted. PBS prescriptions must not be prepared using a computer prescribing program that contains a default which would result in all prescriptions being indicated as Brand Substitution Not Permitted; and
- they must be signed by the prescriber and dated. Forward or back dating is not permitted.

Restrictions

Pharmaceutical benefits listed in the Schedule fall into three broad categories:

Unrestricted benefits - have no restrictions on their therapeutic uses;

Restricted benefits - can only be prescribed for specific therapeutic uses (noted as Restricted benefit); and

Authority required benefits - Authority required benefits fall into two categories:

- *Authority required benefits* are restricted benefits that require prior approval from the Department of Human Services or the DVA (noted as **Authority required**)
- *Authority required (STREAMLINED) benefits* are restricted benefits that do not require prior approval from the Department of Human Services or the DVA but require the recording of a streamlined authority code (noted as **Authority required (STREAMLINED)**).

Authority PBS prescriptions

Authority required benefits fall into two categories - *Authority required* and *Authority required (STREAMLINED)*.

All PBS prescribers (with the exception of dentists) can write authority PBS prescriptions.

Authority PBS prescriptions cannot have retrospective approval.

Authority required PBS Prescriptions

Approval of authority PBS prescriptions by Chief Executive may be sought by:

- posting an Authority Prescription Form to the Department of Human Services - after approval, the Department of Human Services will forward both copies of the prescription to the patient or the prescriber (if it is to be sent direct to the patient, the prescriber should mark the box next to the patient's details);
- calling the Department of Human Services Telephone Authority Applications Freecall service (1800 888 333); or
- using the Department of Human Services PBS authorities website at www.medicareaustralia.gov.au/provider/pbs/doctor/authorities.jsp.

Approval of authority prescriptions by the DVA may be obtained either by posting an Authority Prescription Form to the DVA, or by using the DVA Authority Freecall service (1800 552 580).

An authority PBS/RPBS prescription is not valid until it has been approved by the Department of Human Services or the DVA. Without this approval, a pharmacist must not supply the item as a PBS/RPBS benefit.

Each Authority required PBS/RPBS item must be written on an Authority PBS/RPBS prescription form, one item per form. Authority PBS prescription forms provide for the following:

- the patient/pharmacist copy, which records prescriber, patient, and pharmaceutical benefit item details. Where required a repeat authorisation, which is used for repeat supply, is attached to the pharmacist/patient copy until the last supply is made. The patient/pharmacist copy is then retained by the pharmacist;
- the Department of Human Services/DVA copy which records prescriber, patient, and pharmaceutical benefit item details. After the first dispensing, the Department of Human Services/DVA copy is forwarded to the Department of Human Services for processing and payment;
- the prescriber's copy (for computer generated scripts, this is the tear off portion at the base of the script) or Prescriber/the Department of Human Services/DVA copy (for handwritten scripts this is the long white copy), is kept by the Department of Human Services or the DVA for record purposes when approval is sought in writing. When approval is by telephone or by the authorities website, the prescriber must keep this copy for 12 months. This copy must record the daily dose, details of the disease, clinical justification for using the item, the patient's age (if the patient is a child) and whether the patient has previously received an authority for this pharmaceutical benefit.

Authority required (STREAMLINED) PBS Prescriptions

Prior approval is not required from the Department of Human Services or 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.

This code is listed with the corresponding restriction for each Authority required (STREAMLINED) item and the prescriber must write the code on the authority PBS/RPBS prescription form. An authority prescription for an Authority required (STREAMLINED) item is not valid unless the code is included on the prescription form. Without the streamlined authority code, a pharmacist must not supply the item as a PBS benefit.

There are no Authority Required (STREAMLINED) items in the Repatriation Schedule of Pharmaceutical Benefits.

Authority required (STREAMLINED) PBS prescriptions must be written on an Authority PBS/RPBS Prescription Form, this includes:

- the pharmacist/patient copy, which records prescriber, patient, and pharmaceutical benefit item details. The prescription is given directly to the patient to be dispensed at their pharmacy;
- the Department of Human Services/DVA copy which records prescriber, patient, and pharmaceutical benefit item details. After the first dispensing, the Department of Human Services/DVA copy is forwarded to the Department of Human Services for processing and payment;

- the prescriber's copy is kept by the prescriber for 12 months. This copy must record the daily dose, details of the disease, clinical justification for using the item, the patient's age (if the patient is a child) and whether the patient has previously received an authority for this pharmaceutical benefit.

Writing authority PBS prescriptions

The following rules apply:

- only one item may be prescribed per PBS prescription;
- PBS prescriptions must be completed by prescribers in writing, unless otherwise approved by the Department of Human Services;
- prescribers should include their name, address, telephone number and **prescriber number** (not provider number);
- prescribers must include the patient's name, address and entitlement status (i.e. whether they are a 'concessional' or 'general patient');
- prescribers must indicate when brand substitution is not permitted. PBS prescriptions must not be prepared using a computer prescribing program that contains a default which would result in all PBS prescriptions being indicated as Brand Substitution Not Permitted;
- in certain circumstances, the prescriber must provide additional information to the Department of Human Services with the authority application; and
- the PBS prescription must be signed by the prescriber and dated.

Posted applications which lack necessary information, and therefore cannot be approved, will be returned for correction. If the matter can be clarified via telephone, an Authority to Prescribe Form may be prepared by the Department of Human Services or the DVA and sent to the prescriber.

In the case of authority PBS prescriptions approved by telephone, the approval number must be included on the PBS prescription to enable the pharmacist to supply the medication. A prescriber who is granted approval but decides not to continue with the therapy should advise the Department of Human Services.

In the case of Authority required (STREAMLINED) prescriptions, the streamlined authority code must be written on the PBS/RPBS prescription form. This enables the pharmacist to supply the medication as a PBS benefit.

Maximum quantities and repeats

The maximum quantity and number of repeats allowed for PBS items are recommended by the Pharmaceutical Benefits Advisory Committee (PBAC). In the case of RPBs items, the recommendations are made by the Repatriation Pharmaceutical Reference Committee (RPRC).

There are no repeats included in PBS listings for items for prescribing by dentists.

PBS prescriptions and repeats can be for any quantity up to the maximum. It is not necessary to prescribe the maximum quantity if a lesser quantity is sufficient for the patient's needs. Please clearly indicate the number of tablets, capsules, etc. required and the number of repeats needed, and **do not use** abbreviations such as 'Max. Qty', 'M.Q.', or 'M.R.'.

If a prescriber feels the maximum quantity or number of repeats should be increased for a particular patient, he or she must complete an Authority PBS Prescription Form (see procedures above under 'Authority PBS Prescriptions'). The provision of increased quantities and repeats on authority PBS prescriptions is intended to provide approximately one month's therapy which may be repeated (if clinically appropriate) to provide 6 months' therapy in total. This situation usually arises where higher than normal dosages are required.

Approval for increased quantities and repeats of Authority required, Authority required (STREAMLINED) and Restricted benefit PBS items will be granted only where the reason for the PBS prescription is consistent with the indications published in the Schedule.

Approval for increased quantities and repeats extends only to the provision of a pharmaceutical benefit for the patient and does not imply approval of any aspects of the patient's care, which are the responsibility of the treating prescriber.

Regulation 24

Under this regulation, original and repeat supplies of pharmaceutical benefits can be supplied at the one time if a medical practitioner, a midwife or a nurse practitioner is first satisfied that certain conditions apply, then endorses the PBS prescription 'Regulation 24'. RPBs prescriptions may be endorsed 'hardship conditions apply'.

The medical practitioner, midwife or nurse practitioner must first be satisfied all the following conditions apply:

- the maximum PBS quantity is insufficient for the patient's treatment; **AND**
- the patient has a chronic illness or lives in a remote area where access to PBS supplies is limited; **AND**
- the patient would suffer great hardship trying to get the pharmaceutical benefit on separate occasions.

Regulation 24 does not apply for supply of pharmaceutical benefits on optometrist prescriptions.

Urgent cases

In urgent cases and where State/Territory law allows, a prescriber may telephone a pharmacist and ask that a PBS prescription be supplied. He/she must then forward the written PBS prescription and duplicate to the pharmacist within **seven days of the date of supply**.

This also applies to 'Authority required' authority PBS prescriptions provided prior approval has been given by the Department of Human Services or DVA. The follow-up written PBS prescription must include the approval number provided over the phone by the Department of Human Services or DVA.

Drugs of addiction

Prescribers must heed State/Territory laws when prescribing drugs listed as narcotic, specified or restricted and must notify, or receive approval from, the appropriate health authority.

When a PBS/RPBS authority application is for a drug of addiction (other than dexamphetamine sulfate), the following guidelines apply:

- the maximum quantity authorised is generally for one month's therapy (e.g., one week's therapy with three repeats);
- where supply for a longer period is warranted, quantities are usually for up to three months' therapy;
- telephone approvals are limited to one month's therapy.

Prescribers should also state the interval of repeat where repeats are called for, and ensure State/Territory health authorities are notified about ongoing treatment.

Prescriber bag supplies

Certain pharmaceutical benefits are provided without charge to prescribers who in turn can supply them free to patients for immediate administration or emergency use.

A drug or a pharmaceutical benefit (as a particular form of a drug), may be available for general prescribing and prescriber bag supply, or via prescriber bag provisions only (ie. not for prescribing as a general pharmaceutical benefit). Prescriber bag items are listed according to the PBS prescribers who may obtain and supply them, and may be listed for one or more PBS prescriber types.

To obtain supplies, a prescriber bag supply order form must be completed in triplicate, signed, and the original and duplicate given to a pharmacist. Each form is valid for the month indicated on the form.

Prescribers may order up to the maximum quantity of an item provided they do not already have the maximum quantity on hand. No more than the maximum quantity can be obtained in a calendar month. Prescribers may order a particular brand of a pharmaceutical benefit. A change to specify another listed brand must be initialised by the prescriber.

A receipt must be signed by the prescriber, or by an authorised representative, when supplies are received.

Improving the capacity of the PBS to meet particular Aboriginal and Torres Strait Islander health needs

The PBS includes listings to support the treatment of conditions common in Aboriginal and Torres Strait Islander health settings. These listings are specifically for your patients who identify as Aboriginal and/or Torres Strait Islander persons. Some listings will be medicines recently added to the PBS; others may contain specific restrictions for existing PBS items.

More information is available on the Factsheet: Listings on the PBS for Aboriginal and Torres Strait Islander people

A significant proportion of the higher levels of illness experienced by Aboriginal and Torres Strait Islanders may be addressed through better access to appropriate medicines. The PBS aims to provide greater choice in therapeutic options and to address:

- the greater burden of disease experienced by Aboriginal and Torres Strait Islander peoples; and
- morbidity almost exclusively seen in this population.

How to prescribe these items?

These items are available as "Authority PBS prescriptions". You should obtain approval from the Department of Human Services before prescribing these items for patients who identify as Aboriginal and/or Torres Strait Islander persons through the Authority Freecall service [1800 888 333], on line or by mail.

All PBS prescribers except dentists can write Authority PBS prescriptions and your patients will be required to pay their normal PBS co-payment.

Special arrangements apply in remote area Aboriginal Health Services for supplying these PBS items.

Aboriginal and Torres Strait Islander identification

Establishing a client's background may have clinical significance and should be part of routine medical history taking. In the case of Aboriginal and Torres Strait Islander people, this is also relevant to establish eligibility for services such as health checks, specific immunisation programs, and the some PBS items.

Improving the level of identification of Aboriginal and Torres Strait Islander people will also assist in developing initiatives to meet particular needs.

For the purposes of these PBS items a person is Aboriginal and/or Torres Strait Islander if the person identifies himself or herself as being an Aboriginal and/or Torres Strait Islander. Clients should be asked to self-identify either verbally or by completing a form.

- Some people may give this information without being asked.
- It is important not to assume that a person is or is not Aboriginal or Torres Strait Islander.

Asking about Aboriginal and/or Torres Strait Islander identification

Practitioners should ensure that each person attending their practice has the opportunity to identify if they are Aboriginal or Torres Strait Islander. An environment which maintains confidentiality and provides an explanation for this question if requested will assist this process.

- The inquiry may be made verbally and recorded by the general practitioner as part of routine medical history taking at first consultation, or by a receptionist or other staff member. An appropriate question to ask is:
"Are you (is this child) of Aboriginal or Torres Strait Islander origin?"
- Alternatively, the question may be included on a client self-history or practice record form, using a standard question such as:
"Are you (is this child) of Aboriginal or Torres Strait Islander origin?"
 - Yes - Aboriginal
 - Yes - Torres Strait Islander
 - Yes - Aboriginal and Torres Strait Islander
 - No

Aboriginal and Torres Strait Islander health

Major causes of excess mortality in Aboriginal and Torres Strait Islander peoples are:

- circulatory conditions (including ischaemic heart disease, hypertension, cerebrovascular disease and rheumatic heart disease);
- external causes (including accident and injury);
- endocrine causes (mainly type two diabetes and its complications); and
- respiratory conditions.

Causes of morbidity vary but include the risk factors and precursors of all of these. They also include infections of the respiratory system, the ears (in particular, chronic suppurative otitis media), the eyes (trachoma in some settings), the skin and the gastrointestinal system. End-stage renal disease is a major cause of hospitalisations, and much early renal disease remains undetected. In some settings, sexually transmissible infections are common.

Living environments affect health and may be compromised by overcrowding, limited access to clean water and sanitation, and poverty. Social and family life may be negatively influenced by an excessive burden of care for family members, by substance use and sometimes by family violence.

Communication and cultural issues

Aboriginal cultures are numerous and diverse in language, customs, non-verbal and verbal communication, geographical locations and experiences. Torres Strait Islanders are a separate people with a distinctly different culture and identity. Aboriginal and Torres Strait Islander people often perceive health differently from other Australians.

For Aboriginal and Torres Strait Islander peoples' health does not just entail the freedom of the individual from sickness but requires support for healthy and interdependent relationships between families, communities, land, sea and spirit. The focus must be on spiritual, cultural, emotional and social well-being as well as physical health

Source: National Aboriginal and Torres Strait Islander Health Council. National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013, Context. Canberra: Commonwealth of Australia; 2004.

To provide effective primary health care to Aboriginal and Torres Strait Islander clients, you need to be aware of the issues surrounding this diversity, and which may have an impact on the delivery of services.

- Aboriginal and Torres Strait Islander people may be reluctant to use mainstream medical services. This may be because of a lack of understanding of the mainstream health system and previous negative experiences within the mainstream health care system.
- Access to adequate health care may be hindered by family obligations (often extended family), lack of transport or money, or geographical isolation.
- English may be the person's second, third or even fourth language. Therefore it may be appropriate to consider the use of an interpreter.
- Aboriginal and Torres Strait Islander people may be reluctant to consult a health care provider of the opposite sex, particularly with regard to women's and men's health issues.

The differences between the cultural and language backgrounds of health service providers and patients, whether urban, rural or remote, may range from minor to extreme.

You should:

- Make efforts to ensure waiting rooms are welcoming to Aboriginal and Torres Strait Islander people, including displaying relevant posters and pamphlets;
- Provide a relaxed setting for the consultation (e.g. sit next to your patient rather than across a desk);
- Allow time at the first consultation to build rapport and trust;
- Ensure the person understands clearly what the service entails and the details of any procedures involved, and possible follow-up or referral requirements;
- Obtain health promotion information appropriate for Aboriginal and Torres Strait Islander patients;
- Allow the patient to have family members present if desired. When inviting family or community members to accompany a patient, ensure the patient fully consents to their attendance and that the community/family members are fully aware of the need for confidentiality;

- Provide gender appropriate staff where possible, for both male and female patients, especially in regard to pap smears, mammograms, sexual health checks, pregnancy checks, antenatal care and postnatal care;
- Encourage all staff in the practice to attend Aboriginal and Torres Strait Islander Cultural Awareness programs, which are widely available;
- Ensure practice staff have awareness of appropriate referral and/or support organisations for Aboriginal and Torres Strait Islander patients; and
- Develop partnerships with local Aboriginal and Torres Strait Islander community organisations.

For more information, pbs-indigenous@health.gov.au

3. Supplying Medicines — What Pharmacists Need to Know

Eligible suppliers

Pharmaceutical benefits are mainly supplied by approved pharmacists – pharmacists who comply with certain conditions. These pharmacists are approved to dispense pharmaceutical benefits from a particular pharmacy.

Other suppliers include approved doctors (usually practising in isolated areas), Friendly Society pharmacies, and approved hospitals. All suppliers are issued with approval numbers by the Department of Human Services. They should follow the procedures in these Explanatory Notes.

Unapproved pharmacists *cannot* supply pharmaceutical benefits.

Approval conditions for pharmacists

A pharmacist approved to supply medicines under the PBS:

- can only supply benefits from the pharmacy that he/she is operating;
- will not supply to anyone any pharmaceutical benefit that attracts a Commonwealth contribution for free, or for a price that is less than the relevant patient contribution;
- will clearly advertise that any offer for free or cut-price medicines does not include pharmaceutical benefits which have a Commonwealth contribution;
- will not pay rebates or refunds of patient contributions;
- will publicly display a notice setting out the pharmacy's normal trading hours;
- is obliged to supply pharmaceutical benefits at the pharmacy at any hour if a PBS prescription is marked 'urgent' and initialled by the prescriber;
- will keep adequate stocks for the supply of pharmaceutical benefits;
- may be called on by the Department of Human Services to provide details of stocks of pharmaceutical benefits or preparations for pharmaceutical benefits; and
- must keep the duplicates of all old format PBS prescriptions, and the patient/pharmacist copies of all new format PBS prescriptions, with a Commonwealth contribution for at least one year from the date of supply. This includes PBS prescriptions ordering repeats when it is the final supply, and order forms for prescriber bag supplies. Please note that some State/Territory laws require these copies to be kept for longer periods.

Before supplying pharmaceutical benefits

Several steps must be taken before a pharmaceutical benefit is supplied.

Firstly, a pharmacist must endorse the PBS prescription and duplicate with his/her name and approved supplier number.

Secondly, a PBS prescription identifying number must be given to the PBS prescription item on both the PBS prescription and duplicate. Any recognised series of numbers may be used.

If more than one item is on a PBS prescription, a separate identifying number should be allocated to each item.

In the case of a repeat authorisation, the same PBS prescription identifying number(s) must be carried through for each item. A pharmacist must also allocate his/her own identifying number on the repeat authorisation. It must be written alongside the date and place of supply.

Supplying pharmaceutical benefits

Do's and Don'ts

Except in urgent cases (see details under '2. Prescribing Medicines ... Urgent cases'), pharmacists are authorised to supply pharmaceutical benefits only after they receive:

- the pharmacist/patient and the Department of Human Services or DVA copies of a valid PBS prescription which is not more than 12 months old; or
- the pharmacist/patient and the Department of Human Services or DVA copies of an approved authority PBS prescription or an authority to prescribe which is not more than 12 months old; or

- a repeat authorisation attached to a patient/pharmacist PBS prescription not more than 12 months after the date of the original PBS prescription.

A pharmacist must not supply an Authority required (STREAMLINED) item unless the prescriber has written the four digit streamlined authority code on an authority PBS/RPBS prescription.

A pharmaceutical benefit cannot be supplied more times than specified in the PBS prescription.

A pharmacist cannot add to, delete from, or alter a PBS prescription in any other way. However, there may be circumstances where after contacting a prescriber, the pharmacist can clarify the prescriber's intentions and endorse the PBS prescription accordingly.

Once a pharmaceutical benefit has been supplied to a patient, it may not be supplied to that patient again:

- on the same day or within the next 20 days, if it is a benefit (other than an eye preparation) that has five or more repeats allowed in the Schedule; or
- on the same day or within the next four days (e.g., if a pharmaceutical benefit is supplied on a Monday, it cannot be supplied again to that patient until the next Saturday) in the case of other benefits.

Exceptions to this are:

- when a PBS prescription is endorsed with the words 'Regulation 24' or 'hardship conditions apply' (see below under 'Regulation 24'); and
- If a pharmacist believes a repeat supply is needed without delay for the treatment of the person, or a previous supply has been destroyed, lost or stolen. In this case, the pharmacist can provide another supply but must write 'immediate supply necessary' and sign the PBS prescription.

A pharmacist can supply an alternative pharmaceutical benefit without reference to the prescriber, provided that:

- the PBS prescription does not indicate that only the pharmaceutical benefit prescribed is to be supplied (ie substitution is not permitted); and
- the Schedule states that the prescribed benefit and the substitute benefits are equivalent; and
- supply of the substitute benefit does not contravene relevant State/Territory law; and
- the substitute benefit is a listed brand in the Schedule.

Pharmacists must heed State/Territory laws when supplying drugs listed as narcotic, specified or restricted in legislation of the particular State or Territory.

What to do if the Schedule changes

If an item or brand is deleted from the Schedule, it *cannot* be supplied as a pharmaceutical benefit from the date the deletion takes effect – regardless of whether the PBS prescription was written before this date. This includes repeat authorisations. (Special conditions applying to RPBS prescriptions are detailed in the RPBS Explanatory Notes.)

However, if restrictions on the prescribing of a pharmaceutical benefit change, or the maximum quantity or number of repeats is altered in the Schedule, valid PBS prescriptions written before the date of effect of the change *may* still be supplied as pharmaceutical benefits, under the conditions applying at the date of prescribing.

Suspected forgery

Pharmacists should take all reasonable steps to satisfy themselves that all items on a PBS prescription were written by a medical practitioner, a dentist, an optometrist, a midwife or a nurse practitioner.

Regulation 24

This regulation allows pharmacists to supply a pharmaceutical benefit and all of its repeats at the one time.

The PBS prescription must be endorsed by the medical practitioner, midwife or nurse practitioner with the words 'Regulation 24' if it is an item under the PBS, or 'hardship conditions apply' if it is being supplied under the RPBS. (For more information see under '2. Prescribing Medicines ... Regulation 24'). Regulation 24 does not apply for supply of pharmaceutical benefits on optometrist prescriptions.

Repeat authorisations

When a PBS prescription calls for repeat supplies, the pharmacist shall prepare a Repeat Authorisation Form, except when the PBS prescription is marked 'Regulation 24'.

The repeat may be requested on a standard PBS prescription, an authority PBS prescription or an Authority to Prescribe Form, or on an earlier repeat authorisation. In the latter case, it must come with the duplicate PBS prescription, or in the new format, the "patient/pharmacist copy".

Preparing Repeat Authorisation Forms

A Repeat Authorisation Form must show:

- the category of benefit (concession or general) – by placing a cross (x) in the relevant box;
- the patient's name and full address;
- in the case of repeats authorised on authority PBS prescriptions, the authority prescription number;
- details of the original PBS prescription stating the item, form, strength, quantity and directions;

- if substitution has occurred, the name of the brand actually supplied;
- for the first supply, the pharmacy name, address and approval number, the date of the original PBS prescription and the allotted PBS prescription identifying number;
- for subsequent supplies, the pharmacy approval number, and the date and PBS prescription number of the original prescription;
- the number of times the item is to be repeated and the number of times it has been supplied;
- the name and pharmacy approval number of the pharmacist issuing the repeat authorisation; and
- the date of supply.

When a repeat authorisation is prepared for any further repeats or deferred supply, a pharmacist must attach the duplicate copy of an old format PBS prescription, or the patient/pharmacist copy of a new format PBS prescription, and give both to the patient at the time of supply.

Repeat authorisations for deferred supply

When a PBS prescription orders a number of pharmaceutical benefit items, but the patient does not need all of the items at the same time, a separate repeat authorisation for each deferred item must be prepared. The words 'original supply deferred' should be indicated across the relevant item on the original PBS prescription, its duplicate, and on the repeat authorisation.

Deferred items must not be claimed on the original PBS prescription.

The Repeat Authorisation Form when it is used for a deferred supply, is issued in the same way as normal repeat authorisations except that:

- '0' is to be inserted in the space for 'no. of times already dispensed'; and
- if no repeats are ordered, '0' is to be inserted in the space for 'no. of repeats authorised'.

Supplying a benefit on a deferred supply repeat authorisation is to be treated as if it is the first time of supply. If repeats are directed, the normal procedure for repeat authorisations applies. Details of the pharmacy at which the deferred supply was authorised are to be written onto subsequent repeat authorisations.

Authority PBS prescriptions

If a pharmacist is presented with an authority PBS prescription and is not sure if it has been approved, he or she should contact the Department of Human Services. Please note that the Department of Human Services will not provide clinical information.

If the authority PBS/RPBS prescription is for an Authority required (STREAMLINED) item the pharmacist should ensure that the prescriber has written the four digit streamlined authority code on the prescription, this enables the pharmacist to supply the item as a PBS benefit.

The pharmacist is required to include the four digit streamlined authority code on the claim for the PBS dispensing.

Urgent cases

In urgent cases and where State/Territory law allows, pharmacists can supply a pharmaceutical benefit to a person without a PBS prescription, provided details of the prescription are given by the prescriber via telephone or other means. The prescriber must then forward the written PBS prescription and duplicate to the pharmacist within **seven days of the date of supply**.

Where a pharmaceutical benefit needs prior approval from the Department of Human Services or the DVA, the prescriber must obtain approval and then advise the pharmacist of the PBS prescription and approval details. Only an original supply can be provided in this manner, not repeats.

Receipts

A person receiving a pharmaceutical benefit item must sign and date a receipt for it. If the person is not the patient, that person must also endorse the PBS prescription or repeat authorisation with his/her address. A receipt cannot be obtained until supply of the benefit has been made.

If a pharmaceutical benefit has to be sent through the post, by rail, or by other means, and a receipt is not practical, the pharmacist must certify on the PBS prescription or repeat authorisation that the benefit has been supplied, and write the date of supply and details of how it was sent. For example, if a pharmaceutical benefit is mailed to a patient on 1 April 2008, the pharmacist should write: "Certified supplied – mailed to patient 1 April 2008 (name of pharmacist) (signature of pharmacist) (date of certification)".

If an item is supplied in an urgent case, or to a person who cannot read or write, the pharmacist should sign and date a statement on the PBS prescription or repeat authorisation, stating the item has been supplied and the date on which it was supplied, and explaining why there is no receipt. For example, if a pharmaceutical benefit is supplied to a patient with a broken arm on 1 May 2008, the pharmacist should write: "Certified supplied 1 May 2008 – patient has a broken arm and is unable to sign (name of pharmacist) (signature of pharmacist) (date of certification)".

Only the pharmacist approved to supply pharmaceutical benefits can certify supply.

Prescriber bag supplies

Pharmacists may supply certain pharmaceutical benefit items free of charge to a PBS prescriber if they receive a prescriber bag order form in duplicate, signed by the prescriber. Only items listed under prescriber bag provisions for the relevant prescriber type can be supplied to the prescriber.

Pharmacists must be satisfied the form was completed by a PBS prescriber and includes the prescriber's name and address. If a pharmacist does not know the prescriber, he/she should confirm the prescriber's registration or PBS prescriber number and endorse this on the back of the form.

For more information see '2. Prescribing Medicines ... Prescriber bag supplies'.

4. Patient Charges

Type of patient

There are two types of PBS beneficiaries, general patients, who hold a Medicare card and concessional patients who hold a Medicare card and one of the following:

- Pensioner Concession Card
- Commonwealth Seniors Health Card
- Health Care Card
- Repatriation Health Card for All Conditions (gold) — concessional patients under RPBS
- Repatriation Health Card for Specific Conditions (white) — only regarded as concessional patients for RPBS prescriptions unless they hold a separate entitlement from Centrelink, otherwise they are general patients
- Repatriation Pharmaceutical Benefits Card (orange) — concessional patients under RPBS
- Safety Net Concession Card or Safety Net Entitlement Card — issued by the Department of Human Services.

Concessional patients are recognised by public hospitals in all States and Territories apart from South Australia (where DVA beneficiaries are treated as general patients) and New South Wales (where holders of a white DVA card are treated as general patients).

Under the Reciprocal Health Care Agreements, visitors from participating countries (see the introduction of this section for the list of countries) are treated as general patients and do not have concessional entitlements. To receive pharmaceutical benefits these visitors may need to present a temporary Medicare card or their passport. Pharmacists should contact the Department of Human Services if they have enquiries about these arrangements.

Establishing entitlement

PBS prescription forms supplied by the Department of Human Services have spaces provided for details of a patient's entitlement status. Anyone can enter this information, which must include:

- a cross (x) in the appropriate box to indicate the level of patient contribution;
- the complete Medicare number (including individual reference number) or complete Veteran file number on the card; and
- if applicable, the complete concession number on the card.

The person who signs the receipt for pharmaceutical benefits also accepts responsibility for the validity of the entitlement information on the PBS prescription.

All PBS prescriptions must have a Medicare or Veteran file number. All concessional PBS prescriptions must have a concession number. However, it is not necessary for the Medicare or Veteran file number, or the concession number to be endorsed on the PBS prescription if it is included in the electronic prescription details supplied by a pharmacist who is using the Claims Transmission System.

What to charge

Patient contribution

Under the PBS, the maximum cost for a pharmaceutical benefit item at a pharmacy is \$36.90 for general patients and \$6.00 for concessional patients, plus any applicable special patient contribution, brand premium or therapeutic group premium. General patients who have reached the safety net threshold (see details under '5. The Safety Net Scheme') may receive pharmaceutical benefits at the concessional rate, plus any applicable special patient contribution, brand premium or therapeutic group premium.

Patients who have a Safety Net Entitlement Card (see details under '5. The Safety Net Scheme') may receive PBS items free of charge, except for any applicable special patient contribution, brand premium or therapeutic group premium.

The contribution rate for general patients as outpatients at public hospitals in most of Australia is \$29.50. The exceptions are in Queensland and in hospitals participating in the pharmaceutical reforms where they pay the safety net value of an item listed in the Schedule (see details under '5. The Safety Net Scheme'), or up to the general co-payment amount for items not listed in the Schedule. The public hospital pharmaceutical reforms enable participating public hospitals to prescribe and supply pharmaceutical medication from the PBS to outpatients and patients upon discharge. A range of chemotherapy drugs is also available for day-admitted and non-admitted chemotherapy patients.

The contribution rate for concessional patients in all public hospitals is equal to the concessional co-payment amount.

The supply of a pharmaceutical benefit or a Repatriation pharmaceutical benefit to a patient is GST-free. Goods and services tax must not be included in the price charged to a patient for the supply of a PBS or RPBS script.

It is the patient's responsibility to pay any charge lawfully imposed by an approved pharmacist or supply may be refused.

The patient contribution rates are adjusted on 1 January each year in line with inflation.

Patient contributions for early supply of some PBS medicines

Prescriptions for some PBS and RPBS pharmaceutical benefits are not eligible for safety net benefits if re-supplied within 20 days of a supply of the same pharmaceutical benefit for the same person. This is known as the 'Safety Net 20 day rule' and came into effect on 1 January 2006.

Where a prescription is subject to the Safety Net 20 day rules:

- the patient contribution does not count towards the Safety Net, and
- after the Safety Net threshold is reached, the usual patient co-payment amount for the corresponding entitlement level (not the Safety Net amount) applies.

For example: The payment for such a prescription for a patient with a Safety Net Entitlement Card would be the concessional co-payment amount — not free. For a general patient with a Safety Net Concession Card, the usual general co-payment amount would apply — not the concessional amount.

The Safety Net 20 day rule does not apply to PBS/RPBS prescriptions originating from hospitals or day hospital facilities.

Special patient contributions, brand premiums and therapeutic group premiums

A special patient contribution is payable for a pharmaceutical benefit when a supplier will not supply it at the benchmark price. Any extra charge for a higher priced benefit is paid by the patient, together with their usual patient contribution. Other than for bleomycin sulfate (available under the 'Efficient Funding of Chemotherapy - Section 100 Arrangements'), exemptions on medical grounds are available, but must be granted by the Department of Human Services. For RPBS special patient contribution arrangements see the RPBS Explanatory Notes.

Under the brand premium arrangements, reimbursement to pharmacists is based on the lowest-priced brand. Any extra charge for a higher priced brand is paid by the patient, together with their usual patient contribution.

Under the therapeutic group premium arrangements, reimbursement to pharmacists is based on the lowest priced benefit items within identified therapeutic groups. Any extra charge for a higher priced benefit is paid by the patient, together with their usual patient contribution. Exemptions on medical grounds are available, but must be granted by the Department of Human Services.

Special patient contributions, brand premiums and therapeutic group premiums apply to maximum quantities. When a quantity is less than, or — on an authority or 'Regulation 24' PBS prescription — more than, the maximum, the contributions or premiums will be a factor of the maximum quantity, using standard pricing rules.

There are separate arrangements for PBS prescriptions in certain public hospitals. To obtain pharmaceutical benefits under these arrangements a patient must attend a participating public hospital and be a discharge patient or non-admitted patient. Only a medical practitioner providing medical treatment or a midwife providing midwifery treatment or a nurse practitioner providing nurse practitioner treatment in a participating public hospital may prescribe PBS subsidised medication. Victoria, Queensland, South Australia, Western Australia, Tasmania and the Northern Territory have these arrangements.

Increased quantities

Where a prescriber has written an authority PBS prescription for a quantity greater than the maximum, the patient contribution should be made for each supply of the increased maximum quantity.

Regulation 24

For 'Regulation 24' PBS prescriptions, a pharmacist should charge the usual patient contribution for the original and for each repeat quantity needed to make up the total supply (plus any applicable special patient contribution, brand premium or therapeutic group premium, for the original and each repeat quantity in the total supply).

After hours

A pharmacist may charge an extra fee if supplying a PBS item outside normal trading hours. This charge is paid by the patient and does not count towards the safety net.

Delivery

A charge can be added for delivering pharmaceutical benefits from the pharmacy. This charge does not count towards the safety net. For RPBS delivery arrangements refer to the RPBS Explanatory Notes.

5. The Safety Net Scheme

The PBS safety net protects patients and their families requiring a large number of PBS or RPBS items. For the purposes of the scheme, the family includes the person:

- the partner or de facto partner;
- children under the age of 16 who are in the care and control of the person; or
- dependent full-time students under the age of 25.

The scheme requires pharmacists, on request by patients, to record the supply of PBS and RPBS items on prescription record forms. When a patient reaches the Safety Net threshold within a calendar year, they qualify to receive PBS or RPBS items at a cheaper price or free of charge for the rest of that year. Any applicable special patient contributions, brand premiums or therapeutic group premiums must still be met by the patient.

The safety net threshold is reached by accumulating eligible patient contributions for PBS prescriptions supplied through community pharmacies and private hospitals and for out-patient medication supplied by public hospitals.

Pharmaceutical benefits (including authority items) can only be counted towards the safety net threshold when prescribed and supplied according to PBS conditions. A medicine supplied by a pharmacist not approved to supply pharmaceutical benefits cannot count towards the safety net.

Prescriptions for some pharmaceutical benefits are not eligible for safety net arrangements if re-supplied within 20 days of supply of the same item for the same person and the patient contribution cannot count towards the safety net (see also details under '4. Patient Charges' and '7. How Pharmacists Claim Reimbursement'). This does not apply to out-patient medications in public hospitals or to any prescriptions originating from a hospital or day hospital facility.

There are separate arrangements for PBS prescriptions in certain public hospitals. To obtain pharmaceutical benefits under these arrangements a patient must attend a participating public hospital and be a discharge patient or non-admitted patient. Only a medical practitioner providing medical treatment or a midwife providing midwifery treatment or a nurse practitioner providing nurse practitioner treatment in a participating public hospital may prescribe PBS subsidised medication. Victoria, Queensland, South Australia, Western Australia, Tasmania and the Northern Territory have these arrangements.

Safety net thresholds

There are two safety net thresholds. The general patient safety net threshold is currently \$1,421.20. When a person and/or their family's total applicable co-payments reach this amount, they may apply for a safety net concession card and pay the concessional co-payment amount of \$6.00 plus any applicable premium for pharmaceutical benefits for the rest of that calendar year.

The concessional safety net threshold is \$360.00 (this also applies to gold, white or orange card holders under the RPBS). When a patient and/or their family's total applicable co-payments reach this amount, they may apply for a safety net entitlement card and may receive pharmaceutical benefits free of charge (except for any applicable premium) for the rest of that calendar year.

Brand premiums, therapeutic group premiums and special patient contributions do not count towards the safety net thresholds.

The safety net thresholds are adjusted on 1 January each year in line with inflation.

Safety net cross-over arrangements

Some patients and/or members of their families will change between general patient and concessional patient status during a calendar year. Patients should apply for the safety net card appropriate to their status at the time they apply.

Concessional patients who were previously general patients can apply for a safety net entitlement card when they reach the concessional safety net threshold. In this case, any pharmaceutical benefits previously supplied at the general co-payment rate in that calendar year will be counted at the concessional rate per item.

General patients who were previously concessional patients can apply for a safety net concession card when they reach the general safety net threshold. In this case, any pharmaceutical benefits previously supplied at the concessional rate in that calendar year will be counted at the concessional rate per item.

In the case of families where one parent holds a concession card and other family members are general patients, the family can choose to apply for either a safety net entitlement card or a safety net concession card.

To receive a safety net entitlement card, all pharmaceutical benefits (including general pharmaceutical benefits) are counted at the concessional rate per item until the concessional threshold is reached. To receive a safety net concession card, general pharmaceutical benefits are counted at the general co-payment rate per item and concessional pharmaceutical benefits at the concessional rate per item, until the general safety net threshold is reached.

White DVA card holders may either be general or concessional patients (depending on their Centrelink entitlements). If they are receiving treatment for a specific disability accepted by the DVA, they are also supplied with specified items under the RPBS at the concessional rate per item. Therefore, these patients are encouraged to maintain a concessional prescription record form, plus a general prescription record form for items not covered under the RPBS.

White card holders may choose at any time to count contributions made at the general level towards the concessional safety net threshold and receive credits equal to the concessional co-payment amount for each pharmaceutical benefit purchased. Alternatively, white card holders can count contributions at the concessional level towards the general safety net, and receive credits equal to the concessional co-payment amount for each pharmaceutical benefit purchased.

Gold or orange DVA card holders may receive all of their prescription items under the RPBS, and only pay the concessional co-payment amount for each item.

Dependants of white, gold or orange card holders are treated separately and may be either general patients or concessional patients. Their prescriptions may be included in the cross-over arrangements.

Recording PBS prescriptions

There are two types of prescription record forms to record PBS prescription items. A blue form, used for items obtained at community pharmacies and available from community pharmacies, Medicare Service Centres and the Department of Human Services; and a grey form,

used by out-patients who pay for items at public hospital pharmacies and available from hospital out-patient departments or the Department of Human Services.

Patients should record their general or concessional status on the prescription record form, enter their Centrelink, DVA and/or Safety Net Concession/Entitlement Card number, and list family members covered. General patients must also record their Medicare number when applying for a safety net concession card.

Details to be entered on the form by the pharmacist are:

- date of supply;
- PBS/RPBS code number of the item (for community pharmacies only);
- the safety net value of the item (for community pharmacies only);
- pharmacist's approval number (for community pharmacies only);
- item identification — medicine code, name of medicine or abbreviation (for public hospitals only);
- hospital charge (for public hospitals only);
- hospital safety net number (for public hospitals only); and
- signature of the authorised person making the entry.

Community pharmacists should record in the 'safety net value' column:

- the patient contribution when it is less than the PBS dispensed price; or
- the safety net value shown in the Schedule, or any lesser amount charged, if the PBS dispensed price is less than or equal to the patient contribution. The pharmacist may discount the price for these items.

Some computer software suppliers provide a special label to record this information on the prescription record forms. Some suppliers also provide a computer printout as a prescription record form.

The patient is responsible for maintenance and storage of their prescription record form. However, it may be kept in the pharmacy. A person (or family) may have more than one prescription record form.

Hospital prescription record forms

Items to be recorded on hospital prescription record forms must be approved by the hospital's pharmaceutical advisory committee and may be listed on a hospital's formulary (a list of pharmaceutical items approved by the committee for the treatment of particular illnesses), or authorised on a patient-by-patient basis.

Multi-item prescription forms

If a patient submits a multi-item PBS prescription form, which would take the total co-payments past the safety net threshold, any items in excess are treated as entitled items once a safety net entitlement/concession card is issued.

Excess items should be treated as 'deferred supply' items.

For example, if a family has a new PBS prescription for three items and the first takes the family up to the threshold, then this item should be supplied at the general rate. If the second item takes the family over the threshold, the pharmacist should then issue a safety net concession card and supply both this and the third item at the concessional rate. This involves the deferral of two items, recording the safety net concession card number, and the subsequent supply of these items.

Qualifying PBS prescriptions

A PBS prescription should be supplied at the concessional rate or free of charge plus any applicable premium, when the safety net value or hospital charge for that PBS prescription takes the total co-payments over the qualifying amount for a safety net entitlement/concession card.

Lost prescription record forms

If a prescription record form has been lost, stolen or destroyed, a pharmacist may prepare a duplicate copy, but is under no obligation to do so.

Retrospective entitlement and patient refunds

Responsibility for claiming entitlements rests with the patient. If items recorded on a prescription record form have exceeded the safety net threshold, the cost of those items in excess of the limit cannot be refunded by a pharmacist.

However, if the patient failed to apply for a safety net entitlement/concession card on reaching the safety net threshold they should write to the Department of Human Services and provide copies of pharmacy accounts or a signed statement from the pharmacist giving the date of supply, description and cost of items supplied and paid for. A copy of the relevant prescription record form should also be provided. If these are not available, the patient should give the name of the pharmacy where the card was issued and the number on the card so that the Department of Human Services can locate the prescription record form in its records. Cash refunds are not available. The Department of Human Services contact details are provided in the 'Addresses — Department of Human Services' part of the Schedule.

If the patient cannot satisfy a pharmacist that they have a current entitlement and is charged the general patient price, the pharmacist should issue the patient with a receipt and a claim form (provided by the Department of Human Services). The patient can then obtain a refund via Medicare Service Centres or PBS processing centres. RPBS prescription refunds are paid at DVA State offices.

The Department of Human Services can only pay refunds for PBS items supplied through approved pharmacies. Refunds for hospital supplied items should be referred to the relevant hospital or health department. Refunds cannot be made where the patient was charged the general or concessional amount instead of the safety net concessional or safety net entitlement amount as a result of the safety net 20 day rule. Receipts for prescriptions where the safety net 20 day rule has applied must include 'SN20DR' to indicate the reason for the amount charged.

There are separate arrangements for PBS prescriptions in some public hospitals. To obtain pharmaceutical benefits under these arrangements a patient must attend a participating public hospital and be a discharge patient or non-admitted patient. Only a medical practitioner providing medical treatment or a midwife providing midwifery treatment or a nurse practitioner providing nurse practitioner treatment in a participating public hospital may prescribe PBS subsidised medication. Victoria, Queensland, South Australia, Western Australia, Tasmania and the Northern Territory have these arrangements.

Applying for a Safety Net Entitlement/Concession Card

Once the safety net threshold has been reached, the person covered by a prescription record form may complete the application and declaration to get a safety net entitlement/concession card. Please note that software packages that produce computer generated applications must be approved by the Department of Human Services.

If the card is issued to a dependent child or student, it should be in the name of a parent.

When issuing entitlement/concession cards, pharmacists do not have to check all prescription record form details. However, they should ensure each entry has been signed and that the prescription record form total qualifies the patient for the relevant safety net card.

When appropriate the pharmacist should check that the patient's Medicare card number is on the prescription record form.

Issuing a Safety Net Entitlement/Concession Card

When satisfied that the individual or family is entitled, the pharmacist should issue the next blank safety net entitlement/concession card with the following details:

- the names of family members covered. If there are more than eight family members, a second card should be issued listing the card holder and family members not listed on the first card. The prescription record form has space to record that two cards have been issued, and
- the two-character code to indicate the relationship to the card holder. Applicable codes are:
 - SP - partner;
 - DC - child under 16 years; and
 - DS - dependent full-time student under 25 years.

The pharmacist should be satisfied that only family members are listed on the card. The unused space on the card should be ruled through to prevent extra names being added. The sticky label from the safety net entitlement/concession card, pre-printed with the card number, should be attached to the prescription record form. The pharmacist should sign and stamp each prescription record form with the pharmacy stamp and enter the card issue details on a safety net — claim for payment form.

Issuing supplementary cards

A pharmacist may give a card holder a supplementary card for a partner or dependant only at the time the original card is issued. The duplicate card should be recorded in the additional box on the prescription record form.

Later requests for supplementary cards and requests to add a new family member to the original card are to be referred to the Department of Human Services.

Notification to the Department of Human Services and claim for payment

Payment for issuing a safety net entitlement/concession card is made after the safety net — claim for payment form is sent to the Department of Human Services, no later than one month after a card is issued.

Each form must be accompanied by all supporting documentation (prescription record form and cancelled or void safety net entitlement/concession cards).

Payment will not be made for void cards.

Lost Safety Net Entitlement/Concession Cards

When a card has been lost, damaged, stolen or destroyed, a pharmacist cannot re-issue a person with a replacement card. The original card holder (or partner) must apply to the Department of Human Services.

Pharmacy record of issued cards

A record of all cards issued must be kept at the pharmacy from which the pharmacist is approved to supply pharmaceutical benefits. The duplicate ('bookfast') copy in the safety net — claim for payment book is provided for this purpose.

6. Department of Human Services Entitlement Checks

General Patients

The Department of Human Services validates a patient's entitlement to pharmaceutical benefits by checking the Department of Human Services and/or Veteran file numbers in pharmacist's claims. If a number is not recorded correctly, a patient cannot be identified against the Department of Human Services' Pharmaceutical Benefits Entitlement File and entitlement cannot be established.

If the Medicare or Veteran file number provided in the pharmacists' claims is incorrect or the number and the name supplied do not match the Department of Human Services records to enable patient identification, an appropriate warning or rejection code will be returned to the pharmacy. These notifications of missing or incorrect Medicare or Veteran file numbers are provided to pharmacists in their reconciliation statement produced after the claim period has been paid by the Department of Human Services.

Special numbers are available for use in certain circumstances for eligible people who are unable to provide a Medicare number.

Concessional Patients

The Department of Human Services routinely validates a patient's entitlement to free or concessional benefits by checking concessional numbers in pharmacists' claims. If a number is not recorded correctly, a patient cannot be identified against the Department of Human Services' Pharmaceutical Benefits Entitlement File and entitlement cannot be established.

When a number is found to be from a card which was incorrect, expired at the time of supply or entitlement was withdrawn, warning or rejection codes will be returned to the pharmacy to assist with validation of concessional entitlement in relation to future claims from the same patient.

Entitlement checking procedures

General Patients

Once a pharmacist has been notified by the Department of Human Services of an incorrect Medicare or Veteran file number he/she should correct the number for future claims by:

- updating his/her system to reflect the correct number provided by the Department of Human Services (if patient consent to do so has been obtained); or
- speaking to the patient; or
- obtaining patient consent and calling the Department of Human Services on the Improved Monitoring of Entitlements (IME) (132 290 — select option 1).

If the patient presents a Medicare card that appears correct, but according to the Department of Human Services is not a valid number, or not a valid number for that person, a pharmacist may use a special number. A photocopy of the card, or a form must accompany the use of this number. The form is available on the Department of Human Services' website or by calling 132 290.

Concessional Patients

Once a pharmacist has been notified by the Department of Human Services of an incorrect concessional entitlement number, he/she should view the entitlement card to confirm the entitlement number, and start and end dates, when the patient next presents a PBS prescription.

Step by step

Pharmacists should take the following steps where concession entitlement does not appear to be valid or current:

- Re-confirm entitlement with the cardholder/customer;
- Contact the Department of Human Services on 132 290, with consent, to confirm the cardholder/customer concession status;
- If the Department of Human Services advises that the cardholder/customer is concessionally entitled to receive the PBS medicines on that day, supply the prescription as a concessional entitlement;
- If the Department of Human Services advises that the cardholder/customer is not concessionally entitled to receive the PBS medicines on that day, supply as a general prescription. Provide the customer with the information sheet "Your entitlement card" which explains entitlement checking to the customer and the steps they can follow if they are concessionally entitled.

7. How Pharmacists Claim Reimbursement: Information Required

The Department of Human Services uses a computerised system for pricing PBS prescriptions, repeat authorisations and prescriber bag supply orders, and for calculating claims.

The payment system is designed to pay pharmacists correctly for the pharmaceutical benefits they supply. It is essential instructions are followed carefully and that each document includes all relevant information. Accurate and complete data ensures claim payment is not delayed.

PBS Prescription identification

Pharmacists must include certain information on each PBS prescription sent in for claim, as specified below. It is important that this information is entered correctly and in the right place on the PBS prescription. This information will be included in a sticker produced by pharmacy software.

The sticker should be placed on the extreme left front of a PBS prescription, opposite each item being claimed. It must not obscure any details written by the prescriber. Most prescribers use PBS prescriptions, which have space for the sticker. If a sticker is not used, a PBS prescription identification stamp can be used or the information can be written in the same place, and in the same order.

Pharmacists should avoid writing over, or placing the sticker over, the prescriber number pre-printed on PBS/RPBS prescriptions, or the prescriber number box on PBS dental and optometrist, midwife and nurse practitioner prescriptions.

The sticker is not necessary for current repeat authorisation, prescriber bag supplies, or for old style authority PBS prescription and authority to prescribe forms, as they have printed spaces for the necessary details. However, it is required for the new format authority PBS prescription forms.

The following information should be entered next to the appropriate letter on the sticker or stamp:

- 'S' — the serial number for the claim
- 'A' —
 - a. the price claimed for pricing elected PBS prescriptions, exceptional PBS prescriptions and RPBS non-scheduled prescriptions (see under 'Extemporaneously-prepared pharmaceutical benefits not listed in the Standard Formulae List' for explanations of pricing elected PBS prescriptions and exceptional PBS prescriptions); and/or
 - b. confirmation that the PBS prescription is endorsed 'Regulation 24' or the RPBS prescription is endorsed 'hardship conditions apply'; and/or
 - c. a claim for a glass dropper bottle where applicable; and/or
 - d. any clarification of the prescription which will assist the Department of Human Services payment processing.
- 'No.' — the PBS prescription identifying number.

Serial numbers

PBS prescription, repeat authorisation, authority PBS prescription, and prescriber bag order forms submitted in each claim must bear consecutive serial numbers starting with:

- 1 — for prescriber bag supplies;
- 1 — for general benefits;
- C1 — for concessional and Safety Net Concession Card benefits;
- E1 — for Safety Net Entitlement Card benefits; and
- R1 — for RPBS benefits.

Each serial number should also be noted on any document kept by the pharmacist for record purposes.

Each prescriber bag item should be given a serial number, e.g., if there are five items on the first form in the claim, the first item on the second form in the claim will start with the serial number 6.

For prescriptions subject to the Safety Net 20 day rule, the serial number corresponds to the resulting payment category for the pharmaceutical benefit as supplied, not the patient's entitlement category.

Repeat authorisations for authority PBS prescriptions

When a benefit is supplied on a repeat authorisation which needed an authority PBS prescription, the serial number must be prefixed with the letter 'A' for a general benefit; 'AC' for a concessional benefit or a benefit supplied to a Safety Net Concession Card holder; 'AE' for a Safety Net Entitlement Card holder; or 'AR' for a RPBS benefit.

Repeat authorisations for deferred supply

When a benefit is supplied on a repeat authorisation prepared for deferred supply, the serial number must be prefixed with the letter 'D' for a general benefit; 'DC' for a concessional benefit or a benefit supplied to a Safety Net Concession Card holder; 'DE' for a Safety Net Entitlement Card holder; or 'DR' for a RPBS benefit.

Dropper containers

Dispensed prices for extemporaneously-prepared eye drops, ear drops and nasal instillations include the price of a polythene dropper container. However, if a glass dropper container is supplied, payment should be claimed by writing 'glass bottle' in box 'A' of the stamp.

Extemporaneously-prepared pharmaceutical benefits not listed in the Standard Formulae List

When a formula is not listed on the Standard Formulae List, the PBS prescription is paid at an average of 10 g/mL rate for the type of preparation, unless the pharmacist elects otherwise. A pharmacist may price an exceptional PBS prescription, or elect to price all non-pre-priced extemporaneous PBS prescriptions.

PBS prescriptions paid on an average price basis

If the PBS prescription is to be claimed as an exceptional PBS prescription, the pharmacist should write details of the formula supplied on the PBS prescription or repeat authorisation form; price the PBS prescription in accordance with the pricing principles (as detailed in '9. Pricing PBS Prescriptions'); and enter the calculated price on the sticker.

An exceptional PBS prescription is for an extemporaneously-prepared pharmaceutical benefit that is not included in the Standard Formulae List and for which the price of the ingredients (based on basic pricing rules) is twice or more than the recovery price of the ingredients calculated on an average price basis. Further information on pricing PBS prescriptions can be accessed from the book let titled *Explanation of Current Pricing* on the Department of Human Services' website at www.medicareaustralia.gov.au (PBS publications for Health Care Providers).

Pricing non-pre-priced extemporaneous preparations

Pharmacists should notify the Department of Human Services when they elect to price non-pre-priced extemporaneous preparations. Each PBS prescription should be priced in accordance with the pricing principles and that price entered on the sticker.

RPBS prescriptions for items not included in either the PBS or RPBS Schedule

When a prescription for a RPBS patient is for an item not included in either the PBS or the RPBS Schedule, the price claimed should be entered on the sticker. Full details on pricing and availability of such items under the RPBS are set out in the RPBS Explanatory Notes.

Payment to Pharmacists for Dispensing Premium-free Substitutable Medicines

Premium Free Dispensing Incentive payments will commence for eligible PBS listed products dispensed from 1 August 2008. Premium Free Dispensing Incentive payments will be available to approved suppliers to dispense a substitutable, premium-free medicine. The payment will be available only for PBS items which attract a Government subsidy. This includes PBS items supplied to DVA entitled consumers.

A number of conditions and criteria apply to receive this payment. Scripts will be assessed for validity and the Premium Free Dispensing Incentive payment will be paid by the Department of Human Services. Further information on this payment can be found on the Department of Human Services' website at:

www.medicareaustralia.gov.au/provider/pbs/pharmacists/reforms.jsp#dispensing

8. How Pharmacists Claim Reimbursement: Documents to be Submitted

A claim for pharmaceutical benefits consists of:

- the original and duplicate of a completed Claim for Payment Form;
- the original orders for prescriber bag supplies in a separate bundle;
- the originals of all old format PBS prescriptions and authority PBS prescriptions, the Department of Human Services/DVA copies of new format PBS prescriptions and authority PBS prescriptions, and all repeat authorisations, separated into four bundles for benefits supplied to the general public; concessional beneficiaries/Safety Net Concession Card holders; Safety Net Entitlement Card holders and RPBS patients.

PBS prescriptions in each bundle should be in serial number order, with serial number 1 at the top of the bundle.

PBS prescriptions subject to the Safety Net 20 day rule are bundled according to the resulting payment category. For prescription forms with multiple PBS items, where the Safety Net 20 day rule would result in different payment categories for different items, dispensing via 'deferred supply' should be used where necessary to allow all items to be included in the correct bundles.

PBS prescriptions in the wrong bundle may be returned to the pharmacist for clarification. If appropriate, they can be resubmitted in the correct bundle in the next claim period.

Completing the claim form

The claimant's name, address of the pharmacy from which the pharmacist is approved to supply pharmaceutical benefits, approval number, and claim period number should be entered on the Claim for Payment Form. These details should match the latest written information held by the Department of Human Services, or payments can be delayed while clarification is sought.

The claim period number should state how many claims have been submitted so far in a calendar year, e.g., the sixth claim submitted by an approved pharmacist in 2005 should have a claim period number of 0506.

The first and last serial numbers given to items in each bundle are to be entered on the Claim for Payment Form.

A total claim amount is not required – this will be calculated by the Department of Human Services after the PBS prescriptions have been individually priced.

The declaration must be signed by the pharmacist approved to supply pharmaceutical benefits, unless he/she has made arrangements through the Department of Human Services for another pharmacist to sign it.

Lodging claims

A claim may be lodged at any time during the month at the relevant the Department of Human Services State office. Unless other arrangements have been made with the Department of Human Services, the following conditions apply:

- only one claim period can exist and only one claim can be lodged per month;
- the claim period shall cover pharmaceutical benefits supplied during one month; and
- the claim shall be sent within 30 days from when the benefits were supplied.

Claims for pharmaceutical benefits supplied over 18 months earlier may not be accepted for computer processing. Pharmacists with such claims should contact the Department of Human Services.

Reconciliation statements

As mentioned earlier, a pharmacist will receive a PBS reconciliation statement after a claim period has been processed. It provides details of each prescription for each brand of each pharmaceutical benefit item supplied in that claim period.

Reasons for non-payment of any item are coded, with the code numbers explained in the statement.

PBS prescriptions and repeat authorisations not accepted for payment will be returned, with the exception of PBS prescriptions with a dispensed price equal to or less than the patient contribution. Any other items on those PBS prescriptions that have been paid will have been cancelled.

If a PBS prescription was not accepted and can be re-submitted, it must be given a new serial number and included in a subsequent claim period.

If a PBS prescription is finally rejected for payment and a pharmacist is not satisfied with the decision, he/she may apply to the Administrative Appeals Tribunal for a review of that decision.

9. Pricing PBS Prescriptions

Pricing principles

The same pricing principles apply to all PBS prescriptions.

For ready-prepared pharmaceutical benefits, payment is made on the basis of the lowest-priced brand.

For a pharmaceutical benefit not listed as a ready-prepared item, and where a formulation title is stated but no formulary specified, payment is made on the basis of precedence given to formularies by State/Territory legislation.

Prices published in the Schedule do not include any component for goods and services tax (GST).

Further information on pricing PBS prescriptions can be accessed from the booklet titled *Explanation of Current Pricing* on the Department of Human Services' website at www.medicareaustralia.gov.au (PBS publications for Health Care Providers).

Pricing dates

Ready-prepared pharmaceutical benefits are priced on the first day of April, August and December for items supplied as from each of those days respectively.

Extemporaneously-prepared pharmaceutical benefits and containers are priced on the first day of May each year for items supplied as from the first day of August that year.

Pricing ready-prepared items

For maximum quantities

The price payable for a pharmaceutical benefit is shown in the Schedule against the item. The price is for the maximum quantity available.

The maximum quantity of some pharmaceutical benefits, such as eye drops and oral suspensions, has been determined as a single pack corresponding to the manufacturer's pack. These packs cannot be broken, so if a PBS prescription calls for less, the maximum quantity should be supplied and claimed from the Department of Human Services. Packs not to be broken are indicated by a double dagger (‡) in the Schedule.

For lesser quantities

For items where the standard pack is the same as the maximum quantity, and the pack can be broken, the price payable for a lesser quantity is established as follows:

- an amount equal to the dispensing fee, and if applicable the dangerous drug fee, is deducted from the benefit price as shown in the Schedule;
- to this new amount, a wastage percentage is applied, determined from the Wastage Factor Table;
- then the amount equal to the dispensing fee, dangerous drug fee (if applicable), and appropriate container fee, is added.

In no case shall the price for a broken quantity be more than the dispensed price of the Schedule's maximum quantity.

When a standard pack is not the same as the maximum quantity, the price of the pharmaceutical benefit concerned has an asterisk next to it and the standard pack rate is set out in Section 3 of the Schedule. The price payable for the quantity supplied is established by:

- applying the appropriate wastage table percentage to the standard pack rate;
- then adding an amount equivalent to the dispensing fee, the dangerous drug fee where applicable, and the appropriate container fee.

In no case shall the supply of a broken quantity, which is less than the item's maximum quantity, cost more than the dispensed price for the maximum quantity.

No container fee is payable when the quantity of pharmaceutical benefit supplied is more than the quantity contained in the standard pack.

Wastage table percentage

The following Wastage Factor Table is used to calculate the price payable for quantities supplied from the standard pack.

Wastage Factor Table

Column A - 5, 10, 15, 20, 25, 30, 35, 40, 45, 50, 55, 60, 65, 70, 75, 80, 85, 90, 95, 100

Column B - 10, 18, 26, 32, 38, 44, 50, 54, 58, 62, 66, 70, 74, 78, 82, 86, 90, 94, 98, 100

The appropriate wastage table percentage is as follows:

- the percentage of the amount supplied from the amount in the standard pack is determined; and
- where this percentage is the same as a percentage listed in Column A of the table, the percentage used is the figure shown in Column B; or
- where the percentage is not the same as a percentage in Column A, then the nearest upward percentage in Column A applies, and the percentage used is the figure in Column B.

For example, 24 tablets are supplied from a standard pack of 100. Thus 24 per cent of the number contained in the standard pack is supplied. As this percentage does not appear in Column A, the next higher (i.e., 25 per cent) is used. Reading down from 25 per cent to Column B, the wastage table percentage is found to be 38 per cent.

Pricing extemporaneously-prepared items

General

The price payable for supplying the maximum quantity of standard formula preparations is shown in the Standard Formulae List.

The following principles apply in determining prices of all pre-priced extemporaneous formulae on the list.

They also apply when a pharmacist elects to price extemporaneous PBS prescriptions outside the list, including exceptional PBS prescriptions.

The amount payable is the sum of:

- the recovery price of each ingredient as shown in the Drug Tariff;
- the price of the appropriate container as shown in the price section; and
- a dispensing fee as shown in the price section.

Pricing of ingredients

When the quantity dispensed is not specified in the Drug Tariff, the recovery price is as follows:

1. determine the basic pricing unit relative to the quantity dispensed by referring to the following table:

Quantity	Basic Pricing Unit
Up to and including 700 mg	100 mg price rate
Over 700 mg and up to and including 1 g	price as if 1 g
Over 1 g and up to and including 7 g	1 g price rate
Over 7 g and up to and including 10 g	price as if 10 g
Over 10 g and up to and including 80 g	10 g price rate
Over 80 g and up to and including 90 g	price as if 80 g
Over 90 g	100 g price rate

2. find the recovery price of the basic pricing unit by applying the following quantity divisors to the recovery price shown for the ingredient in the Drug Tariff:
 - 100 g price is 500 g price divided by 5, or 1 kg price divided by 10
 - 10 g price is 100 g price plus 12.5 per cent divided by 10
 - 1 g price is 10 g price plus 25 per cent divided by 10
 - 100 mg price is 1 g price plus 25 per cent divided by 10
3. find the recovery price by multiplying the price of the basic pricing unit – as established in 2 – by the fraction that the quantity dispensed bears to the basic pricing unit.

For pricing purposes the quantity is to be taken to the next upward 50 milligrams or 0.05 millilitres.

The minimum recovery price for any ingredient is one cent. In other cases where a fraction of a cent occurs, the price is to be taken to the nearest cent (a half cent being taken up to the next cent).

In no case shall the recovery price for a quantity of an ingredient exceed the recovery price for a greater quantity of that ingredient.

Where liquids are purchased by weight, the recovery price includes the 'Specific Gravity Factor'.

Special pricing provisions apply to drugs marked '(a)' or '(b)' in the Drug Tariff.

For drugs marked '(a)', the pricing rules shown above apply to quantities up to the quantity listed in the Drug Tariff. Greater quantities are priced on a linear basis: the recovery price is ascertained by multiplying the fraction that the quantity dispensed bears to the quantity listed in the Drug Tariff by the price shown for the quantity listed.

Drugs marked '(b)' are packed sterile or are unstable, and all quantities are priced as if whole pack(s) were required. The recovery price is ascertained by multiplying the fraction that the quantity dispensed bears to the quantity listed in the Drug Tariff, taken to the next whole number, by the price shown for the quantity listed.

Pricing PBS prescriptions where extra ingredients are added to a formula

Where the vehicle is liquid and one or more solid ingredients are added, displacement of the liquid by the solid ingredients is disregarded for pricing purposes.

Containers

When a quantity is for more than the container sizes listed in this Schedule, payment will be made as if that quantity had been supplied in the minimum number of containers necessary to supply that quantity.

A double size container is allowed for bulk powders.

Special provisions for extemporaneous PBS prescriptions outside the Standard Formulae List

If a pharmacist elects to price extemporaneous PBS prescriptions outside the Standard Formulae List, there can be no variation for three months. This applies to all extemporaneously-prepared formulae not on the list, and includes both PBS and RPBS prescriptions.

If a pharmacist does not elect to price out these PBS prescriptions, he/she will be paid at an average reimbursement rate.

Under this system, payment is made on the basis of an average 10 g/mL rate applied to the category of preparation concerned, i.e., the price will be determined by multiplying the appropriate 10 g/mL rate by the number of 10 g/mL units supplied and adding container and dispensing fees. For example, an 80 mL mixture would be priced at eight times the average 10 mL rate for mixtures, with container and dispensing fee added.

The average 10 g/mL rate for each type of preparation is calculated monthly. It applies to PBS prescriptions supplied in the following month.

PBS prescriptions ordering a combination of standard formula preparations fall outside the scope of the Standard Formulae List and therefore are subject to this section.

Any variant to a formula included in the list (adding or deleting an ingredient or varying the dose) takes the formula dispensed outside the list.

When an ingredient is added to a standard formula and the recovery price for the standard formula plus additive under the average price system is less than for the standard formula alone, the pharmacist may have the PBS prescription priced as a basic standard formula item.

10. Miscellaneous

References

This Schedule identifies monographs of the British Pharmacopoeia, the British Pharmaceutical Codex, and the Australian Pharmaceutical Formulary and Handbook by the letters BP, BPC and APF respectively. References to all editions of the BPC and to earlier editions of the BP and APF also include the year of publication or the number of the edition.

Standards

Pharmacists can only supply under the PBS medicines which, or whose ingredients, conform to the standards of composition or purity prescribed. These standards are those specified in the *Therapeutic Goods Act 1989*.

Legislation

Copies of the *National Health Act 1953* and the *National Health (Pharmaceutical Benefits) Regulations 1960* are available from Government AusInfo shops in each capital city. The Act and the Regulations may also be accessed through the Attorney-General's Department website at www.comlaw.gov.au.

Nurse practitioner PBS prescribing

MEDICINES WHICH MAY BE PRESCRIBED BY AUTHORISED NURSE PRACTITIONERS

From 1 September 2010, nurse practitioners endorsed to prescribe under state or territory legislation can apply for approval as PBS prescribers (*authorised nurse practitioners*). Information for nurse practitioners to become authorised PBS prescribers is available from the Department of Human Services.

The medicines listed for prescribing by authorised nurse practitioners from 1 November 2010 are identified by 'NP' in the PBS Schedule. Nurse practitioners must not write PBS prescriptions for other medicines.

PBS prescribing is limited by a nurse practitioner's scope of practice, and state and territory prescribing rights. Prescribing of PBS medicines is also contingent on a prescriber being an *authorised nurse practitioner* and having collaborative arrangements in place, as required by amendments to the *National Health Act 1953*.

The Pharmaceutical Benefits Advisory Committee (PBAC) is responsible for making recommendations to the Minister for Health regarding medicines for prescribing by authorised nurse practitioners.

Further to prescribing within collaborative arrangements, certain medicines also have additional conditions for prescribing by nurse practitioners, as recommended by the PBAC. These medicines are identified by the codes 'CTO' for continuation therapy only or 'SCM' for prescribing within a shared care model, as outlined below:

- *Continuing therapy only model*

Where the patient's treatment and prescribing of a medicine has been initiated by a medical practitioner, but prescribing is continued by a nurse practitioner. (This is similar to existing arrangements between specialists and medical practitioners for prescribing certain medicines.)

- *Shared care model*

Where care is shared between a nurse practitioner and medical practitioner in a formalised arrangement with an agreed plan to manage the patient, in a patientcentred model of care. The details surrounding shared care arrangements will depend on the practitioners involved, patient needs and the healthcare context.

Some medicines are included in more than one section of the Schedule, and for more than one prescriber type. For a prescription to be eligible for subsidy, prescribers must ensure that they prescribe under the PBS only those medicines, and in accordance with the restrictions, listed for their prescriber type. Listing details for the same product may differ between sections and different PBS item codes apply for each prescriber type.

Nurse practitioner PBS prescriptions are identifiable by colour, and include the indicator 'NP' on personalised forms and a tick box on non-personalised (blank) forms.

Prescriptions must include the nurse practitioner's PBS prescriber number. For unrestricted and restricted PBS medicines, midwives/nurse practitioners can use the personalised or non-personalised PBS prescriber forms. For authority required and authority required (streamlined) PBS medicines, midwives/nurse practitioners can use the authority personalised or non-personalised PBS prescriber forms. Nurse practitioner PBS prescriptions may include repeats.

Regulation 24 applies for nurse practitioner prescribing. A nurse practitioner can direct that original and repeat supplies of pharmaceutical benefits be supplied at the one time, if certain conditions are satisfied.

Authority prescriptions: Authority prescriptions for authority required items, or for increased quantities or repeats, require prior approval from the Department of Human Services for each prescription. (Refer to Prescribing Medicines — Information for PBS prescribers and Supplying medicines — What Pharmacists Need to Know, for more information on authority prescriptions.)

State and territory requirements: Nurse practitioners may prescribe medicines as private prescriptions according to their state/territory prescribing accreditation. The medicines which can be prescribed differ between states and territories. It is the nurse practitioner's responsibility to ensure adherence to State/Territory law for all prescriptions (PBS and private) and additionally to all PBS requirements for PBS prescriptions.

Midwife PBS prescribing

MEDICINES WHICH MAY BE PRESCRIBED BY AUTHORISED MIDWIVES

From 1 September 2010, midwives endorsed to prescribe under state or territory legislation can apply for approval as PBS prescribers (*authorised midwives*). Information for midwives to become authorised PBS prescribers is available from the Department of Human Services.

The medicines listed for prescribing by authorised midwives are identified by 'MW' in the PBS Schedule. Midwives must not write PBS prescriptions for other medicines.

PBS prescribing by midwives is limited by state and territory prescribing rights. It is also contingent on a prescriber being an *authorised midwife* and having collaborative arrangements in place, as required by amendments to the *National Health Act 1953*.

The Pharmaceutical Benefits Advisory Committee (PBAC) is responsible for making recommendations to the Minister for Health regarding medicines for prescribing by authorised midwives.

Some medicines are included in more than one section of the Schedule, and for more than one prescriber type. For a prescription to be eligible for subsidy, prescribers must ensure that they prescribe under the PBS only those medicines, and in accordance with the restrictions, listed for their prescriber type. Listing details for the same product may differ between sections and different PBS item codes apply for each prescriber type.

Midwife PBS prescriptions are identifiable by colour, and include the indicator 'MW' on personalised forms and a tick box on non-personalised (blank) forms. Prescriptions must include the midwife's PBS prescriber number. For unrestricted and restricted PBS medicines, midwives/nurse practitioners can use the personalised or non-personalised PBS prescriber forms. For authority required and authority required (streamlined)

PBS medicines, midwives/nurse practitioners can use the authority personalised or non-personalised PBS prescriber forms. Midwife PBS prescriptions may include repeats.

Regulation 24 applies for midwife prescribing. A midwife can direct that original and repeat supplies of pharmaceutical benefits be supplied at the one time, if certain conditions are satisfied.

Authority prescriptions: Authority prescriptions for authority required items, or for increased quantities or repeats, require prior approval from the Department of Human Services for each prescription. (Refer to Prescribing Medicines—Information for PBS prescribers and Supplying Medicines — What Pharmacists Need to Know, for more information on authority prescriptions.)

State and Territory requirements: Midwives may prescribe medicines as private prescriptions according to their state/territory prescribing accreditation. The medicines which can be prescribed differ between states and territories. It is the midwife's responsibility to ensure adherence to state/territory law for all prescriptions (PBS and private) and additionally to all PBS requirements for PBS prescriptions.

Optometrist PBS prescribing

PREPARATIONS WHICH MAY BE PRESCRIBED BY AUTHORISED OPTOMETRISTS

From 1 January 2008, optometrists accredited to prescribe under State or Territory legislation can apply for approval as PBS prescribers (*authorised optometrists*). Information for optometrists on becoming a PBS prescriber is available from the Department of Human Services.

The medications listed for prescribing by authorised optometrists are identified by 'OP' in the PBS Schedule. Optometrists must not write PBS prescriptions for any other medicines listed on the PBS.

The Pharmaceutical Benefits Advisory Committee (PBAC) is responsible for making recommendations to the Minister of Health regarding preparations for prescribing by authorised optometrists.

Some products are included in more than one section of the Schedule, and for more than one prescriber type. For a prescription to be eligible for subsidy, prescribers must ensure that they prescribe under the PBS only those medicines, and in accordance with the restrictions, listed for their practitioner type.

Optometrist PBS prescriptions are identifiable by colour, and include the words 'PBS/RPBS optometrist'. Prescriptions must include the optometrist's PBS prescriber number. The same optometrist prescription form is used to prescribe unrestricted, restricted or authority items. Only one item is allowed per form. Optometrist PBS prescriptions may include repeats.

Regulation 24 does not apply for optometrist prescribing. An optometrist cannot direct that original and repeat supplies of pharmaceutical benefits be supplied at the one time.

Authority prescriptions: Authority prescriptions for authority required items, or for increased quantities or repeats, require prior approval from the Department of Human Services or the Department of Veterans' Affairs (DVA) for each prescription. (Refer to Prescribing Medicines — Information for PBS prescribers and Supplying Medicines — What Pharmacists Need to Know, for more information on authority prescriptions.) DVA approval for non-Schedule items is not available for optometrist prescribing.

RPBS: Optometrists approved as PBS prescribers may write prescriptions for supply under the RPBS. The medicines available for prescribing by authorised optometrists under the RPBS are the same as those available under the PBS. There are no optometrist listings in the Repatriation 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 Schedule (non-Schedule items).

State and Territory requirements: Optometrists may prescribe medications as private prescriptions according to their State/Territory prescribing accreditation. The medicines which can be prescribed differ between States and Territories. It is the optometrist's responsibility to ensure adherence to State/Territory law for all prescriptions (PBS and private) and additionally to all PBS requirements for PBS/RPBS prescriptions.

GUIDELINES FOR SHARED CARE OF GLAUCOMA PATIENTS

Under these guidelines, authorised optometrists who are approved to use therapeutic drugs in their practices and who have adequate professional indemnity cover, will be able to co-manage glaucoma patients in a shared care arrangement with an ophthalmologist.

By writing a PBS prescription for the treatment of glaucoma, the prescriber is certifying the criteria set out in these guidelines are satisfied, and use of the drug is in accordance with the registered indications – refer to the current Product Information for details.

Note that all anti-glaucoma drugs listed on the PBS for prescribing by authorised optometrists must be delivered in a shared care model.

Initial Referral to Ophthalmologist

An authorised optometrist who makes a provisional diagnosis of glaucoma is to refer the patient to an ophthalmologist for confirmation of the diagnosis and the development of a management plan.

Where clinically important delays are expected before the patient's first review by an ophthalmologist, the optometrist should seek interim advice on the patient's management from the ophthalmologist by telephone (or alternate means).

The patient's consent is to be obtained by the ophthalmologist and optometrist for all aspects of the management plan, including the sharing of care between the two practitioners, and the communication of clinical information to the patient's nominated general practitioner.

Patients being considered for anti-glaucoma therapy with a beta blocking agent should be assessed for any potential cardiovascular or respiratory risk by a medical practitioner (often the patient's general practitioner), prior to initiating therapy. This assessment should be repeated if a change in dose of the beta blocker is proposed.

Once the diagnosis of glaucoma is confirmed by the ophthalmologist and a treatment plan is in place for the patient, the optometrist can perform ongoing reviews to monitor the patient and prescribe topical drugs under the PBS providing that:

- Periodic review demonstrates the treatment to be effective, and
- Changes to management are only initiated following consultation between treating practitioners.

Patient Management Plan

The management plan must be in writing and specify the following:

1. All the agreed components of treatment including any drug therapy;
2. Target pressures and action to be taken if these are not achieved within a specified time frame;
3. An agreed approach to monitoring visual fields and optic disc imaging and action to be taken following changes in visual fields;
4. Triggers for referral for more immediate ophthalmological and general practitioner review;
5. Likely side effects from agreed treatment and the action to be taken to address these;
6. An agreed schedule for patient review by both practitioners;
7. Who is responsible for performing each of the required tests and the required frequency for performing them;
8. An agreed method for timely communication of clinical findings and patient management between the two practitioners and the patient's nominated general practitioner.

Ophthalmologists must be available for consultation by the treating optometrist and for consultation by the patient where that consultation has been recommended or requested by the optometrist.

The involvement of a pharmacist to provide medicines information, advice relating to administration and techniques to limit systemic absorption and side effects of ophthalmic medications is recommended.

Therapeutic Index

ALIMENTARY TRACT AND METABOLISM	66
STOMATOLOGICAL PREPARATIONS	66
STOMATOLOGICAL PREPARATIONS	66
DRUGS FOR ACID RELATED DISORDERS	66
ANTACIDS	66
DRUGS FOR PEPTIC ULCER AND GASTRO-OESOPHAGEAL REFLUX DISEASE (GORD)	66
DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS	73
BELLADONNA AND DERIVATIVES, PLAIN	73
PROPULSIVES	73
ANTIEMETICS AND ANTINAUSEANTS	74
ANTIEMETICS AND ANTINAUSEANTS	74
BILE AND LIVER THERAPY	78
BILE THERAPY	78
DRUGS FOR CONSTIPATION	78
DRUGS FOR CONSTIPATION	78
ANTIDIARRHEALS, INTESTINAL ANTIINFLAMMATORY/ANTIINFECTIVE AGENTS	82
INTESTINAL ANTIINFECTIVES	82
ELECTROLYTES WITH CARBOHYDRATES	82
ANTIPROPULSIVES	83
INTESTINAL ANTIINFLAMMATORY AGENTS	83
DIGESTIVES, INCL. ENZYMES	86
DIGESTIVES, INCL. ENZYMES	86
DRUGS USED IN DIABETES	87
INSULINS AND ANALOGUES	87
BLOOD GLUCOSE LOWERING DRUGS, EXCL. INSULINS	89
VITAMINS	104
VITAMIN A AND D, INCL. COMBINATIONS OF THE TWO	104
VITAMIN B1, PLAIN AND IN COMBINATION WITH VITAMIN B6 AND B12	105
MINERAL SUPPLEMENTS	105
CALCIUM	105
POTASSIUM	105
OTHER MINERAL SUPPLEMENTS	106
ANABOLIC AGENTS FOR SYSTEMIC USE	106
ANABOLIC STEROIDS	106
OTHER ALIMENTARY TRACT AND METABOLISM PRODUCTS	106
OTHER ALIMENTARY TRACT AND METABOLISM PRODUCTS	106
BLOOD AND BLOOD FORMING ORGANS	108
ANTITHROMBOTIC AGENTS	108
ANTITHROMBOTIC AGENTS	108
ANTIHEMORRHAGICS	122
ANTIFIBRINOLYTICS	122
ANTIANEMIC PREPARATIONS	122
IRON PREPARATIONS	122
VITAMIN B12 AND FOLIC ACID	123
BLOOD SUBSTITUTES AND PERFUSION SOLUTIONS	124
BLOOD AND RELATED PRODUCTS	124
I.V. SOLUTIONS	124
OTHER HEMATOLOGICAL AGENTS	125
OTHER HEMATOLOGICAL AGENTS	125
CARDIOVASCULAR SYSTEM	126
CARDIAC THERAPY	126
CARDIAC GLYCOSIDES	126
ANTIARRHYTHMICS, CLASS I AND III	126
CARDIAC STIMULANTS EXCL. CARDIAC GLYCOSIDES	127
VASODILATORS USED IN CARDIAC DISEASES	128
OTHER CARDIAC PREPARATIONS	129
ANTIHYPERTENSIVES	130
ANTIADRENERGIC AGENTS, CENTRALLY ACTING	130

ANTIADRENERGIC AGENTS, PERIPHERALLY ACTING	130
ARTERIOLAR SMOOTH MUSCLE, AGENTS ACTING ON.....	130
DIURETICS	131
LOW-CEILING DIURETICS, THIAZIDES	131
LOW-CEILING DIURETICS, EXCL. THIAZIDES	131
HIGH-CEILING DIURETICS.....	131
POTASSIUM-SPARING AGENTS	132
DIURETICS AND POTASSIUM-SPARING AGENTS IN COMBINATION	133
PERIPHERAL VASODILATORS	133
PERIPHERAL VASODILATORS.....	133
BETA BLOCKING AGENTS	133
BETA BLOCKING AGENTS	133
CALCIUM CHANNEL BLOCKERS	137
SELECTIVE CALCIUM CHANNEL BLOCKERS WITH MAINLY VASCULAR EFFECTS	137
SELECTIVE CALCIUM CHANNEL BLOCKERS WITH DIRECT CARDIAC EFFECTS	139
AGENTS ACTING ON THE RENIN-ANGIOTENSIN SYSTEM.....	139
ACE INHIBITORS, PLAIN.....	139
ACE INHIBITORS, COMBINATIONS	146
ANGIOTENSIN II ANTAGONISTS, PLAIN.....	148
ANGIOTENSIN II ANTAGONISTS, COMBINATIONS	152
LIPID MODIFYING AGENTS.....	161
LIPID MODIFYING AGENTS, PLAIN	161
LIPID MODIFYING AGENTS, COMBINATIONS	176
DERMATOLOGICALS	190
ANTIFUNGALS FOR DERMATOLOGICAL USE.....	190
ANTIFUNGALS FOR TOPICAL USE	190
ANTIFUNGALS FOR SYSTEMIC USE.....	190
ANTIPSORIATICS	191
ANTIPSORIATICS FOR TOPICAL USE	191
ANTIPSORIATICS FOR SYSTEMIC USE	192
ANTIBIOTICS AND CHEMOTHERAPEUTICS FOR DERMATOLOGICAL USE.....	192
CHEMOTHERAPEUTICS FOR TOPICAL USE	192
CORTICOSTEROIDS, DERMATOLOGICAL PREPARATIONS.....	193
CORTICOSTEROIDS, PLAIN	193
ANTI-ACNE PREPARATIONS	195
ANTI-ACNE PREPARATIONS FOR TOPICAL USE	195
ANTI-ACNE PREPARATIONS FOR SYSTEMIC USE	195
OTHER DERMATOLOGICAL PREPARATIONS.....	196
OTHER DERMATOLOGICAL PREPARATIONS.....	196
GENITO URINARY SYSTEM AND SEX HORMONES.....	198
OTHER GYNECOLOGICALS.....	198
OXYTOCICS.....	198
CONTRACEPTIVES FOR TOPICAL USE	198
OTHER GYNECOLOGICALS.....	198
SEX HORMONES AND MODULATORS OF THE GENITAL SYSTEM	199
HORMONAL CONTRACEPTIVES FOR SYSTEMIC USE	199
ANDROGENS	200
ESTROGENS.....	201
PROGESTOGENS.....	202
PROGESTOGENS AND ESTROGENS IN COMBINATION	203
GONADOTROPINS AND OTHER OVULATION STIMULANTS.....	204
ANTIANDROGENS	205
OTHER SEX HORMONES AND MODULATORS OF THE GENITAL SYSTEM	206
UROLOGICALS.....	207
UROLOGICALS	207
DRUGS USED IN BENIGN PROSTATIC HYPERTROPHY.....	207
SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS.....	209
PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES	209
ANTERIOR PITUITARY LOBE HORMONES AND ANALOGUES	209
POSTERIOR PITUITARY LOBE HORMONES	209
HYPOTHALAMIC HORMONES	210
CORTICOSTEROIDS FOR SYSTEMIC USE	210

CORTICOSTEROIDS FOR SYSTEMIC USE, PLAIN	210
THYROID THERAPY	214
THYROID PREPARATIONS	214
ANTITHYROID PREPARATIONS	214
PANCREATIC HORMONES	215
GLYCOGENOLYTIC HORMONES	215
CALCIUM HOMEOSTASIS	215
PARATHYROID HORMONES AND ANALOGUES	215
ANTI-PARATHYROID AGENTS	216
ANTIINFECTIVES FOR SYSTEMIC USE	218
ANTIBACTERIALS FOR SYSTEMIC USE	218
TETRACYCLINES	218
BETA-LACTAM ANTIBACTERIALS, PENICILLINS	219
OTHER BETA-LACTAM ANTIBACTERIALS	226
SULFONAMIDES AND TRIMETHOPRIM	232
MACROLIDES, LINCOSAMIDES AND STREPTOGRAMINS	232
AMINOGLYCOSIDE ANTIBACTERIALS	235
QUINOLONE ANTIBACTERIALS	237
OTHER ANTIBACTERIALS	238
ANTIMYCOTICS FOR SYSTEMIC USE	240
ANTIMYCOTICS FOR SYSTEMIC USE	240
ANTIMYCOBACTERIALS	244
DRUGS FOR TREATMENT OF TUBERCULOSIS	244
DRUGS FOR TREATMENT OF LEPRA	244
ANTIVIRALS FOR SYSTEMIC USE	245
DIRECT ACTING ANTIVIRALS	245
VACCINES	250
BACTERIAL VACCINES	250
ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	251
ANTINEOPLASTIC AGENTS	251
ALKYLATING AGENTS	251
ANTIMETABOLITES	253
PLANT ALKALOIDS AND OTHER NATURAL PRODUCTS	254
CYTOTOXIC ANTIBIOTICS AND RELATED SUBSTANCES	254
OTHER ANTINEOPLASTIC AGENTS	255
ENDOCRINE THERAPY	285
HORMONES AND RELATED AGENTS	285
HORMONE ANTAGONISTS AND RELATED AGENTS	287
IMMUNOSTIMULANTS	292
IMMUNOSTIMULANTS	292
IMMUNOSUPPRESSANTS	294
IMMUNOSUPPRESSANTS	294
MUSCULO-SKELETAL SYSTEM	462
ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS	462
ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS, NON-STERIODS	462
SPECIFIC ANTIRHEUMATIC AGENTS	467
MUSCLE RELAXANTS	468
MUSCLE RELAXANTS, CENTRALLY ACTING AGENTS	468
MUSCLE RELAXANTS, DIRECTLY ACTING AGENTS	468
ANTIGOUT PREPARATIONS	468
ANTIGOUT PREPARATIONS	468
DRUGS FOR TREATMENT OF BONE DISEASES	469
DRUGS AFFECTING BONE STRUCTURE AND MINERALIZATION	469
NERVOUS SYSTEM	482
ANALGESICS	482
OPIOIDS	482
OTHER ANALGESICS AND ANTIPYRETICS	494
ANTIMIGRAINE PREPARATIONS	495
ANTIEPILEPTICS	499
ANTIEPILEPTICS	499
ANTI-PARKINSON DRUGS	509
ANTICHOLINERGIC AGENTS	509

DOPAMINERGIC AGENTS	510
PSYCHOLEPTICS	515
ANTIPSYCHOTICS	515
ANXIOLYTICS	531
HYPNOTICS AND SEDATIVES	532
PSYCHOANALEPTICS	534
ANTIDEPRESSANTS	534
PSYCHOSTIMULANTS, AGENTS USED FOR ADHD AND NOOTROPICS	543
ANTI-DEMENTIA DRUGS	546
OTHER NERVOUS SYSTEM DRUGS	554
PARASYMPATHOMIMETICS	554
DRUGS USED IN ADDICTIVE DISORDERS	554
OTHER NERVOUS SYSTEM DRUGS	558
ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS.....	561
ANTIPROTOZOALS	561
AGENTS AGAINST AMOEBIASIS AND OTHER PROTOZOAL DISEASES.....	561
ANTIMALARIALS.....	561
ANTHELMINTICS	562
ANTITREMATODALS.....	562
ANTINEMATODAL AGENTS	562
ECTOPARASITICIDES, INCL. SCABICIDES, INSECTICIDES AND REPELLENTS.....	563
ECTOPARASITICIDES, INCL. SCABICIDES	563
RESPIRATORY SYSTEM.....	564
NASAL PREPARATIONS.....	564
DECONGESTANTS AND OTHER NASAL PREPARATIONS FOR TOPICAL USE	564
DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES.....	564
ADRENERGICS, INHALANTS.....	564
OTHER DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES, INHALANTS	570
ADRENERGICS FOR SYSTEMIC USE.....	572
OTHER SYSTEMIC DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES	573
COUGH AND COLD PREPARATIONS	574
COUGH SUPPRESSANTS, EXCL. COMBINATIONS WITH EXPECTORANTS.....	574
ANTIHISTAMINES FOR SYSTEMIC USE	574
ANTIHISTAMINES FOR SYSTEMIC USE.....	574
SENSORY ORGANS.....	575
OPHTHALMOLOGICALS.....	575
ANTIINFECTIVES.....	575
ANTIINFLAMMATORY AGENTS	577
ANTIGLAUCOMA PREPARATIONS AND MIOTICS	578
MYDRIATICS AND CYCLOPLEGICS	584
DECONGESTANTS AND ANTIALLERGICS.....	584
OCULAR VASCULAR DISORDER AGENTS	584
OTHER OPHTHALMOLOGICALS	588
OTOLOGICALS	594
ANTIINFECTIVES.....	594
CORTICOSTEROIDS AND ANTIINFECTIVES IN COMBINATION	594
OPHTHALMOLOGICAL AND OTOLOGICAL PREPARATIONS.....	595
ANTIINFECTIVES.....	595
VARIOUS.....	596
ALLERGENS	596
ALLERGENS	596
ALL OTHER THERAPEUTIC PRODUCTS.....	596
ALL OTHER THERAPEUTIC PRODUCTS.....	596
DIAGNOSTIC AGENTS.....	598
URINE TESTS	598
OTHER DIAGNOSTIC AGENTS.....	599
GENERAL NUTRIENTS.....	601
OTHER NUTRIENTS.....	601
Pharmaceutical Benefits for Palliative Care.....	631
ALIMENTARY TRACT AND METABOLISM	632

STOMATOLOGICAL PREPARATIONS.....	632
STOMATOLOGICAL PREPARATIONS.....	632
DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS.....	633
BELLADONNA AND DERIVATIVES, PLAIN	633
DRUGS FOR CONSTIPATION.....	633
DRUGS FOR CONSTIPATION.....	633
MUSCULO-SKELETAL SYSTEM.....	638
ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS	638
ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS, NON-STERIODS.....	638
NERVOUS SYSTEM.....	642
ANALGESICS.....	642
OPIOIDS	642
OTHER ANALGESICS AND ANTIPYRETICS	644
ANTIEPILEPTICS.....	645
ANTIEPILEPTICS.....	645
PSYCHOLEPTICS	646
ANXIOLYTICS	646
HYPNOTICS AND SEDATIVES	647

Section 2 – READY-PREPARED PHARMACEUTICAL BENEFITS

SYMBOLS USED IN THE SCHEDULE

An asterisk (*) against the dispensed price of a benefit indicates that the manufacturer's pack does not coincide with the maximum quantity.

A double dagger (‡) in the maximum quantity column indicates an item for which the maximum quantity has been specially determined to correspond to the manufacturer's pack and the manufacturer's standard pack should be prescribed and supplied. For any item where a maximum quantity greater than 1 is marked with a double dagger (‡), that maximum quantity should be prescribed and supplied.

A gauge sign (#) against the dispensed price of a benefit indicates that the product is not preconstituted and that an extemporaneously-prepared dispensing fee is included in the dispensed price and, where appropriate, an amount for purified water.

Where a STATE is indicated after a manufacturer's code, that brand may be available only in the State indicated. NSW–(N); Vic–(V); Qld–(Q); SA–(S); WA–(W); Tas–(T).

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.

A straight line is drawn between entries for different forms and strengths of an item to indicate clearly the different restrictions which apply to these various forms and strengths.

The maximum quantity and/or number of repeats in respect of an item shown in the Schedule may be varied by the Chief Executive Medicare when approving an Authority Prescription or an Authority to Prescribe. The quantity and number of repeats shown on the authority shall be supplied. (See Explanatory Notes). Payment will be made on the basis of the price shown for that item in the Schedule.

BRAND EQUIVALENCE

'a' located immediately before brand names of a particular strength of an item indicates that the sponsors of these brands have submitted evidence that they have been demonstrated to be bioequivalent or therapeutically equivalent, or that justification for not needing bioequivalence or therapeutic equivalence data has been provided to and accepted by the Therapeutic Goods Administration. It would thus be expected that these brands may be interchanged without differences in clinical effect.

For other brands of an item, i.e., those not indicated as above, it is unknown whether or not they are equivalent. There may be several reasons for this, such as bioequivalence data not being considered necessary when the products were approved for marketing, or that advice or data have not been forthcoming from sponsors. This does not necessarily suggest a lack of safety or efficacy, but in these circumstances caution should be taken if brands are interchanged.

'b' attached to brand names indicates that these brands are also equivalent, but that it is not known if there is equivalence between brands marked 'a' and brands marked 'b'.

BRAND PREMIUM POLICY

The Brand Premium Policy was introduced on 1 December 1990 to increase price competition by allowing pharmaceutical manufacturers to set their own price on multi-branded items listed on the Pharmaceutical Benefits Scheme and to encourage the development of the generic pharmaceutical industry in Australia. The policy does this by increasing prescribers' and patients' consciousness about the price of drugs. In effect, it makes both groups question whether it is necessary for the patient to pay more for the drugs when a cheaper brand is available. The policy also allows companies to establish prices taking into account competition and consumer acceptance.

The policy operates where there is more than one brand of a particular drug available through the Pharmaceutical Benefits Scheme and where the brands are therapeutically interchangeable. Due to this, the policy mainly applies to out of patent drugs.

Basically the policy operates by:

- the Australian Government subsidising a drug to the level of the lowest priced brand (except in those instances where the lowest priced brand has, as part of its price, a therapeutic group premium);
- suppliers of other brands of that drug being able to set a price above the price charged by the supplier(s) of the lowest priced brand(s); and
- the patient paying the brand premium which is the price difference between the lowest price brand and the brand prescribed.

If a prescription is written generically or for the lowest priced brand, and the lowest priced brand is supplied, there is no brand premium payable.

'B' located immediately before an amount in the premium column indicates a brand premium which applies to that particular brand of the item.

If a brand of a drug which is subject to a therapeutic group premium also has a brand premium, there will be two amounts shown on separate lines in the premium column, prefixed by 'T' and 'B' respectively.

If a brand of a drug which is subject to a special patient contribution also has a brand premium, there will be two amounts shown on separate lines in the premium column, prefixed by 'S' and 'B' respectively.

THERAPEUTIC GROUP PREMIUM POLICY

The Therapeutic Group Premium Policy was introduced on 1 February 1998 as an extension of the Brand Premium Policy to encourage greater competition between manufacturers of drugs and to make doctors and patients more aware of the costs of medicines.

The Therapeutic Group Premium policy applies within narrowly defined therapeutic sub-groups where the drugs concerned are of similar safety, efficacy and health outcomes.

Basically the policy operates by:

- the Australian Government subsidising drugs within a defined therapeutic sub-group to the level of the lowest priced drug in the sub-group;
- suppliers of other drugs within that sub-group being able to set prices above the price charged by the supplier(s) of the lowest priced drug; and
- the patient paying the therapeutic group premium which is the price difference between the lowest price drug and the drug prescribed.

'T' located immediately before an amount in the premium column indicates a therapeutic group premium which applies to that particular item.

If a brand of a drug which is subject to a therapeutic group premium also has a brand premium, there will be two amounts shown on separate lines in the premium column, prefixed by 'T' and 'B' respectively.

The success of the Government in controlling prices of products supplied through the Pharmaceutical Benefits Scheme has often been criticised by the pharmaceutical industry. Under both the Brand Premium Policy and the Therapeutic Group Premium Policy, suppliers of multi-branded items and therapeutically similar drugs are able to set their own prices at a level that they think the market will bear. At the same time, the prescriber and the patient can decide whether it is necessary to pay more for a particular brand or drug when a cheaper one is available and is therapeutically interchangeable.

The brand premium or therapeutic group premium does not count toward the patient's safety net.

It should be noted that the brand premium or therapeutic group premium is not a Government charge or revenue. The premium arises from the manufacturer's price and the majority goes to the manufacturer with wholesalers and pharmacists receiving a small percentage.

Prescriber Bag

PRESCRIBER BAG

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	Dispensed Price for Max. Qty		Brand Name and Manufacturer	
				\$		
3451P NP	ADRENALINE adrenaline 1 in 1000 (1 mg/mL) injection, 5 x 1 mL ampoules	1		20.68	Link Medical Products Pty Ltd	LM
3453R NP	ATROPINE ATROPINE Injection 600 micrograms in 1 mL, 10	1		20.88	Pfizer Australia Pty Ltd	PF
10016E NP or	BENZTROPINE benztropine mesylate 2 mg/2 mL injection, 10 x 2 mL vials or	1		287.65	Benztropine Omega	FK
3457Y NP	BENZTROPINE benztropine mesylate 2 mg/2 mL injection, 5 x 2 mL ampoules	1		103.93	Cogentin	FK
3486L NP or	BENZYLPENICILLIN benzylpenicillin 600 mg injection, 1 x 600 mg vial or	10		*55.06	BenPen	CS
3485K NP	PROCAINE PENICILLIN procaine penicillin 1.5 g/3.4 mL injection, 5 x 3.4 mL syringes	1		92.56	Cilicaine	QA
3487M NP	BENZYLPENICILLIN benzylpenicillin 3 g injection, 1 x 3 g vial	1		15.44	BenPen	CS
3478C NP	CLONAZEPAM clonazepam 2.5 mg/mL oral liquid, 10 mL	‡1		11.07	Rivotril	RO
3472R NP	DEXAMETHASONE SODIUM PHOSPHATE DEXAMETHASONE SODIUM PHOSPHATE Injection equivalent to 4 mg dexamethasone phosphate in 1 mL, 5	1		13.55	^a Hospira Pty Limited	HH
					^a Dexmethsone	AF
or	or					
3470P NP	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	2		*18.04	Solu-Cortef	PF
or	or					
3471Q NP	HYDROCORTISONE SODIUM SUCCINATE hydrocortisone (as sodium succinate) 250 mg injection [1 x 250 mg vial] (& inert substance diluent [1 x 2 mL vial], 1 pack	1		16.83	Solu-Cortef	PF
3458B NP	DIAZEPAM diazepam 10 mg/2 mL injection, 5 x 2 mL ampoules	1		13.68	Hospira Pty Limited	HH
3463G NP	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	4		*275.36	ADT Booster	CS
3466K NP	FRUSEMIDE frusemide 20 mg/2 mL injection, 5 x 2 mL ampoules	1		8.63	^a Frusemide Sandoz	SZ
					^a Lasix	SW
					^a Frusemide-Clarix	AE
3467L NP	GLUCAGON HYDROCHLORIDE glucagon hydrochloride 1 mg injection [1 x 1 mg vial] (&) inert substance diluent [1 x 1 mL syringe], 1 pack	1		49.44	GlucaGen Hypokit	NO
3475X NP	GLYCERYL TRINITRATE glyceryl trinitrate 400 microgram/actuation spray, 200 actuations	‡1		20.47	Nitrolingual Pumpspray	SW
3456X NP or	HALOPERIDOL haloperidol 5 mg/mL injection, 10 x 1 mL ampoules or	1		22.62	Serenace	QA
3455W NP	CHLORPROMAZINE chlorpromazine hydrochloride 50 mg/2 mL injection, 10 x 2 mL ampoules	1		20.82	Largactil	SW
3473T	HYOSCINE BUTYLBROMIDE	1		24.55	Buscopan	BY

PRESCRIBER BAG

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer	
NP	hyoscine butylbromide 20 mg/mL injection, 5 x 1 mL ampoules				
3474W NP	LIGNOCAINE lignocaine hydrochloride anhydrous 2% (100 mg/5 mL) injection, 5 x 5 mL ampoules	1	37.67	Pfizer Australia Pty Ltd	PF
3489P	METHOXYFLURANE methoxyflurane 999.9 mg/g inhalation: solution, 1 x 3 mL bottle	1	45.12	Pentrox	DV
3476Y NP	METOCLOPRAMIDE metoclopramide hydrochloride 10 mg/2 mL injection, 10 x 2 mL ampoules	1	13.33	Maxolon	IA
or	or				
3477B NP	PROCHLORPERAZINE prochlorperazine mesylate 12.5 mg/mL injection, 10 x 1 mL ampoules	1	17.89	Stemetil	SW
10178Q NP	MIDAZOLAM midazolam 5 mg/mL injection, 10 x 1 mL ampoules	1	38.91	Pfizer Australia Pty Ltd	PF
3479D NP	MORPHINE morphine sulfate 15 mg/mL injection, 5 x 1 mL ampoules	1	17.30	Hospira Pty Limited	HH
or	or				
3480E NP	MORPHINE morphine sulfate 30 mg/mL injection, 5 x 1 mL ampoules	1	19.43	Hospira Pty Limited	HH
2200T NP	NALOXONE naloxone hydrochloride 400 microgram/mL injection, 1 x 1 mL syringe	10	*203.56	Naloxone minijet	UC
3488N NP	PROMETHAZINE promethazine hydrochloride 50 mg/2 mL injection, 5 x 2 mL ampoules	2	*30.58	Hospira Pty Limited	HH
3495Y NP	SALBUTAMOL salbutamol 100 microgram/actuation inhalation: pressurised, 200	‡1	11.62	^a Ventolin CFC-free	GK
3495Y NP	SALBUTAMOL salbutamol 100 microgram/actuation inhalation: pressurised, 200	‡1	10.45	^a Asmol CFC-free	AL
				^a APO-Salbutamol Inhaler	TX
or	or				
3496B NP	SALBUTAMOL salbutamol 2.5 mg/2.5 mL inhalation: solution, 30 x 2.5 mL ampoules	‡1	11.36	^a Asmol 2.5 uni-dose	AF
				^a GenRx Salbutamol	GX
				^a Butamol 2.5	QA
				^a Salbutamol-GA	GN
				^a APO-Salbutamol	TX
				^a Salbutamol Actavis	UA
				^a Pharmacor Salbutamol 2.5	CR
				^a Salbutamol Sandoz	SZ
3496B NP	SALBUTAMOL salbutamol 2.5 mg/2.5 mL inhalation: solution, 30 x 2.5 mL ampoules	‡1	11.96	^a Ventolin Nebules	GK
3497C NP	SALBUTAMOL salbutamol 5 mg/2.5 mL inhalation: solution, 30 x 2.5 mL ampoules	‡1	11.60	^a Pharmacor Salbutamol 5	CR
				^a Salbutamol-GA	GN
				^a APO-Salbutamol	TX
				^a Asmol 5 uni-dose	AF
				^a GenRx Salbutamol	GX

PRESCRIBER BAG

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	Dispensed Price for Max. Qty		Brand Name and Manufacturer	
				\$		
3497C NP	SALBUTAMOL salbutamol 5 mg/2.5 mL inhalation: solution, 30 x 2.5 mL ampoules	‡1	12.18	^a	Salbutamol Sandoz	SZ
				^a	Salbutamol Actavis	UA
				^a	Butamol 5	QA
				^a	Ventolin Nebules	GK
3491R NP	TERBUTALINE terbutaline sulfate 500 microgram/mL injection, 5 x 1 mL ampoules	1	30.93		Bricanyl	AP
3484J NP	TRAMADOL tramadol hydrochloride 100 mg/2 mL injection, 5 x 2 mL ampoules	1	12.51	^a	Tramal 100	CS
				^a	Tramadol Sandoz	SZ
				^a	Tramadol ACT	GN

General Pharmaceutical Benefits

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

ALIMENTARY TRACT AND METABOLISM

STOMATOLOGICAL PREPARATIONS

STOMATOLOGICAL PREPARATIONS

Antiinfectives and antiseptics for local oral treatment

AMPHOTERICIN B

2931G NP	amphotericin B 10 mg lozenge, 20	1	1	..	12.37	13.52	Fungilin	QA
3306B DP	amphotericin B 10 mg lozenge, 20	1	..	..	12.37	13.52	Fungilin	QA

NYSTATIN

3033P NP	nystatin 100 000 international units/mL oral liquid, 24 mL	1	1	..	11.48	12.63	^a Mycostatin	FM
				^b 3.01	14.49	12.63	^a Nilstat	QA
3343Y DP	nystatin 100 000 international units/mL oral liquid, 24 mL	1	..	..	11.48	12.63	^a Mycostatin	FM
				^b 3.01	14.49	12.63	^a Nilstat	QA

Other agents for local oral treatment

BENZYDAMINE

Restricted benefit

Radiation induced mucositis

1121B NP	benzylamine hydrochloride 0.15% mouthwash, 500 mL	1	1	..	22.60	23.75	Diffiam	IA
5032W DP	benzylamine hydrochloride 0.15% mouthwash, 500 mL	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

2159P NP	aluminium hydroxide 250 mg/5 mL + magnesium hydroxide 120 mg/5 mL + magnesium trisilicate 120 mg/5 mL oral liquid, 500 mL	2	5	..	*18.04	19.19	Gastrogel	FM

ALUMINIUM HYDROXIDE WITH MAGNESIUM HYDROXIDE

2157M NP	ALUMINIUM HYDROXIDE with MAGNESIUM HYDROXIDE Oral suspension 200 mg-200 mg per 5 mL, 500 mL, 1	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.

1158Y NP	cimetidine 400 mg tablet, 60	1	5	..	17.11	18.26	Magical 400	AF

FAMOTIDINE

Note

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

2487X NP	famotidine 20 mg tablet, 60	1	5	..	11.80	12.95	^a Ausfam 20	QA
							^a Chem mart Famotidine	CH
							^a Famotidine AN	EA
							^a Famotidine Sandoz	SZ
							^a GenRx Famotidine	GX
							^a Pamacid 20	AF

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
2488Y NP	famotidine 40 mg tablet, 30	1	5	..	11.80	12.95	^a Pepzan	GN
							^a Terry White Chemists Famotidine	TW
							^a Ausfam 40	QA
							^a Chem mart Famotidine	CH
							^a Famotidine AN	EA
							^a Famotidine Sandoz	SZ
							^a GenRx Famotidine	GX
							^a Pamacid 40	AF
							^a Pepzan	GN
							^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.								
1505F NP	nizatidine 150 mg capsule, 60	1	5	..	18.77	19.92	^a Nizac	LN
				^b 5.32	24.09	19.92	^a Tacidine	AF
1504E NP	nizatidine 300 mg capsule, 30	1	5	..	18.77	19.92	^a Tazac	AS
							^a Nizac	LN
				^b 5.32	24.09	19.92	^a Tacidine	AF
							^a Tazac	AS
RANITIDINE								
Note								
Helicobacter pylori eradication therapy should be considered prior to commencing initial treatment of peptic ulcer with this drug.								
1978D NP,MW	ranitidine 150 mg tablet, 60	1	5	..	13.23	14.38	^a APO-Ranitidine	TX
							^a Ausran	QA
							^a Chem mart Ranitidine	CH
							^a GenRx Ranitidine	GX
							^a Rani 2	AF
							^a Ranitidine AN	EA
							^a Ranitidine Sandoz	SZ
							^a Ranoxyl	GN
							^a Terry White Chemists Ranitidine	TW
				^b 1.41	14.64	14.38	^a Ulcaid	RA
1937Y NP	ranitidine 150 mg tablet: effervescent, 30	2	5	..	*13.26	14.41	^a Zantac	AS
8162N NP	ranitidine 150 mg/10 mL oral liquid, 300 mL	2	5	..	*24.86	26.01	Zantac Syrup	AS
1977C NP	ranitidine 300 mg tablet, 30	1	5	..	13.23	14.38	^a APO-Ranitidine	TX
							^a Ausran	QA
							^a Chem mart Ranitidine	CH
							^a GenRx Ranitidine	GX
							^a Rani 2	AF
							^a Ranitidine Sandoz	SZ
							^a Ranoxyl	GN
							^a Terry White Chemists Ranitidine	TW
				^b 1.41	14.64	14.38	^a Zantac	AS

Proton pump inhibitors

ESOMEPRAZOLE

Restricted benefit

Maintenance of healed gastro-oesophageal reflux disease

Restricted benefit

Scleroderma oesophagus

Restricted benefit

[illegible]

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer		
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.									
2240X NP	lansoprazole 30 mg capsule: enteric, 28	1	1	..	21.09	22.24	^a	APO-Lansoprazole	TX
							^a	Lanzopran	RA
							^a	Zopral	AF
9477T NP	lansoprazole 30 mg tablet: orally disintegrating, 28 tablets	1	1	..	21.09	22.24	^a	Zopral ODT	AF
							^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.									
2241Y NP	lansoprazole 30 mg capsule: enteric, 28	1	5	..	21.09	22.24	^a	APO-Lansoprazole	TX
							^a	Lanzopran	RA
							^a	Zopral	AF
9478W NP	lansoprazole 30 mg tablet: orally disintegrating, 28 tablets	1	5	..	21.09	22.24	^a	Zopral ODT	AF
							^a	Zoton FasTabs	PF
OMEPRAZOLE Restricted benefit Gastro-oesophageal reflux disease Restricted benefit Scleroderma oesophagus Restricted benefit Zollinger-Ellison syndrome									
8332M NP	omeprazole 10 mg tablet: enteric, 30 tablets	1	5	..	12.67	13.82		Losec Tablets	AP
OMEPRAZOLE Restricted benefit Peptic ulcer Treatment Phase: Initial treatment Note Helicobacter pylori eradication therapy should be considered. 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. Note No increase in the maximum number of repeats may be authorised.									
1326T NP	omeprazole 20 mg capsule, 30	1	1	..	15.14	16.29	^a	APO-Omeprazole	TX
							^a	Maxor	AF
							^a	Omeprazole Sandoz	HX
							^a	Omepro-GA	GN
							^a	Pemzo	QA
							^a	Pharmacor Omeprazole 20	CR
							^a	Probitor	SZ
8331L NP	omeprazole 20 mg tablet: enteric, 30 tablets	1	1	..	15.14	16.29	^a	APO-Omeprazole	TX
							^a	Chem mart Omeprazole	CH
							^a	Meprazol	SZ
							^a	Omeprazole AN	EA

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer				
9109K NP	omeprazole 20 mg tablet: enteric, 30 tablets	1	1	..	15.14	16.29	^a Omeprazole-GA	GN			
							^a Omeprazole generichealth	GQ			
							^a Omeprazole RBX	RA			
							^a Ozmep	ZP			
							^a Terry White Chemists Omeprazole	TW			
							^a Acimax Tablets	AL			
										^a Omepral	TX
										^a Omeprazole Sandoz	SZ
							^B 3.06	18.20	16.29	^a Losec Tablets	AP
				OMEPRAZOLE <u>Restricted benefit</u> Gastro-oesophageal reflux disease <u>Restricted benefit</u> Scleroderma oesophagus <u>Restricted benefit</u> Zollinger-Ellison syndrome <u>Note</u> 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.							
1327W NP	omeprazole 20 mg capsule, 30	1	5	..	15.14	16.29	^a APO-Omeprazole	TX			
							^a Maxor	AF			
							^a Omeprazole Sandoz	HX			
							^a Omepro-GA	GN			
							^a Pemzo	QA			
							^a Pharmacor Omeprazole 20	CR			
8333N NP	omeprazole 20 mg tablet: enteric, 30 tablets	1	5	..	15.14	16.29	^a Probitor	SZ			
							^a APO-Omeprazole	TX			
							^a Chem mart Omeprazole	CH			
							^a Meprazol	SZ			
							^a Omeprazole AN	EA			
							^a Omeprazole-GA	GN			
							^a Omeprazole generichealth	GQ			
							^a Omeprazole RBX	RA			
							^a Ozmep	ZP			
							^a Terry White Chemists Omeprazole	TW			
9110L NP	omeprazole 20 mg tablet: enteric, 30 tablets	1	5	..	15.14	16.29	^a Acimax Tablets	AL			
							^a Omepral	TX			
							^a Omeprazole Sandoz	SZ			
							^a Losec Tablets	AP			
PANTOPRAZOLE <u>Restricted benefit</u> Gastro-oesophageal reflux disease <u>Restricted benefit</u> Scleroderma oesophagus <u>Restricted benefit</u> Zollinger-Ellison syndrome											
8399C NP	pantoprazole 20 mg tablet: enteric, 30 tablets	1	5	..	9.83	10.98	^a APO-Pantoprazole	TX			
							^a Chem mart Pantoprazole	CH			
							^a I-Pantoprazole	CR			
							^a Ozpan	RA			
							^a Panthron	ER			

PANTOPRAZOLE

Initial treatment of peptic ulcer

Helicobacter pylori eradication therapy should be considered.

No applications for increased repeats will be authorised.

[illegible]

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Sozol	QA
							^a Terry White Chemists Pantoprazole	TW
							^a Topra 40	DO
							^a Torzole 40	VN
	RABEPRAZOLE							
	<u>Restricted benefit</u>							
	Gastro-oesophageal reflux disease							
	<u>Restricted benefit</u>							
	Scleroderma oesophagus							
8507R NP	rabeprazole sodium 10 mg tablet: enteric, 28	1	5	..	17.40	18.55	^a APO-Rabeprazole	TX
							^a Chem mart Rabeprazole	CH
							^a Pariet	JC
							^a Parzol 10	ZP
							^a Prabez	AF
							^a Rabeprazole AN	EA
							^a Rabeprazole-DRLA	RZ
							^a Rabeprazole-GA	GN
							^a Rabeprazole generichealth	GQ
							^a Rabeprazole Sandoz	SZ
							^a Razit 10	DO
							^a Terry White Chemists Rabeprazole	TW
8508T NP	rabeprazole sodium 20 mg tablet: enteric, 30	1	5	..	17.40	18.55	^a APO-Rabeprazole	TX
							^a Chem mart Rabeprazole	CH
							^a Pariet	JC
							^a Parzol 20	ZP
							^a Prabez	AF
							^a Rabeprazole Actavis 20	UA
							^a Rabeprazole AN	EA
							^a Rabeprazole-DRLA	RZ
							^a Rabeprazole generichealth	GQ
							^a Rabeprazole RBX	RA
							^a Rabeprazole Sandoz	SZ
							^a Razit 20	DO
							^a Terry White Chemists Rabeprazole	TW
	RABEPRAZOLE							
	<u>Restricted benefit</u>							
	Initial treatment of peptic ulcer							
	<u>Note</u>							
	Helicobacter pylori eradication therapy should be considered.							
	<u>Note</u>							
	No applications for increased repeats will be authorised.							
8509W NP	rabeprazole sodium 20 mg tablet: enteric, 30	1	2	..	17.40	18.55	^a APO-Rabeprazole	TX
							^a Chem mart Rabeprazole	CH
							^a Pariet	JC
							^a Parzol 20	ZP
							^a Prabez	AF
							^a Rabeprazole Actavis 20	UA
							^a Rabeprazole AN	EA
							^a Rabeprazole-DRLA	RZ
							^a Rabeprazole generichealth	GQ
							^a Rabeprazole RBX	RA
							^a Rabeprazole Sandoz	SZ
							^a Razit 20	DO

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Terry White Chemists Rabeprazole	TW
Combinations for eradication of <i>Helicobacter pylori</i>								
ESOMEPRAZOLE (&) CLARITHROMYCIN (&) AMOXYCILLIN								
<u>Restricted benefit</u>								
Eradication of <i>Helicobacter pylori</i> associated with peptic ulcer disease								
8738X NP	esomeprazole 20 mg tablet: enteric [14 tablets] (&) clarithromycin 500 mg tablet [14 tablets] (&) amoxicillin 500 mg capsule [28 capsules], 1 pack	#1	..	..	50.95	36.90	Nexium Hp7	AP
Other drugs for peptic ulcer and gastro-oesophageal reflux disease (GORD)								
ALGINATE SODIUM + CALCIUM CARBONATE + BICARBONATE								
2014B NP	alginate sodium 500 mg/10 mL + calcium carbonate 160 mg/10 mL + sodium bicarbonate 267 mg/10 mL oral liquid, 500 mL	2	5	..	*15.02	16.17	Gaviscon P	RC
SUCRALFATE								
2055E NP	sucralfate 1 g tablet, 120	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

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.

1089H NP	ATROPINE Injection 600 micrograms in 1 mL, 10	1	1	..	20.88	22.03	Pfizer Australia Pty Ltd	PF
5022H DP	ATROPINE Injection 600 micrograms in 1 mL, 10	1	..	..	20.88	22.03	Pfizer Australia Pty Ltd	PF

PROPULSIVES

Propulsives

DOMPERIDONE

1347X NP	domperidone 10 mg tablet, 25	1	..	..	9.23	10.38	Motilium	JC

METOCLOPRAMIDE

1207M NP,MW	metoclopramide hydrochloride 10 mg tablet, 25	1	..	..	8.26	9.41	^a APO-Metoclopramide	TX
							^a Metoclopramide Actavis	GN
							^a Metoclopramide AN	EA
							^a Pramin	AF
				^b 2.54	10.80	9.41	^a Maxolon	IA
5151D DP	metoclopramide hydrochloride 10 mg tablet, 25	1	..	..	8.26	9.41	^a Pramin	AF
							^a APO-Metoclopramide	TX
							^a Metoclopramide Actavis	GN
							^a Metoclopramide AN	EA
				^b 2.54	10.80	9.41	^a Maxolon	IA
1206L NP,MW	metoclopramide hydrochloride 10 mg/2 mL injection, 10 x 2 mL ampoules	1	..	..	13.33	14.48	Maxolon	IA
5153F DP	metoclopramide hydrochloride 10 mg/2 mL injection, 10 x 2 mL ampoules	1	..	..	13.33	14.48	Maxolon	IA

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
ANTIEMETICS AND ANTINAUSEANTS								
ANTIEMETICS AND ANTINAUSEANTS								
<i>Serotonin (5HT3) antagonists</i>								
GRANISETRON								
<u>Restricted benefit</u>								
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.								
8728J NP	granisetron 2 mg tablet, 1	2	..	..	*29.74	30.89	Kytril	RO
GRANISETRON								
<u>Authority required (STREAMLINED)</u>								
4102								
Nausea and vomiting								
Clinical criteria:								
The condition must be associated with radiotherapy being used to treat malignancy.								
8873B NP	granisetron 2 mg tablet, 5	1	1	..	61.69	36.90	Kytril	RO
GRANISETRON								
<u>Restricted benefit</u>								
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.								
8729K NP	granisetron 3 mg/3 mL injection, 1 x 3 mL ampoule	1	..	..	11.68	12.83	^a Granisetron-AFT	AE
							^a Granisetron Kabi	PK
							^a Kytril	RO
GRANISETRON								
<u>Authority required (STREAMLINED)</u>								
4092								
Nausea and vomiting								
Clinical criteria:								
The condition must be associated with radiotherapy being used to treat malignancy.								
8730L NP	granisetron 3 mg/3 mL injection, 1 x 3 mL ampoule	1	..	..	11.68	12.83	^a Granisetron-AFT	AE
							^a Granisetron Kabi	PK
							^a Kytril	RO
ONDANSETRON								
<u>Authority required (STREAMLINED)</u>								
3611								
Management of nausea and vomiting associated with radiotherapy being used to treat malignancy								
<u>Note</u>								
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.								
5472B NP	ONDANSETRON Tablet (orally disintegrating) 4 mg, 10	1	1	..	32.21	33.36	^a Ondansetron AN ODT	EA
							^a Ondansetron ODT-DRLA	RZ
							^a Onsetron ODT 4	GN
8412R NP	ondansetron 4 mg wafer, 10	1	1	..	32.21	33.36	^a Ondaz Zydis	SZ
							^a Zofran Zydis	AS

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
ONDANSETRON								
<u>Restricted benefit</u>								
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								
<u>Note</u>								
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.								
5470X NP	ONDANSETRON Tablet (orally disintegrating) 4 mg, 4	1	..	..	16.94	18.09	^a Ondansetron AN ODT	EA
							^a Ondansetron ODT-DRLA	RZ
							^a Onsetron ODT 4	GN
8410P NP	ondansetron 4 mg wafer, 4	1	..	..	16.94	18.09	^a Ondaz Zydis	SZ
							^a Zofran Zydis	AS
ONDANSETRON								
<u>Authority required (STREAMLINED)</u>								
3611								
Management of nausea and vomiting associated with radiotherapy being used to treat malignancy								
<u>Note</u>								
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.								
5473C NP	ONDANSETRON Tablet (orally disintegrating) 8 mg, 10	1	1	..	45.91	36.90	^a Ondansetron AN ODT	EA
							^a Ondansetron ODT-DRLA	RZ
							^a Onsetron ODT 8	GN
8413T NP	ondansetron 8 mg wafer, 10	1	1	..	45.91	36.90	^a Ondaz Zydis	SZ
							^a Zofran Zydis	AS
ONDANSETRON								
<u>Restricted benefit</u>								
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								
<u>Note</u>								
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.								
5471Y NP	ONDANSETRON Tablet (orally disintegrating) 8 mg, 4	1	..	..	22.70	23.85	^a Ondansetron AN ODT	EA
							^a Ondansetron ODT-DRLA	RZ
							^a Onsetron ODT 8	GN
8411Q NP	ondansetron 8 mg wafer, 4	1	..	..	22.70	23.85	^a Ondaz Zydis	SZ
							^a Zofran Zydis	AS
ONDANSETRON								
<u>Authority required (STREAMLINED)</u>								
3611								
Management of nausea and vomiting associated with radiotherapy being used to treat malignancy								
1594X NP	ondansetron 4 mg tablet, 10	1	1	..	32.21	33.36	^a APO-Ondansetron	TX
							^a Ondansetron AN	EA
							^a Ondansetron-DRLA	RZ
							^a Ondaz	SZ
							^a Onsetron 4	ZP
							^a Zilfojim 4	DO
							^a Zofran	AS
1596B NP	ondansetron 4 mg/2 mL injection, 1 x 2 mL ampoule	1	..	..	7.88	9.03	^a Ondansetron Alphapharm	AF
							^a Ondansetron-Clarix	AE
							^a Ondansetron Kabi	PK

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
8233H NP	ondansetron 4 mg/5 mL oral liquid, 50 mL	#1	1	..	102.30	36.90	^a Ondaz	SZ
							^a Onsetron	ZP
							Zofran syrup 50 mL	AS
1595Y NP	ondansetron 8 mg tablet, 10	1	1	..	45.91	36.90	^a APO-Ondansetron	TX
							^a Ondansetron AN	EA
							^a Ondansetron-DRLA	RZ
							^a Ondaz	SZ
							^a Onsetron 8	ZP
							^a Zilfojim 8	DO
							^a Zofran	AS
							^a Ondansetron	AF
							Alphapharm	
							^a Ondansetron-Clarix	AE
1597C NP	ondansetron 8 mg/4 mL injection, 1 x 4 mL ampoule	1	..	..	8.53	9.68	^a Ondansetron Kabi	PK
							^a Ondaz	SZ
							^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

8224W NP	ondansetron 4 mg tablet, 4	1	..	..	16.94	18.09	^a APO-Ondansetron	TX
							^a Ondansetron AN	EA
							^a Ondansetron-DRLA	RZ
							^a Ondaz	SZ
							^a Onsetron 4	ZP
8226Y NP	ondansetron 4 mg/2 mL injection, 1 x 2 mL ampoule	1	..	..	7.88	9.03	^a Zofran	AS
							^a Ondansetron	AF
							Alphapharm	
							^a Ondansetron-Clarix	AE
							^a Ondansetron Kabi	PK
9441X NP	ondansetron 4 mg/5 mL oral liquid, 50 mL	#1	..	..	102.30	36.90	^a Ondaz	SZ
							^a Onsetron	ZP
8225X NP	ondansetron 8 mg tablet, 4	1	..	..	22.70	23.85	Zofran syrup 50 mL	AS
							^a APO-Ondansetron	TX
							^a Ondansetron AN	EA
							^a Ondansetron-DRLA	RZ
							^a Ondaz	SZ
							^a Onsetron 8	ZP
							^a Zofran	AS
							^a Ondansetron	AF
							Alphapharm	
							^a Ondansetron-Clarix	AE
8227B NP	ondansetron 8 mg/4 mL injection, 1 x 4 mL ampoule	1	..	..	8.53	9.68	^a Ondansetron Kabi	PK
							^a Ondaz	SZ
							^a Onsetron	ZP

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.

5295Q NP	palonosetron 250 microgram/5 mL injection, 1 x 5 mL vial	1	..	..	48.20	36.90	Aloxi	TS

TROPISETRON

Restricted benefit

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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							
2746M NP	tropisetron 5 mg/5 mL injection, 1 x 5 mL ampoule	1	..	..	18.84	19.99	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.

Note

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

Note

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

2518M NP	aprepitant 165 mg capsule, 1	1	5	..	138.13	36.90	Emend	MK

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
2895J NP	prochlorperazine maleate 25 mg suppository, 5	#1	2	..	20.27	21.42	Stemetil	SW
2893G NP	prochlorperazine maleate 5 mg tablet, 25	1	..	..	8.38	9.53	^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 3.08	11.46	9.53	^a Stemetil	SW
2369Q NP	prochlorperazine mesylate 12.5 mg/mL injection, 10 x 1 mL ampoules	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.								
5208D DP	prochlorperazine maleate 25 mg suppository, 5	#1	..	..	20.27	21.42	Stemetil	SW
5205Y DP	prochlorperazine maleate 5 mg tablet, 25	1	..	..	8.38	9.53	^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 3.08	11.46	9.53	^a Stemetil	SW
5206B DP	prochlorperazine mesylate 12.5 mg/mL injection, 10 x 1 mL ampoules	1	..	..	17.89	19.04	Stemetil	SW
PROMETHAZINE								
3374N DP	promethazine hydrochloride 50 mg/2 mL injection, 5 x 2 mL ampoules	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.

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.

8448P NP	ursodeoxycholic acid 250 mg capsule, 100	2	2	..	*372.94	36.90	Ursosalk	OA

DRUGS FOR CONSTIPATION

DRUGS FOR CONSTIPATION

Contact laxatives

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
BISACODYL								
<u>Restricted benefit</u>								
Paraplegic and quadriplegic patients and others with severe neurogenic impairment of bowel function								
<u>Restricted benefit</u>								
Patients who are receiving long-term nursing care on account of age, infirmity or other condition in hospitals, nursing homes or residential facilities								
<u>Restricted benefit</u>								
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								
<u>Restricted benefit</u>								
Patients receiving palliative care								
<u>Restricted benefit</u>								
Terminal malignant neoplasia								
<u>Restricted benefit</u>								
Anorectal congenital abnormalities								
<u>Restricted benefit</u>								
Megacolon								
1260H NP	bisacodyl 10 mg suppository, 10	3	5	..	*21.28	22.43	^a Petrus Bisacodyl Suppositories	PP
				^b 1.50	*22.78	22.43	^a Dulcolax	BY
1258F NP	bisacodyl 10 mg suppository, 12	3	4	..	*18.67	19.82	Petrus Bisacodyl Suppositories	PP
1259G NP	bisacodyl 5 mg tablet: enteric, 200 tablets	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

1104D NP	rhamnus frangula 80 mg/g + sterculia 620 mg/g granules, 500 g	£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

3064G NP	LACTULOSE Mixture 3.34 g per 5 mL, 500 mL, 1	£1	5	..	10.70	11.85	^a Genlac	QA
				^b 0.89	11.59	11.85	^a Actilax	AF

MACROGOL-3350

Restricted benefit

Constipation

Clinical criteria:

Patient must have malignant neoplasia.

Restricted benefit

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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.						
	<u>Restricted benefit</u>						
	Constipation						
	Clinical criteria:						
	Patient must be receiving palliative care.						
	<u>Restricted benefit</u>						
	Chronic constipation						
	Clinical criteria:						
	The condition must be inadequately controlled with first line interventions such as bulk-forming agents.						
	<u>Restricted benefit</u>						
	Faecal impaction						
	Clinical criteria:						
	The condition must be inadequately controlled with first line interventions such as bulk-forming agents.						
	<u>Note</u>						
	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.						
2373X NP	macrogol-3350 1 g/g oral liquid: powder for, 30 x 17 g sachets	\$1	5	..	20.89	22.04 ^a	MediHealth ClearLax ON
3416T NP	macrogol-3350 1 g/g oral liquid: powder for, 510 g	\$1	5	..	20.89	22.04 ^a	OsmoLax KY
	MACROGOL-3350 + SODIUM CHLORIDE + POTASSIUM CHLORIDE + BICARBONATE						
	<u>Restricted benefit</u>						
	Constipation						
	Clinical criteria:						
	Patient must have malignant neoplasia.						
	<u>Restricted benefit</u>						
	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.						
	<u>Restricted benefit</u>						
	Constipation						
	Clinical criteria:						
	Patient must be receiving palliative care.						
	<u>Restricted benefit</u>						
	Chronic constipation						
	Clinical criteria:						
	The condition must be inadequately controlled with first line interventions such as bulk-forming agents.						
	<u>Restricted benefit</u>						
	Faecal impaction						
	Clinical criteria:						
	The condition must be inadequately controlled with first line interventions such as bulk-forming agents.						
8612G NP	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	\$1	5	..	20.89	22.04 ^a	APO-MACROGOL plus ELECTROLYTES TX
						^a	LaxaCon GN
						^a	lax-sachets AE
						^a	Macrovic QA

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Molaxole	HM
							^a Movicol	NE
10126Y NP	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	2	5	..	*25.60	26.75	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

1263L NP	bisacodyl 10 mg/5 mL enema, 25 x 5 mL	†1	2	..	38.28	36.90	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

2091C NP	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	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

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	Terminal malignant neoplasia							
	<u>Restricted benefit</u>							
	Anorectal congenital abnormalities							
	<u>Restricted benefit</u>							
	Megacolon							
2556M NP	glycerol 1.4 g suppository, 12	3	5	..	*20.23	21.38	Petrus Pharmaceuticals Pty Ltd	PP
2557N NP	glycerol 2.8 g suppository, 12	3	5	..	*20.74	21.89	Petrus Pharmaceuticals Pty Ltd	PP
2555L NP	glycerol 700 mg suppository, 12	3	5	..	*19.81	20.96	Petrus Pharmaceuticals Pty Ltd	PP

ANTIDIARRHEALS, INTESTINAL ANTIINFLAMMATORY/ANTIINFECTIVE AGENTS

INTESTINAL ANTIINFECTIVES

Antibiotics

NYSTATIN

1699K NP	nystatin 500 000 international units capsule, 50	1	..	..	18.32	19.47	Nilstat	QA
3345C DP	nystatin 500 000 international units capsule, 50	1	..	..	18.32	19.47	Nilstat	QA
1696G NP	nystatin 500 000 international units tablet, 50	1	..	..	18.32	19.47	Nilstat	QA
3342X DP	nystatin 500 000 international units tablet, 50	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.

Note

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

10001J	rifaximin 550 mg tablet, 56	1	5	..	495.10	36.90	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.

3113W	vancomycin 125 mg capsule, 20	2	..	..	*232.60	36.90	Vancocin	AS
3114X	vancomycin 250 mg capsule, 20	2	..	..	*440.38	36.90	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.

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
3196F NP	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	\$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

2501P NP	diphenoxylate hydrochloride 2.5 mg + atropine sulfate 25 microgram tablet, 20	1	..	..	8.81	9.96	^a Lofenoxal	IA
				^b 1.73	10.54	9.96	^a Lomotil	IV

LOPERAMIDE

1571Q NP	loperamide hydrochloride 2 mg capsule, 12	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.

10034D NP	budesonide 2mg/application enema, 2 x 14 applications	1	3	..	211.65	36.90	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.

1502C NP	hydrocortisone acetate 10% (100 mg/g) enema, 21.1 g	2	3	..	*40.78	36.90	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.

1920C NP	prednisolone (as sodium phosphate) 20 mg/100 mL enema, 7 x 100 mL	4	3	..	*211.68	36.90	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.

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
2554K NP	prednisolone (as sodium phosphate) 5 mg suppository, 10	3	3	..	*42.04	36.90	Predsol	QA
Aminosalicylic acid and similar agents								
BALSALAZIDE								
<u>Authority required (STREAMLINED)</u>								
1708								
Ulcerative colitis where hypersensitivity to sulfonamides exists								
<u>Authority required (STREAMLINED)</u>								
1709								
Ulcerative colitis where intolerance to sulfasalazine exists								
<u>Note</u>								
Not for the treatment of Crohn disease.								
<u>Note</u>								
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.								
8845M NP	balsalazide sodium 750 mg capsule, 180	1	5	..	125.19	36.90	Colazide	PK
MESALAZINE								
<u>Authority required (STREAMLINED)</u>								
1708								
Ulcerative colitis where hypersensitivity to sulfonamides exists								
<u>Authority required (STREAMLINED)</u>								
1709								
Ulcerative colitis where intolerance to sulfasalazine exists								
<u>Note</u>								
Not for the treatment of Crohn disease.								
<u>Note</u>								
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.								
8599N NP	mesalazine 1 g granules: modified release, 100 x 1 g sachets	1	5	..	279.97	36.90	Salofalk	OA
9353G NP	mesalazine 1.2 g tablet: modified release, 60 tablets	1	5	..	221.33	36.90	Mezavant	ZI
9206M NP	mesalazine 1.5 g granules, 60 x 1.5 g sachets	1	5	..	245.26	36.90	Salofalk	OA
8598M NP	mesalazine 500 mg granules, 100 x 500 mg sachets	2	5	..	*297.78	36.90	Salofalk	OA
MESALAZINE								
<u>Authority required (STREAMLINED)</u>								
1708								
Ulcerative colitis where hypersensitivity to sulfonamides exists								
<u>Authority required (STREAMLINED)</u>								
1709								
Ulcerative colitis where intolerance to sulfasalazine exists								
<u>Authority required (STREAMLINED)</u>								
2268								
Crohn disease where hypersensitivity to sulfonamides exists								
<u>Authority required (STREAMLINED)</u>								
2269								
Crohn disease where intolerance to sulfasalazine exists								
<u>Note</u>								
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.								
2234N NP	mesalazine 1 g granules: modified release, 120 x 1 g sachets	1	5	..	331.01	36.90	Pentasa	FP
3413P	mesalazine 1 g tablet: modified release,	2	5	..	*331.02	36.90	Pentasa	FP

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
NP	60 tablets							
2287J	mesalazine 2 g granules: modified release, 60 x 2 g sachets	1	5	..	312.64	36.90	Pentasa	FP
NP								
1611T	mesalazine 250 mg tablet: enteric, 100 tablets	1	5	..	93.77	36.90	Mesasal	AS
NP								
8731M	mesalazine 500 mg tablet: enteric, 100 tablets	2	5	..	*297.78	36.90	Salofalk	OA
NP								
2214M	mesalazine 500 mg tablet: modified release, 100 tablets	2	5	..	*297.78	36.90	Pentasa	FP
NP								

MESALAZINE

Restricted benefit

Acute episode of mild to moderate ulcerative proctitis

Note

Not for the treatment of Crohn disease.

Note

No applications for increased maximum quantities and/or 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.

5461K	mesalazine 1 g suppository, 30	1	1	..	136.73	36.90	Salofalk	OA
NP								
8752P	mesalazine 1 g suppository, 30	1	1	..	136.73	36.90	Pentasa	FP
NP								

MESALAZINE

Authority required (STREAMLINED)

1707

Acute episode of mild to moderate ulcerative colitis

Note

Not for the treatment of Crohn disease.

Note

No applications for increased maximum quantities and/or 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.

8753Q	mesalazine 1 g/100 mL enema, 7 x 100 mL	4	1	..	*336.56	36.90	Pentasa	FP
NP								
8768L	mesalazine 1 g/application enema, 14 applications	4	1	..	*336.56	36.90	Salofalk	OA
NP								
8616L	mesalazine 2 g/60 mL enema, 7 x 60 mL	4	1	..	*336.56	36.90	Salofalk	OA
NP								
8617M	mesalazine 4 g/60 mL enema, 7 x 60 mL	4	1	..	*446.24	36.90	Salofalk	OA
NP								

OLSALAZINE

Authority required (STREAMLINED)

1708

Ulcerative colitis where hypersensitivity to sulfonamides exists

Authority required (STREAMLINED)

1709

Ulcerative colitis where intolerance to sulfasalazine exists

Note

Not for the treatment of Crohn disease.

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.

1728Y	olsalazine sodium 250 mg capsule, 100	1	5	..	61.75	36.90	Dipentum	IX
NP								
8086N	olsalazine sodium 500 mg tablet, 100	1	5	..	103.63	36.90	Dipentum	IX

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
NP							

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.

2096H NP	SULFASALAZINE Tablet 500 mg (enteric coated), 100	2	5	..	*54.60	36.90	^a Pyralin EN	FZ
				^b 2.48	*57.08	36.90	^a Salazopyrin-EN	PF
2093E NP	sulfasalazine 500 mg tablet, 100	2	5	..	*50.62	36.90	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 applications for increased maximum quantities and/or repeats will be authorised.

9209Q	SULFASALAZINE Tablet 500 mg (enteric coated), 100	2	11	..	*54.60	36.90	^a Pyralin EN	FZ
				^b 2.48	*57.08	36.90	^a Salazopyrin-EN	PF
9208P	sulfasalazine 500 mg tablet, 100	2	11	..	*50.62	36.90	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.

8020D NP	pancreatic extract 10 000 international units capsule: modified release, 100 capsules	5	10	..	*184.01	36.90	Creon 10,000	AB
8021E NP	pancreatic extract 25 000 international units capsule: modified release, 100 capsules	2	10	..	*148.08	36.90	Creon 25,000	AB
9412J NP	pancreatic extract 40 000 international units capsule: modified release, 100 capsules	2	10	..	*230.30	36.90	Creon 40,000	AB
5453B NP	pancreatic extract 5000 international units/100 mg granules: enteric-coated, 20 g	3	10	..	*142.12	36.90	Creon Micro	AB

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.

9226N	pancreatic extract 10 000 international units capsule: modified release, 100 capsules	5	21	..	*184.01	36.90	Creon 10,000	AB
9227P	pancreatic extract 25 000 international units capsule: modified release, 100 capsules	2	21	..	*148.08	36.90	Creon 25,000	AB
9413K	pancreatic extract 40 000 international units capsule: modified release, 100 capsules	2	21	..	*230.30	36.90	Creon 40,000	AB
5454C	pancreatic extract 5000 international units/100 mg granules: enteric-coated, 20 g	3	21	..	*142.12	36.90	Creon Micro	AB

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
8366H NP	pancrelipase 25 000 units capsule, 100	2	10	..	*138.24	36.90	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.								
9229R	pancrelipase 25 000 units capsule, 100	2	21	..	*138.24	36.90	Panzytrat 25000	TM

DRUGS USED IN DIABETES

INSULINS AND ANALOGUES

Insulins and analogues for injection, fast-acting

INSULIN ASPART								
8571D NP	insulin aspart 100 international units/mL injection, 1 x 10 mL vial	5	2	..	*159.61	36.90	NovoRapid	NO
8435Y NP	insulin aspart 100 international units/mL injection, 5 x 3 mL cartridges	5	1	..	*264.56	36.90	NovoRapid FlexPen	NF
							NovoRapid Penfill 3 mL	NO
INSULIN GLULISINE								
9224L NP	insulin glulisine 100 international units/mL injection, 1 x 10 mL vial	5	2	..	*159.61	36.90	Apidra	SW
1921D NP	insulin glulisine 100 international units/mL injection, 5 x 3 mL cartridges	5	1	..	*264.56	36.90	Apidra	AV
							Apidra SoloStar	SW
INSULIN LISPRO								
8084L NP	insulin lispro 100 international units/mL injection, 1 x 10 mL vial	5	2	..	*159.61	36.90	Humalog	LY
8212F NP	insulin lispro 100 international units/mL injection, 5 x 3 mL cartridges	5	1	..	*264.56	36.90	Humalog	LY
							Humalog KwikPen	KP
INSULIN NEUTRAL BOVINE								
Authority required								
Diabetes mellitus								
Clinical criteria:								
Patient must be intolerant to human insulin.								
1713E NP	insulin neutral bovine 100 international units/mL injection, 1 x 10 mL vial	5	2	..	*401.06	36.90	Hypurin Neutral	AS
INSULIN NEUTRAL HUMAN								
1531N NP	insulin neutral human 100 international units/mL injection, 1 x 10 mL vial	5	2	..	*134.16	36.90	Actrapid	NO
1762R NP	insulin neutral human 100 international units/mL injection, 5 x 3 mL cartridges	5	1	..	*224.66	36.90	Humulin R	LY
							Actrapid Penfill 3 mL	NO
							Humulin R	LY

Insulins and analogues for injection, intermediate-acting

INSULIN ISOPHANE BOVINE

Authority required

Diabetes mellitus

Clinical criteria:

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	Patient must be intolerant to human insulin.							
1711C NP	insulin isophane bovine 100 international units/mL injection, 1 x 10 mL vial	5	2	..	*401.06	36.90	Hypurin Isophane	AS
	INSULIN ISOPHANE HUMAN							
1533Q NP	insulin isophane human 100 international units/mL injection, 1 x 10 mL vial	5	2	..	*134.16	36.90	Humulin NPH	LY
1761Q NP	insulin isophane human 100 international units/mL injection, 5 x 3 mL cartridges	5	1	..	*224.66	36.90	Protophane Humulin NPH	NO LY
							Protophane InnoLet	NI
							Protophane Penfill 3 mL	NO
Insulins and analogues for injection, intermediate-acting combined with fast-acting								
	INSULIN ASPART + INSULIN ASPART PROTAMINE							
8609D NP	insulin aspart 30 international units/mL + insulin aspart protamine 70 international units/mL injection, 5 x 3 mL syringes	5	1	..	*264.56	36.90	NovoMix 30 FlexPen	NF
							NovoMix 30 Penfill 3 mL	NO
	INSULIN ISOPHANE HUMAN + INSULIN NEUTRAL HUMAN							
1763T NP	insulin isophane human 70 international units/mL + insulin neutral human 30 international units/mL injection, 5 x 3 mL cartridges	5	1	..	*224.66	36.90	Humulin 30/70	LY
							Mixtard 30/70 InnoLet	NI
							Mixtard 30/70 Penfill 3 mL	NO
1426C NP	insulin neutral human 30 international units/mL + insulin isophane human 70 international units/mL injection, 1 x 10 mL vial	5	2	..	*134.16	36.90	Humulin 30/70	LY
2062M NP	insulin neutral human 50 international units/mL + insulin isophane human 50 international units/mL injection, 5 x 3 mL cartridges	5	1	..	*224.66	36.90	Mixtard 50/50 Penfill 3 mL	NO
	INSULIN LISPRO + INSULIN LISPRO PROTAMINE							
8390N NP	insulin lispro 25 international units/mL + insulin lispro protamine 75 international units/mL injection, 5 x 3 mL cartridges	5	1	..	*264.56	36.90	Humalog Mix25	LY
							Humalog Mix25 KwikPen	KP
8874C NP	insulin lispro 50 international units/mL + insulin lispro protamine 50 international units/mL injection, 5 x 3 mL cartridges	5	1	..	*264.56	36.90	Humalog Mix50	LY
							Humalog Mix50 KwikPen	KP
Insulins and analogues for injection, long-acting								
	INSULIN DETEMIR							
	<u>Restricted benefit</u>							
	Type 1 diabetes							
9040T NP	insulin detemir 100 international units/mL injection, 5 x 3 mL cartridges	5	1	..	*433.06	36.90	Levemir FlexPen	NF
							Levemir Penfill	NO
	INSULIN GLARGINE							
9039R NP	insulin glargine 100 international units/mL injection, 5 x 3 mL cartridges	5	1	..	*433.06	36.90	Lantus	SW
							Lantus SoloStar	AV

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
BLOOD GLUCOSE LOWERING DRUGS, EXCL. INSULINS							
<i>Biguanides</i>							
METFORMIN							
8607B NP	metformin hydrochloride 1 g tablet, 90	1	5	..	13.57	14.72	^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 2.85	16.42	14.72	^a Diabex 1000 AL
3439B NP	metformin hydrochloride 1 g tablet: modified release, 60 tablets	1	5	..	13.02	14.17	^a Diaformin XR 1000 AF
				^b 2.85	15.87	14.17	^a Diabex XR 1000 AL
2430X NP	metformin hydrochloride 500 mg tablet, 100	1	5	..	10.67	11.82	^a APO-Metformin 500 TX
							^a Chem mart Metformin CH
							^a Diaformin AF
							^a Formet Aspen 500 AS
							^a GenRx Metformin GX
							^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
				^b 2.85	13.52	11.82	^a Diabex AL
9435N NP	metformin hydrochloride 500 mg tablet: modified release, 120 tablets	1	5	..	13.02	14.17	^a APO-Metformin XR 500 TX
							^a Chem mart Metformin XR 500 CH
							^a Diaformin XR AF
							^a Metex XR QA
							^a Terry White Chemists Metformin XR 500 TW
				^b 2.85	15.87	14.17	^a Diabex XR AL
1801T NP	metformin hydrochloride 850 mg tablet, 60	1	5	..	10.67	11.82	^a APO-Metformin 850 TX
							^a Chem mart Metformin CH
							^a Diaformin 850 AF
							^a Formet Aspen 850 AS
							^a GenRx Metformin GX
							^a Glucobete 850 DO
							^a Metformin 850 CR
							^a Metformin AN EA
							^a Metformin-GA GN
							^a Metformin generichealth GQ
							^a Metformin Ranbaxy RA
							^a Metformin Sandoz SZ

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Terry White Chemists Metformin	TW
				^B 0.64	11.31	11.82	^a Glucophage	MQ
				^B 2.85	13.52	11.82	^a Diabex 850	AL
Sulfonamides, urea derivatives								
GLIBENCLAMIDE								
Caution								
Sulfonylureas may cause hypoglycaemia, particularly in the elderly.								
2939Q NP	glibenclamide 5 mg tablet, 100	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.								
8535F NP	gliclazide 30 mg tablet: modified release, 100 tablets	1	5	..	13.69	14.84	^a APO-Gliclazide MR	TX
							^a Chem mart Gliclazide MR	CH
							^a Glyade MR	AF
							^a Oziclide MR	RA
							^a Terry White Chemists Gliclazide MR	TW
9302N NP	gliclazide 60 mg tablet: modified release, 60 tablets	1	5	..	15.09	16.24	^a ARDIX GLICLAZIDE 60mg MR	RX
				^B 1.94	17.03	16.24	^a Diamicron 60mg MR	SE
2449X NP	gliclazide 80 mg tablet, 100	1	5	..	13.50	14.65	^a Chem mart Gliclazide	CH
							^a GenRx Gliclazide	GX
							^a Glyade	AF
							^a Nidem	QA
							^a Terry White Chemists Gliclazide	TW
GLIMEPIRIDE								
Caution								
Sulfonylureas may cause hypoglycaemia, particularly in the elderly.								
8450R NP	glimepiride 1 mg tablet, 30	1	5	..	8.19	9.34	^a APO-Glimepiride	TX
							^a Aylide 1	AF
							^a Diapride 1	QA
							^a Dimirel	AV
							^a Glimepiride AN	EA
							^a Glimepiride GA 1	GN
							^a Glimepiride Sandoz	SZ
				^B 2.89	11.08	9.34	^a Amaryl	SW
8451T NP	glimepiride 2 mg tablet, 30	1	5	..	9.49	10.64	^a APO-Glimepiride	TX
							^a Aylide 2	AF
							^a Diapride 2	QA
							^a Dimirel	AV
							^a Glimepiride AN	EA
							^a Glimepiride GA 2	GN
							^a Glimepiride Sandoz	SZ
				^B 2.82	12.31	10.64	^a Amaryl	SW
8533D NP	glimepiride 3 mg tablet, 30	1	5	..	10.22	11.37	^a APO-Glimepiride	TX
							^a Aylide 3	AF
							^a Diapride 3	QA
							^a Dimirel	AV
							^a Glimepiride AN	EA
							^a Glimepiride GA 3	GN
							^a Glimepiride Sandoz	SZ
				^B 2.84	13.06	11.37	^a Amaryl	SW

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
8452W NP	glimepiride 4 mg tablet, 30	1	5	..	11.02	12.17	^a APO-Glimepiride	TX
							^a Aylide 4	AF
							^a Diapride 4	QA
							^a Dimirel	AV
							^a Glimepiride AN	EA
							^a Glimepiride GA 4	GN
							^a Glimepiride Sandoz	SZ
				^b 2.84	13.86	12.17	^a Amaryl	SW

GLIPIZIDE

Caution

Sulfonylureas may cause hypoglycaemia, particularly in the elderly.

2440K NP	glipizide 5 mg tablet, 100	1	5	..	12.61	13.76	^a Melizide	AF
				^b 4.51	17.12	13.76	^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.

10035E NP	alogliptin 12.5 mg + metformin hydrochloride 1 g tablet, 56	1	5	..	63.26	36.90	Nesina Met 12.5/1000	TK
10033C NP	alogliptin 12.5 mg + metformin hydrochloride 500 mg tablet, 56	1	5	..	61.30	36.90	Nesina Met 12.5/500	TK
10032B	alogliptin 12.5 mg + metformin	1	5	..	62.70	36.90	Nesina Met 12.5/850	TK

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
NP	hydrochloride 850 mg tablet, 56						

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.

10044P NP	linagliptin 2.5 mg + metformin hydrochloride 1 g tablet, 60	1	5	..	67.29	36.90	Trajentamet	BY
10038H NP	linagliptin 2.5 mg + metformin hydrochloride 500 mg tablet, 60	1	5	..	65.20	36.90	Trajentamet	BY
10045Q NP	linagliptin 2.5 mg + metformin hydrochloride 850 mg tablet, 60	1	5	..	66.69	36.90	Trajentamet	BY

METFORMIN + GLIBENCLAMIDE

Caution

Sulfonylureas may cause hypoglycaemia, particularly in the elderly.

8838E NP	metformin hydrochloride 250 mg + glibenclamide 1.25 mg tablet, 90	1	5	..	13.61	14.76	Glucovance 250mg/1.25mg	AL
8810Q NP	metformin hydrochloride 500 mg + glibenclamide 2.5 mg tablet, 90	1	5	..	14.48	15.63	Glucovance 500mg/2.5mg	AL
8811R NP	metformin hydrochloride 500 mg + glibenclamide 5 mg tablet, 90	1	5	..	15.60	16.75	Glucovance 500mg/5mg	AL

ROSIGLITAZONE + METFORMIN

Authority required

Diabetes mellitus type 2

Clinical criteria:

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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.						
9060W NP	rosiglitazone 2 mg + metformin hydrochloride 1 g tablet, 56	1	5	..	65.54	36.90	Avandamet GK
9059T NP	rosiglitazone 2 mg + metformin hydrochloride 500 mg tablet, 56	1	5	..	63.58	36.90	Avandamet GK
9062Y NP	rosiglitazone 4 mg + metformin hydrochloride 1 g tablet, 56	1	5	..	95.00	36.90	Avandamet GK
9061X NP	rosiglitazone 4 mg + metformin hydrochloride 500 mg tablet, 56	1	5	..	93.04	36.90	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

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

10048W NP	saxagliptin 2.5 mg + metformin hydrochloride 1 g tablet: modified release, 56	1	5	..	63.26	36.90	Kombiglyze XR 2.5/1000	AP
10051B NP	saxagliptin 5 mg + metformin hydrochloride 1 g tablet: modified release, 28	1	5	..	61.30	36.90	Kombiglyze XR 5/1000	AP
10055F NP	saxagliptin 5 mg + metformin hydrochloride 500 mg tablet: modified release, 28	1	5	..	60.25	36.90	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

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
combination with a thiazolidinedione (glitazone), a glucagon-like peptide-1 or an SGLT2 inhibitor.								
10089B NP	sitagliptin 100 mg + metformin hydrochloride 1 g tablet: modified release, 28	1	5	..	61.30	36.90	Janumet XR	MK
9451K NP	sitagliptin 50 mg + metformin hydrochloride 1 g tablet, 56	1	5	..	63.26	36.90	Janumet	MK
10090C NP	sitagliptin 50 mg + metformin hydrochloride 1 g tablet: modified release, 56	1	5	..	63.26	36.90	Janumet XR	MK
9449H NP	sitagliptin 50 mg + metformin hydrochloride 500 mg tablet, 56	1	5	..	61.30	36.90	Janumet	MK
9450J NP	sitagliptin 50 mg + metformin hydrochloride 850 mg tablet, 56	1	5	..	62.70	36.90	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.

5476F NP	vildagliptin 50 mg + metformin hydrochloride 1 g tablet, 60	1	5	..	64.21	36.90	Galvumet 50/1000	NV
5474D NP	vildagliptin 50 mg + metformin hydrochloride 500 mg tablet, 60	1	5	..	62.12	36.90	Galvumet 50/500	NV
5475E NP	vildagliptin 50 mg + metformin hydrochloride 850 mg tablet, 60	1	5	..	63.61	36.90	Galvumet 50/850	NV

Alpha glucosidase inhibitors

ACARBOSE

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
8189B NP	acarbose 100 mg tablet, 90	1	5	..	45.87	36.90	Glucobay 100	BN
8188Y NP	acarbose 50 mg tablet, 90	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:

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

- (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.

8694N NP	pioglitazone 15 mg tablet, 28	1	5	..	28.78	29.93	^a	Acpio 15	QA
							^a	Actos	TK
							^a	APOTEX-Pioglitazone	TX
							^a	Chem mart Pioglitazone	CH
							^a	Pharmacor Pioglitazone 15	CR
							^a	Pioglitazone AN	EA
							^a	Pioglitazone-GA	GN
							^a	Pioglitazone generichealth 15	GQ
							^a	Pioglitazone Sandoz	SZ
							^a	Pizaccord	RA
							^a	Prioten 15	DO
							^a	Terry White Chemists Pioglitazone	TW
							^a	Vexazone	AF
							^a	Acpio 30	QA
8695P NP	pioglitazone 30 mg tablet, 28	1	5	..	40.64	36.90	^a	Actos	TK
							^a	APOTEX-Pioglitazone	TX
							^a	Chem mart Pioglitazone	CH

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
8696Q NP	pioglitazone 45 mg tablet, 28	1	5	..	49.56	36.90	^a Pharmacor Pioglitazone 30 CR
							^a Pioglitazone AN EA
							^a Pioglitazone-GA GN
							^a Pioglitazone generichealth 30 GQ
							^a Pioglitazone Sandoz SZ
							^a Pizaccord RA
							^a Prioten 30 DO
							^a Terry White Chemists Pioglitazone TW
							^a Vexazone AF
							^a Acpio 45 QA
							^a Actos TK
							^a APOTEX-Pioglitazone TX
							^a Chem mart Pioglitazone CH
							^a Pharmacor Pioglitazone 45 CR
							^a Pioglitazone AN EA
							^a Pioglitazone-GA GN
							^a Pioglitazone generichealth 45 GQ
							^a Pioglitazone Sandoz SZ
							^a Pizaccord RA
							^a Prioten 45 DO
							^a Terry White Chemists Pioglitazone TW
							^a Vexazone AF

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.

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
8689H NP	rosiglitazone 4 mg tablet, 28	1	5	..	61.49	36.90	Avandia	GK
8690J NP	rosiglitazone 8 mg tablet, 28	1	5	..	90.94	36.90	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.

2933J NP	alogliptin 12.5 mg tablet, 28	1	5	..	59.20	36.90	Nesina	TK
2986E NP	alogliptin 25 mg tablet, 28	1	5	..	59.20	36.90	Nesina	TK
2944Y NP	alogliptin 6.25 mg tablet, 28	1	5	..	59.20	36.90	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

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
3387G NP	linagliptin 5 mg tablet, 30	1	5	..	62.95	36.90	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.

10128C NP	saxagliptin 2.5 mg tablet, 28	1	5	..	59.20	36.90	Onglyza	AP
8983T NP	saxagliptin 5 mg tablet, 28	1	5	..	59.20	36.90	Onglyza	AP

SITAGLIPTIN

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

9182G NP	sitagliptin 100 mg tablet, 28	1	5	..	59.20	36.90	Januvia	MK
9180E NP	sitagliptin 25 mg tablet, 28	1	5	..	59.20	36.90	Januvia	MK
9181F NP	sitagliptin 50 mg tablet, 28	1	5	..	59.20	36.90	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.

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
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.							
3415R NP	vildagliptin 50 mg tablet, 60	1	5	..	62.95	36.90	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.

Note

Canagliflozin 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.

2873F NP	canagliflozin 100 mg tablet, 30	1	5	..	96.61	36.90	Invokana	JC
2987F NP	canagliflozin 300 mg tablet, 30	1	5	..	96.61	36.90	Invokana	JC

DAPAGLIFLOZIN

Authority required (STREAMLINED)

4736

Diabetes mellitus type 2

Clinical criteria:

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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.						
	<u>Note</u> 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. <u>Note</u> Dapagliflozin 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.						
10011X NP	dapagliflozin 10 mg tablet, 28	1	5	..	58.66	36.90	Forxiga AP

EXENATIDE

Authority required (STREAMLINED)

4392

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.

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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)

4405

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.

Note

Special Pricing Arrangements apply.

3424F NP	exenatide 10 microgram/0.04 mL injection, 60 unit doses	1	5	..	131.65	36.90	Byetta 10 microgram	AP
3423E NP	exenatide 5 microgram/0.02 mL injection, 60 unit doses	1	5	..	122.79	36.90	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)

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	1166 Hypoparathyroidism <u>Authority required (STREAMLINED)</u>							
	1167 Hypophosphataemic rickets <u>Authority required (STREAMLINED)</u>							
	1467 Vitamin D-resistant rickets <u>Authority required (STREAMLINED)</u>							
	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							
2502Q NP	calcitriol 0.25 microgram capsule, 100	1	3	..	30.62	31.77	^a Calciprox ^a Calcitriol AN ^a Calcitriol-GA ^a Calcitriol Sandoz ^a GenRx Calcitriol ^a Kosteo ^a Rocaltrol ^a Sical	ER EA UA SZ GX QA RO 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

1070H NP	thiamine hydrochloride 100 mg tablet, 100	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.

3116B NP	CALCIUM Tablet (chewable) 500 mg (as carbonate), 60	4	1	..	*29.24	30.39	^a Cal-500	PP
							^a Cal-Sup	IA
3117C NP	CALCIUM Tablet 600 mg (as carbonate), 240	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.

2642C NP	potassium chloride 600 mg (8 mmol potassium) tablet: modified release, 100 tablets	2	1	..	*13.22	14.37	^a Duro-K	NM
				^b 2.94	*16.16	14.37	^a Slow-K	NV
1841X NP	potassium chloride 600 mg (8 mmol potassium) tablet: modified release,	1	1	..	13.21	14.36	^a Span-K	AS

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	200 tablets							
	POTASSIUM CHLORIDE + POTASSIUM BICARBONATE + POTASSIUM CARBONATE							
3012M NP	potassium chloride 595 mg + potassium bicarbonate 384 mg + potassium carbonate 152 mg (total potassium 14 mmol) tablet: effervescent, 60	1	1	..	15.48	16.63	Chlorvescent	AS
OTHER MINERAL SUPPLEMENTS								
<i>Magnesium</i>								
MAGNESIUM ASPARTATE DIHYDRATE								
<u>Authority required</u>								
Hypomagnesaemia in an Aboriginal or a Torres Strait Islander person								
<u>Authority required</u>								
Chronic renal disease in an Aboriginal or a Torres Strait Islander person								
5146W NP	magnesium aspartate dihydrate 500 mg (equivalent to 37.4 mg of magnesium) tablet, 50	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.

1671Y	nandrolone decanoate 50 mg/mL injection, 1 x 1 mL syringe	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

BETAINE

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.

10119N	betaine 1 g/g oral liquid: powder for, 180 g	1	5	..	570.55	36.90	Cystadane	EU

Various alimentary tract and metabolism products

SAPROPTERIN

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	<u>Authority required</u> 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. <u>Note</u> Patients will be eligible for a maximum of one script as initial therapy to enable their response to treatment with sapropterin to be assessed. If a 30% or greater reduction in blood phenylalanine levels is not achieved within one month, the patient is no longer eligible for PBS-subsidised treatment with sapropterin. <u>Note</u> 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							
10086W	sapropterin dihydrochloride 100 mg tablet: soluble, 30 tablets	6	..	..	*5306.74	36.90	Kuvan	SG
	SAPROPTERIN <u>Authority required</u> Hyperphenylalaninaemia Treatment Phase: Continuing Clinical criteria: Patient must have hyperphenylalaninaemia (HPA) due to tetrahydrobiopterin (BH4) deficiency, AND Patient must have demonstrated a 30% or greater reduction in blood phenylalanine levels in response to treatment with sapropterin; 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. <u>Note</u> 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							
10087X	sapropterin dihydrochloride 100 mg tablet: soluble, 30 tablets	6	5	..	*5306.74	36.90	Kuvan	SG

BLOOD AND BLOOD FORMING ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

2843P NP	warfarin sodium 1 mg tablet, 50	1	2	..	12.75	13.90	Coumadin	QA
							Marevan	FM
2209G NP	warfarin sodium 2 mg tablet, 50	1	2	..	13.11	14.26	Coumadin	QA
2844Q NP	warfarin sodium 3 mg tablet, 50	1	2	..	13.03	14.18	Marevan	FM
2211J NP	warfarin sodium 5 mg tablet, 50	1	2	..	14.37	15.52	Coumadin	QA
							Marevan	FM

Heparin group

DALTEPARIN SODIUM

Restricted benefit

Management of symptomatic venous thromboembolism in a patient with a solid tumour(s)

Note

No applications for increased maximum quantities will be authorised.

8959M NP	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	3	5	..	*415.09	36.90	Fragmin	PF
8960N NP	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	3	5	..	*493.93	36.90	Fragmin	PF
8957K NP	dalteparin sodium 10 000 anti-Xa international units/mL injection, 10 x 1 mL syringes	3	5	..	*255.40	36.90	Fragmin	PF
8958L NP	dalteparin sodium 12 500 anti-Xa international units/0.5 mL injection, 10 x 0.5 mL syringes	3	5	..	*350.05	36.90	Fragmin	PF
8956J NP	dalteparin sodium 7500 anti-Xa international units/0.75 mL injection, 10 x 0.75 mL syringes	3	5	..	*192.64	36.90	Fragmin	PF

DALTEPARIN SODIUM

Restricted benefit

Haemodialysis

1229Q NP	dalteparin sodium 10 000 anti-Xa international units/mL injection, 10 x 1 mL syringes	2	3	..	*175.90	36.90	Fragmin	PF
1296F NP	dalteparin sodium 12 500 anti-Xa international units/0.5 mL injection, 10 x 0.5 mL syringes	2	3	..	*241.62	36.90	Fragmin	PF
8641T NP	dalteparin sodium 2500 anti-Xa international units/0.2 mL injection, 10 x 0.2 mL syringes	2	3	..	*105.08	36.90	Fragmin	PF
8642W NP	dalteparin sodium 5000 anti-Xa international units/0.2 mL injection, 10 x 0.2 mL syringes	2	3	..	*109.22	36.90	Fragmin	PF
8643X NP	dalteparin sodium 7500 anti-Xa international units/0.75 mL injection, 10 x 0.75 mL syringes	2	3	..	*130.68	36.90	Fragmin	PF

BLOOD AND BLOOD FORMING ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
DALTEPARIN SODIUM								
8269F NP	dalteparin sodium 10 000 anti-Xa international units/mL injection, 10 x 1 mL syringes	1	1	..	91.33	36.90	Fragmin	PF
5445N NP	dalteparin sodium 12 500 anti-Xa international units/0.5 mL injection, 10 x 0.5 mL syringes	1	1	..	126.03	36.90	Fragmin	PF
8603T NP	dalteparin sodium 2500 anti-Xa international units/0.2 mL injection, 10 x 0.2 mL syringes	2	..	..	*105.08	36.90	Fragmin	PF
2816F NP	dalteparin sodium 5000 anti-Xa international units/0.2 mL injection, 10 x 0.2 mL syringes	2	..	..	*109.22	36.90	Fragmin	PF
8271H NP	dalteparin sodium 7500 anti-Xa international units/0.75 mL injection, 10 x 0.75 mL syringes	1	1	..	68.72	36.90	Fragmin	PF
ENOXAPARIN SODIUM								
<u>Restricted benefit</u>								
Haemodialysis								
5435C NP	enoxaparin sodium 100 mg/mL injection, 10 x 1 mL syringes	2	3	..	*211.42	36.90	Clexane	SW
8716R NP	enoxaparin sodium 20 mg/0.2 mL injection, 10 x 0.2 mL syringes	2	3	..	*105.08	36.90	Clexane	SW
9196B NP	enoxaparin sodium 40 mg/0.4 mL injection, 10 x 0.4 mL ampoules	2	3	..	*109.22	36.90	Clexane	SW
8639Q NP	enoxaparin sodium 40 mg/0.4 mL injection, 10 x 0.4 mL syringes	2	3	..	*109.22	36.90	Clexane	SW
8640R NP	enoxaparin sodium 60 mg/0.6 mL injection, 10 x 0.6 mL syringes	2	3	..	*153.28	36.90	Clexane	SW
5434B NP	enoxaparin sodium 80 mg/0.8 mL injection, 10 x 0.8 mL syringes	2	3	..	*175.32	36.90	Clexane	SW
ENOXAPARIN SODIUM								
8264Y NP	enoxaparin sodium 100 mg/mL injection, 10 x 1 mL syringes	1	1	..	109.42	36.90	Clexane	SW
8558K NP	enoxaparin sodium 20 mg/0.2 mL injection, 10 x 0.2 mL syringes	2	..	..	*105.08	36.90	Clexane	SW
9195Y NP	enoxaparin sodium 40 mg/0.4 mL injection, 10 x 0.4 mL ampoules	2	..	..	*109.22	36.90	Clexane	SW
8510X NP	enoxaparin sodium 40 mg/0.4 mL injection, 10 x 0.4 mL syringes	2	..	..	*109.22	36.90	Clexane	SW
8262W NP	enoxaparin sodium 60 mg/0.6 mL injection, 10 x 0.6 mL syringes	1	1	..	80.02	36.90	Clexane	SW
8263X NP	enoxaparin sodium 80 mg/0.8 mL injection, 10 x 0.8 mL syringes	1	1	..	91.04	36.90	Clexane	SW
HEPARIN SODIUM								
1076P NP	heparin sodium 35 000 international units/35 mL injection, 1 x 35 mL vial	12	5	..	*380.56	36.90	Hospira Pty Limited	HH
1466E NP	heparin sodium 5000 international units/0.2 mL injection, 5 x 0.2 mL ampoules	1	5	..	19.44	20.59	Hospira Pty Limited	HH
1463B NP	heparin sodium 5000 international units/5 mL injection, 50 x 5 mL ampoules	1	5	..	71.86	36.90	Pfizer Australia Pty Ltd	PF

Platelet aggregation inhibitors excl. heparin

ABCIXIMAB

Authority required (STREAMLINED)

1716

Patients undergoing percutaneous coronary balloon angioplasty

Authority required (STREAMLINED)

1717

Patients undergoing percutaneous coronary atherectomy

Authority required (STREAMLINED)

1718

BLOOD AND BLOOD FORMING ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
8048N	Patients undergoing percutaneous coronary stent placement abciximab 10 mg/5 mL injection, 1 x 5 mL vial	3	..	..	*1453.45	36.90	ReoPro	LY
8202Q NP	ASPIRIN aspirin 100 mg tablet, 112	1	1	..	8.21	9.36	^a Mayne Pharma Aspirin	YT
1010E NP	aspirin 300 mg tablet: effervescent, 96	1	1	^b 2.32	10.53	9.36	^a Spren 100	QA
				..	8.51	9.66	^a Astrix	YN
							Solprin	RC
CLOPIDOGREL								
<u>Authority required (STREAMLINED)</u>								
4166								
Acute coronary syndrome (myocardial infarction or unstable angina)								
Clinical criteria:								
The treatment must be in combination with aspirin.								
<u>Authority required (STREAMLINED)</u>								
4165								
Cardiac stent insertion								
Clinical criteria:								
The treatment must be in combination with aspirin,								
AND								
The treatment must follow insertion of a cardiac stent.								
<u>Note</u>								
Not for prophylaxis of deep vein thrombosis or peripheral arterial disease.								
<u>Note</u>								
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.								
<u>Note</u>								
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.								
2275R NP	clopidogrel 75 mg tablet, 28	1	5	..	19.33	20.48	^a Clopidogrel-GA	GN
9317J NP	clopidogrel 75 mg tablet, 28	1	5	..	19.33	20.48	^a Clovix 75	QA
							^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

BLOOD AND BLOOD FORMING ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	gastrointestinal bleeding						
	<u>Authority required (STREAMLINED)</u>						
	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						
	<u>Authority required (STREAMLINED)</u>						
	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						
	<u>Note</u>						
	Not for prophylaxis of DVT or peripheral arterial disease.						
	<u>Note</u>						
	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.						
	<u>Note</u>						
	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.						
5436D NP	clopidogrel 75 mg tablet, 28	1	5	..	19.33	20.48	^a Clopidogrel-DRLA RZ
8358X NP	clopidogrel 75 mg tablet, 28	1	5	..	19.33	20.48	^a APO-Clopidogrel TX
							^a Chem mart Clopidogrel CH
							^a Clopidogrel AN EA
							^a Clopidogrel RBX RA
							^a Clopidogrel Sandoz SZ
							^a Clopidogrel Winthrop WA
							^a Iscover AV
							^a Piax AF
							^a Plavacor 75 CR
							^a Plavix SW
							^a Terry White Chemists Clopidogrel TW

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.

Note

BLOOD AND BLOOD FORMING ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
	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.							
9354H NP	clopidogrel 75 mg tablet, 28	1	5	..	19.33	20.48	^a Clopidogrel Actavis	UA
							^a Clopidogrel-GA	GN
							^a Clopidogrel GH	GQ
							^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.

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.

9296G NP	clopidogrel 75 mg + aspirin 100 mg tablet, 30	1	5	..	55.09	36.90	^a APO- Clopidogrel/Aspirin 75/100	TX
							^a Chem mart Clopidogrel/Aspirin 75/100	CH
							^a Clopidogrel Winthrop plus aspirin	WA
							^a CoPlavix	SW
							^a DuoCover	AV
							^a DuoPlidogrel	GZ
							^a Terry White Chemists Clopidogrel/Aspirin 75/100	TW

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.

8335Q NP	dipyridamole 200 mg capsule: modified release, 60 capsules	1	5	..	37.30	36.90	Persantin SR	BY

DIPYRIDAMOLE + ASPIRIN

Restricted benefit

BLOOD AND BLOOD FORMING ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

8382E NP	dipyridamole 200 mg + aspirin 25 mg capsule: modified release, 60 capsules	1	5	..	32.61	33.76	^a APO-Dipyridamole/Aspirin 200/25	TX
							^a Asasantin SR	BY

EPTIFIBATIDE

Authority required (STREAMLINED)

1884

Patients undergoing non-urgent percutaneous intervention with intracoronary stenting

8683B	eptifibatide 20 mg/10 mL injection, 1 x 10 mL vial	2	..	..	*262.88	36.90	Integrilin	MK
8684C	eptifibatide 75 mg/100 mL injection, 1 x 100 mL vial	3	..	..	*1020.70	36.90	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.

9496T NP	prasugrel 10 mg tablet, 28	1	5	..	106.77	36.90	Effient	LY
9495R NP	prasugrel 5 mg tablet, 28	1	5	..	96.77	36.90	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.

1418P NP	TICAGRELOR Tablet 90 mg, 56	1	5	..	149.34	36.90	Brilinta	AP

TICLOPIDINE

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)

1260

Patients established on this drug as a pharmaceutical benefit prior to 1 November 1999

Caution

Severe neutropenia is common in the early months of therapy. Haematological monitoring should be undertaken at commencement and every two

BLOOD AND BLOOD FORMING ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	weeks in the first four months of 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.							
2095G NP	ticlopidine hydrochloride 250 mg tablet, 60	1	5	..	97.85	36.90	Tilodene	AF
	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.							
8350L NP	tirofiban 12.5 mg/50 mL injection, 1 x 50 mL vial	1	2	..	309.26	36.90	^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.

8253J NP	reteplase 10 units (17.4 mg) injection [2 x 10 units vials] (&) inert substance diluent [2 x 10 mL syringes], 1 pack	\$1	..	..	2067.30	36.90	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.

8527T NP	tenecteplase 10 000 international units (50 mg) injection [1 x 50 mg vial] (&) inert substance diluent [1 x 10 mL syringe], 1 pack	1	..	..	2057.40	36.90	Metalyse	BY
8526R NP	tenecteplase 8000 international units (40 mg) injection [1 x 40 mg vial] (&) inert substance diluent [1 x 8 mL syringe], 1 pack	1	..	..	1961.10	36.90	Metalyse	BY

Direct thrombin inhibitors

BIVALIRUDIN

Authority required (STREAMLINED)

3075

A patient undergoing percutaneous coronary intervention

8844L	bivalirudin 250 mg injection, 1 x 250 mg vial	1	..	..	672.09	36.90	Angiomax	XM

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.

BLOOD AND BLOOD FORMING ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
Treatment criteria:								
Patient must be undergoing total hip replacement.								
Note								
No increase in the maximum quantity or number of units may be authorised.								
Note								
No increase in the maximum number of repeats may be authorised.								
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.								
9319L NP	dabigatran etexilate 110 mg capsule, 10	2	1	..	*37.94	36.90	Pradaxa	BY
9318K NP	dabigatran etexilate 75 mg capsule, 10	2	1	..	*45.88	36.90	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.

Note

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

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.

9323Q NP	dabigatran etexilate 110 mg capsule, 10	2	..	..	*37.94	36.90	Pradaxa	BY
9322P NP	dabigatran etexilate 75 mg capsule, 10	2	..	..	*45.88	36.90	Pradaxa	BY

Direct factor Xa inhibitors

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.

Note

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

Note

BLOOD AND BLOOD FORMING ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
5500L NP	apixaban 2.5 mg tablet, 20	1	..	..	39.79	36.90	Eliquis	BQ
APIXABAN								
<u>Authority required (STREAMLINED)</u>								
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.								
<u>Authority required (STREAMLINED)</u>								
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.								
<u>Note</u>								
No increase in the maximum quantity or number of units may be authorised.								
<u>Note</u>								
No increase in the maximum number of repeats may be authorised.								
<u>Note</u>								
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.								
5054B NP	apixaban 2.5 mg tablet, 30	1	..	..	54.34	36.90	Eliquis	BQ
APIXABAN								
<u>Authority required (STREAMLINED)</u>								
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.								
<u>Note</u>								
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.								
<u>Note</u>								
No increase in the maximum quantity or number of units may be authorised.								
<u>Note</u>								
No increase in the maximum number of repeats may be authorised.								
<u>Note</u>								
Special Pricing Arrangements apply.								

BLOOD AND BLOOD FORMING ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
2744K NP	apixaban 2.5 mg tablet, 60	1	5	..	101.54	36.90	Eliquis	BQ
2735Y NP	apixaban 5 mg tablet, 60	1	5	..	101.53	36.90	Eliquis	BQ

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.

Note

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

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.

5061J NP	apixaban 2.5 mg tablet, 60	1	..	..	101.54	36.90	Eliquis	BQ

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.

Note

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

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.

9467G NP	RIVAROXABAN Tablet 10 mg, 30	1	..	..	101.14	36.90	Xarelto	BN
9466F NP	rivaroxaban 10 mg tablet, 15	1	1	..	54.16	36.90	Xarelto	BN

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.

Note

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

Note

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
9465E NP	rivaroxaban 10 mg tablet, 10	1	1	..	39.65	36.90	Xarelto	BN
RIVAROXABAN								
<u>Authority required (STREAMLINED)</u>								
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.								
<u>Note</u>								
No increase in the maximum quantity or number of units may be authorised.								
<u>Note</u>								
No increase in the maximum number of repeats may be authorised.								
<u>Note</u>								
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.								
9468H NP	rivaroxaban 10 mg tablet, 10	1	..	..	39.65	36.90	Xarelto	BN
RIVAROXABAN								
<u>Authority required (STREAMLINED)</u>								
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.								
<u>Note</u>								
No increase in the maximum quantity or number of units may be authorised.								
<u>Note</u>								
No increase in the maximum number of repeats may be authorised.								
<u>Note</u>								
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.								
9469J NP	rivaroxaban 10 mg tablet, 15	1	..	..	54.16	36.90	Xarelto	BN
RIVAROXABAN								
<u>Authority required (STREAMLINED)</u>								
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;								

BLOOD AND BLOOD FORMING ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

(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.

Note

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

Note

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

Note

Special Pricing Arrangements apply.

2691P NP	rivaroxaban 15 mg tablet, 28	1	5	..	94.85	36.90	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.

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.

Note

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

Note

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

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.

Note

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

Note

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

Note

Special Pricing Arrangements apply.

2160Q NP	rivaroxaban 15 mg tablet, 42	1	..	..	138.89	36.90	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,

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	AND						
	Patient must not have symptomatic pulmonary embolism.						
	<u>Note</u>						
	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.						
	<u>Note</u>						
	No increase in the maximum quantity or number of units may be authorised.						
	<u>Note</u>						
	No increase in the maximum number of repeats may be authorised.						
	<u>Authority required (STREAMLINED)</u>						
	4132						
	Prevention of recurrent venous thromboembolism						
	Treatment Phase: Continuing treatment						
	Clinical criteria:						
	Patient must have a history of venous thromboembolism.						
	<u>Note</u>						
	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.						
	<u>Note</u>						
	No increase in the maximum quantity or number of units may be authorised.						
	<u>Note</u>						
	No increase in the maximum number of repeats may be authorised.						
	<u>Authority required (STREAMLINED)</u>						
	4268						
	Pulmonary embolism						
	Treatment Phase: Continuing treatment						
	Clinical criteria:						
	Patient must have confirmed acute symptomatic pulmonary embolism.						
	<u>Note</u>						
	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.						
	<u>Note</u>						
	No increase in the maximum quantity or number of units may be authorised.						
	<u>Note</u>						
	No increase in the maximum number of repeats may be authorised.						
	<u>Note</u>						
	Special Pricing Arrangements apply.						
	<u>Authority required (STREAMLINED)</u>						
	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.						
	<u>Note</u>						

BLOOD AND BLOOD FORMING ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
Note								
No increase in the maximum quantity or number of units may be authorised.								
Note								
No increase in the maximum number of repeats may be authorised.								
Note								
Special Pricing Arrangements apply.								
2268J NP	rivaroxaban 20 mg tablet, 28	1	5	..	94.85	36.90	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.

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.

8775W NP	FONDAPARINUX SODIUM Injection 2.5 mg in 0.5 mL single dose pre-filled syringe, 2	3.5	..	..	*140.88	36.90	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.

2180R NP	tranexamic acid 500 mg tablet, 100	1	2	..	52.02	36.90	Cyklokapron	PF

ANTIANEMIC PREPARATIONS

IRON PREPARATIONS

Iron bivalent, oral preparations

FERROUS FUMARATE

8985X NP	ferrous fumarate 200 mg (equivalent to 65.7 mg of elemental iron) tablet, 60	1	1	..	11.96	13.11	Ferro-tab	AE

FERROUS SULFATE

8815Y NP	ferrous sulfate 30 mg/mL (equivalent to 6 mg/mL elemental iron) oral liquid, 250 mL	1	2	..	19.69	20.84	Ferro-Liquid	AE

Iron trivalent, parenteral preparations

IRON

10104T NP	iron (as ferric carboxymaltose) 500 mg/10 mL injection, 1 x 10 mL vial	2	1	..	*317.22	36.90	ferinject	VL

IRON POLYMALTOSE

2593L	iron (as polymaltose) 100 mg/2 mL	1	..	..	31.88	33.03 ^a	Ferrosig	SI

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
NP	injection, 5 x 2 mL ampoules						^a Ferrum H	AS
IRON POLYMALTOSE								
<u>Authority required (STREAMLINED)</u>								
4302								
Iron deficiency anaemia								
Treatment criteria:								
Patient must be undergoing chronic haemodialysis.								
2805P	iron (as polymaltose) 100 mg/2 mL	1	5	..	31.88	33.03	^a Ferrosig	SI
NP	injection, 5 x 2 mL ampoules						^a Ferrum H	AS
IRON SUCROSE								
<u>Authority required (STREAMLINED)</u>								
4292								
Iron deficiency anaemia								
Clinical criteria:								
The treatment must be in combination with an erythropoiesis stimulating agent,								
AND								
Patient must have had a documented hypersensitivity reaction to iron polymaltose,								
AND								
Patient must be a person in whom continued intravenous iron therapy is appropriate.								
Treatment criteria:								
Patient must be undergoing chronic haemodialysis.								
8807M	iron (as sucrose) 100 mg/5 mL injection,	1	5	..	139.82	36.90	Venofer	AS
NP	5 x 5 mL ampoules							
<i>Iron in combination with folic acid</i>								
FERROUS FUMARATE + FOLIC ACID								
9011G	ferrous fumarate 310 mg (equivalent to	1	1	..	13.13	14.28	Ferro-f-tab	AE
NP	100 mg elemental iron) + folic acid							
350 microgram tablet, 60								
VITAMIN B12 AND FOLIC ACID								
<i>Vitamin B12 (cyanocobalamin and analogues)</i>								
HYDROXOCOBALAMIN								
<u>Restricted benefit</u>								
Pernicious anaemia								
<u>Restricted benefit</u>								
Proven vitamin B12 deficiencies other than pernicious anaemia								
<u>Restricted benefit</u>								
Anaemias associated with vitamin B12 deficiency								
Clinical criteria:								
Patient must have had a gastrectomy,								
AND								
The treatment must be for prophylaxis.								
<u>Note</u>								
One injection of hydroxocobalamin 1 mg every three months provides appropriate maintenance therapy in vitamin B12 deficiencies.								
<u>Note</u>								
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.								
2162T	hydroxocobalamin 1 mg/mL injection, 3	1	..	..	12.25	13.40	^a Vita-B12	GH
NP	x 1 mL ampoules							
9048F	hydroxocobalamin 1 mg/mL injection, 3	1	..	..	12.25	13.40	^a Hydroxo-B12	AS
NP	x 1 mL ampoules						^a Neo-B12	HH

BLOOD AND BLOOD FORMING ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	Note The 5 mg strength tablet should be used in malabsorption states only.							
1437P NP	folic acid 5 mg tablet, 100	2	1	..	*14.36	15.51	Megafof 5	AF
	FOLIC ACID							
2958Q NP	folic acid 500 microgram tablet, 100	2	..	..	*11.68	12.83	^a Foltabs 500	PP
							^a Megafof 0.5	AF

BLOOD SUBSTITUTES AND PERFUSION SOLUTIONS

BLOOD AND RELATED PRODUCTS

Blood substitutes and plasma protein fractions

	GELATIN-SUCCINYLATED							
8444K NP	gelatin-succinylated 20 g/500 mL injection, 1 x 500 mL bag	3	..	..	*46.09	36.90	Gelofusine	BR
	PENTASTARCH + SODIUM CHLORIDE							
9487H NP	HYDROXYETHYL STARCH 130/0.4 I.V. infusion 30 g per 500 mL, 500 mL, 1	3	..	..	*46.09	36.90	Voluven 6%	PK

I.V. SOLUTIONS

Solutions for parenteral nutrition

	GLUCOSE							
2245E NP	glucose 5% (50 g/1000 mL) injection, 1 x 1000 mL bag	5	1	..	*17.11	18.26	Baxter Healthcare Pty Ltd	BX
5106R DP	glucose 5% (50 g/1000 mL) injection, 1 x 1000 mL bag	5	..	..	*17.11	18.26	Baxter Healthcare Pty Ltd	BX

Solutions affecting the electrolyte balance

	LACTATE + SODIUM CHLORIDE + POTASSIUM CHLORIDE + CALCIUM CHLORIDE DIHYDRATE							
2286H NP	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	5	1	..	*14.66	15.81	Baxter Healthcare Pty Ltd	BX
	SODIUM CHLORIDE							
2264E NP	sodium chloride 0.9% (9 g/1000 mL) injection, 1 x 1000 mL bag	5	1	..	*15.21	16.36	Baxter Healthcare Pty Ltd	BX
5212H DP	sodium chloride 0.9% (9 g/1000 mL) injection, 1 x 1000 mL bag	5	..	..	*15.21	16.36	Baxter Healthcare Pty Ltd	BX
2260Y NP	sodium chloride 3% (30 g/1000 mL) injection, 1 x 1000 mL bag	2	1	..	*11.88	13.03	Baxter Healthcare Pty Ltd	BX
5213J DP	sodium chloride 3% (30 g/1000 mL) injection, 1 x 1000 mL bag	2	..	..	*11.88	13.03	Baxter Healthcare Pty Ltd	BX
	SODIUM CHLORIDE + GLUCOSE							
2281C NP	sodium chloride 0.18% (1.8 g/1000 mL) + glucose 4% (40 g/1000 mL) injection, 1 x 1000 mL bag	5	1	..	*23.86	25.01	Baxter Healthcare Pty Ltd	BX
5214K DP	sodium chloride 0.18% (1.8 g/1000 mL) + glucose 4% (40 g/1000 mL) injection, 1 x 1000 mL bag	5	..	..	*23.86	25.01	Baxter Healthcare Pty Ltd	BX
2279Y NP	sodium chloride 0.225% (1.125 g/500 mL) + glucose 3.75% (18.75 g/500 mL) injection, 1 x 500 mL bag	5	1	..	*29.11	30.26	Baxter Healthcare Pty Ltd	BX
5215L DP	sodium chloride 0.225% (1.125 g/500 mL) + glucose 3.75% (18.75 g/500 mL) injection, 1 x 500 mL bag	5	..	..	*29.11	30.26	Baxter Healthcare Pty Ltd	BX
2278X NP	sodium chloride 0.45% (2.25 g/500 mL) + glucose 2.5% (12.5 g/500 mL) injection, 1 x 500 mL bag	5	1	..	*29.11	30.26	Baxter Healthcare Pty Ltd	BX
5216M DP	sodium chloride 0.45% (2.25 g/500 mL) + glucose 2.5% (12.5 g/500 mL) injection, 1 x 500 mL bag	5	..	..	*29.11	30.26	Baxter Healthcare Pty Ltd	BX

BLOOD AND BLOOD FORMING ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
SODIUM CHLORIDE + POTASSIUM CHLORIDE + CALCIUM CHLORIDE DIHYDRATE								
2266G NP	sodium chloride 8.6 g/1000 mL + potassium chloride 300 mg/1000 mL + calcium chloride dihydrate 330 mg/1000 mL injection, 1 x 1000 mL bag	4	1	..	*30.36	31.51	Baxter Healthcare Pty Ltd	BX
SODIUM GLUCONATE + SODIUM CHLORIDE + POTASSIUM CHLORIDE + MAGNESIUM CHLORIDE + SODIUM ACETATE TRIHYDRATE + GLUCOSE								
3199J NP	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	2	1	..	*22.30	23.45	Plasma-Lyte 148	BX

OTHER HEMATOLOGICAL AGENTS

OTHER HEMATOLOGICAL AGENTS

Drugs used in hereditary angioedema

ICATIBANT

Authority required

Initial supply for anticipated emergency treatment of an acute attack of hereditary angioedema in a patient with confirmed diagnosis of C1-esterase inhibitor deficiency who has been assessed to be at significant risk of an acute attack of hereditary angioedema by or in consultation with a clinical immunologist, respiratory physician, specialist allergist or 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 name of the Approved Pathology Authority and date of the diagnosing pathology test must be included in the authority application

Authority required

Continuing supply for anticipated emergency treatment of an acute attack of hereditary angioedema, where the patient has 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)

1976B	ICATIBANT Injection 30 mg (as acetate) in 3 mL single use pre-filled syringe, 1	1	1	..	2571.70	36.90	Firazyr	ZI

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

1322N NP	digoxin 250 microgram tablet, 100	1	1	..	11.05	12.20	^a Sigmaxin	FM
				^b 2.94	13.99	12.20	^a Lanoxin	QA
3164M NP	digoxin 50 microgram/mL oral liquid, 60 mL	2	3	..	*41.46	36.90	Lanoxin	QA
2605D NP	digoxin 62.5 microgram tablet, 200	1	1	..	10.76	11.91	^a Sigmaxin-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.

2923W NP	disopyramide 100 mg capsule, 100	1	5	..	29.47	30.62	Rythmodan	SW
2924X NP	disopyramide 150 mg capsule, 100	1	5	..	46.85	36.90	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.

2875H NP	lignocaine hydrochloride anhydrous 2% (100 mg/5 mL) injection, 5 x 5 mL ampoules	1	..	..	37.67	36.90	Pfizer Australia Pty Ltd	PF
2876J NP	lignocaine hydrochloride anhydrous 500 mg/5 mL injection, 10 x 5 mL ampoules	1	..	..	29.93	31.08	Xylocard 500	AP

LIGNOCAINE

5142P DP	lignocaine hydrochloride anhydrous 2% (100 mg/5 mL) injection, 5 x 5 mL ampoules	1	..	..	37.67	36.90	Pfizer Australia Pty Ltd	PF

Antiarrhythmics, class Ic

FLECAINIDE

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)

Caution

Flecainide acetate should be avoided in patients with poor cardiac function.

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

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.								
1090J NP	flecainide acetate 100 mg tablet, 60	1	5	..	45.03	36.90	^a Flecatab	AF
1088G NP	flecainide acetate 50 mg tablet, 60	1	5	..	38.07	36.90	^a Tambocor	IA
							Tambocor	IA

Antiarrhythmics, class III

AMIODARONE

Restricted benefit

Severe cardiac arrhythmias

Caution

Amiodarone hydrochloride has been reported to cause frequent and potentially serious toxicity.

Regular monitoring of hepatic and thyroid function is recommended.

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.

2344J NP	amiodarone hydrochloride 100 mg tablet, 30	1	5	..	12.42	13.57	^a Aratac 100	AF
2343H NP	amiodarone hydrochloride 200 mg tablet, 30	1	5	..	16.83	17.98	^a Cordarone X 100	SW
							^a Amiodarone Sandoz	SZ
							^a Aratac 200	AF
							^a Chem mart Amiodarone	CH
							^a Cordarone X 200	SW
							^a GenRx Amiodarone	GX
							^a Rithmik 200	QA
							^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.

2043M NP	sotalol hydrochloride 160 mg tablet, 60	1	5	..	16.98	18.13	^a APO-Sotalol	TX
							^a Cardol	AF
							^a Chem mart Sotalol	CH
							^a GenRx Sotalol	GX
							^a Solavert	QA
							^a Sotalol Sandoz	SZ
							^a Terry White Chemists Sotalol	TW
8398B NP	sotalol hydrochloride 80 mg tablet, 60	1	5	^b 3.76	20.74	18.13	^a Sotacor	FM
				..	11.52	12.67	^a APO-Sotalol	TX
							^a GenRx Sotalol	GX
							^a Solavert	QA
							^a Sotalol Sandoz	SZ
				^b 3.75	15.27	12.67	^a Sotacor	FM

CARDIAC STIMULANTS EXCL. CARDIAC GLYCOSIDES

Adrenergic and dopaminergic agents

ADRENALINE

1016L NP	adrenaline 1 in 1000 (1 mg/mL) injection, 5 x 1 mL ampoules	1	1	..	20.68	21.83	Link Medical Products Pty Ltd	LM
5004J DP	adrenaline 1 in 1000 (1 mg/mL) injection, 5 x 1 mL ampoules	1	..	..	20.68	21.83	Link Medical Products Pty Ltd	LM

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

ADRENALINE

Authority required

Initial sole PBS-subsidised supply for anticipated emergency treatment of acute allergic reactions with anaphylaxis in a patient who has been assessed to be at significant risk of anaphylaxis by, or in consultation with, a clinical immunologist, allergist, paediatrician or respiratory physician. The name of the specialist consulted must be provided at the time of application for initial supply

Authority required

Initial sole PBS-subsidised supply for anticipated emergency treatment of acute allergic reactions with anaphylaxis in a patient who has been discharged from hospital or an emergency department after treatment with adrenaline for acute allergic reaction with anaphylaxis

Authority required

Continuing sole PBS-subsidised supply for anticipated emergency treatment of acute allergic reactions with anaphylaxis, where the patient has previously been issued with an authority prescription for this drug

Caution

EpiPen and Anapen products have different administration techniques and should not be prescribed to the same patient without training in their use.

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.)

Note

Authority approvals will be limited to a maximum quantity of 2 auto-injectors (Anapen or EpiPen) at any one time.

No repeats will be issued.

3408J NP	adrenaline 150 microgram/0.3 mL injection, 1 x 0.3 mL syringe	1	..	..	106.34	36.90	Anapen Junior	LM
8697R NP	adrenaline 150 microgram/0.3 mL injection, 1 x 0.3 mL syringe	1	..	..	106.34	36.90	EpiPen Jr.	AL
3409K NP	adrenaline 300 microgram/0.3 mL injection, 1 x 0.3 mL syringe	1	..	..	106.34	36.90	Anapen	LM
8698T NP	adrenaline 300 microgram/0.3 mL injection, 1 x 0.3 mL syringe	1	..	..	106.34	36.90	EpiPen	AL

VASODILATORS USED IN CARDIAC DISEASES

Organic nitrates

GLYCERYL TRINITRATE

1516T NP	glyceryl trinitrate 10 mg/24 hours patch, 30	1	5	..	31.22	32.37	Transiderm-Nitro 50	NV
8011P NP	glyceryl trinitrate 10 mg/24 hours patch, 30	1	5	..	31.22	32.37	Nitro-Dur 10	MK
8028M NP	glyceryl trinitrate 10 mg/24 hours patch, 30	1	5	..	31.22	32.37	Minitran 10	IA
8026K NP	glyceryl trinitrate 15 mg/24 hours patch, 30	1	5	..	31.22	32.37	Nitro-Dur 15	MK
8119H NP	glyceryl trinitrate 15 mg/24 hours patch, 30	1	5	..	31.22	32.37	Minitran 15	IA
1515R NP	glyceryl trinitrate 5 mg/24 hours patch, 30	1	5	..	25.41	26.56	Transiderm-Nitro 25	NV
8010N NP	glyceryl trinitrate 5 mg/24 hours patch, 30	1	5	..	25.41	26.56	Nitro-Dur 5	MK
8027L NP	glyceryl trinitrate 5 mg/24 hours patch, 30	1	5	..	25.41	26.56	Minitran 5	IA
1459T NP	glyceryl trinitrate 600 microgram tablet: sublingual, 100 tablets	1	5	..	15.17	16.32	^a Lycinate	FM
				^b 2.94	18.11	16.32	^a Anginine Stabilised	QA
5108W DP	glyceryl trinitrate 600 microgram tablet: sublingual, 100 tablets	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.

8171C NP	glyceryl trinitrate 400 microgram/actuation spray, 200 actuations	1	5	..	20.47	21.62	Nitrolingual Pumpspray	SW

ISOSORBIDE DINITRATE

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
2588F NP	isosorbide dinitrate 5 mg tablet: sublingual, 100	2	2	..	*14.90	16.05	Isordil Sublingual	QA
ISOSORBIDE MONONITRATE								
8273K NP	isosorbide mononitrate 120 mg tablet: modified release, 30 tablets	1	5	..	17.24	18.39	^a Monodur 120 mg	PM
1558B NP	isosorbide mononitrate 60 mg tablet: modified release, 30 tablets	1	5	..	^b 3.37 20.61	18.39	^a Imdur 120 mg	AP
					11.19	12.34	^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 2.47	13.66	12.34	^a Monodur 60 mg	PM
				^b 3.37	14.56	12.34	^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.

8228C NP	nicorandil 10 mg tablet, 60	£1	5	..	25.90	27.05	Ikorel	SW
8229D NP	nicorandil 20 mg tablet, 60	£1	5	..	33.42	34.57	Ikorel	SW

PERHEXILINE

Authority required (STREAMLINED)

1023

Angina not responding to other therapy

Caution

Regular monitoring of drug serum levels is recommended.

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.

1822X NP	perhexiline maleate 100 mg tablet, 100	1	5	..	62.96	36.90	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.

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
10012Y NP	ivabradine 5 mg tablet, 56	1	5	..	56.44	36.90	Coralan	SE
2960T NP	ivabradine 7.5 mg tablet, 56	1	5	..	56.44	36.90	Coralan	SE

ANTIHYPERTENSIVES

ANTIADRENERGIC AGENTS, CENTRALLY ACTING

Methyldopa

METHYLDOPA

1629R NP	methyldopa 250 mg tablet, 100	1	5	..	16.88	18.03	^a Hydopa	AF
				^b 3.54	20.42	18.03	^a Aldomet	AS

Imidazoline receptor agonists

CLONIDINE

3145M NP	clonidine hydrochloride 100 microgram tablet, 100	1	5	..	29.22	30.37	Catapres 100	BY
3141H NP	clonidine hydrochloride 150 microgram tablet, 100	1	5	..	37.78	36.90	Catapres	BY

MOXONIDINE

Restricted benefit

Hypertension in patients receiving concurrent antihypertensive therapy

9019Q NP	moxonidine 200 microgram tablet, 30	1	5	..	19.87	21.02	Physiotens	AB
9020R NP	moxonidine 400 microgram tablet, 30	1	5	..	29.12	30.27	Physiotens	AB

ANTIADRENERGIC AGENTS, PERIPHERALLY ACTING

Alpha-adrenoreceptor antagonists

PRazosin

1479W NP	prazosin 1 mg tablet, 100	1	5	..	11.00	12.15	^a APO-Prazosin	TX
							^a Chem mart Prazosin	CH
							^a Minipress	PF
							^a Terry White Chemists Prazosin	TW
1480X NP	prazosin 2 mg tablet, 100	1	5	..	13.52	14.67	^a APO-Prazosin	TX
							^a Chem mart Prazosin	CH
							^a Minipress	PF
							^a Terry White Chemists Prazosin	TW
1478T NP	prazosin 5 mg tablet, 100	1	5	..	18.90	20.05	^a APO-Prazosin	TX
							^a Chem mart Prazosin	CH
							^a Minipress	PF
							^a Terry White Chemists Prazosin	TW

ARTERIOLAR SMOOTH MUSCLE, AGENTS ACTING ON

Hydrazinophthalazine derivatives

HYDRALAZINE

1640H NP	hydralazine hydrochloride 25 mg tablet, 100	2	2	..	*17.64	18.79	Alphapress 25	AF
1639G NP	hydralazine hydrochloride 50 mg tablet, 100	2	2	..	*19.36	20.51	Alphapress 50	AF

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

Pyrimidine derivatives

MINOXIDIL

Authority required (STREAMLINED)

2759

Severe refractory hypertension. 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.

2313R NP	minoxidil 10 mg tablet, 100	1	5	..	60.61	36.90	Loniten	PF

DIURETICS

LOW-CEILING DIURETICS, THIAZIDES

Thiazides, plain

HYDROCHLOROTHIAZIDE

1484D NP	hydrochlorothiazide 25 mg tablet, 100	1	1	..	21.58	22.73	Dithiazide	PL

LOW-CEILING DIURETICS, EXCL. THIAZIDES

Sulfonamides, plain

CHLORTHALIDONE

1585K NP	chlorthalidone 25 mg tablet, 50	2	1	..	*17.92	19.07	Hygroton 25	LM

INDAPAMIDE

8532C NP	indapamide hemihydrate 1.5 mg tablet: modified release, 90 tablets	1	1	..	19.64	20.79	^a APO-Indapamide SR	TX
							^a Chem mart Indapamide SR	CH
							^a Natrilix SR	SE
							^a Tenaxil SR	QA
							^a Terry White Chemists Indapamide SR	TW
2436F NP	indapamide hemihydrate 2.5 mg tablet, 90	1	1	..	15.59	16.74	^a Chem mart Indapamide	CH
							^a Dapa-Tabs	AF
							^a GenRx Indapamide	GX
							^a Indapamide AN	EA
							^a Indapamide-GA	GN
							^a Indapamide Sandoz	SZ
							^a Insig	QA
							^a Terry White Chemists Indapamide	TW
				^B 4.11	19.70	16.74	^a Natrilix	SE

HIGH-CEILING DIURETICS

Sulfonamides, plain

FRUSEMIDE

2411X NP	frusemide 10 mg/mL oral liquid, 30 mL	#1	3	..	25.18	26.33	Lasix	SW
2413B NP	frusemide 20 mg/2 mL injection, 5 x 2 mL ampoules	1	..	..	8.63	9.78	^a Frusemide-Clarix	AE
							^a Frusemide Sandoz	SZ
							^a Lasix	SW
2412Y NP	frusemide 40 mg tablet, 100	1	1	..	8.36	9.51	^a APO-Frusemide	TX
							^a Chem mart Frusemide	CH
							^a Frusax	ER
							^a Frusemide AN	EA
							^a Frusemide Sandoz	SZ
							^a Frusid	UA

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a GenRx Frusemide	GX
							^a Terry White Chemists Frusemide	TW
							^a Uremide	AF
				^b 2.41	10.77	9.51	^a Urex	FM
							^a Lasix	SW
2415D NP	frusemide 500 mg tablet, 50	1	3	..	15.07	16.22	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.								
2414C NP	frusemide 20 mg tablet, 100	1	1	..	8.52	9.67	^a APO-Frusemide	TX
							^a Chem mart Frusemide	CH
							^a Frusemide AN	EA
							^a Frusid	GN
							^a GenRx Frusemide	GX
							^a Terry White Chemists Frusemide	TW
1810G NP	frusemide 20 mg tablet, 50	2	1	..	*8.50	9.65	^a Urex-M	FM
				^b 1.94	*10.44	9.65	^a Lasix-M	SW

Aryloxyacetic acid derivatives

ETHACRYNIC ACID

Restricted benefit

Patients hypersensitive to other oral diuretics

8748K NP	ethacrynic acid 25 mg tablet, 100	2	1	..	*197.64	36.90	Edecrin	FK

POTASSIUM-SPARING AGENTS

Aldosterone antagonists

EPLERENONE

Authority required (STREAMLINED)

2637

Heart failure with a left ventricular ejection fraction of 40% or less occurring within 3 to 14 days following an acute myocardial infarction. Treatment with eplerenone must be commenced within 14 days of an acute myocardial infarction.

The date of the acute myocardial infarction and the date of initiation of eplerenone treatment must be documented in the patient's medical records when PBS-subsidised treatment is initiated

Caution

Serum electrolytes should be checked regularly.

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.

8879H NP	eplerenone 25 mg tablet, 30	1	5	..	113.11	36.90	Inspira	PF
8880J NP	eplerenone 50 mg tablet, 30	1	5	..	113.11	36.90	Inspira	PF

SPIRONOLACTONE

Caution

Serum electrolytes should be checked regularly.

Caution

Appropriate contraceptive measures should be taken by women of child-bearing age in whom spironolactone therapy has been initiated.

2340E NP	spironolactone 100 mg tablet, 100	1	5	..	29.46	30.61	^a Spiractin 100	AF
				^b 3.16	32.62	30.61	^a Aldactone	PF
2339D NP	spironolactone 25 mg tablet, 100	1	5	..	12.53	13.68	^a Spiractin 25	AF
				^b 2.59	15.12	13.68	^a Aldactone	PF

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

DIURETICS AND POTASSIUM-SPARING AGENTS IN COMBINATION

Low-ceiling diuretics and potassium-sparing agents

HYDROCHLOROTHIAZIDE + AMILORIDE

Caution

Serum electrolytes should be checked regularly.

1486F NP	hydrochlorothiazide 50 mg + amiloride hydrochloride 5 mg tablet, 50	2	1	..	*13.84	14.99	Moduretic	AS

HYDROCHLOROTHIAZIDE + TRIAMTERENE

Caution

Serum electrolytes should be checked regularly.

1280J NP	hydrochlorothiazide 25 mg + triamterene 50 mg tablet, 100	1	1	..	13.23	14.38	Hydrene 25/50	AF

PERIPHERAL VASODILATORS

PERIPHERAL VASODILATORS

Other peripheral vasodilators

PHENOXYBENZAMINE

Restricted benefit

Phaeochromocytoma

Restricted benefit

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.

1862B NP	phenoxybenzamine hydrochloride 10 mg capsule, 100	1	5	..	67.71	36.90	Dibenyline	GH
9286R NP	phenoxybenzamine hydrochloride 10 mg capsule, 100	1	5	..	1164.81	36.90	Dibenzyliline	BZ
1166J NP	phenoxybenzamine hydrochloride 10 mg capsule, 30	3	5	..	*205.24	36.90	Dibenyline	GH

BETA BLOCKING AGENTS

BETA BLOCKING AGENTS

Beta blocking agents, non-selective

OXPRENOLOL

2961W NP	oxprenolol hydrochloride 40 mg tablet, 100	1	5	..	48.58	36.90	Corbeton 40	AF

PINDOLOL

3065H NP	pindolol 15 mg tablet, 50	1	5	..	16.26	17.41	Visken 15	NV
3062E NP	pindolol 5 mg tablet, 100	1	5	..	30.77	31.92	Barbloc 5	AF

PROPRANOLOL

2565B NP	propranolol hydrochloride 10 mg tablet, 100	1	5	..	10.53	11.68	Deralin 10	AF
				^B 3.75	14.28	11.68	Inderal	AP
2899N NP	propranolol hydrochloride 160 mg tablet, 50	1	5	..	12.80	13.95	Deralin 160	AF
2566C NP	propranolol hydrochloride 40 mg tablet, 100	1	5	..	10.90	12.05	Deralin 40	AF
				^B 3.75	14.65	12.05	Inderal	AP

Beta blocking agents, selective

ATENOLOL

1081X NP	atenolol 50 mg tablet, 30	1	5	..	8.39	9.54	^a APO-Atenolol	TX
						^a	Atenolol AN	EA

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Atenolol-GA	GN
							^a Atenolol GH	GQ
							^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 2.44	10.83	9.54	^a Tenormin	AP
ATENOLOL								
<u>Restricted benefit</u>								
For a patient who is unable to take a solid dose form of atenolol.								
2243C NP	atenolol 50 mg/10 mL oral liquid, 300 mL	1	5	..	27.78	28.93	Atenolol-AFT	AE
BISOPROLOL								
<u>Authority required (STREAMLINED)</u>								
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								
<u>Note</u>								
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.								
8606Y NP	bisoprolol fumarate 10 mg tablet, 28	1	5	..	38.75	36.90	^a APO-Bisoprolol	TX
							^a Beprol 10	DO
							^a Bicard 10	QA
							^a Biso 10	GN
							^a Bisoprolol AN	EA
							^a Bisoprolol GH	GQ
							^a Bisoprolol Sandoz	SZ
							^a Bispro 10	AF
							^a Chem mart Bisoprolol	CH
							^a Terry White Chemists Bisoprolol	TW
				^b 3.00	41.75	36.90	^a Bicor	AL
8604W NP	bisoprolol fumarate 2.5 mg tablet, 28	1	5	..	27.24	28.39	^a APO-Bisoprolol	TX
							^a Beprol 2.5	DO
							^a Bicard 2.5	QA
							^a Biso 2.5	GN
							^a Bisoprolol AN	EA
							^a Bisoprolol GH	GQ
							^a Bisoprolol Sandoz	SZ
							^a Bispro 2.5	AF
							^a Chem mart Bisoprolol	CH
							^a Terry White Chemists Bisoprolol	TW
				^b 3.00	30.24	28.39	^a Bicor	AL
8605X NP	bisoprolol fumarate 5 mg tablet, 28	1	5	..	32.35	33.50	^a APO-Bisoprolol	TX
							^a Beprol 5	DO
							^a Bicard 5	QA
							^a Biso 5	GN
							^a Bisoprolol AN	EA
							^a Bisoprolol GH	GQ
							^a Bisoprolol Sandoz	SZ
							^a Bispro 5	AF
							^a Chem mart Bisoprolol	CH
							^a Terry White Chemists Bisoprolol	TW

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
				^b 3.00	35.35	33.50	^a Bicor	AL
METOPROLOL SUCCINATE								
<u>Authority required (STREAMLINED)</u>								
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								
<u>Note</u>								
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.								
8735R NP	METOPROLOL SUCCINATE Tablet 190 mg (controlled release), 30	1	5	..	93.43	36.90	^a Metrol-XL 190	QA
							^a Minax XL	AF
							^a Toprol-XL 190	AP
8732N NP	METOPROLOL SUCCINATE Tablet 23.75 mg (controlled release), 15	1	..	..	19.04	20.19	^a Metrol-XL 23.75	QA
							^a Minax XL	AF
							^a Toprol-XL 23.75	AP
8733P NP	METOPROLOL SUCCINATE Tablet 47.5 mg (controlled release), 30	1	5	..	62.24	36.90	^a Metrol-XL 47.5	QA
							^a Minax XL	AF
							^a Toprol-XL 47.5	AP
8734Q NP	METOPROLOL SUCCINATE Tablet 95 mg (controlled release), 30	1	5	..	76.09	36.90	^a Metrol-XL 95	QA
							^a Minax XL	AF
							^a Toprol-XL 95	AP
METOPROLOL TARTRATE								
1325R NP	METOPROLOL TARTRATE Tablet 100 mg, 60	1	5	..	10.23	11.38	^b Chem mart Metoprolol	CH
							^b GenRx Metoprolol	GX
							^b Metoprolol Sandoz	SZ
							^b Metrol 100	QA
							^b Minax 100	AF
							^b Terry White Chemists Metoprolol	TW
							^a Metatar	FM
							^a Metoprolol Actavis	GN
							^a Metoprolol AN	EA
							^a Mistrom	ER
				^b 2.00	12.23	11.38	^a Lopresor 100	NV
				^b 3.76	13.99	11.38	^b Betaloc	AP
1324Q NP	METOPROLOL TARTRATE Tablet 50 mg, 100	1	5	..	9.49	10.64	^b Chem mart Metoprolol	CH
							^b GenRx Metoprolol	GX
							^b Metoprolol Sandoz	SZ
							^b Metrol 50	QA
							^b Minax 50	AF
							^b Terry White Chemists Metoprolol	TW
							^a Metatar	FM
							^a Metoprolol Actavis	GN
							^a Metoprolol AN	EA
							^a Mistrom	ER
				^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

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
9316H NP	nebivolol 1.25 mg tablet, 28	2	5	..	*50.96	36.90	Nebilet	FK
9312D NP	nebivolol 10 mg tablet, 28	1	5	..	68.36	36.90	Nebilet	FK
9311C NP	nebivolol 5 mg tablet, 28	1	5	..	61.28	36.90	Nebilet	FK
Alpha and beta blocking agents								
CARVEDILOL								
<u>Authority required (STREAMLINED)</u>								
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								
<u>Authority required (STREAMLINED)</u>								
1735								
Patients receiving this drug as a pharmaceutical benefit prior to 1 August 2002								
<u>Note</u>								
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.								
8257N NP	carvedilol 12.5 mg tablet, 28	1	5	..	29.50	30.65	^a APO-Carvedilol	TX
							^a Carvedilol AN	EA
							^a Carvedilol generichealth	GQ
							^a Carvedilol Sandoz	SZ
							^a Chem mart Carvedilol 12.5 mg	CH
							^a Dicarz	AF
							^a Dilatrend 12.5	RO
							^a GN-Carvedilol	GN
							^a Terry White Chemists Carvedilol 12.5 mg	TW
							^a Vedilol 12.5	QA
							^a Volirop 12.5	DO
8258P NP	carvedilol 25 mg tablet, 60	1	5	..	35.19	36.34	^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
8255L NP	carvedilol 3.125 mg tablet, 30	1	..	..	10.60	11.75	^a APO-Carvedilol	TX
							^a Carvedilol AN	EA
							^a Chem mart Carvedilol 3.125 mg	CH
							^a Dilatrend 3.125	RO
							^a GN-Carvedilol	GN
							^a Terry White Chemists Carvedilol 3.125 mg	TW
							^a Vedilol 3.125	QA
							^a Volirop 3.125	DO
8256M	carvedilol 6.25 mg tablet, 60	1	5	..	24.95	26.10	^a APO-Carvedilol	TX

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
NP								
							^a Carvedilol AN	EA
							^a Carvedilol generichealth	GQ
							^a Carvedilol Sandoz	SZ
							^a Chem mart Carvedilol 6.25 mg	CH
							^a Dicarz	AF
							^a Dilatrend 6.25	RO
							^a GN-Carvedilol	GN
							^a Terry White Chemists Carvedilol 6.25 mg	TW
							^a Vedilol 6.25	QA
							^a Volirop 6.25	DO
	LABETALOL							
1566K	labetalol hydrochloride 100 mg tablet, 100	1	5	..	15.62	16.77	^a Presolol 100	AF
NP				^B 3.13	18.75	16.77	^a Trandate	QA
1567L	labetalol hydrochloride 200 mg tablet, 100	1	5	..	21.34	22.49	^a Presolol 200	AF
NP				^B 3.14	24.48	22.49	^a Trandate	QA

CALCIUM CHANNEL BLOCKERS

SELECTIVE CALCIUM CHANNEL BLOCKERS WITH MAINLY VASCULAR EFFECTS

Dihydropyridine derivatives

AMLODIPINE

Note

Pharmaceutical benefits that have the form amlodipine tablet 10 mg (as besylate) and pharmaceutical benefits that have the form amlodipine tablet 10 mg (as maleate) are equivalent for the purposes of substitution.

2752W	amlodipine 10 mg tablet, 30	1	5	..	9.90	11.05	^a Amllo 10	QA
NP							^a Amlodipine-DRLA	RZ
							^a Amlodipine generichealth	GQ
							^a Amlodipine Sandoz	SZ
							^a APO-Amlodipine	TX
							^a Auro-Amlodipine 10	DO
							^a Chem mart Amlodipine	CH
							^a Nordip	AF
							^a Norvapine	GN
							^a Ozlodip	RA
							^a Terry White Chemists Amlodipine	TW
				^B 8.19	18.09	11.05	^a Norvasc	PF

AMLODIPINE

Note

Pharmaceutical benefits that have the form amlodipine tablet 5 mg (as besylate) and pharmaceutical benefits that have the form amlodipine tablet 5 mg (as maleate) are equivalent for the purposes of substitution.

2751T	amlodipine 5 mg tablet, 30	1	5	..	8.55	9.70	^a Amllo 5	QA
NP							^a Amlodipine-DRLA	RZ
							^a Amlodipine generichealth	GQ
							^a Amlodipine Sandoz	SZ
							^a APO-Amlodipine	TX
							^a Auro-Amlodipine 5	DO
							^a Chem mart Amlodipine	CH
							^a Nordip	AF
							^a Norvapine	GN
							^a Ozlodip	RA
							^a Terry White Chemists Amlodipine	TW

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
				^B 5.54	14.09	9.70	^a Norvasc	PF
FELODIPINE								
2367N NP	felodipine 10 mg tablet: modified release, 30 tablets	1	5	..	17.83	18.98	^a Felodil XR 10	QA
							^a Felodur ER 10 mg	TX
							^a Fendex ER	AF
				^B 3.18	21.01	18.98	^a Plendil ER	GX
2361G NP	felodipine 2.5 mg tablet: modified release, 30 tablets	1	5	..	11.02	12.17	^a Felodur ER 2.5 mg	TX
							^a Fendex ER	AF
				^B 3.16	14.18	12.17	^a Plendil ER	GX
2366M NP	felodipine 5 mg tablet: modified release, 30 tablets	1	5	..	12.88	14.03	^a Felodil XR 5	QA
							^a Felodur ER 5 mg	TX
							^a Fendex ER	AF
				^B 3.15	16.03	14.03	^a Plendil ER	GX
LERCANIDIPINE								
8534E NP	lercanidipine hydrochloride 10 mg tablet, 28	1	5	..	10.35	11.50	^a APO-Lercanidipine	TX
							^a Chem mart Lercanidipine	CH
							^a Ledip	RA
							^a Lercadip	GN
							^a Lercan	QA
							^a Lercanidipine AN	EA
							^a Lercanidipine GH	GQ
							^a Lercanidipine Sandoz	SZ
							^a Terry White Chemists Lercanidipine	TW
							^a Zircol	AF
				^B 3.49	13.84	11.50	^a Zandip	AB
8679T NP	lercanidipine hydrochloride 20 mg tablet, 28	1	5	..	12.74	13.89	^a APO-Lercanidipine	TX
							^a Chem mart Lercanidipine	CH
							^a Ledip	RA
							^a Lercadip	GN
							^a Lercan	QA
							^a Lercanidipine AN	EA
							^a Lercanidipine GH	GQ
							^a Lercanidipine Sandoz	SZ
							^a Terry White Chemists Lercanidipine	TW
							^a Zircol	AF
				^B 3.50	16.24	13.89	^a Zandip	AB
NIFEDIPINE								
1694E NP	nifedipine 10 mg tablet, 60	1	5	..	13.19	14.34	^a Adefin 10	AF
				^B 0.84	14.03	14.34	^a Adalat 10	BN
1695F NP	nifedipine 20 mg tablet, 60	1	5	..	14.67	15.82	^a Adefin 20	AF
							^a GenRx Nifedipine	GX
							^a Nifehexal	SZ
				^B 1.57	16.24	15.82	^a Adalat 20	BN
8610E NP	nifedipine 20 mg tablet: modified release, 30 tablets	1	5	..	14.98	16.13	Adalat Oros 20mg	BN
1906H NP	nifedipine 30 mg tablet: modified release, 30 tablets	1	5	..	15.65	16.80	^a Addos XR 30	QA
							^a Adefin XL 30	AF
							^a APO-Nifedipine XR	TX
				^B 1.82	17.47	16.80	^a Adalat Oros 30	BN
1907J NP	nifedipine 60 mg tablet: modified release, 30 tablets	1	5	..	17.93	19.08	^a Addos XR 60	QA

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Adefin XL 60	AF
				^B 1.99	19.92	19.08	^a APO-Nifedipine XR	TX
							^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.

2206D NP	verapamil hydrochloride 160 mg capsule: modified release, 30 capsules	1	5	..	12.49	13.64	Veracaps SR	QA
2208F NP	verapamil hydrochloride 180 mg tablet: modified release, 30 tablets	1	5	..	13.69	14.84	^a Cordilox 180 SR	KN
				^B 3.50	17.19	14.84	^a Isoptin 180 SR	AB
2207E NP	verapamil hydrochloride 240 mg capsule: modified release, 30 capsules	1	5	..	16.09	17.24	Veracaps SR	QA
1241H NP	verapamil hydrochloride 240 mg tablet: modified release, 30 tablets	1	5	..	16.01	17.16	^a Cordilox SR	KN
				^B 3.50	19.51	17.16	^a Isoptin SR	AB
1248Q NP	verapamil hydrochloride 40 mg tablet, 100	1	5	..	12.36	13.51	Anpec 40	AF
1250T NP	verapamil hydrochloride 80 mg tablet, 100	1	5	..	15.35	16.50	^a Anpec 80	AF
				^B 3.49	18.84	16.50	^a Isoptin	AB

Benzothiazepine derivatives

DILTIAZEM

Caution

The myocardial depressant effects of this drug and of beta-blocking drugs are additive.

1312C NP	diltiazem hydrochloride 180 mg capsule: modified release, 30 capsules	1	5	..	15.41	16.56	^a Cardizem CD	SW
							^a Chem mart Diltiazem CD	CH
							^a Diltiazem Sandoz CD	SZ
							^a GenRx Diltiazem CD	GX
							^a Terry White Chemists Diltiazem CD	TW
							^a Vasocardol CD	AV
1313D NP	diltiazem hydrochloride 240 mg capsule: modified release, 30 capsules	1	5	..	18.44	19.59	^a Cardizem CD	SW
							^a Chem mart Diltiazem CD	CH
							^a Diltiazem Sandoz CD	SZ
							^a GenRx Diltiazem CD	GX
							^a Terry White Chemists Diltiazem CD	TW
							^a Vasocardol CD	AV
8480H NP	diltiazem hydrochloride 360 mg capsule: modified release, 30 capsules	1	5	..	22.08	23.23	^a Cardizem CD	SW
							^a Diltiazem Sandoz CD	SZ
							^a Vasocardol CD	AV
1335G NP	diltiazem hydrochloride 60 mg tablet, 90	1	5	..	14.56	15.71	^a Cardizem	SW
							^a Diltiazem Actavis	UA
							^a Diltiazem AN	EA
							^a Diltiazem Sandoz	SZ
							^a Dilzem 60 mg	GN
							^a Vasocardol	AV

AGENTS ACTING ON THE RENIN-ANGIOTENSIN SYSTEM

ACE INHIBITORS, PLAIN

ACE inhibitors, plain

CAPTOPRIL

Caution

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.								
1147J NP	captopril 12.5 mg tablet, 90	1	5	..	12.07	13.22	^a APO-Captopril	TX
							^a Captopril Sandoz	SZ
							^a GenRx Captopril	GX
							^a Zedace	AF
1148K NP	captopril 25 mg tablet, 90	1	5	..	14.45	15.60	^a APO-Captopril	TX
							^a Captopril Sandoz	SZ
							^a GenRx Captopril	GX
							^a Zedace	AF
				^B 4.47	18.92	15.60	^a Capoten	QA
1149L NP	captopril 50 mg tablet, 90	1	5	..	21.93	23.08	^a APO-Captopril	TX
							^a Captopril Sandoz	SZ
							^a GenRx Captopril	GX
							^a Zedace	AF
				^B 3.46	25.39	23.08	^a Capoten	QA
CAPTOPRIL								
<u>Restricted benefit</u>								
For patients unable to take a solid dose form of an ACE inhibitor								
<u>Caution</u>								
Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.								
8760C NP	captopril 5 mg/mL oral liquid, 95 mL	#1	5	..	112.16	36.90	Capoten	QA
ENALAPRIL								
<u>Caution</u>								
Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.								
1368B NP	enalapril maleate 10 mg tablet, 30	1	5	..	12.05	13.20	^a Acetec	AL
							^a APO-Enalapril	TX
							^a Auspril	QA
							^a Chem mart Enalapril	CH
							^a Enalapril Actavis	UA
							^a Enalapril AN	EA
							^a Enalapril-GA	GN
							^a Enalapril generichealth	GQ
							^a Enalapril Sandoz	SZ
							^a GenRx Enalapril	GX
							^a Malean	FM
							^a Terry White Chemists Enalapril	TW
				^B 4.65	16.70	13.20	^a Renitec	MK
1369C NP	enalapril maleate 20 mg tablet, 30	1	5	..	13.50	14.65	^a Acetec	AL
							^a APO-Enalapril	TX
							^a Auspril	QA
							^a Chem mart Enalapril	CH
							^a Enalapril Actavis	UA
							^a Enalapril AN	EA
							^a Enalapril-GA	GN
							^a Enalapril generichealth	GQ
							^a Enalapril Sandoz	SZ
							^a GenRx Enalapril	GX
							^a Malean	FM
							^a Terry White Chemists Enalapril	TW
				^B 4.65	18.15	14.65	^a Renitec 20	MK
1370D NP	enalapril maleate 5 mg tablet, 30	1	5	..	9.98	11.13	^a Acetec	AL
							^a APO-Enalapril	TX
							^a Auspril	QA

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Chem mart Enalapril	CH
							^a Enalapril Actavis	UA
							^a Enalapril AN	EA
							^a Enalapril-GA	GN
							^a Enalapril generichealth	GQ
							^a Enalapril Sandoz	SZ
							^a GenRx Enalapril	GX
							^a Malean	FM
							^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.								
1182F NP	fosinopril sodium 10 mg tablet, 30	1	5	..	13.74	14.89	^a APO-Fosinopril	TX
							^a Fosipril 10	QA
							^a GenRx Fosinopril	GX
							^a Monace 10	AF
							^a Monopril	BQ
1183G NP	fosinopril sodium 20 mg tablet, 30	1	5	..	17.21	18.36	^a APO-Fosinopril	TX
							^a Fosipril 20	QA
							^a GenRx Fosinopril	GX
							^a Monace 20	AF
							^a Monopril	BQ
LISINOPRIL								
Caution								
Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.								
2457H NP	lisinopril 10 mg tablet, 30	1	5	..	12.42	13.57	^a APO-Lisinopril	TX
							^a Auro-Lisinopril 10	DO
							^a Chem mart Lisinopril	CH
							^a Fibsol 10	QA
							^a Lisinopril AN	EA
							^a Lisinopril-DRLA	RZ
							^a Lisinopril-GA	GN
							^a Lisinopril generichealth	GQ
							^a Lisinopril Sandoz	SZ
							^a Terry White Chemists Lisinopril	TW
				^B 3.28	15.70	13.57	^a Zinopril 10	AL
				^B 3.75	16.17	13.57	^a Zestril	AP
				..	13.90	15.05	^a Prinivil 10	MK
2458J NP	lisinopril 20 mg tablet, 30	1	5	..	13.90	15.05	^a APO-Lisinopril	TX
							^a Auro-Lisinopril 20	DO
							^a Chem mart Lisinopril	CH
							^a Fibsol 20	QA
							^a Lisinopril AN	EA
							^a Lisinopril-DRLA	RZ
							^a Lisinopril-GA	GN
							^a Lisinopril generichealth	GQ
							^a Lisinopril Sandoz	SZ
							^a Terry White Chemists Lisinopril	TW
				^B 3.31	17.21	15.05	^a Zinopril 20	AL
				^B 3.75	17.65	15.05	^a Zestril	AP
				..	10.54	11.69	^a Prinivil 20	MK
2456G NP	lisinopril 5 mg tablet, 30	1	5	..	10.54	11.69	^a APO-Lisinopril	TX
							^a Auro-Lisinopril 5	DO
							^a Chem mart Lisinopril	CH

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Fibsol 5	QA
							^a Lisinopril AN	EA
							^a Lisinopril-DRLA	RZ
							^a Lisinopril-GA	GN
							^a Lisinopril generichealth	GQ
							^a Lisinopril Sandoz	SZ
							^a Terry White Chemists	TW
							Lisinopril	
				^b 3.29	13.83	11.69	^a Zinopril 5	AL
							^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 8 mg and pharmaceutical benefits that have the form perindopril arginine tablet 10 mg are equivalent for the purposes of substitution.

9008D NP	perindopril arginine 10 mg tablet, 30	1	5	..	16.45	17.60	^a Coversyl 10mg	SE
							^a PREXUM 10	RX
8704D NP	perindopril erbumine 8 mg tablet, 30	1	5	..	16.45	17.60	^a APO-Perindopril	TX
							^a Chem mart Perindopril	CH
							^a Idaprex 8	SZ
							^a Indopril 8	QA
							^a Indosyl Mono 8	FM
							^a Ozapace	RA
							^a Perindo	AF
							^a Perindopril Actavis 8	UA
							^a Perindopril CH	EA
							^a Perindopril generichealth	GQ
							^a Terry White Chemists	TW
							Perindopril	

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.

9006B NP	perindopril arginine 2.5 mg tablet, 30	1	5	^b 1.95	12.10	11.30	^a Coversyl 2.5mg	SE
							^a PREXUM 2.5	RX
3050M NP	perindopril erbumine 2 mg tablet, 30	1	5	..	10.15	11.30	^a APO-Perindopril	TX
							^a Chem mart Perindopril	CH
							^a Idaprex 2	SZ
							^a Indopril 2	QA
							^a Indosyl Mono 2	FM
							^a Ozapace	RA
							^a Perindo	AF
							^a Perindopril Actavis 2	UA
							^a Terry White Chemists	TW
							Perindopril	

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.

9007C NP	perindopril arginine 5 mg tablet, 30	1	5	..	13.10	14.25	^a Coversyl 5mg	SE

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
3051N NP	perindopril erbumine 4 mg tablet, 30	1	5	..	13.10	14.25	^a PREXUM 5	RX
							^a APO-Perindopril	TX
							^a Chem mart Perindopril	CH
							^a Idaprex 4	SZ
							^a Indopril 4	QA
							^a Indosyl Mono 4	FM
							^a Ozapace	RA
							^a Perindo	AF
							^a Perindopril Actavis 4	UA
							^a Perindopril CH	EA
							^a Perindopril generichealth	GQ
							^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.								
1969P NP	quinapril 10 mg tablet, 30	1	5	..	12.54	13.69	^a Acquin Aspen 10	AS
							^a APO-Quinapril	TX
							^a Aquinafil	GN
							^a Qpril 10	AF
1970Q NP	quinapril 20 mg tablet, 30	1	5	^B 1.47	14.01	13.69	^a Accupril	PF
				..	13.90	15.05	^a Acquin Aspen 20	AS
							^a APO-Quinapril	TX
							^a Aquinafil	GN
							^a Qpril 20	AF
							^a Quinapril-GA	UA
1968N NP	quinapril 5 mg tablet, 30	1	5	^B 1.46	15.36	15.05	^a Quinapril generichealth	GQ
				..	10.81	11.96	^a Accupril	PF
							^a Acquin Aspen 5	AS
							^a APO-Quinapril	TX
							^a Aquinafil	GN
							^a Qpril 5	AF
							^B 1.45	12.26
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.								
9120B NP	ramipril 1.25 mg capsule, 30	1	5	..	8.55	9.70	^a APO-Ramipril	TX
							^a Chem mart Ramipril	CH
							^a Ramipril-GA	GN
							^a Terry White Chemists Ramipril	TW
1944H NP	ramipril 1.25 mg tablet, 30	1	5	..	8.55	9.70	^a Tryzan Caps 1.25	AF
							^a APO-Ramipril	TX
							^a Chem mart Ramipril	CH
							^a Ramace 1.25 mg	AV
							^a Ramipril AN	EA
							^a Ramipril Sandoz	SZ
							^a Ramipril Winthrop	WA
							^a Terry White Chemists Ramipril	TW
							^a Tritace 1.25 mg	SW
							^a Tryzan Tabs 1.25	AF
							^a Vascalace 1.25	DO

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
RAMIPRIL							
<u>Caution</u>							
Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.							
<u>Note</u>							
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.							
8470T NP	ramipril 10 mg capsule, 30	1	5	..	12.56	13.71	a APO-Ramipril TX a Chem mart Ramipril CH a GenRx Ramipril GX a Pharmacor Ramipril 10 CR a Prilace 10 QA a Ramace 10 mg AV a Ramipril CH EA a Ramipril-GA GN a Ramipril generichealth GQ a Ramipril Sandoz SZ a Ramipril Winthrop WA a Terry White Chemists Ramipril TW a Tritace 10 mg SW a Tryzan Caps 10 AF
1316G NP	ramipril 10 mg tablet, 30	1	5	..	12.56	13.71	a APO-Ramipril TX a Chem mart Ramipril CH a Ramipril AN EA a Ramipril RBX Tabs RA a Ramipril Sandoz SZ a Terry White Chemists Ramipril TW a Tritace SW a Tryzan Tabs 10 AF a Vascalace 10 DO
RAMIPRIL							
<u>Caution</u>							
Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.							
<u>Note</u>							
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.							
9121C NP	ramipril 2.5 mg capsule, 30	1	5	..	9.38	10.53	a APO-Ramipril TX a Chem mart Ramipril CH a Ramipril-GA GN a Ramipril generichealth GQ a Terry White Chemists Ramipril TW a Tryzan Caps 2.5 AF
1945J NP	ramipril 2.5 mg tablet, 30	1	5	..	9.38	10.53	a APO-Ramipril TX a Chem mart Ramipril CH a Prilace 2.5 QA a Ramace 2.5 mg AV a Ramipril AN EA a Ramipril RBX Tabs RA a Ramipril Sandoz SZ a Ramipril Winthrop WA a Terry White Chemists Ramipril TW a Tritace 2.5 mg SW a Tryzan Tabs 2.5 AF a Vascalace 2.5 DO

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
RAMIPRIL								
Caution								
Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.								
8668F NP	ramipril 2.5 mg tablet [7 tablets] (& ramipril 5 mg tablet [21 tablets] (& ramipril 10 mg capsule [10 capsules], 1 pack	#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 5 mg and pharmaceutical benefits that have the form ramipril capsule 5 mg are equivalent for the purposes of substitution.								
9122D NP	ramipril 5 mg capsule, 30	1	5	..	10.05	11.20	^a APO-Ramipril	TX
							^a Chem mart Ramipril	CH
							^a Pharmacor Ramipril 5	CR
							^a Ramipril-GA	GN
							^a Ramipril generichealth	GQ
							^a Terry White Chemists	TW
							^a Ramipril	
							^a Tryzan Caps 5	AF
1946K NP	ramipril 5 mg tablet, 30	1	5	..	10.05	11.20	^a APO-Ramipril	TX
							^a Chem mart Ramipril	CH
							^a Prilace 5	QA
							^a Ramace 5 mg	AV
							^a Ramipril AN	EA
							^a Ramipril RBX Tabs	RA
							^a Ramipril Sandoz	SZ
							^a Ramipril Winthrop	WA
							^a Terry White Chemists	TW
							^a Ramipril	
							^a Tritace 5 mg	SW
							^a Tryzan Tabs 5	AF
							^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.								
2792Y NP	trandolapril 1 mg capsule, 28	1	5	..	11.90	13.05	^a APO-Trandolapril	TX
							^a Dolapril 1	QA
							^a Tranalpha	AF
							^a Trandolapril-DP	GN
				^B 3.49	15.39	13.05	^a Gopten	AB
2793B NP	trandolapril 2 mg capsule, 28	1	5	..	12.97	14.12	^a APO-Trandolapril	TX
							^a Dolapril 2	QA
							^a Tranalpha	AF
							^a Trandolapril-DP	GN
				^B 3.50	16.47	14.12	^a Gopten	AB
8758Y NP	trandolapril 4 mg capsule, 28	1	5	..	18.41	19.56	^a APO-Trandolapril	TX
							^a Dolapril 4	QA
							^a Tranalpha	AF
							^a Trandolapril-DP	GN
				^B 3.50	21.91	19.56	^a Gopten	AB
2791X NP	trandolapril 500 microgram capsule, 28	1	5	..	8.70	9.85	^a APO-Trandolapril	TX
							^a Dolapril 0.5	QA
							^a Tranalpha	AF
							^a Trandolapril-DP	GN

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
				^b 3.50	12.20	9.85	^a Gopten	AB

ACE INHIBITORS, COMBINATIONS

ACE inhibitors and diuretics

ENALAPRIL + 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 ACE inhibitor; OR

The condition must be inadequately controlled with a thiazide diuretic.

Caution

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

8477E NP	enalapril maleate 20 mg + hydrochlorothiazide 6 mg tablet, 30	1	5	..	27.94	29.09	^a Enalapril/HCT Sandoz	SZ
							^a Renitec Plus 20/6	MK

FOSINOPRIL + 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 ACE inhibitor; OR

The condition must be inadequately controlled with a thiazide diuretic.

Caution

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

8400D NP	fosinopril sodium 10 mg + hydrochlorothiazide 12.5 mg tablet, 30	1	5	..	21.66	22.81	^a APO-Fosinopril HCTZ 10/12.5	TX
							^a Monoplus 10/12.5	BQ
8401E NP	fosinopril sodium 20 mg + hydrochlorothiazide 12.5 mg tablet, 30	1	5	..	28.64	29.79	^a APO-Fosinopril HCTZ 20/12.5	TX
							^a Fosetic 20/12.5	ZP
							^a Fosinopril/HCT Actavis 20/12.5	UA
							^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.

2190G NP	perindopril arginine 2.5 mg + indapamide hemihydrate 0.625 mg tablet, 30	1	5	..	13.80	14.95	Coversyl Plus LD 2.5mg/0.625mg	SE

PERINDOPRIL + INDAPAMIDE

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.

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 with indapamide hemihydrate tablet (containing 4 mg perindopril erbumine-1.25 mg

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
2845R NP	perindopril arginine 5 mg + indapamide hemihydrate 1.25 mg tablet, 30	1	5	..	22.57	23.72	^a Coversyl Plus 5mg/1.25mg	SE
							^a Prexum Combi 5/1.25	RX
8449Q NP	perindopril erbumine 4 mg + indapamide hemihydrate 1.25 mg tablet, 30	1	5	..	22.57	23.72	^a Chem mart Perindopril/ Indapamide 4/1.25	CH
							^a GenRx Perindopril/ Indapamide 4/1.25	GX
							^a Idaprex Combi 4/1.25	SZ
							^a Indosyl Combi 4/1.25	QA
							^a Perindo Combi 4/1.25	AF
							^a Perindopril/ Indapamide GH 4/1.25	GQ
							^a Perindopril and Indapamide CH 4/1.25	EA
							^a Perindopril Combi Actavis 4/1.25	GN
							^a Terry White Chemists Perindopril/ Indapamide 4/1.25	TW

QUINAPRIL + 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 ACE inhibitor; OR

The condition must be inadequately controlled with a thiazide diuretic.

Caution

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

8589C NP	quinapril 10 mg + hydrochlorothiazide 12.5 mg tablet, 30	1	5	..	14.78	15.93	Accuretic 10/12.5mg	PF
8590D NP	quinapril 20 mg + hydrochlorothiazide 12.5 mg tablet, 30	1	5	..	16.13	17.28	Accuretic 20/12.5mg	PF

ACE inhibitors and calcium channel blockers

LERCANIDIPINE + ENALAPRIL

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.

Caution

Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.

9144G NP	lercanidipine hydrochloride 10 mg + enalapril maleate 10 mg tablet, 28	1	5	..	15.28	16.43	Zan-Extra 10/10	AB
9145H NP	lercanidipine hydrochloride 10 mg + enalapril maleate 20 mg tablet, 28	1	5	..	16.64	17.79	Zan-Extra 10/20	AB

PERINDOPRIL + AMLODIPINE

Restricted benefit

Hypertension

Clinical criteria:

The treatment must not be for the initiation of anti-hypertensive therapy,

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
AND								
The condition must be inadequately controlled with an ACE inhibitor; OR								
The condition must be inadequately controlled with a dihydropyridine calcium channel blocker.								
<u>Restricted benefit</u>								
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.								
<u>Caution</u>								
Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.								
9349C NP	perindopril arginine 10 mg + amlodipine 10 mg tablet, 30	1	5	..	40.60	36.90	^a Coveram 10/10	SE
9348B NP	perindopril arginine 10 mg + amlodipine 5 mg tablet, 30	1	5	..	33.28	34.43	^a Reaptan 10/10 ^a Coveram 10/5	RX SE
9347Y NP	perindopril arginine 5 mg + amlodipine 10 mg tablet, 30	1	5	..	34.79	35.94	^a Reaptan 10/5 ^a Coveram 5/10	RX SE
9346X NP	perindopril arginine 5 mg + amlodipine 5 mg tablet, 30	1	5	..	27.45	28.60	^a Reaptan 5/10 ^a Coveram 5/5	RX SE
							^a Reaptan 5/5	RX
RAMIPRIL + FELODIPINE								
<u>Restricted benefit</u>								
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.								
<u>Caution</u>								
Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.								
2626F NP	ramipril 2.5 mg + felodipine 2.5 mg tablet: modified release, 30 tablets	1	5	..	13.64	14.79	Triasyn 2.5/2.5	SW
2629J NP	ramipril 5 mg + felodipine 5 mg tablet: modified release, 30 tablets	1	5	..	16.17	17.32	Triasyn 5.0/5.0	SW
TRANDOLAPRIL + VERAPAMIL								
<u>Restricted benefit</u>								
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.								
<u>Caution</u>								
Use of ACE inhibitors during pregnancy is contraindicated since these drugs have been associated with foetal death in utero.								
<u>Caution</u>								
The myocardial depressant effects of verapamil hydrochloride and of beta-blocking drugs are additive.								
9387C NP	trandolapril 2 mg + verapamil hydrochloride 180 mg tablet: modified release, 28 tablets	1	5	..	19.44	20.59	Tarka 2/180	AB
2857J NP	trandolapril 4 mg + verapamil hydrochloride 240 mg tablet: modified release, 28 tablets	1	5	..	27.03	28.18	Tarka 4/240	AB

ANGIOTENSIN II ANTAGONISTS, PLAIN

Angiotensin II antagonists, plain

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
CANDESARTAN							
8297Q NP	candesartan cilexetil 16 mg tablet, 30	1	5	..	22.26	23.41	^a Adesan AF ^a APO-Candesartan TX ^a Auro-Candesartan 16 DO ^a Candesartan AN EA ^a Candesartan Aspen 16 QA ^a Candesartan-GA GN ^a Candesartan GH GQ ^a Candesartan RBX RA ^a Candesartan Sandoz SZ ^a Chem mart CH ^a Candesartan Pharmacor Candesartan 16 CR ^a Terry White Chemists Candesartan TW
8889W NP	candesartan cilexetil 32 mg tablet, 30	1	5	^B 2.00 ..	24.26 25.51	23.41 26.66	^a Atacand AP ^a Adesan AF ^a APO-Candesartan TX ^a Auro-Candesartan 32 DO ^a Candesartan AN EA ^a Candesartan Aspen 32 QA ^a Candesartan-GA GN ^a Candesartan GH GQ ^a Candesartan RBX RA ^a Candesartan Sandoz SZ ^a Chem mart CH ^a Candesartan Pharmacor Candesartan 32 CR ^a Terry White Chemists Candesartan TW
8295N NP	candesartan cilexetil 4 mg tablet, 30	1	5	^B 2.00 ..	27.51 8.50	26.66 9.65	^a Atacand AP ^a Adesan AF ^a APO-Candesartan TX ^a Auro-Candesartan 4 DO ^a Candesartan AN EA ^a Candesartan Aspen 4 QA ^a Candesartan-GA GN ^a Candesartan GH GQ ^a Candesartan RBX RA ^a Candesartan Sandoz SZ ^a Chem mart CH ^a Candesartan Pharmacor Candesartan 4 CR ^a Terry White Chemists Candesartan TW
8296P NP	candesartan cilexetil 8 mg tablet, 30	1	5	^B 2.00 ..	10.50 11.95	9.65 13.10	^a Atacand AP ^a Adesan AF ^a APO-Candesartan TX ^a Auro-Candesartan 8 DO ^a Candesartan AN EA ^a Candesartan Aspen 8 QA ^a Candesartan-GA GN ^a Candesartan GH GQ ^a Candesartan RBX RA ^a Candesartan Sandoz SZ ^a Chem mart CH ^a Candesartan Pharmacor Candesartan CR

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							8	
							^a Terry White Chemists Candesartan	TW
				^B 2.00	13.95	13.10	^a Atacand	AP
EPROSARTAN								
8397Y NP	eprosartan 400 mg tablet, 28	2	5	^T 3.50	*24.48	22.13	Teveten	AB
8447N NP	eprosartan 600 mg tablet, 28	1	5	^T 3.50	28.07	25.72	Teveten	AB
EPROSARTAN								
<u>Authority required</u>								
Adverse effects occurring with all of the base-priced drugs								
<u>Authority required</u>								
Drug interactions occurring with all of the base-priced drugs								
<u>Authority required</u>								
Drug interactions expected to occur with all of the base-priced drugs								
<u>Authority required</u>								
Transfer to a base-priced drug would cause patient confusion resulting in problems with compliance								
8951D NP	eprosartan 400 mg tablet, 28	2	5	..	*24.48	25.63	Teveten	AB
5491B NP	eprosartan 600 mg tablet, 28	1	5	..	28.07	29.22	Teveten	AB
IRBESARTAN								
8247C NP	irbesartan 150 mg tablet, 30	1	5	..	12.64	13.79	^a Abisart	AF
							^a APO-Irbesartan	TX
							^a Avapro	AV
							^a Chem mart Irbesartan	CH
							^a Irbesartan AN	EA
							^a Irbesartan-DRLA	RZ
							^a Irbesartan-GA	GN
							^a Irbesartan GH	GQ
							^a Irbesartan RBX	RA
							^a Irbesartan Sandoz	SZ
							^a Irbesartan Winthrop	WA
							^a Irprestan 150	ZP
							^a Karbesat 150	QA
							^a Karvea	SW
							^a Terry White Chemists Irbesartan	TW
8248D NP	irbesartan 300 mg tablet, 30	1	5	..	18.49	19.64	^a Abisart	AF
							^a APO-Irbesartan	TX
							^a Avapro	AV
							^a Chem mart Irbesartan	CH
							^a Irbesartan Actavis 300	UA
							^a Irbesartan AN	EA
							^a Irbesartan-DRLA	RZ
							^a Irbesartan-GA	GN
							^a Irbesartan GH	GQ
							^a Irbesartan RBX	RA
							^a Irbesartan Sandoz	SZ
							^a Irbesartan Winthrop	WA
							^a Irprestan 300	ZP
							^a Karbesat 300	QA
							^a Karvea	SW
							^a Terry White Chemists Irbesartan	TW
8246B NP	irbesartan 75 mg tablet, 30	1	5	..	10.88	12.03	^a Abisart	AF
							^a APO-Irbesartan	TX
							^a Avapro	AV

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Chem mart Irbesartan	CH
							^a Irbesartan Actavis 75	UA
							^a Irbesartan AN	EA
							^a Irbesartan-DRLA	RZ
							^a Irbesartan-GA	GN
							^a Irbesartan GH	GQ
							^a Irbesartan RBX	RA
							^a Irbesartan Sandoz	SZ
							^a Irbesartan Winthrop	WA
							^a Irprestan 75	ZP
							^a Karbesat 75	QA
							^a Karvea	SW
							^a Terry White Chemists Irbesartan	TW
LOSARTAN								
5452Y NP	losartan potassium 25 mg tablet, 30	1	5	..	13.05	14.20	Cozavan	AF
8203R NP	losartan potassium 50 mg tablet, 30	2	5	..	*24.74	25.89	Cozavan	AF
OLMESARTAN MEDOXOMIL								
2147B NP	olmesartan medoxomil 20 mg tablet, 30	1	5	T2.51	18.46	17.10	Olmotec	MK
2148C NP	olmesartan medoxomil 40 mg tablet, 30	1	5	T2.51	28.76	27.40	Olmotec	MK
OLMESARTAN MEDOXOMIL								
<u>Authority required</u>								
Adverse effects occurring with all of the base-priced drugs								
<u>Authority required</u>								
Drug interactions occurring with all of the base-priced drugs								
<u>Authority required</u>								
Drug interactions expected to occur with all of the base-priced drugs								
<u>Authority required</u>								
Transfer to a base-priced drug would cause patient confusion resulting in problems with compliance								
5492C NP	olmesartan medoxomil 20 mg tablet, 30	1	5	..	18.46	19.61	Olmotec	MK
5493D NP	olmesartan medoxomil 40 mg tablet, 30	1	5	..	28.76	29.91	Olmotec	MK
TELMISARTAN								
8355R NP	telmisartan 40 mg tablet, 28	1	5	..	13.28	14.43	^a APO-Telmisartan	TX
							^a Chem mart Telmisartan	CH
							^a Micardis	BY
							^a Mizart	AF
							^a Pharmacor Telmisartan 40	CR
							^a Telmigen	GN
							^a Telmisartan AN	EA
							^a Telmisartan-DRLA	RZ
							^a Telmisartan GH	GQ
							^a Telmisartan RBX	RA
							^a Telmisartan Sandoz	SZ
							^a Teltartan	QA
							^a Terry White Chemists Telmisartan	TW
8356T NP	telmisartan 80 mg tablet, 28	1	5	..	25.65	26.80	^a APO-Telmisartan	TX
							^a Chem mart Telmisartan	CH
							^a Micardis	BY
							^a Mizart	AF
							^a Pharmacor Telmisartan 80	CR

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Telmigen	GN
							^a Telmisartan AN	EA
							^a Telmisartan-DRLA	RZ
							^a Telmisartan GH	GQ
							^a Telmisartan RBX	RA
							^a Telmisartan Sandoz	SZ
							^a Teltartan	QA
							^a Terry White Chemists Telmisartan	TW
	VALSARTAN							
9370E NP	valsartan 160 mg tablet, 28	1	5	..	19.90	21.05	^a APO-Valsartan	TX
							^a Diovan	NV
9368C NP	valsartan 40 mg tablet, 28	1	..	..	13.79	14.94	^a APO-Valsartan	TX
							^a Diovan	NV
9369D NP	valsartan 80 mg tablet, 28	1	5	..	17.00	18.15	^a APO-Valsartan	TX
							^a Diovan	NV
	VALSARTAN							
	Note							
	No applications for increased maximum quantities and/or repeats will be authorised for the 320 mg tablet.							
9371F NP	valsartan 320 mg tablet, 28	1	5	..	23.61	24.76	^a APO-Valsartan	TX
							^a Diovan	NV
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.								
8504N NP	candesartan cilexetil 16 mg + hydrochlorothiazide 12.5 mg tablet, 30	1	5	..	22.84	23.99	^a Adesan HCT 16/12.5	AF
							^a APO-Candesartan HCTZ 16/12.5	TX
							^a Candesartan/HCT Sandoz	SZ
							^a Candesartan Combi Aspen 16/12.5	QA
							^a Candesartan HCT GH 16/12.5	GQ
							^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
9314F	candesartan cilexetil 32 mg +	1	5	..	25.88	27.03	^a Adesan HCT 32/12.5	AF

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer							
NP	hydrochlorothiazide 12.5 mg tablet, 30						^a APO-Candesartan HCTZ 32/12.5 TX							
							^a Candesartan/HCT Sandoz SZ							
							^a Candesartan Combi Aspen 32/12.5 QA							
							^a Candesartan HCT GH 32/12.5 GQ							
							^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							
							^a Atacand Plus 32/12.5 AP							
							^a Adesan HCT 32/25 AF							
							9315G NP	candesartan cilexetil 32 mg + hydrochlorothiazide 25 mg tablet, 30	1	5	^B 2.02	27.90	27.03	^a APO-Candesartan HCTZ 32/25 TX
											..	27.33	28.48	^a Candesartan/HCT Sandoz SZ
			^a Candesartan Combi Aspen 32/25 QA											
			^a Candesartan HCT GH 32/25 GQ											
			^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											
			^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.

8624X NP	eprosartan 600 mg + hydrochlorothiazide 12.5 mg tablet, 28	1	5	..	26.64	27.79	Teveten Plus 600/12.5	AB

IRBESARTAN + HYDROCHLOROTHIAZIDE

Restricted benefit

Hypertension

Clinical criteria:

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
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.							
8404H NP	irbesartan 150 mg + hydrochlorothiazide 12.5 mg tablet, 30	1	5	..	13.89	15.04	^a Abisart HCT 150/12.5 AF ^a APO-Irbesartan HCTZ TX ^a Avapro HCT 150/12.5 AV ^a Chem mart Irbesartan HCTZ CH ^a Irbesartan/HCT Sandoz SZ ^a Irbesartan/HCTZ RBX RA 150/12.5 ^a Irbesartan HCT Actavis UA 150/12.5 ^a Irbesartan HCT GH GQ 150/12.5 ^a Irbesartan HCT Winthrop 150/12.5 WA ^a Irbesartan HCTZ AN EA 150/12.5 ^a Irbesartan HCTZ-GA GN 150/12.5 ^a Karvezide 150/12.5 SW ^a KSART HCT 150/12.5 QA ^a Terry White Chemists Irbesartan HCTZ TW
8405J NP	irbesartan 300 mg + hydrochlorothiazide 12.5 mg tablet, 30	1	5	..	19.86	21.01	^a Abisart HCT 300/12.5 AF ^a APO-Irbesartan HCTZ TX ^a Avapro HCT 300/12.5 AV ^a Chem mart Irbesartan HCTZ CH ^a Irbesartan/HCT Sandoz SZ ^a Irbesartan/HCTZ RBX RA 300/12.5 ^a Irbesartan HCT GH GQ 300/12.5 ^a Irbesartan HCT Winthrop 300/12.5 WA ^a Irbesartan HCTZ AN EA 300/12.5 ^a Irbesartan HCTZ-GA GN 300/12.5 ^a Karvezide 300/12.5 SW ^a KSART HCT 300/12.5 QA ^a Terry White Chemists Irbesartan HCTZ TW
2136K NP	irbesartan 300 mg + hydrochlorothiazide 25 mg tablet, 30	1	5	..	21.02	22.17	^a Abisart HCT 300/25 AF ^a APO-Irbesartan HCTZ TX ^a Avapro HCT 300/25 AV ^a Chem mart Irbesartan HCTZ CH ^a Irbesartan/HCT Sandoz SZ ^a Irbesartan/HCTZ RBX RA 300/25 ^a Irbesartan HCT Actavis UA 300/25 ^a Irbesartan HCT GH GQ 300/25 ^a Irbesartan HCT Winthrop 300/25 WA ^a Irbesartan HCTZ AN EA 300/25

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Irbesartan HCTZ-GA 300/25	GN
							^a Karvezide 300/25	SW
							^a KSART HCT 300/25	QA
							^a Terry White Chemists Irbesartan HCTZ	TW
OLMESARTAN MEDOXOMIL + HYDROCHLOROTHIAZIDE								
<u>Restricted benefit</u>								
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.								
2161R NP	olmesartan medoxomil 20 mg + hydrochlorothiazide 12.5 mg tablet, 30	1	5	..	18.16	19.31	Olmetec Plus	MK
2166B NP	olmesartan medoxomil 40 mg + hydrochlorothiazide 12.5 mg tablet, 30	1	5	..	28.46	29.61	Olmetec Plus	MK
2170F NP	olmesartan medoxomil 40 mg + hydrochlorothiazide 25 mg tablet, 30	1	5	..	30.70	31.85	Olmetec Plus	MK
TELMISARTAN + HYDROCHLOROTHIAZIDE								
<u>Restricted benefit</u>								
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.								
8622T NP	telmisartan 40 mg + hydrochlorothiazide 12.5 mg tablet, 28	1	5	..	15.02	16.17	^a APO-Telmisartan HCTZ 40/12.5	TX
							^a Chem mart Telmisartan HCTZ 40/12.5	CH
							^a Micardis Plus 40/12.5 mg	BY
							^a Mizart HCT 40/12.5 mg	AF
							^a Pritor Plus 40/12.5 mg	FI
							^a Telmigen HCT 40/12.5	GN
							^a Telmisartan/HCT Sandoz	SZ
							^a Telmisartan HCT GH 40/12.5	GQ
							^a Telmisartan HCTZ AN 40/12.5	EA
							^a Teltartan HCT 40/12.5	QA
							^a Terry White Chemists Telmisartan HCTZ 40/12.5	TW
8623W NP	telmisartan 80 mg + hydrochlorothiazide 12.5 mg tablet, 28	1	5	..	27.40	28.55	^a APO-Telmisartan HCTZ 80/12.5	TX
							^a Chem mart Telmisartan HCTZ 80/12.5	CH
							^a Micardis Plus 80/12.5 mg	BY
							^a Mizart HCT 80/12.5 mg	AF
							^a Pritor Plus 80/12.5 mg	FI
							^a Telmigen HCT 80/12.5	GN
							^a Telmisartan/HCT Sandoz	SZ

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Telmisartan HCT GH 80/12.5	GQ
							^a Telmisartan HCTZ AN 80/12.5	EA
							^a Teltartan HCT 80/12.5	QA
							^a Terry White Chemists Telmisartan HCTZ 80/12.5	TW
9381R NP	telmisartan 80 mg + hydrochlorothiazide 25 mg tablet, 28	1	5	..	29.14	30.29	^a APO-Telmisartan HCTZ 80/25	TX
							^a Chem mart Telmisartan HCTZ 80/25	CH
							^a Micardis Plus 80/25 mg	BY
							^a Mizart HCT 80/25 mg	AF
							^a Pritor Plus 80/25 mg	FI
							^a Telmigen HCT 80/25	GN
							^a Telmisartan/HCT Sandoz	SZ
							^a Telmisartan HCT GH 80/25	GQ
							^a Telmisartan HCTZ AN 80/25	EA
							^a Teltartan HCT 80/25	QA
							^a Terry White Chemists Telmisartan HCTZ 80/25	TW

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.

9373H NP	valsartan 160 mg + hydrochlorothiazide 12.5 mg tablet, 28	1	5	..	21.65	22.80	^a APO-Valsartan HCTZ 160/12.5	TX
							^a Co-Diovan 160/12.5	NV
9374J NP	valsartan 160 mg + hydrochlorothiazide 25 mg tablet, 28	1	5	..	24.06	25.21	Co-Diovan 160/25	NV
9372G NP	valsartan 80 mg + hydrochlorothiazide 12.5 mg tablet, 28	1	5	..	19.08	20.23	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.

9481B NP	valsartan 320 mg + hydrochlorothiazide 12.5 mg tablet, 28	1	5	..	25.36	26.51	^a APO-Valsartan HCTZ 320/12.5	TX
							^a Co-Diovan 320/12.5	NV
9482C NP	valsartan 320 mg + hydrochlorothiazide 25 mg tablet, 28	1	5	..	27.10	28.25	^a APO-Valsartan HCTZ 320/25	TX
							^a Co-Diovan 320/25	NV

Angiotensin II antagonists and calcium channel blockers

AMLODIPINE + VALSARTAN

Restricted benefit

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
9377M NP	amlodipine 10 mg + valsartan 160 mg tablet, 28	1	5	..	28.98	30.13	Exforge 10/160	NV
5460J NP	amlodipine 10 mg + valsartan 320 mg tablet, 28	1	5	..	32.81	33.96	Exforge 10/320	NV
9376L NP	amlodipine 5 mg + valsartan 160 mg tablet, 28	1	5	..	25.44	26.59	Exforge 5/160	NV
5459H NP	amlodipine 5 mg + valsartan 320 mg tablet, 28	1	5	..	29.28	30.43	Exforge 5/320	NV
9375K NP	amlodipine 5 mg + valsartan 80 mg tablet, 28	1	5	..	22.37	23.52	^a Exforge 5/80	NV
						^a	Valsartan/Amlodipine Sandoz 80/5	NM
	OLMESARTAN MEDOXOMIL + AMLODIPINE							
	<u>Restricted benefit</u>							
	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.							
5292M NP	olmesartan medoxomil 20 mg + amlodipine 5 mg tablet, 30	1	5	..	17.74	18.89	Sevikar 20/5	MK
5294P NP	olmesartan medoxomil 40 mg + amlodipine 10 mg tablet, 30	1	5	..	29.39	30.54	Sevikar 40/10	MK
5293N NP	olmesartan medoxomil 40 mg + amlodipine 5 mg tablet, 30	1	5	..	28.04	29.19	Sevikar 40/5	MK
	TELMISARTAN + AMLODIPINE							
	<u>Restricted benefit</u>							
	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.							
8979N NP	telmisartan 40 mg + amlodipine 10 mg tablet, 28	1	5	..	16.66	17.81	^a Pritor/Amlodipine	FI
							^a Twynsta	BY
8978M NP	telmisartan 40 mg + amlodipine 5 mg tablet, 28	1	5	..	15.21	16.36	^a Pritor/Amlodipine	FI
							^a Twynsta	BY
8981Q NP	telmisartan 80 mg + amlodipine 10 mg tablet, 28	1	5	..	29.05	30.20	^a Pritor/Amlodipine	FI
							^a Twynsta	BY
8980P NP	telmisartan 80 mg + amlodipine 5 mg tablet, 28	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,

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
5287G NP	amlodipine 10 mg + valsartan 160 mg + hydrochlorothiazide 12.5 mg tablet, 28	1	5	..	30.71	31.86	Exforge HCT 10/160/12.5	NV
5288H NP	amlodipine 10 mg + valsartan 160 mg + hydrochlorothiazide 25 mg tablet, 28	1	5	..	32.45	33.60	Exforge HCT 10/160/25	NV
5289J NP	amlodipine 10 mg + valsartan 320 mg + hydrochlorothiazide 25 mg tablet, 28	1	5	..	36.32	36.90	Exforge HCT 10/320/25	NV
5285E NP	amlodipine 5 mg + valsartan 160 mg + hydrochlorothiazide 12.5 mg tablet, 28	1	5	..	27.17	28.32	^a Exforge HCT 5/160/12.5	NV
						^a	Valsartan/Amlodipine/HCT Sandoz 160/5/12.5	NM
5286F NP	amlodipine 5 mg + valsartan 160 mg + hydrochlorothiazide 25 mg tablet, 28	1	5	..	28.92	30.07	Exforge HCT 5/160/25	NV
OLMESARTAN + AMLODIPINE + HYDROCHLOROTHIAZIDE								
<u>Restricted benefit</u>								
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.								
10005N NP	olmesartan medoxomil 20 mg + amlodipine 5 mg + hydrochlorothiazide 12.5 mg tablet, 30	1	5	..	19.96	21.11	Sevikar HCT 20/5/12.5	MK
2836G NP	olmesartan medoxomil 40 mg + amlodipine 10 mg + hydrochlorothiazide 12.5 mg tablet, 30	1	5	..	31.61	32.76	Sevikar HCT 40/10/12.5	MK
2953K NP	olmesartan medoxomil 40 mg + amlodipine 10 mg + hydrochlorothiazide 25 mg tablet, 30	1	5	..	33.84	34.99	Sevikar HCT 40/10/25	MK
2880N NP	olmesartan medoxomil 40 mg + amlodipine 5 mg + hydrochlorothiazide 12.5 mg tablet, 30	1	5	..	30.27	31.42	Sevikar HCT 40/5/12.5	MK
2864R NP	olmesartan medoxomil 40 mg + amlodipine 5 mg + hydrochlorothiazide 25 mg tablet, 30	1	5	..	32.49	33.64	Sevikar HCT 40/5/25	MK

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

GENERAL STATEMENT FOR LIPID-LOWERING DRUGS PRESCRIBED AS PHARMACEUTICAL BENEFITS

Use the following criteria to determine patient eligibility for subsidisation under the PBS for the following drugs:

- atorvastatin calcium
- fluvastatin sodium
- pravastatin sodium
- rosuvastatin calcium
- simvastatin
- fenofibrate
- gemfibrozil

By writing a PBS prescription, the prescriber is certifying the patient satisfies the qualifying criteria set out below and the use is in accordance with the registered indications which differ between agents in this class - refer to the current Product Information for details. Note also that patients already established on a particular lipid-lowering drug, where use satisfies the PBS qualifying criteria, but is outside the registered indications for that drug, are not required to switch to another drug in the class to retain PBS eligibility.

Patients in very high risk categories (see below) may commence drug therapy with statins or fibrates immediately (ie simultaneously with an appropriate diet). For all other patients, dietary therapy should be trialled prior to initiation of drug therapy.

Dietary therapy should be continued concurrently with pharmacological therapy and should be reviewed on at least an annual basis.

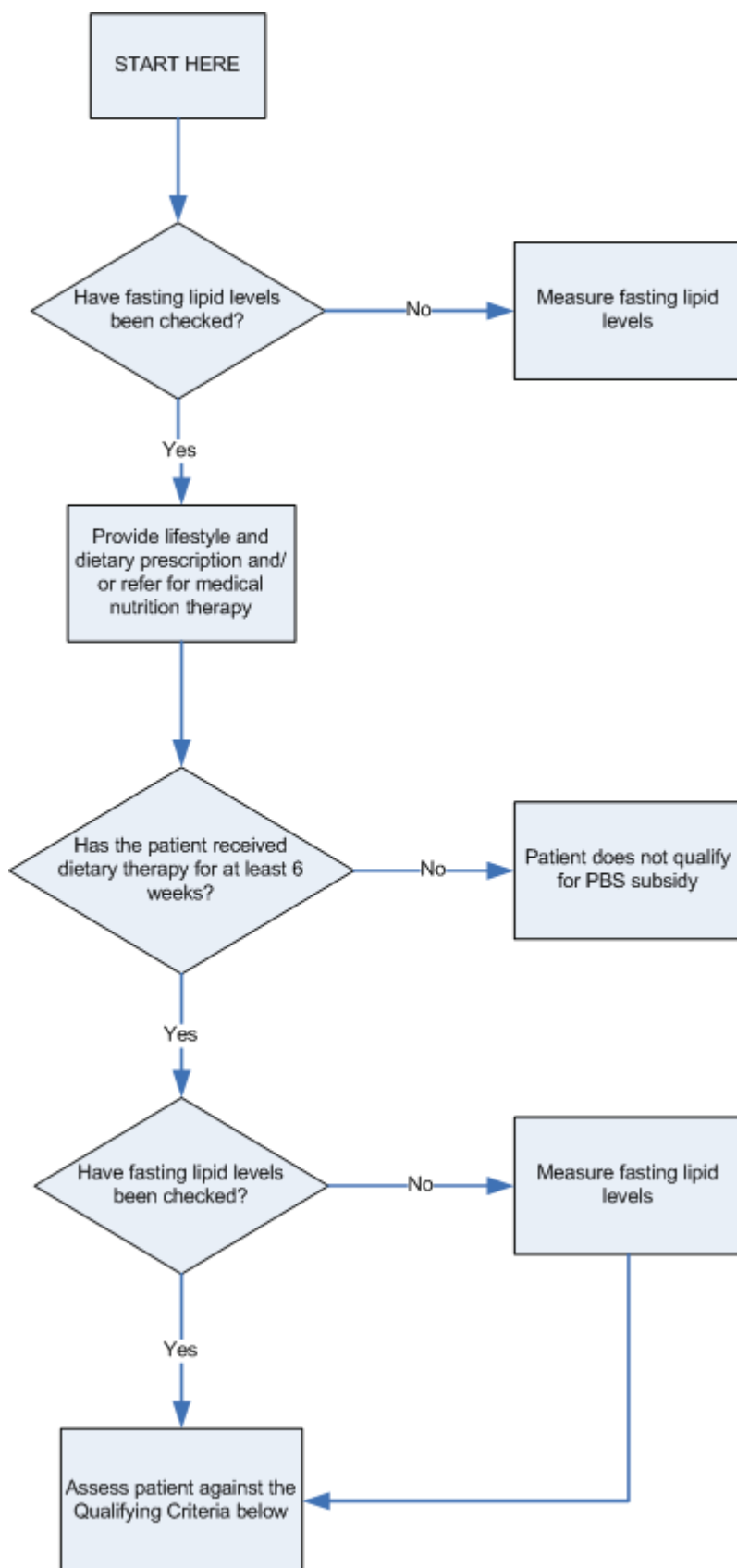
Patients identified as being in one of the following very high risk categories may commence drug therapy with statins or fibrates at any cholesterol level:

- coronary heart disease which has become symptomatic
- cerebrovascular disease which has become symptomatic
- peripheral vascular disease which has become symptomatic
- diabetes mellitus with microalbuminuria (defined as urinary albumin excretion rate of >20mcg/min or urinary albumin to creatinine ratio of > 2.5 for males, > 3.5 for females)
- diabetes mellitus in Aboriginal or Torres Strait Islander patients
- diabetes mellitus in patients aged 60 years or more
- family history of coronary heart disease which has become symptomatic before the age of 55 years in two or more first degree relatives
- family history of coronary heart disease which has become symptomatic before the age of 45 years in one or more first degree relatives

If your patient is not identified as being in any of the above very high risk categories, then use the flow-chart and table below to determine whether your patient satisfies the following criteria for subsidisation under the PBS. Document how the patient meets each of these steps in the patient record. Lipid levels must be measured at an accredited laboratory.

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer



CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

POST-DIETARY QUALIFYING CRITERIA

Dietary therapy should be continued concurrently with pharmacological therapy and should be reviewed on at least an annual basis.

PATIENT CATEGORY	LIPID LEVELS FOR PBS SUBSIDY
Patients with diabetes mellitus not otherwise included	total cholesterol > 5.5 mmol/L
Aboriginal or Torres Strait Islander patients Patients with hypertension	total cholesterol > 6.5 mmol/L or total cholesterol > 5.5 mmol/L and HDL cholesterol < 1 mmol/L
Patients with HDL cholesterol < 1 mmol/L	total cholesterol > 6.5 mmol/L
Patients with familial hypercholesterolaemia identified by: - DNA mutation; or - tendon xanthomas in the patient or their first or second degree relative Patients with: - family history of coronary heart disease which has become symptomatic before the age of 60 years in one or more first degree relatives; or - family history of coronary heart disease which has become symptomatic before the age of 50 years in one or more second degree relatives	If aged 18 years or less at treatment initiation: LDL cholesterol > 4 mmol/L If aged more than 18 years at treatment initiation: LDL cholesterol > 5 mmol/L or total cholesterol > 6.5 mmol/L or total cholesterol > 5.5 mmol/L and HDL cholesterol < 1 mmol/L
Patients not eligible under the above: - men aged 35 to 75 years - post-menopausal women aged up to 75 years	total cholesterol > 7.5 mmol/L or triglyceride > 4 mmol/L
Patients not otherwise included	total cholesterol > 9 mmol/L or triglyceride > 8 mmol/L

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

8213G NP	atorvastatin 10 mg tablet, 30	1	5	..	12.98	14.13	^a	APO-Atorvastatin	TX
							^a	Atorvachol	GN
							^a	Atorvastatin AN	EA
							^a	Atorvastatin GH	GQ
							^a	Atorvastatin Pfizer	FZ
							^a	Atorvastatin Sandoz	SZ
							^a	Atorvastatin SCP 10	RZ
							^a	Atorvastatin SZ	HX
							^a	Chem mart Atorvastatin	CH
							^a	Lipitor	PF
							^a	Lorstat 10	AF
							^a	Terry White Chemists Atorvastatin	TW
							^a	Torvastat 10	QA
							^a	Trovas	RA

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
8214H NP	atorvastatin 20 mg tablet, 30	1	5	..	15.94	17.09	^a APO-Atorvastatin	TX
							^a Atorvachol	GN
							^a Atorvastatin AN	EA
							^a Atorvastatin GH	GQ
							^a Atorvastatin Pfizer	FZ
							^a Atorvastatin Sandoz	SZ
							^a Atorvastatin SCP 20	RZ
							^a Atorvastatin SZ	HX
							^a Chem mart Atorvastatin	CH
							^a Lipitor	PF
							^a Lorstat 20	AF
							^a Terry White Chemists Atorvastatin	TW
							^a Torvastat 20	QA
							^a Trovas	RA
							^a APO-Atorvastatin	TX
8215J NP	atorvastatin 40 mg tablet, 30	1	5	..	19.69	20.84	^a Atorvachol	GN
							^a Atorvastatin AN	EA
							^a Atorvastatin GH	GQ
							^a Atorvastatin Pfizer	FZ
							^a Atorvastatin Sandoz	SZ
							^a Atorvastatin SCP 40	RZ
							^a Atorvastatin SZ	HX
							^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
							^a APO-Atorvastatin	TX
							^a Atorvachol	GN
8521L NP	atorvastatin 80 mg tablet, 30	1	5	..	25.23	26.38	^a Atorvastatin AN	EA
							^a Atorvastatin GH	GQ
							^a Atorvastatin Pfizer	FZ
							^a Atorvastatin Sandoz	SZ
							^a Atorvastatin SCP 80	RZ
							^a Atorvastatin SZ	HX
							^a Chem mart Atorvastatin	CH
							^a Lipitor	PF
							^a Lorstat 80	AF
							^a Terry White Chemists Atorvastatin	TW
							^a Torvastat 80	QA
							^a Trovas	RA

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.

9230T	atorvastatin 10 mg tablet, 30	1	11	..	12.98	14.13	^a APO-Atorvastatin	TX
							^a Atorvachol	GN
							^a Atorvastatin AN	EA
							^a Atorvastatin GH	GQ
							^a Atorvastatin Pfizer	FZ
							^a Atorvastatin Sandoz	SZ
							^a Atorvastatin SCP 10	RZ

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
9231W	atorvastatin 20 mg tablet, 30	1	11	..	15.94	17.09	^a Atorvastatin SZ	HX
							^a Chem mart Atorvastatin	CH
							^a Lipitor	PF
							^a Lorstat 10	AF
							^a Terry White Chemists Atorvastatin	TW
							^a Torvastat 10	QA
							^a Trovas	RA
							^a APO-Atorvastatin	TX
							^a Atorvachol	GN
							^a Atorvastatin AN	EA
9232X	atorvastatin 40 mg tablet, 30	1	11	..	19.69	20.84	^a Atorvastatin GH	GQ
							^a Atorvastatin Pfizer	FZ
							^a Atorvastatin Sandoz	SZ
							^a Atorvastatin SCP 20	RZ
							^a Atorvastatin SZ	HX
							^a Chem mart Atorvastatin	CH
							^a Lipitor	PF
							^a Lorstat 20	AF
							^a Terry White Chemists Atorvastatin	TW
							^a Torvastat 20	QA
9233Y	atorvastatin 80 mg tablet, 30	1	11	..	25.23	26.38	^a Trovas	RA
							^a APO-Atorvastatin	TX
							^a Atorvachol	GN
							^a Atorvastatin AN	EA
							^a Atorvastatin GH	GQ
							^a Atorvastatin Pfizer	FZ
							^a Atorvastatin Sandoz	SZ
							^a Atorvastatin SCP 40	RZ
							^a Atorvastatin SZ	HX
							^a Chem mart Atorvastatin	CH
8023G NP	fluvastatin 20 mg capsule, 28	1	5	..	25.80	26.95	^a Lipitor	PF
							^a Lorstat 80	AF
							^a Terry White Chemists Atorvastatin	TW
							^a Torvastat 80	QA
							^a Trovas	RA
							^a Atorvachol	GN
							^a Atorvastatin AN	EA
							^a Atorvastatin GH	GQ
							^a Atorvastatin Pfizer	FZ
							^a Atorvastatin Sandoz	SZ
8024H	fluvastatin 40 mg capsule, 28	1	5	..	30.11	31.26	^a Atorvastatin SCP 80	RZ
							^a Atorvastatin SZ	HX
							^a Chem mart Atorvastatin	CH
							^a Lipitor	PF
							^a Lorstat 80	AF
							^a Terry White Chemists Atorvastatin	TW
							^a Torvastat 80	QA
							^a Trovas	RA
							^a Atorvachol	GN
							^a Atorvastatin AN	EA

FLUVASTATIN

Restricted benefit

For use in patients that meet the criteria set out in the General Statement for Lipid-Lowering Drugs

8023G NP	fluvastatin 20 mg capsule, 28	1	5	..	25.80	26.95	^a Lescol	NV
				^B 3.09	28.89	26.95	^a Vastin	NM
8024H	fluvastatin 40 mg capsule, 28	1	5	..	30.11	31.26	^a Lescol	NV

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
NP								
2863Q	fluvastatin 80 mg tablet: modified release, 28 tablets	1	5	^B 3.38 ..	33.49 45.76	31.26 36.90	^a Vastin Lescol XL	NM NV
NP								
FLUVASTATIN								
<u>Restricted benefit</u>								
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								
<u>Note</u>								
No applications for increased maximum quantities and/or repeats will be authorised.								
9234B	fluvastatin 20 mg capsule, 28	1	11	..	25.80	26.95	^a Lescol	NV
9235C	fluvastatin 40 mg capsule, 28	1	11	^B 3.09 ..	28.89 30.11	26.95 31.26	^a Vastin ^a Lescol	NM NV
9236D	fluvastatin 80 mg tablet: modified release, 28 tablets	1	11	^B 3.38 ..	33.49 45.76	31.26 36.90	^a Vastin Lescol XL	NM NV
PRAVASTATIN								
<u>Restricted benefit</u>								
For use in patients that meet the criteria set out in the General Statement for Lipid-Lowering Drugs								
2833D	pravastatin sodium 10 mg tablet, 30	1	5	..	9.73	10.88	^a APO-Pravastatin	TX
NP							^a Chem mart Pravastatin	CH
							^a Cholstat 10	AF
							^a Lipostat 10	QA
							^a Pharmacor Pravastat 10	CR
							^a Pravastatin Actavis 10	UA
							^a Pravastatin AN	EA
							^a Pravastatin-GA 10	GN
							^a Pravastatin generichealth	GQ
							^a Pravastatin Sandoz	SZ
							^a Terry White Chemists Pravastatin	TW
				^B 1.65	11.38	10.88	^a Pravachol	FM
2834E	pravastatin sodium 20 mg tablet, 30	1	5	..	11.48	12.63	^a APO-Pravastatin	TX
NP							^a Chem mart Pravastatin	CH
							^a Cholstat 20	AF
							^a Cholvastin	RA
							^a Lipostat 20	QA
							^a Pharmacor Pravastat 20	CR
							^a Pravastatin Actavis 20	UA
							^a Pravastatin AN	EA
							^a Pravastatin-GA 20	GN
							^a Pravastatin generichealth	GQ
							^a Pravastatin Sandoz	SZ
							^a Terry White Chemists Pravastatin	TW
				^B 1.64	13.12	12.63	^a Pravachol	FM
8197K	pravastatin sodium 40 mg tablet, 30	1	5	..	14.11	15.26	^a APO-Pravastatin	TX
NP							^a Chem mart Pravastatin	CH
							^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

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$		Brand Name and Manufacturer							
8829Q NP	pravastatin sodium 80 mg tablet, 30	1	5	^B 1.75 ..	15.86 18.05	15.26 19.20	^a	Pravastatin generichealth	GQ						
							^a	Pravastatin Sandoz	SZ						
							^a	Terry White Chemists Pravastatin	TW						
							^a	Pravachol	FM						
							^a	APO-Pravastatin	TX						
							^a	Chem mart Pravastatin	CH						
							^a	Lipostat 80	QA						
							^a	Pravastatin AN	EA						
							^a	Pravastatin-GA 80	GN						
							^a	Pravastatin generichealth	GQ						
							^a	Pravastatin Sandoz	SZ						
							^a	Terry White Chemists Pravastatin	TW						
							^B 1.75	19.80	19.20	^a	Pravachol	FM			
							PRAVASTATIN								
							<u>Restricted benefit</u>								
							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								
<u>Note</u>															
No applications for increased maximum quantities and/or repeats will be authorised.															
9237E	pravastatin sodium 10 mg tablet, 30	1	11	..	9.73	10.88	^a	APO-Pravastatin	TX						
9238F	pravastatin sodium 20 mg tablet, 30	1	11	^B 1.65 ..	11.38 11.48	10.88 12.63	^a	Chem mart Pravastatin	CH						
							^a	Cholstat 10	AF						
							^a	Lipostat 10	QA						
							^a	Pharmacor Pravastat 10	CR						
							^a	Pravastatin Actavis 10	UA						
							^a	Pravastatin AN	EA						
							^a	Pravastatin-GA 10	GN						
							^a	Pravastatin generichealth	GQ						
							^a	Pravastatin Sandoz	SZ						
							^a	Terry White Chemists Pravastatin	TW						
							^a	Pravachol	FM						
							^a	APO-Pravastatin	TX						
							^a	Chem mart Pravastatin	CH						
							^a	Cholstat 20	AF						
							^a	Cholvastin	RA						
							^a	Lipostat 20	QA						
9239G	pravastatin sodium 40 mg tablet, 30	1	11	^B 1.64 ..	13.12 14.11	12.63 15.26	^a	Pharmacor Pravastat 20	CR						
							^a	Pravastatin Actavis 20	UA						
							^a	Pravastatin AN	EA						
							^a	Pravastatin-GA 20	GN						
							^a	Pravastatin generichealth	GQ						
							^a	Pravastatin Sandoz	SZ						
							^a	Terry White Chemists Pravastatin	TW						
							^a	Pravachol	FM						
^a	APO-Pravastatin	TX													
							^a	Chem mart Pravastatin	CH						
							^a	Cholstat 40	AF						
							^a	Cholvastin	RA						
							^a	Lipostat 40	QA						
							^a	Pharmacor Pravastat 40	CR						
							^a	Pravastatin Actavis 40	UA						

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
9240H	pravastatin sodium 80 mg tablet, 30	1	11	^B 1.75 ..	15.86 18.05	15.26 19.20	^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
							^a APO-Pravastatin	TX
							^a Chem mart Pravastatin	CH
							^a Lipostat 80	QA
							^a Pravastatin AN	EA
							^a Pravastatin-GA 80	GN
							^a Pravastatin generichealth	GQ
							^a Pravastatin Sandoz	SZ
							^a Terry White Chemists Pravastatin	TW
				^B 1.75	19.80	19.20	^a Pravachol	FM

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.

Note

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

2584B	rosuvastatin 10 mg tablet, 30	1	11	..	30.71	31.86	^a Cavstat	AF
2609H	rosuvastatin 20 mg tablet, 30	1	11	..	40.86	36.90	^a Crestor	AP
							^a Croсуva 10	ZP
							^a Rosuvastatin Actavis 10	GN
							^a Rosuvastatin-DRLA	RI
							^a Rosuvastatin GH	GQ
2636R	rosuvastatin 40 mg tablet, 30	1	11	..	53.55	36.90	^a Cavstat	AF
							^a Crestor	AP
							^a Croсуva 20	ZP
							^a Rosuvastatin Actavis 20	GN
							^a Rosuvastatin-DRLA	RI
2590H	rosuvastatin 5 mg tablet, 30	1	11	..	23.08	24.23	^a Rosuvastatin GH	GQ
							^a Cavstat	AF
							^a Crestor	AP
							^a Croсуva 40	ZP
							^a Rosuvastatin Actavis 40	GN
							^a Rosuvastatin-DRLA	RI
							^a Rosuvastatin GH	GQ
							^a Rosuvastatin GH	GQ

ROSUVASTATIN

Restricted benefit

For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
2628H NP	rosuvastatin 10 mg tablet, 30	1	5	..	30.71	31.86	^a Cavstat	AF
							^a Crestor	AP
							^a Croсуva 10	ZP
							^a Rosuvastatin Actavis 10	GN
							^a Rosuvastatin-DRLA	RI
							^a Rosuvastatin GH	GQ
2606E NP	rosuvastatin 5 mg tablet, 30	1	5	..	23.08	24.23	^a Cavstat	AF
							^a Crestor	AP
							^a Croсуva 5	ZP
							^a Rosuvastatin Actavis 5	GN
							^a Rosuvastatin-DRLA	RI
							^a Rosuvastatin GH	GQ
ROSUVASTATIN								
<u>Restricted benefit</u>								
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.								
<u>Note</u>								
No increase in the maximum quantity or number of units may be authorised.								
<u>Note</u>								
No increase in the maximum number of repeats may be authorised.								
3403D	rosuvastatin 10 mg tablet, 30	1	11	..	30.71	31.86	^a APO-Rosuvastatin	TX
							^a Cavstat	AF
							^a Chem mart	CH
							Rosuvastatin	
							^a Crestor	AP
							^a Croсуva 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	TW
							Rosuvastatin	
3404E	rosuvastatin 20 mg tablet, 30	1	11	..	40.86	36.90	^a APO-Rosuvastatin	TX
							^a Cavstat	AF
							^a Chem mart	CH
							Rosuvastatin	
							^a Crestor	AP
							^a Croсуva 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	TW
							Rosuvastatin	
3405F	rosuvastatin 40 mg tablet, 30	1	11	..	53.55	36.90	^a APO-Rosuvastatin	TX
							^a Cavstat	AF

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Chem mart	CH
							^a Rosuvastatin	
							^a Crestor	AP
							^a Croсуva 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	TW
							^a Rosuvastatin	
3402C	rosuvastatin 5 mg tablet, 30	1	11	..	23.08	24.23	^a APO-Rosuvastatin	TX
							^a Cavstat	AF
							^a Chem mart	CH
							^a Rosuvastatin	
							^a Crestor	AP
							^a Croсуva 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	TW
							^a Rosuvastatin	

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.

9043Y NP	rosuvastatin 10 mg tablet, 30	1	5	..	30.71	31.86	^a APO-Rosuvastatin	TX
							^a Cavstat	AF
							^a Chem mart	CH
							^a Rosuvastatin	
							^a Crestor	AP
							^a Croсуva 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	TW
							^a Rosuvastatin	
9042X NP	rosuvastatin 5 mg tablet, 30	1	5	..	23.08	24.23	^a APO-Rosuvastatin	TX
							^a Cavstat	AF
							^a Chem mart	CH
							^a Rosuvastatin	
							^a Crestor	AP
							^a Croсуva 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

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Rosuvastatin Sandoz	SZ
							^a Terry White Chemists Rosuvastatin	TW
ROSUVASTATIN								
<u>Restricted benefit</u>								
For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs								
2574L NP	rosuvastatin 20 mg tablet, 30	1	5	..	40.86	36.90	^a Cavstat	AF
							^a Crestor	AP
							^a Croсуva 20	ZP
							^a Rosuvastatin Actavis 20	GN
							^a Rosuvastatin-DRLA	RI
							^a Rosuvastatin GH	GQ
ROSUVASTATIN								
<u>Restricted benefit</u>								
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.								
9044B NP	rosuvastatin 20 mg tablet, 30	1	5	..	40.86	36.90	^a APO-Rosuvastatin	TX
							^a Cavstat	AF
							^a Chem mart Rosuvastatin	CH
							^a Crestor	AP
							^a Croсуva 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								
<u>Restricted benefit</u>								
For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs								
2594M NP	rosuvastatin 40 mg tablet, 30	1	5	..	53.55	36.90	^a Cavstat	AF
							^a Crestor	AP
							^a Croсуva 40	ZP
							^a Rosuvastatin Actavis 40	GN
							^a Rosuvastatin-DRLA	RI
							^a Rosuvastatin GH	GQ
ROSUVASTATIN								
<u>Restricted benefit</u>								
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.								
9045C NP	rosuvastatin 40 mg tablet, 30	1	5	..	53.55	36.90	^a APO-Rosuvastatin	TX
							^a Cavstat	AF
							^a Chem mart Rosuvastatin	CH
							^a Crestor	AP
							^a Croсуva 40	ZP
							^a Rostor 40	DO
							^a Rosuvastatin Actavis 40	GN
							^a Rosuvastatin AN	EA

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Rosuvastatin-DRLA	RI
							^a Rosuvastatin GH	GQ
							^a Rosuvastatin RBX	RA
							^a Rosuvastatin Sandoz	SZ
							^a Terry White Chemists Rosuvastatin	TW
SIMVASTATIN								
<u>Restricted benefit</u>								
For use in patients that meet the criteria set out in the General Statement for Lipid-Lowering Drugs								
2011W NP	simvastatin 10 mg tablet, 30	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
				^B 3.33	12.28	10.10	^a Zimstat	AF
							^a Lipex 10	FR
							^a Zocor	MK
2012X NP	simvastatin 20 mg tablet, 30	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
				^B 3.33	13.25	11.07	^a Zimstat	AF
							^a Lipex 20	FR
							^a Zocor	MK
8173E NP	simvastatin 40 mg tablet, 30	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

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
2013Y NP	simvastatin 5 mg tablet, 30	1	5	..	8.35	9.50	^a Zimstat	AF
							^a Lipex 40	FR
							^a Zocor	MK
							^a Simvastatin Sandoz	SZ
8313M NP	simvastatin 80 mg tablet, 30	1	5	..	13.29	14.44	^a Zimstat	AF
							^a APO-Simvastatin	TX
							^a Auro-Simvastatin 80	DO
							^a Chem mart Simvastatin	CH
							^a Ransim	RA
							^a Simvacor 80	CR
							^a Simvar 80	QA
							^a Simvastatin AN	EA
							^a Simvastatin-DP	UA
							^a Simvastatin-DRLA	RZ
							^a Simvastatin-GA 80	GN
							^a Simvastatin generichealth	GQ
							^a Simvastatin Sandoz	SZ
							^a Terry White Chemists Simvastatin	TW
							^a Zimstat	AF
							^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.

9242K	simvastatin 10 mg tablet, 30	1	11	..	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
							^a Lipex 10	FR
							^a Zocor	MK
9243L	simvastatin 20 mg tablet, 30	1	11	..	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 Zimstat	AF
							^a Lipex 20	FR

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Simvastatin generichealth	GQ
							^a Simvastatin Sandoz	SZ
							^a Terry White Chemists Simvastatin	TW
				^B 3.33	13.25	11.07	^a Zimstat	AF
							^a Lipex 20	FR
							^a Zocor	MK
9244M	simvastatin 40 mg tablet, 30	1	11	..	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
				^B 3.33	14.64	12.46	^a Zimstat	AF
							^a Lipex 40	FR
							^a Zocor	MK
9241J	simvastatin 5 mg tablet, 30	1	11	..	8.35	9.50	^a Simvastatin Sandoz	SZ
							^a Zimstat	AF
9245N	simvastatin 80 mg tablet, 30	1	11	..	13.29	14.44	^a APO-Simvastatin	TX
							^a Auro-Simvastatin 80	DO
							^a Chem mart Simvastatin	CH
							^a Ransim	RA
							^a Simvacor 80	CR
							^a Simvar 80	QA
							^a Simvastatin AN	EA
							^a Simvastatin-DP	UA
							^a Simvastatin-DRLA	RZ
							^a Simvastatin-GA 80	GN
							^a Simvastatin generichealth	GQ
							^a Simvastatin Sandoz	SZ
							^a Terry White Chemists Simvastatin	TW
				^B 3.33	16.62	14.44	^a Zimstat	AF
							^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.

9023X NP	fenofibrate 145 mg tablet, 30	1	5	..	42.09	36.90	Lipidil	AB
9022W NP	fenofibrate 48 mg tablet, 60	1	5	..	30.39	31.54	Lipidil	AB

FENOFIBRATE

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
<u>Restricted benefit</u>								
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								
<u>Note</u>								
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.								
<u>Note</u>								
No applications for increased maximum quantities and/or repeats will be authorised.								
9247Q	fenofibrate 145 mg tablet, 30	1	11	..	42.09	36.90	Lipidil	AB
9246P	fenofibrate 48 mg tablet, 60	1	11	..	30.39	31.54	Lipidil	AB
GEMFIBROZIL								
<u>Restricted benefit</u>								
For use in patients that meet the criteria set out in the General Statement for Lipid-Lowering Drugs								
<u>Note</u>								
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.								
1453L NP	gemfibrozil 600 mg tablet, 60	1	5	..	18.15	19.30	^a Ausgem	QA
							^a Chem mart Gemfibrozil	CH
							^a Gemfibrozil-GA	UA
							^a Gemhexal	SZ
							^a GenRx Gemfibrozil	GX
							^a Jezil	GN
							^a Lipigem	AF
							^a Terry White Chemists Gemfibrozil	TW
GEMFIBROZIL								
<u>Restricted benefit</u>								
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								
<u>Note</u>								
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.								
<u>Note</u>								
No applications for increased maximum quantities and/or repeats will be authorised.								
9248R	gemfibrozil 600 mg tablet, 60	1	11	..	18.15	19.30	^a Ausgem	QA
							^a Chem mart Gemfibrozil	CH
							^a Gemfibrozil-GA	UA
							^a Gemhexal	SZ
							^a GenRx Gemfibrozil	GX
							^a Jezil	GN
							^a Lipigem	AF
							^a Terry White Chemists Gemfibrozil	TW

Bile acid sequestrants

CHOLESTYRAMINE								
2967E NP	cholestyramine 4 g oral liquid: powder for, 50 x 4.7 g sachets	2	5	..	*72.28	36.90	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

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
9249T	cholestyramine 4 g oral liquid: powder for, 50 x 4.7 g sachets	2	11	..	*72.28	36.90	Questran Lite	QA
1224K NP	COLESTIPOL HYDROCHLORIDE colestipol hydrochloride 5 g granules, 120 x 5 g sachets	1	5	..	85.38	36.90	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.							
9250W	colestipol hydrochloride 5 g granules, 120 x 5 g sachets	1	11	..	85.38	36.90	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

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	<u>Authority required (STREAMLINED)</u>						
	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						
	<u>Authority required (STREAMLINED)</u>						
	1991						
	Homozygous sitosterolaemia						
	<u>Authority required (STREAMLINED)</u>						
	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.						
8757X NP	ezetimibe 10 mg tablet, 30	1	5	..	71.31	36.90	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-

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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-subsided 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-subsided 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-subsided 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-subsided lipid-lowering medication (according to the criteria set out in the General Statement for Lipid-Lowering Drugs).						

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
<u>Authority required (STREAMLINED)</u>							
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.							
10002K NP	atorvastatin 10 mg tablet [30] (&) ezetimibe 10 mg tablet [30], 1 pack	\$1	5	..	77.26	36.90	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

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
2874G NP	atorvastatin 20 mg tablet [30] (&) ezetimibe 10 mg tablet [30], 1 pack	1	5	..	80.09	36.90	Atozet Composite Pack	MK
2821L NP	atorvastatin 40 mg tablet [30] (&) ezetimibe 10 mg tablet [30], 1 pack	1	5	..	83.67	36.90	Atozet Composite Pack	MK
10006P NP	atorvastatin 80 mg tablet [30] (&) ezetimibe 10 mg tablet [30], 1 pack	1	5	..	88.99	36.90	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-

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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. <u>Authority required (STREAMLINED)</u> 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. <u>Authority required (STREAMLINED)</u> 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). <u>Authority required (STREAMLINED)</u> 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. <u>Note</u> 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.						
9483D	ezetimibe 10 mg + simvastatin 10 mg	1	5	..	89.13	36.90	Vytorin MK

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
NP	tablet, 30							
9484E	ezetimibe 10 mg + simvastatin 20 mg	1	5	..	96.93	36.90	Vytorin	MK
NP	tablet, 30							

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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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.						
	<u>Authority required (STREAMLINED)</u>						
	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.						
	<u>Authority required (STREAMLINED)</u>						
	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.						
	<u>Authority required (STREAMLINED)</u>						
	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						

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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. <u>Authority required (STREAMLINED)</u> 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. <u>Authority required (STREAMLINED)</u> 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). <u>Note</u> 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.							
8881K NP	ezetimibe 10 mg + simvastatin 40 mg tablet, 30	1	5	..	108.19	36.90	Vytorin	MK
8882L NP	ezetimibe 10 mg + simvastatin 80 mg tablet, 30	1	5	..	124.31	36.90	Vytorin	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

9053L NP	amlodipine 10 mg + atorvastatin 10 mg tablet, 30	1	5	..	45.64	36.90	^a APO- Amlodipine/Atorvast	TX

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							atin 10/10	
							^a Blooms the Chemist Amlodipine/Atorvastatin 10/10	IB
							^a Cadatin 10/10	FZ
							^a Cadivast 10/10	AF
							^a Caduet 10/10	PF
							^a Chem mart Amlodipine/Atorvastatin 10/10	CH
							^a Terry White Chemists Amlodipine/Atorvastatin 10/10	TW
9054M NP	amlodipine 10 mg + atorvastatin 20 mg tablet, 30	1	5	..	58.54	36.90	^a APO- Amlodipine/Atorvastatin 10/20	TX
							^a Blooms the Chemist Amlodipine/Atorvastatin 10/20	IB
							^a Cadatin 10/20	FZ
							^a Cadivast 10/20	AF
							^a Caduet 10/20	PF
							^a Chem mart Amlodipine/Atorvastatin 10/20	CH
							^a Terry White Chemists Amlodipine/Atorvastatin 10/20	TW
9055N NP	amlodipine 10 mg + atorvastatin 40 mg tablet, 30	1	5	..	76.23	36.90	^a APO- Amlodipine/Atorvastatin 10/40	TX
							^a Blooms the Chemist Amlodipine/Atorvastatin 10/40	IB
							^a Cadatin 10/40	FZ
							^a Cadivast 10/40	AF
							^a Caduet 10/40	PF
							^a Chem mart Amlodipine/Atorvastatin 10/40	CH
							^a Terry White Chemists Amlodipine/Atorvastatin 10/40	TW
9056P NP	amlodipine 10 mg + atorvastatin 80 mg tablet, 30	1	5	..	102.43	36.90	^a APO- Amlodipine/Atorvastatin 10/80	TX
							^a Blooms the Chemist Amlodipine/Atorvastatin 10/80	IB
							^a Cadatin 10/80	FZ
							^a Cadivast 10/80	AF
							^a Caduet 10/80	PF
							^a Chem mart Amlodipine/Atorvastatin 10/80	CH
							^a Terry White Chemists Amlodipine/Atorvastatin 10/80	TW
9049G NP	amlodipine 5 mg + atorvastatin 10 mg tablet, 30	1	5	..	42.34	36.90	^a APO- Amlodipine/Atorvastatin 5/10	TX
							^a Blooms the Chemist Amlodipine/Atorvastatin 5/10	IB
							^a Cadatin 5/10	FZ
							^a Cadivast 5/10	AF
							^a Caduet 5/10	PF
							^a Chem mart Amlodipine/Atorvastatin 5/10	CH

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
9050H NP	amlodipine 5 mg + atorvastatin 20 mg tablet, 30	1	5	..	55.03	36.90	a atin 5/10 Terry White Chemists Amlodipine/Atorvastatin 5/10	TW
							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
9051J NP	amlodipine 5 mg + atorvastatin 40 mg tablet, 30	1	5	..	72.60	36.90	a Terry White Chemists Amlodipine/Atorvastatin 5/20	TW
							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
9052K NP	amlodipine 5 mg + atorvastatin 80 mg tablet, 30	1	5	..	98.80	36.90	a Terry White Chemists Amlodipine/Atorvastatin 5/40	TW
							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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

1698J NP	nystatin 100 000 international units/g cream, 15 g	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

9025B NP	ketoconazole 1% (10 mg/g) shampoo, 100 mL	1	1	..	17.94	19.09	Nizoral 1%	JT
9024Y NP	ketoconazole 2% (20 mg/g) cream, 30 g	1	2	..	23.46	24.61	Nizoral 2% Cream	JT
1574W NP	ketoconazole 2% (20 mg/g) shampoo, 60 mL	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

9031H NP	miconazole 2% solution, 30 mL	1	2	..	19.81	20.96	Daktarin Tincture	JT
9027D NP	miconazole nitrate 2% (20 mg/g) cream, 30 g	1	2	..	15.13	16.28	Daktarin	JT
9028E NP	miconazole nitrate 2% (20 mg/g) cream, 70 g	1	1	..	17.13	18.28	Daktarin	JT
9029F NP	miconazole nitrate 2% (20 mg/g) powder: dusting, 30 g	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

9160D NP	terbinafine hydrochloride 1% cream, 15 g	2	3	..	*37.70	36.90	Lamisil	NC

ANTIFUNGALS FOR SYSTEMIC USE

Antifungals for systemic use

GRISEOFULVIN

1460W NP	griseofulvin 125 mg tablet, 100	1	2	..	26.21	27.36	Grisovin	QA
2982Y NP	griseofulvin 500 mg tablet, 28	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

2285G	terbinafine 250 mg tablet, 42	1	..	..	45.58	36.90 ^a	GenRx Terbinafine	GX

DERMATOLOGICALS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
NP								
							^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-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.

2804N	terbinafine 250 mg tablet, 42	1	1	..	45.58	36.90	^a GenRx Terbinafine	GX
NP								
							^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-DRLA	RZ
							^a Terbinafine GH	GQ
							^a Terbinafine Sandoz	SZ
							^a Tinasil	AF

ANTIPSORIATICS

ANTIPSORIATICS FOR TOPICAL USE

Tars

COAL TAR PREPARED

8864M	coal tar prepared 1% (10 mg/g) lotion, 100 mL	£1	2	..	33.42	34.57	Exorex	GN
NP								

Other antipsoriatics for topical use

CALCIPOTRIOL

Restricted benefit

Chronic stable plaque type psoriasis vulgaris

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.

2080L	calcipotriol 0.005% cream, 30 g	£1	1	..	28.40	29.55	Daivonex	LO
NP								

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,

DERMATOLOGICALS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
10075G NP	betamethasone (as dipropionate) 0.05% + calcipotriol 0.005% gel, 60 g	\$1	1	..	74.88	36.90	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.								
5276Q NP	calcipotriol 0.005% + betamethasone (as dipropionate) 0.05% gel, 30 g	\$1	1	..	42.23	36.90	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.								
9494Q NP	calcipotriol 0.005% + betamethasone (as dipropionate) 0.05% ointment, 30 g	\$1	1	..	42.23	36.90	Daivobet	LO

ANTIPSORIATICS FOR SYSTEMIC USE

Retinoids for treatment of psoriasis

ACITRETIN

Authority required (STREAMLINED)

1366

Severe intractable psoriasis

Authority required (STREAMLINED)

1363

Severe forms of disorders of keratinisation

Caution

This drug is a potent teratogen—pregnancy should be avoided for at least two years after cessation of therapy.

Note

Care must be taken to comply with the provisions of State/Territory law when prescribing acitretin.

2019G	acitretin 10 mg capsule, 100	1	2	..	174.32	36.90	^a Acitretin Actavis	GN
							^a Neotigason	UA
							^a Novatin	TX
2020H	acitretin 25 mg capsule, 100	1	2	..	334.55	36.90	^a Acitretin Actavis	GN
							^a Neotigason	UA
							^a Novatin	TX

ANTIBIOTICS AND CHEMOTHERAPEUTICS FOR DERMATOLOGICAL USE

CHEMOTHERAPEUTICS FOR TOPICAL USE

Sulfonamides

SULFADIAZINE SILVER

Restricted benefit

DERMATOLOGICALS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	Prevention and treatment of infection in partial or full skin thickness loss due to burns							
	<u>Restricted benefit</u>							
	Prevention and treatment of infection in partial or full skin thickness loss due to epidermolysis bullosa							
	<u>Restricted benefit</u>							
	Stasis ulcers							
9479X NP	sulfadiazine silver 1% (10 mg/g) cream, 50 g	#1	..	..	19.49	20.64	Flamazine	SN

CORTICOSTEROIDS, DERMATOLOGICAL PREPARATIONS

CORTICOSTEROIDS, PLAIN

Corticosteroids, weak (group I)

HYDROCORTISONE ACETATE

Restricted benefit

Treatment of corticosteroid-responsive dermatoses

2887Y NP	hydrocortisone acetate 1% (10 mg/g) cream, 30 g	#1	1	..	9.23	10.38	^a	Cortic-DS 1%	FM
				^B 2.69	11.92	10.38	^a	Sigmacort	QA
5111B DP	hydrocortisone acetate 1% (10 mg/g) cream, 30 g	#1	..	..	9.23	10.38	^a	Cortic-DS 1%	FM
				^B 2.69	11.92	10.38	^a	Sigmacort	QA
2881P NP	hydrocortisone acetate 1% (10 mg/g) cream, 50 g	#1	1	..	8.90	10.05	^a	Cortic-DS 1%	FM
				^B 2.70	11.60	10.05	^a	Sigmacort	QA
5113D DP	hydrocortisone acetate 1% (10 mg/g) cream, 50 g	#1	..	..	8.90	10.05	^a	Cortic-DS 1%	FM
				^B 2.70	11.60	10.05	^a	Sigmacort	QA
2888B NP	hydrocortisone acetate 1% (10 mg/g) ointment, 30 g	#1	1	..	9.23	10.38	^a	Cortic-DS 1%	FM
				^B 2.69	11.92	10.38	^a	Sigmacort	QA
5112C DP	hydrocortisone acetate 1% (10 mg/g) ointment, 30 g	#1	..	..	9.23	10.38	^a	Cortic-DS 1%	FM
				^B 2.69	11.92	10.38	^a	Sigmacort	QA
2882Q NP	hydrocortisone acetate 1% (10 mg/g) ointment, 50 g	#1	1	..	8.90	10.05	^a	Cortic-DS 1%	FM
				^B 2.70	11.60	10.05	^a	Sigmacort	QA
5114E DP	hydrocortisone acetate 1% (10 mg/g) ointment, 50 g	#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

2117K NP	triamcinolone acetate 0.02% (200 microgram/g) cream, 100 g	2	..	..	*14.74	15.89	^a	Tricortone	FM
				^B 3.78	*18.52	15.89	^a	Aristocort 0.02%	QA
2118L NP	triamcinolone acetate 0.02% (200 microgram/g) ointment, 100 g	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

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.

1115Q NP	betamethasone (as dipropionate) 0.05% cream, 15 g	#1	1	..	13.48	14.63	^a	Eleuphrat	FR
				^B 2.45	15.93	14.63	^a	Diprosone	MK
1119X	betamethasone (as dipropionate)	#1	1	..	13.48	14.63	^a	Eleuphrat	FR

DERMATOLOGICALS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
NP	0.05% ointment, 15 g			^a 2.45	15.93	14.63	^a Diprosone	MK
BETAMETHASONE VALERATE								
<u>Restricted benefit</u>								
Treatment of corticosteroid-responsive dermatoses								
2812B NP	betamethasone (as valerate) 0.02% (200 microgram/g) cream, 100 g	2	..	..	*24.56	25.71	^b Antroquoril	FR
				^b 2.46	*27.02	25.71	^a Cortival 1/5	FM
				^b 6.88	*31.44	25.71	^b Celestone-M	MK
							^a Betnovate 1/5	QA
BETAMETHASONE VALERATE								
<u>Restricted benefit</u>								
Treatment of corticosteroid-responsive dermatoses								
<u>Note</u>								
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.								
2813C NP	betamethasone (as valerate) 0.05% (500 microgram/g) cream, 15 g	\$1	1	..	8.75	9.90	^a Cortival 1/2	FM
				^b 2.94	11.69	9.90	^a Betnovate 1/2	QA
METHYLPREDNISOLONE								
<u>Restricted benefit</u>								
Treatment of corticosteroid-responsive dermatoses								
<u>Note</u>								
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.								
8054X NP	methylprednisolone aceponate 0.1% (1 mg/g) cream, 15 g	\$1	..	..	14.32	15.47	Advantan	BN
8055Y NP	methylprednisolone aceponate 0.1% (1 mg/g) ointment, 15 g	\$1	..	..	14.32	15.47	Advantan	BN
8128T NP	methylprednisolone aceponate 0.1% (1 mg/g) ointment, 15 g	\$1	..	..	14.32	15.47	Advantan	BN
METHYLPREDNISOLONE								
<u>Restricted benefit</u>								
Eczema								
<u>Note</u>								
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.								
8618N NP	methylprednisolone aceponate 0.1% (1 mg/g) lotion, 20 g	\$1	..	..	14.99	16.14	Advantan	BN
MOMETASONE								
<u>Restricted benefit</u>								
Treatment of corticosteroid-responsive dermatoses								
<u>Note</u>								
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.								
1913Q NP	mometasone furoate 0.1% (1 mg/g) cream, 15 g	\$1	..	..	12.35	13.50	^a Momasone	QA
				^b 3.07	15.42	13.50	^a Novasone	FR
8043H NP	mometasone furoate 0.1% lotion, 30 mL	\$1	..	..	15.58	16.73	^a Elocon	MK
							^a Novasone	FR
				^b 3.06	18.64	16.73	^a Zatamil	EO
1915T	mometasone furoate 0.1% ointment, 15	\$1	..	..	12.35	13.50	^a Elocon	MK
							^a Novasone	FR

DERMATOLOGICALS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
NP	g							
				^B 3.07	15.42	13.50	^a Zatamil ^a Elocon	EO 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.

10080M	clobetasol propionate 0.05% shampoo, 125 mL	\$1	1	..	48.98	36.90	Clobex	GA

ANTI-ACNE PREPARATIONS

ANTI-ACNE PREPARATIONS FOR TOPICAL USE

Retinoids for topical use in acne

ADAPALENE + BENZOYL PEROXIDE

Restricted benefit

Acute treatment, in combination with an oral antibiotic, of severe acne vulgaris

8954G	adapalene 0.1% + benzoyl peroxide 2.5% gel, 30 g	\$1	1	..	37.27	36.90	Epiduo	GA

ADAPALENE + BENZOYL PEROXIDE

Restricted benefit

Maintenance treatment of severe acne vulgaris

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.

8955H NP	adapalene 0.1% + benzoyl peroxide 2.5% gel, 30 g	\$1	3	..	37.27	36.90	Epiduo	GA

ANTI-ACNE PREPARATIONS FOR SYSTEMIC USE

Retinoids for treatment of acne

ISOTRETINOIN

Authority required (STREAMLINED)

1354

Severe cystic acne not responsive to other therapy

Caution

This drug causes birth defects. Isotretinoin has been reported to cause other frequent and potentially serious toxicity.

Note

Care must be taken to comply with the provisions of State/Territory law when prescribing isotretinoin.

2591J	isotretinoin 10 mg capsule, 60	1	3	..	47.84	36.90	^a APO-Isotretinoin	TX
							^a Dermatane	ER
							^a Isotretinoin AN	EA
							^a Isotretinoin SCP 10	CR
							^a Oratane	GN
							^a Roaccutane	RO
							^a Rocta 10	QA
2592K	isotretinoin 20 mg capsule, 60	1	3	..	69.47	36.90	^a APO-Isotretinoin	TX
							^a Dermatane	ER
							^a GenRx Isotretinoin	GX
							^a Isotretinoin AN	EA
							^a Isotretinoin SCP 20	CR

DERMATOLOGICALS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Oratane	GN
							^a Roaccutane	RO
							^a Rocta 20	QA
2549E	isotretinoin 40 mg capsule, 30	1	3	..	63.37	36.90	^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.

8802G	pimecrolimus 1% (10 mg/g) cream, 15 g	£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.

1272Y NP	dapsone 100 mg tablet, 100	1	1	..	114.18	36.90	Link Medical Products Pty Ltd	LM
8801F NP	dapsone 25 mg tablet, 100	1	1	..	100.92	36.90	Link Medical Products Pty Ltd	LM

IMIQUIMOD

Authority required

Superficial basal cell carcinoma

Clinical criteria:

The condition must be previously untreated,

AND

DERMATOLOGICALS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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. Note No increase in the maximum quantity or number of units may be authorised. Note No increase in the maximum number of repeats may be authorised. Note Treatment of recurrent (previously treated) lesions will not be authorised. 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.						
2546B	imiquimod 5% cream, 12 x 250 mg sachets	1	1	..	135.72	36.90	^a Aldara
							^a Aldiq
							^a APO-Imiquimod
2637T	imiquimod 5% cream, 2 x 2 g pump packs	1	1	..	135.72	36.90	^a Aldara Pump
							QA
							TX
							IA

GENITO URINARY SYSTEM AND SEX HORMONES

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

GENITO URINARY SYSTEM AND SEX HORMONES

OTHER GYNECOLOGICALS

OXYTOCICS

Prostaglandins

MISOPROSTOL

Authority required

Termination of an intra-uterine pregnancy

Clinical criteria:

The condition must be an intra-uterine pregnancy of up to 49 days of gestation,

AND

The treatment must be in sequential combination with mifepristone 200 mg.

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.

Note

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

2672P	misoprostol 200 microgram tablet, 4	1	1	..	8.08	9.23	GyMiso	XH

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

8633J NP	levonorgestrel 52 mg drug delivery system: intrauterine, 1 system	1	..	..	266.56	36.90	Mirena	BN

OTHER GYNECOLOGICALS

Prolactine inhibitors

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.

Note

For item codes 1443Y and 1559C, pharmaceutical benefits that have the form tablet 2.5 mg (base) are equivalent for the purposes of substitution.

1443Y	bromocriptine 2.5 mg tablet, 30	2	5	..	*31.76	32.91 ^a	Parlodel	NV

GENITO URINARY SYSTEM AND SEX HORMONES

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
1559C	bromocriptine 2.5 mg tablet, 60	1	5	..	31.76	32.91	^a Krypton 2.5	AF
BROMOCRIPTINE <u>Restricted benefit</u> Prevention of the onset of lactation in the puerperium for medical reasons								
1444B NP	bromocriptine 2.5 mg tablet, 30	1	..	..	19.26	20.41	^a Krypton 2.5	AF
							^a Parlodel	NV
CABERGOLINE <u>Restricted benefit</u> Prevention of the onset of lactation in the puerperium for medical reasons								
8115D NP	cabergoline 500 microgram tablet, 2	1	..	..	22.12	23.27	^a Dostan	GN
							^a Dostinex	PF
CABERGOLINE <u>Authority required (STREAMLINED)</u> 2659 Pathological hyperprolactinaemia where surgery is not indicated <u>Authority required (STREAMLINED)</u> 2660 Pathological hyperprolactinaemia where surgery has already been used with incomplete resolution <u>Authority required (STREAMLINED)</u> 2661 Pathological hyperprolactinaemia where radiotherapy is not indicated <u>Authority required (STREAMLINED)</u> 2662 Pathological hyperprolactinaemia where radiotherapy has already been used with incomplete resolution								
8114C	cabergoline 500 microgram tablet, 8	1	5	..	65.57	36.90	^a Dostan	GN
							^a Dostinex	PF
QUINAGOLIDE <u>Authority required (STREAMLINED)</u> 2659 Pathological hyperprolactinaemia where surgery is not indicated <u>Authority required (STREAMLINED)</u> 2660 Pathological hyperprolactinaemia where surgery has already been used with incomplete resolution <u>Authority required (STREAMLINED)</u> 2661 Pathological hyperprolactinaemia where radiotherapy is not indicated <u>Authority required (STREAMLINED)</u> 2662 Pathological hyperprolactinaemia where radiotherapy has already been used with incomplete resolution								
8860H	quinagolide 25 microgram tablet [3 tablets] (&) quinagolide 50 microgram tablet [3 tablets], 6	1	..	..	11.81	12.96	Norprolac	FP
8822H	quinagolide 75 microgram tablet, 30	1	5	..	55.13	36.90	Norprolac	FP

SEX HORMONES AND MODULATORS OF THE GENITAL SYSTEM

HORMONAL CONTRACEPTIVES FOR SYSTEMIC USE

Progestogens and estrogens, fixed combinations

ETHINYLLOESTRADIOL + LEVONORGESTREL								
1394J NP	ethinylloestradiol 30 microgram + levonorgestrel 150 microgram tablet [84] (&) inert substance tablet [28], 112 [4 x 28]	1	2	..	15.64	16.79	^a Evelyn 150/30 ED	GQ
							^a Femme-Tab ED 30/150	AE

GENITO URINARY SYSTEM AND SEX HORMONES

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Levlen ED	SY
							^a Micronelle 30 ED	TX
							^b Monofeme 28	FZ
				^B 11.41	27.05	16.79	^a Microgynon 30 ED	BN
				^B 14.37	30.01	16.79	^b Nordette 28	PF
1456P NP	ethinylloestradiol 50 microgram + levonorgestrel 125 microgram tablet [84] (&) inert substance tablet [28], 112 [4 x 28]	1	2	..	15.64	16.79	Microgynon 50 ED	BN
2416E NP	ethinylloestradiol 20 microgram + levonorgestrel 100 microgram tablet [84] (&) inert substance tablet [28], 112 [4 x 28]	1	2	..	15.64	16.79	Femme-Tab ED 20/100	AE
ETHINYLLOESTRADIOL + NORETHISTERONE								
2775C NP	ethinylloestradiol 35 microgram + norethisterone 1 mg tablet [84] (&) inert substance tablet [28], 112 [4 x 28]	1	2	..	16.80	17.95	^a Norimin-1 28 Day	FZ
				^B 10.67	27.47	17.95	^a Brevinor-1	PF
2774B NP	ethinylloestradiol 35 microgram + norethisterone 500 microgram tablet [84] (&) inert substance tablet [28], 112 [4 x 28]	1	2	..	16.80	17.95	^a Norimin 28 Day	FZ
				^B 10.67	27.47	17.95	^a Brevinor	PF
MESTRANOL + NORETHISTERONE								
3179H NP	mestranol 50 microgram + norethisterone 1 mg tablet [84] (&) inert substance tablet [28], 112 [4 x 28]	1	2	..	16.80	17.95	Norinyl-1/28	PF
Progestogens and estrogens, sequential preparations								
ETHINYLLOESTRADIOL + LEVONORGESTREL								
1392G NP	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]	1	2	..	15.64	16.79	^b Trifeme 28	FZ
				^B 11.41	27.05	16.79	^a Logynon ED	SY
				^B 14.37	30.01	16.79	^a Triquilar ED	BN
							^b Triphasil 28	PF
Progestogens								
ETONOGESTREL								
8487Q NP,MW	etonogestrel 68 mg implant, 1	1	..	..	216.26	36.90	Implanon NXT	MK
LEVONORGESTREL								
2913H NP,MW	levonorgestrel 30 microgram tablet, 112 [4 x 28 tablets]	1	2	..	17.66	18.81	Microlut 28	BN
MEDROXYPROGESTERONE								
3118D NP	medroxyprogesterone acetate 150 mg/mL injection, 1 x 1 mL vial	1	1	..	23.01	24.16	^a Depo-Ralovera	FZ
				^B 6.19	29.20	24.16	^a Depo-Provera	PF
NORETHISTERONE								
1967M NP	norethisterone 350 microgram tablet, 112 [4 x 28]	1	2	..	16.80	17.95	Micronor	JC
							Noriday 28 Day	PF

ANDROGENS

3-oxoandrosten (4) derivatives

GENITO URINARY SYSTEM AND SEX HORMONES

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
TESTOSTERONE								
<u>Authority required</u>								
Androgen deficiency in males with established pituitary or testicular disorders								
<u>Authority required</u>								
Androgen deficiency in males 40 years and older who do not have established pituitary or testicular disorders other than aging, confirmed by at least 2 morning blood samples taken on different mornings. Androgen deficiency is confirmed by testosterone less than 8 nmol per L, or 8-15 nmol per L with high LH (greater than 1.5 times the upper limit of the eugonadal reference range for young men)								
<u>Authority required</u>								
Micropenis, pubertal induction, or constitutional delay of growth or puberty, in males under 18 years of age								
8830R	testosterone 1% (50 mg/5 g) gel, 30 x 5 g sachets	\$1	5	..	95.46	36.90	Testogel	HB
2341F	testosterone 2% (30 mg/1.5 mL actuation) transdermal solution, 60 actuations	\$1	5	..	82.79	36.90	Axiron	LY
8460G	testosterone 2.5 mg/24 hours patch, 60	\$1	5	..	96.18	36.90	Androderm	GN
8619P	testosterone 5 mg/24 hours patch, 30	\$1	5	..	96.18	36.90	Androderm	GN
TESTOSTERONE ENANTHATE								
<u>Authority required</u>								
Androgen deficiency in males with established pituitary or testicular disorders								
<u>Authority required</u>								
Androgen deficiency in males 40 years and older who do not have established pituitary or testicular disorders other than aging, confirmed by at least 2 morning blood samples taken on different mornings. Androgen deficiency is confirmed by testosterone less than 8 nmol per L, or 8-15 nmol per L with high LH (greater than 1.5 times the upper limit of the eugonadal reference range for young men)								
<u>Authority required</u>								
Micropenis, pubertal induction, or constitutional delay of growth or puberty, in males under 18 years of age								
2114G	testosterone enanthate 250 mg/mL injection, 3 x 1 mL syringes	1	3	..	33.82	34.97	Primoteston Depot	BN
TESTOSTERONE UNDECANOATE								
<u>Authority required</u>								
Androgen deficiency in males with established pituitary or testicular disorders								
<u>Authority required</u>								
Androgen deficiency in males 40 years and older who do not have established pituitary or testicular disorders other than aging, confirmed by at least 2 morning blood samples taken on different mornings. Androgen deficiency is confirmed by testosterone less than 8 nmol per L, or 8-15 nmol per L with high LH (greater than 1.5 times the upper limit of the eugonadal reference range for young men)								
<u>Authority required</u>								
Micropenis, pubertal induction, or constitutional delay of growth or puberty, in males under 18 years of age								
9004X	testosterone undecanoate 1 g/4 mL injection, 1 x 4 mL ampoule	1	1	..	147.75	36.90	Reandron 1000	BN
2115H	testosterone undecanoate 40 mg capsule, 60	1	5	..	37.87	36.90	Andriol Testocaps	MK
ESTROGENS								
<i>Natural and semisynthetic estrogens, plain</i>								
OESTRADIOL								
<u>Note</u>								
Oestradiol should be used in conjunction with an oral progestogen in women with an intact uterus.								
<u>Note</u>								
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.								
8286D NP	oestradiol 0.1% (1 mg/g) gel, 28 x 1 g sachets	\$1	5	..	17.43	18.58	Sandrena	AS
8126Q NP	oestradiol 100 microgram/24 hours patch, 4	\$1	5	..	19.47	20.62	Climara 100	BN
8312L NP	oestradiol 100 microgram/24 hours patch, 8	\$1	5	..	19.47	20.62	Estraderm MX 100	NV
8765H	oestradiol 100 microgram/24 hours	\$1	5	..	19.47	20.62	Estradot 100	NV

GENITO URINARY SYSTEM AND SEX HORMONES

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
NP	patch, 8							
8485N	oestradiol 25 microgram/24 hours	#1	5	..	17.43	18.58	Climara 25	BN
NP	patch, 4							
8311K	oestradiol 25 microgram/24 hours	#1	5	..	17.43	18.58	Estraderm MX 25	NV
NP	patch, 8							
8761D	oestradiol 25 microgram/24 hours	#1	5	..	17.43	18.58	Estradot 25	NV
NP	patch, 8							
8762E	oestradiol 37.5 microgram/24 hours	#1	5	..	17.43	18.58	Estradot 37.5	NV
NP	patch, 8							
8125P	oestradiol 50 microgram/24 hours	#1	5	..	17.43	18.58	Climara 50	BN
NP	patch, 4							
8140K	oestradiol 50 microgram/24 hours	#1	5	..	17.43	18.58	Estraderm MX 50	NV
NP	patch, 8							
8763F	oestradiol 50 microgram/24 hours	#1	5	..	17.43	18.58	Estradot 50	NV
NP	patch, 8							
8486P	oestradiol 75 microgram/24 hours	#1	5	..	19.47	20.62	Climara 75	BN
NP	patch, 4							
8764G	oestradiol 75 microgram/24 hours	#1	5	..	19.47	20.62	Estradot 75	NV
NP	patch, 8							

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.

8274L	oestradiol 2 mg tablet, 56	1	2	..	13.89	15.04	Zumenon	AB
NP								
1742Q	oestradiol 25 microgram pessary:	#1	2	..	27.12	28.27	Vagifem	NO
NP	modified release, 15							
1663M	oestradiol valerate 1 mg tablet, 56	1	2	..	12.02	13.17	Progynova	BN
NP								
1664N	oestradiol valerate 2 mg tablet, 56	1	2	..	14.24	15.39	Progynova	BN
NP								

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.

1781R	oestriol 0.1% (1 mg/g) cream, 15 g	#1	1	..	19.43	20.58	Ovestin	AS
NP								
1771F	oestriol 500 microgram pessary, 15	#1	2	..	21.60	22.75	Ovestin Ovula	AS
NP								

PROGESTOGENS

Pregnen (4) derivatives

MEDROXYPROGESTERONE

Restricted benefit

Endometriosis

2722G	medroxyprogesterone acetate 10 mg tablet, 100	1	2	..	33.10	34.25	^a Ralovera	FZ
				^b 2.53	35.63	34.25	^a Provera	PF

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.

2321E	medroxyprogesterone acetate 10 mg tablet, 30	1	2	..	14.66	15.81	^a Medroxyprogesterone Sandoz	SZ
NP							^a Ralovera	FZ
				^b 2.46	17.12	15.81	^a Provera	PF
2323G	medroxyprogesterone acetate 5 mg tablet, 56	1	2	..	15.96	17.11	^a Ralovera	FZ
NP								
				^b 2.59	18.55	17.11	^a Provera	PF

Estren derivatives

GENITO URINARY SYSTEM AND SEX HORMONES

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

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.

2993M NP	norethisterone 5 mg tablet, 30	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.

8427M NP	oestradiol 50 microgram/24 hours + norethisterone acetate 140 microgram/24 hours patch, 8	1	5	..	19.47	20.62	Estalis continuous 50/140	NV
8428N NP	oestradiol 50 microgram/24 hours + norethisterone acetate 250 microgram/24 hours patch, 8	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.

10142T NP	oestradiol 1 mg + dydrogesterone 5 mg tablet, 28	1	5	..	19.10	20.25	Femoston-Conti	AB

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.

8425K NP	oestradiol 50 microgram/24 hours patch [4 patches] (&) oestradiol 50 microgram/24 hours + norethisterone acetate 140 microgram/24 hours patch [4 patches], 8	1	5	..	19.47	20.62	Estalis sequi 50/140	NV
8426L NP	oestradiol 50 microgram/24 hours patch [4 patches] (&) oestradiol 50 microgram/24 hours + norethisterone acetate 250 microgram/24 hours patch [4 patches], 8	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.

10146B NP	oestradiol 1 mg tablet [14] (&) oestradiol 1 mg + dydrogesterone 10 mg tablet [14], 28	1	5	..	19.10	20.25	Femoston 1/10	AB

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.

8244X NP	oestradiol 2 mg tablet [14] (&) oestradiol 2 mg + dydrogesterone 10	1	5	..	19.10	20.25	Femoston 2/10	AB

GENITO URINARY SYSTEM AND SEX HORMONES

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

mg tablet [14], 28

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.

8713N	follitropin alfa 300 international units / 0.5 mL (21.84 microgram/0.5 mL) injection, 1 x 0.5 mL cartridge	3	5	..	*493.84	36.90	Gonal-f Pen	SG
8714P	follitropin alfa 450 international units / 0.75 mL (32.76 microgram/0.75 mL) injection, 1 x 0.75 mL cartridge	3	5	..	*737.41	36.90	Gonal-f Pen	SG
8715Q	follitropin alfa 900 international units / 1.5 mL (65.52 microgram/1.5 mL) injection, 1 x 1.5 mL cartridge	2	5	..	*980.94	36.90	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.

8565T	follitropin beta 300 international units/0.36 mL injection, 1 x 0.36 mL cartridge	3	5	..	*509.95	36.90	Puregon 300 IU/0.36 mL	MK
8566W	follitropin beta 600 international units/0.72 mL injection, 1 x 0.72 mL cartridge	2	5	..	*661.40	36.90	Puregon 600 IU/0.72 mL	MK
8871X	follitropin beta 900 international units/1.08 mL injection, 1 x 1.08 mL cartridge	2	5	..	*979.92	36.90	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

GENITO URINARY SYSTEM AND SEX HORMONES

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

1581F	gonadotrophin chorionic human 1500 international units injection [3 x 1500 international units ampoules] (& inert substance diluent [3 x 1 mL ampoules], 1 pack	1	5	..	53.81	36.90	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.

1211R	clomiphene citrate 50 mg tablet, 10	1	5	..	34.85	36.00	^a Clomid	SW
							^a Serophene	SG

ANTIANDROGENS

Antiandrogens, plain

CYPROTERONE

Authority required (STREAMLINED)

1014

Advanced carcinoma of the prostate

Authority required (STREAMLINED)

1404

To reduce drive in sexual deviations in males

8019C	cyproterone acetate 100 mg tablet, 50	1	5	..	99.89	36.90	^a Cyprocur 100	QA
							^a Cyprostat-100	SY
							^a Cyproterone AN	EA
							^a Cyproterone Sandoz	HX
							^a GenRx Cyproterone Acetate	GX
							^a Procur 100	GN
				^b 0.94	100.83	36.90	^a Androcur-100	BN
1270W	cyproterone acetate 50 mg tablet, 50	2	5	..	*126.34	36.90	^a Cyprocur 50	QA
							^a Cyprone	AF
							^a Cyprostat	SY
							^a Cyproterone AN	EA
							^a Cyproterone Sandoz	HX
							^a Cyrotone	ER
							^a GenRx Cyproterone Acetate	GX
							^a Procur	GN
				^b 2.24	*128.58	36.90	^a Androcur	BN

CYPROTERONE

Authority required (STREAMLINED)

1230

Moderate to severe androgenisation in non-pregnant women (acne alone is not a sufficient indication of androgenisation)

Caution

GENITO URINARY SYSTEM AND SEX HORMONES

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
This drug should not be used during pregnancy as it may result in feminisation of the male foetus.								
1269T	cyproterone acetate 50 mg tablet, 20	1	5	..	31.76	32.91	^a Cyprocur 50	QA
							^a Cyprone	AF
							^a Cyprostat	SY
							^a Cyproterone AN	EA
							^a Cyproterone Sandoz	HX
							^a GenRx Cyproterone Acetate	GX
							^a Procur	GN
				^b 2.44	34.20	32.91	^a Androcur	BN

OTHER SEX HORMONES AND MODULATORS OF THE GENITAL SYSTEM

Antigonadotropins and similar agents

DANAZOL

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)

Caution

Pregnancy must be excluded prior to administration of this drug.

1285P	danazol 100 mg capsule, 100	1	5	..	58.92	36.90	Azol 100	AF
1287R	danazol 200 mg capsule, 100	1	5	..	87.31	36.90	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)

8015W	gestrinone 2.5 mg capsule, 8	1	5	..	82.15	36.90	Dimetrioze	SW

Antiprogestogens

MIFEPRISTONE

Authority required

Termination of an intra-uterine pregnancy

Clinical criteria:

The condition must be an intra-uterine pregnancy of up to 49 days of gestation,

AND

The treatment must be in sequential combination with misoprostol 800 micrograms.

Treatment criteria:

Must be treated by a prescriber who is registered with the MS 2 Step Prescribing Program.

An authority prescription for misoprostol 200 microgram tablets must be sought at the time of authority application.

Note

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

Note

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

2710P	mifepristone 200 mg tablet, 1	1	..	..	320.22	36.90	Mifepristone Linepharma	XH

GENITO URINARY SYSTEM AND SEX HORMONES

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

UROLOGICALS

UROLOGICALS

Drugs for urinary frequency and incontinence

OXYBUTYNIN

Restricted benefit

Detrusor overactivity in a patient who cannot tolerate oral oxybutynin, or who cannot swallow oral oxybutynin

9454N NP	oxybutynin 3.9 mg/24 hours patch, 8	\$1	5	..	35.57	36.72	Oxytrol	GN

OXYBUTYNIN

Restricted benefit

Detrusor overactivity

8039D NP	oxybutynin hydrochloride 5 mg tablet, 100	1	5	..	13.80	14.95	^a Ditropan	SW
							^a Oxybutynin Sandoz	SZ
							^a Oxybutynin Winthrop	WA

PROPANTHELINE

Restricted benefit

Detrusor overactivity

1953T NP	propantheline bromide 15 mg tablet, 100	2	5	..	*26.80	27.95	Pro-Banthine	QA

Other urologicals

BICARBONATE

9470K NP	sodium bicarbonate 840 mg capsule, 100	1	2	..	14.34	15.49	Sodibic	AS

PHENOXYBENZAMINE

Restricted benefit

Phaeochromocytoma

Restricted benefit

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.

1862B NP	phenoxybenzamine hydrochloride 10 mg capsule, 100	1	5	..	67.71	36.90	Dibenyline	GH
9286R NP	phenoxybenzamine hydrochloride 10 mg capsule, 100	1	5	..	1164.81	36.90	Dibenzyline	BZ
1166J NP	phenoxybenzamine hydrochloride 10 mg capsule, 30	3	5	..	*205.24	36.90	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.

5490Y NP	dutasteride 500 microgram + tamsulosin hydrochloride 400 microgram capsule: modified release, 30	1	5	..	35.63	36.78	Duodart 500ug/400ug	GK

Testosterone-5-alpha reductase inhibitors

DUTASTERIDE

GENITO URINARY SYSTEM AND SEX HORMONES

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
<u>Authority required (STREAMLINED)</u>							
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							
<u>Note</u>							
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.							
5468T NP	dutasteride 500 microgram capsule, 30	1	5	..	30.77	31.92	Avodart GK

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES

ANTERIOR PITUITARY LOBE HORMONES AND ANALOGUES

ACTH

TETRACOSACTRIN

2832C	tetracosactrin 1 mg/mL injection: modified release, 1 x 1 mL ampoule	5	5	..	*71.61	36.90	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

2700D	thyrotropin alfa 900 microgram injection, 2 x 900 microgram vials	1	..	..	1901.76	36.90	Thyrogen	GZ

POSTERIOR PITUITARY LOBE HORMONES

Vasopressin and analogues

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.

Note

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.

9398P NP	desmopressin 120 microgram wafer: sublingual, 30	1	5	..	71.19	36.90	Minirin Melt	FP
8975J NP	desmopressin 240 microgram wafer: sublingual, 30	1	5	..	116.28	36.90	Minirin Melt	FP

DESMOPRESSIN

Authority required (STREAMLINED)

1678

Cranial diabetes insipidus

8711L	desmopressin acetate 10 microgram/actuation nasal spray, 60 actuations	2	5	..	*161.38	36.90	Minirin Nasal Spray	FP
2129C	desmopressin acetate 100 microgram/mL nasal drops, 2.5 mL	5	5	..	*161.51	36.90	Minirin	FP
8662X	desmopressin acetate 200 microgram tablet, 30	3	5	..	*180.25	36.90	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

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

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.

8712M NP	desmopressin acetate 10 microgram/actuation nasal spray, 60 actuations	\$1	5	..	84.07	36.90	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.

Note

Only one application per six months with no more than twice the maximum quantity will be authorised for the tablets.

8663Y NP	desmopressin acetate 200 microgram tablet, 30	1	5	..	64.59	36.90	Minirin	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

2962X	nafarelin 200 microgram/actuation nasal spray, 60 actuations	\$1	5	..	132.13	36.90	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.

1433K NP	fludrocortisone acetate 100 microgram tablet, 100	2	1	..	*46.84	36.90	Florinef	QA

Glucocorticoids

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

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	<u>Restricted benefit</u> Lichen simplex chronicus							
	<u>Restricted benefit</u> Lupus erythematosus, chronic discoid							
	<u>Restricted benefit</u> Necrobiosis lipoidica							
	<u>Restricted benefit</u> Uveitis							
	<u>Note</u> 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.							
2694T NP	betamethasone (as acetate) 2.71 mg/mL + betamethasone (as sodium phosphate) 2.96 mg/mL injection, 5 x 1 mL ampoules	1	..	..	25.34	26.49	Celestone Chronodose	MK
	BETAMETHASONE ACETATE + BETAMETHASONE SODIUM PHOSPHATE							
	<u>Restricted benefit</u> For local intra-articular or peri-articular infiltration							
	<u>Restricted benefit</u> Keloid							
	<u>Restricted benefit</u> Lichen planus hypertrophic							
5034Y DP	betamethasone (as acetate) 2.71 mg/mL + betamethasone (as sodium phosphate) 2.96 mg/mL injection, 5 x 1 mL ampoules	1	..	..	25.34	26.49	Celestone Chronodose	MK
	CORTISONE							
	<u>Note</u> 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.							
1247P NP	cortisone acetate 25 mg tablet, 60	1	4	..	18.08	19.23	Cortate	AS
1246N NP	cortisone acetate 5 mg tablet, 50	1	4	..	15.64	16.79	Cortate	AS
	DEXAMETHASONE							
	<u>Note</u> 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.							
2507Y NP	DEXAMETHASONE Tablet 4 mg, 30	1	4	..	12.74	13.89	Dexamethsone	AS
1292B NP	DEXAMETHASONE Tablet 500 micrograms, 30	1	4	..	9.18	10.33	Dexamethsone	AS
	DEXAMETHASONE SODIUM PHOSPHATE							
	<u>Note</u> 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.							
2509C NP	DEXAMETHASONE SODIUM PHOSPHATE Injection equivalent to 4 mg dexamethasone phosphate in 1 mL, 5	1	..	..	13.55	14.70 ^a	Dexamethsone	AF
1291Y NP	DEXAMETHASONE SODIUM PHOSPHATE Injection equivalent to 8 mg dexamethasone phosphate in 2 mL, 5	1	1	..	19.10	20.25 ^a	Hospira Pty Limited Dexamethsone	HH AF

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer ^a	
							Hospira Pty Limited	HH
	HYDROCORTISONE							
	<u>Note</u>							
	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.							
1500Y NP	hydrocortisone 20 mg tablet, 60	1	4	..	30.50	31.65	Hysone 20	AF
1499X NP	hydrocortisone 4 mg tablet, 50	1	4	..	23.39	24.54	Hysone 4	AF
	HYDROCORTISONE SODIUM SUCCINATE							
1501B NP	hydrocortisone (as sodium succinate) 100 mg injection [1 x 100 mg vial] (& inert substance diluent [1 x 2 mL vial], 1 pack	2	..	..	*18.04	19.19	Solu-Cortef	PF
3096Y NP	hydrocortisone (as sodium succinate) 250 mg injection [1 x 250 mg vial] (& inert substance diluent [1 x 2 mL vial], 1 pack	1	..	..	16.83	17.98	Solu-Cortef	PF
	HYDROCORTISONE SODIUM SUCCINATE							
	<u>Restricted benefit</u>							
	For use in a hospital							
1510L NP	hydrocortisone (as sodium succinate) 100 mg injection [1 x 100 mg vial] (& inert substance diluent [1 x 2 mL vial], 1 pack	6	..	..	*40.60	36.90	Solu-Cortef	PF
5118J DP	hydrocortisone (as sodium succinate) 100 mg injection [1 x 100 mg vial] (& inert substance diluent [1 x 2 mL vial], 1 pack	6	..	..	*40.60	36.90	Solu-Cortef	PF
1511M NP	hydrocortisone (as sodium succinate) 250 mg injection [1 x 250 mg vial] (& inert substance diluent [1 x 2 mL vial], 1 pack	6	..	..	*64.60	36.90	Solu-Cortef	PF
5119K DP	hydrocortisone (as sodium succinate) 250 mg injection [1 x 250 mg vial] (& inert substance diluent [1 x 2 mL vial], 1 pack	6	..	..	*64.60	36.90	Solu-Cortef	PF
	METHYLPREDNISOLONE							
	<u>Note</u>							
	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.							
8834Y NP	methylprednisolone 1 g injection [1 x 1 g vial] (& inert substance diluent [1 x 16 mL vial], 1 pack	1	..	..	70.47	36.90	^a Solu-Medrol	PF
5264C NP	methylprednisolone Powder for injection 1 g (as sodium succinate), 1	1	..	..	70.47	36.90	^a Methylpred	AL
							^a Methylprednisolone Alphapharm	AF
	METHYLPREDNISOLONE							
	<u>Note</u>							
	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.							
2981X NP	methylprednisolone 40 mg injection [5 x 40 mg vials] (& inert substance diluent [5 x 1 mL vials], 1 pack	1	..	..	27.67	28.82	^a Solu-Medrol	PF
5263B NP	methylprednisolone Powder for injection 40 mg (as sodium succinate), 5	1	..	..	27.67	28.82	^a Methylpred	AL
	METHYLPREDNISOLONE							
	<u>Restricted benefit</u>							
	For local intra-articular or peri-articular infiltration							

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
1928L NP	methylprednisolone acetate 40 mg/mL injection, 5 x 1 mL vials	1	..	..	23.96	25.11	^a Depo-Nisolone	FZ
				^B 1.45	25.41	25.11	^a Depo-Medrol	PF
5148Y DP	methylprednisolone acetate 40 mg/mL injection, 5 x 1 mL vials	1	..	..	23.96	25.11	^a Depo-Nisolone	FZ
				^B 1.45	25.41	25.11	^a Depo-Medrol	PF
PREDNISOLONE								
3152X NP	prednisolone 1 mg tablet, 100	1	4	..	8.67	9.82	^a Predsolone	LN
				^B 0.82	9.49	9.82	^a Panafcortelone	AS
1916W NP	prednisolone 25 mg tablet, 30	1	4	..	10.47	11.62	Panafcortelone	AS
							Solone	IA
1917X NP	prednisolone 5 mg tablet, 60	1	4	..	8.81	9.96	Panafcortelone	AS
							Solone	IA
PREDNISOLONE SODIUM PHOSPHATE								
8285C NP	prednisolone (as sodium phosphate) 5 mg/mL oral liquid, 30 mL	±1	5	..	15.04	16.19	^a PredMix	LN
				^B 2.70	17.74	16.19	^a Redipred	AS
PREDNISONE								
1934T NP	prednisone 1 mg tablet, 100	1	4	..	9.20	10.35	^a Predsone	LN
				^B 0.91	10.11	10.35	^a Panafcort	AS
1936X NP	prednisone 25 mg tablet, 30	1	4	..	11.75	12.90	Panafcort	AS
							Sone	IA
1935W NP	prednisone 5 mg tablet, 60	1	4	..	9.52	10.67	Panafcort	AS
							Sone	IA
TRIAMCINOLONE								
<u>Restricted benefit</u>								
Alopecia areata								
<u>Restricted benefit</u>								
For local intra-articular or peri-articular infiltration								
<u>Restricted benefit</u>								
Granulomata, dermal								
<u>Restricted benefit</u>								
Keloid								
<u>Restricted benefit</u>								
Lichen planus hypertrophic								
<u>Restricted benefit</u>								
Lichen simplex chronicus								
<u>Restricted benefit</u>								
Lupus erythematosus, chronic discoid								
<u>Restricted benefit</u>								
Necrobiosis lipoidica								
<u>Restricted benefit</u>								
Psoriasis								
<u>Note</u>								
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.								
2990J NP	triamcinolone acetonide 10 mg/mL injection, 5 x 1 mL ampoules	1	..	..	25.34	26.49	Kenacort-A10	QA
TRIAMCINOLONE								
<u>Restricted benefit</u>								
For local intra-articular or peri-articular infiltration								

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	<u>Restricted benefit</u> Keloid							
	<u>Restricted benefit</u> Lichen planus hypertrophic							
5233K DP	triamcinolone acetonide 10 mg/mL injection, 5 x 1 mL ampoules	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.

2318B NP	liothyronine sodium 20 microgram tablet, 100	1	2	..	83.87	36.90	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.

2175L NP	thyroxine sodium 100 microgram tablet, 200	1	1	..	24.32	25.47	^a Eutroxsig	FM
				^b 2.21	26.53	25.47	^a Oroxine	QA
2173J NP	thyroxine sodium 200 microgram tablet, 200	1	1	..	27.35	28.50	^a Eutroxsig	FM
				^b 2.21	29.56	28.50	^a Oroxine	QA
2174K NP	thyroxine sodium 50 microgram tablet, 200	1	1	..	23.71	24.86	^a Eutroxsig	FM
				^b 2.20	25.91	24.86	^a Oroxine	QA
9287T NP	thyroxine sodium 75 microgram tablet, 200	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.

1955X NP	propylthiouracil 50 mg tablet, 100	2	2	..	*49.98	36.90	PTU	PL

Sulfur-containing imidazole derivatives

CARBIMAZOLE

Note

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
1153Q NP	carbimazole 5 mg tablet, 100	2	2	..	*31.38	32.53	Carbimazol ARISTO	PQ
							Neo-Mercazole	LM

PANCREATIC HORMONES

GLYCOGENOLYTIC HORMONES

Glycogenolytic hormones

GLUCAGON HYDROCHLORIDE

1449G NP	glucagon hydrochloride 1 mg injection [1 x 1 mg vial] (&) inert substance diluent [1 x 1 mL syringe], 1 pack	1	1	..	49.44	36.90	GlucaGen Hypokit	NO
5105Q DP	glucagon hydrochloride 1 mg injection [1 x 1 mg vial] (&) inert substance diluent [1 x 1 mL syringe], 1 pack	1	..	..	49.44	36.90	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.

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	<u>Note</u> Details of accepted toxicities including severity can be found on the Department of Human Services website at www.humanservices.gov.au. <u>Note</u> No increase in the maximum quantity or number of units may be authorised. <u>Note</u> No increase in the maximum number of repeats may be authorised. <u>Note</u> Special Pricing Arrangements apply. <u>Authority required</u> 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. <u>Note</u> Up to a maximum of 18 pens will be reimbursed through the PBS. <u>Note</u> No increase in the maximum quantity or number of units may be authorised. <u>Note</u> No increase in the maximum number of repeats may be authorised. <u>Note</u> Special Pricing Arrangements apply.						
9411H	teriparatide 20 microgram/dose injection, 1 x 2.4 mL cartridge	1	5	..	438.71	36.90	Forteo LY

ANTI-PARATHYROID AGENTS

Calcitonin preparations

SALCATONIN

Authority required (STREAMLINED)

3256

Symptomatic Paget disease of bone

Authority required (STREAMLINED)

1412

Treatment initiated in a hospital (in-patient or out-patient) of hypercalcaemia

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.

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.

2997R NP	salcatonin 100 international units/mL injection, 5 x 1 mL ampoules	3	5	..	*161.47	36.90	Miacalcic 100	NV
2995P NP	salcatonin 50 international units/mL injection, 5 x 1 mL ampoules	6	5	..	*208.00	36.90	Miacalcic 50	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

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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. Note Special Pricing Arrangements apply. 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.								
9157Y NP	cinacalcet 30 mg tablet, 28	1	5	..	232.23	36.90	Sensipar	AN
9158B NP	cinacalcet 60 mg tablet, 28	1	5	..	439.70	36.90	Sensipar	AN
9159C NP	cinacalcet 90 mg tablet, 28	1	5	..	654.07	36.90	Sensipar	AN

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

ANTIINFECTIVES FOR SYSTEMIC USE

ANTIBACTERIALS FOR SYSTEMIC USE

TETRACYCLINES

Tetracyclines

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.

2715X NP	doxycycline 100 mg capsule: modified release, 21 capsules	1	..	^B 2.25	12.83	11.73	^a	Mayne Pharma Doxycycline	YT
				^B 5.51	16.09	11.73	^a	Doryx	YN
10176N NP	doxycycline 100 mg tablet, 21	1	..	..	10.58	11.73	^a	Doxycycline AN	EA
1800R NP	doxycycline 100 mg tablet, 21	1	..	..	10.58	11.73	^a	GenRx Doxycycline	GX
2714W NP	doxycycline 100 mg tablet, 7	3	..	..	*10.60	11.75	^a	Doxsig	QA
							^a	Doxy-100	GN
							^a	Doxycycline AN	EA
							^a	Doxylin 100	AF
9108J NP	doxycycline 100 mg tablet, 7	3	..	..	*10.60	11.75	^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.

2703G NP	doxycycline 100 mg capsule: modified release, 7 capsules	4	..	^B 3.96	*15.84	13.03	^a	Mayne Pharma Doxycycline	YT
				^B 9.36	*21.24	13.03	^a	Doryx	YN
2702F NP	doxycycline 100 mg tablet, 7	4	..	..	*11.88	13.03	^a	Doxsig	QA
							^a	Doxy-100	GN
							^a	Doxylin 100	AF
9107H NP	doxycycline 100 mg tablet, 7	4	..	..	*11.88	13.03	^a	Chem mart Doxycycline	CH
							^a	Doxycycline Sandoz	HX
							^a	GenRx Doxycycline	GX
							^a	Terry White Chemists Doxycycline	TW

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.

2708M NP	doxycycline 100 mg capsule: modified release, 7 capsules	1	1	^B 0.99	9.03	9.19	^a	Mayne Pharma Doxycycline	YT
				^B 2.34	10.38	9.19	^a	Doryx	YN
3322W DP	doxycycline 100 mg capsule: modified release, 7 capsules	1	..	^B 0.99	9.03	9.19	^a	Mayne Pharma Doxycycline	YT
				^B 2.34	10.38	9.19	^a	Doryx	YN
2709N NP	doxycycline 100 mg tablet, 7	1	1	..	8.04	9.19	^a	Doxsig	QA
							^a	Doxy-100	GN

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
3321T <i>DP</i>	doxycycline 100 mg tablet, 7	1	..	..	8.04	9.19	^a Doxycycline AN	EA
							^a Doxylin 100	AF
							^a Doxsig	QA
5082L <i>DP</i>	doxycycline 100 mg tablet, 7	1	..	..	8.04	9.19	^a Doxy-100	GN
							^a Doxycycline AN	EA
							^a Doxylin 100	AF
9105F <i>NP</i>	doxycycline 100 mg tablet, 7	1	1	..	8.04	9.19	^a Chem mart Doxycycline	CH
							^a Doxycycline Sandoz	HX
							^a GenRx Doxycycline	GX
							^a Terry White Chemists Doxycycline	TW
							^a Chem mart Doxycycline	CH
							^a Doxycycline Sandoz	HX
							^a GenRx Doxycycline	GX
							^a Terry White Chemists Doxycycline	TW
							^a Doxycycline Sandoz	HX

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.

2707L <i>NP</i>	doxycycline 50 mg capsule: modified release, 25 capsules	1	5	^B 1.63	10.66	10.18	^a Mayne Pharma Doxycycline	YT
				^B 3.93	12.96	10.18	^a Doryx	YN
2711Q <i>NP</i>	doxycycline 50 mg tablet, 25	1	5	..	9.03	10.18	^a Doxy-50	GN
							^a Doxycycline AN	EA
9106G <i>NP</i>	doxycycline 50 mg tablet, 25	1	5	..	9.03	10.18	^a Doxylin 50	AF
							^a Chem mart Doxycycline	CH
							^a Doxycycline Sandoz	HX
							^a Frakas	QA
							^a GenRx Doxycycline	GX
							^a Terry White Chemists Doxycycline	TW

MINOCYCLINE

Restricted benefit

Severe acne not responding to other tetracyclines

Caution

There are concerns about the incidence of benign intracranial hypertension associated with this drug.

Note

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

1616C <i>NP</i>	minocycline 50 mg tablet, 60	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

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
AMOXYCILLIN							
<u>Restricted benefit</u>							
Acute exacerbations of chronic bronchitis							
8581P NP	amoxycillin 1 g tablet, 14	1	1	..	8.58	9.73	^a Amoxycillin Sandoz BG
				^b 0.48	9.06	9.73	^a Maxamox SZ
AMOXYCILLIN							
1888J NP	amoxycillin 100 mg/mL oral liquid: powder for, 20 mL	#1	1	^s 0.61	#14.23	15.12	Amoxil AS
3310F DP	amoxycillin 100 mg/mL oral liquid: powder for, 20 mL	#1	..	^s 0.61	#14.23	15.12	Amoxil AS
1886G NP	amoxycillin 125 mg/5 mL oral liquid: powder for, 100 mL	#1	1	..	#10.18	11.68	^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 3.35	#13.53	11.68	^a Amoxil AS
3302T DP	amoxycillin 125 mg/5 mL oral liquid: powder for, 100 mL	#1	..	..	#10.18	11.68	^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 3.35	#13.53	11.68	^a Amoxil AS
1884E NP,MW	amoxycillin 250 mg capsule, 20	1	1	..	7.65	8.80	^a Alphamox 250 AF
							^a Amoxycillin AN EA
							^a Amoxycillin-GA GN
							^a Amoxycillin Ranbaxy RA
							^a Amoxycillin Sandoz SZ
							^a APO-Amoxycillin TX
							^a Chem mart Amoxycillin CH
							^a Cilamox QA
							^a Terry White Chemists Amoxycillin TW
							^a Yomax 250 DO
				^b 3.37	11.02	8.80	^a Amoxil AS
3301R DP	amoxycillin 250 mg capsule, 20	1	..	..	7.65	8.80	^a Alphamox 250 AF
							^a Amoxycillin AN EA
							^a Amoxycillin-GA GN
							^a Amoxycillin Ranbaxy RA
							^a Amoxycillin Sandoz SZ
							^a APO-Amoxycillin TX
							^a Chem mart Amoxycillin CH
							^a Cilamox QA
							^a Terry White Chemists Amoxycillin TW
							^a Yomax 250 DO
				^b 3.37	11.02	8.80	^a Amoxil AS
1887H NP	amoxycillin 250 mg/5 mL oral liquid: powder for, 100 mL	#1	1	..	#10.53	12.03	^a Alphamox 250 AF
							^a Amoxycillin Sandoz SZ
							^a APO-Amoxycillin TX

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
3393N <i>DP</i>	amoxycillin 250 mg/5 mL oral liquid: powder for, 100 mL	#1	..	..	#10.53	12.03	^a Bgramin	GN
							^a Chem mart Amoxycillin	CH
							^a Cilamox	QA
							^a GenRx Amoxycillin	GX
							^a Ranmoxy	RA
							^a Terry White Chemists Amoxycillin	TW
							^a Amoxil Forte	AS
							^a Alphamox 250	AF
							^a Amoxycillin Sandoz	SZ
							^a APO-Amoxycillin	TX
							^a Bgramin	GN
							^a Chem mart Amoxycillin	CH
							^a Cilamox	QA
							^a GenRx Amoxycillin	GX
1889K <i>NP, MW</i>	amoxycillin 500 mg capsule, 20	1	1	..	#8.53	9.68	^a Ranmoxy	RA
							^a Terry White Chemists Amoxycillin	TW
							^a Amoxil Forte	AS
							^a Alphamox 500	AF
							^a Amoxycillin AN	EA
							^a Amoxycillin-GA	GN
							^a Amoxycillin generichealth 500	GQ
							^a Amoxycillin Ranbaxy	RA
							^a Amoxycillin Sandoz	SZ
							^a APO-Amoxycillin	TX
							^a Chem mart Amoxycillin	CH
							^a Cilamox	QA
							^a Terry White Chemists Amoxycillin	TW
							^a Yomax 500	DO
3300Q <i>DP</i>	amoxycillin 500 mg capsule, 20	1	..	..	#8.53	9.68	^a Amoxil	AS
							^a Alphamox 500	AF
							^a Amoxycillin AN	EA
							^a Amoxycillin-GA	GN
							^a Amoxycillin generichealth 500	GQ
							^a Amoxycillin Ranbaxy	RA
							^a Amoxycillin Sandoz	SZ
							^a APO-Amoxycillin	TX
							^a Chem mart Amoxycillin	CH
							^a Cilamox	QA
							^a Terry White Chemists Amoxycillin	TW
							^a Yomax 500	DO
							^a Amoxil	AS
							^a Maxamox	SZ
							^a Maxamox	SZ
5225B <i>DP</i>	amoxycillin 500 mg/5 mL oral liquid: powder for, 100 mL	#1	..	..	#11.79	13.29	Maxamox	SZ
8705E <i>NP</i>	amoxycillin 500 mg/5 mL oral liquid: powder for, 100 mL	#1	1	..	#11.79	13.29	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

9714G <i>NP</i>	amoxycillin 100 mg/mL oral liquid: powder for, 20 mL	#1	1	..	#14.23	15.73	Amoxil	AS

AMPICILLIN

2977Q <i>NP</i>	ampicillin 1 g injection, 5 x 1 g vials	1	1	..	13.22	14.37	^a Aspen Ampicyn	AF
							^a Austrapen	AL

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
3314K DP	ampicillin 1 g injection, 5 x 1 g vials	1	..	..	13.22	14.37	^a Ibimicyn ^a Aspen Ampicyn	GN AF
2390T NP	ampicillin 500 mg injection, 5 x 500 mg vials	1	1	..	10.69	11.84	^a Austrapen ^a Ibimicyn ^a Austrapen	AL GN AL
3313J DP	ampicillin 500 mg injection, 5 x 500 mg vials	1	..	..	10.69	11.84	^a Ibimicyn ^a Austrapen ^a Ibimicyn	GN AL GN
Beta-lactamase sensitive penicillins								
BENZATHINE BENZYL PENICILLIN								
2267H NP	BENZATHINE BENZYL PENICILLIN Injection 900 mg in 2.3 mL single use pre-filled syringe, 10	1	..	..	318.90	36.90	Bicillin L-A	PF
5027N DP	BENZATHINE BENZYL PENICILLIN Injection 900 mg in 2.3 mL single use pre-filled syringe, 10	1	..	..	318.90	36.90	Bicillin L-A	PF
BENZYL PENICILLIN								
2647H NP	benzylpenicillin 3 g injection, 1 x 3 g vial	10	..	..	*89.86	36.90	BenPen	CS
3399X DP	benzylpenicillin 3 g injection, 1 x 3 g vial	10	..	..	*89.86	36.90	BenPen	CS
1775K NP, MW	benzylpenicillin 600 mg injection, 1 x 600 mg vial	10	1	..	*55.06	36.90	BenPen	CS
3398W DP	benzylpenicillin 600 mg injection, 1 x 600 mg vial	10	..	..	*55.06	36.90	BenPen	CS
PHENOXYMETHYL PENICILLIN								
5024K DP	phenoxymethylpenicillin 125 mg/5 mL oral liquid: powder for, 100 mL	2	..	..	*#17.15	18.65	Phenoxymethylpenicillin-AFT	AE
8976K NP	phenoxymethylpenicillin 125 mg/5 mL oral liquid: powder for, 100 mL	2	1	..	*#17.15	18.65	Phenoxymethylpenicillin-AFT	AE
5012T DP	phenoxymethylpenicillin 150 mg/5 mL oral liquid, 100 mL	2	..	..	*21.94	23.09	^a Cilicaine V	FM
9143F NP	phenoxymethylpenicillin 150 mg/5 mL oral liquid, 100 mL	2	1	^B 1.90	*23.84 *21.94	23.09 23.09	^a Abbecillin-V ^a Cilicaine V	QA FM
1789E NP	phenoxymethylpenicillin 250 mg capsule, 50	1	..	..	11.50	12.65	^a Abbecillin-V LPV	QA IA
3363B DP	phenoxymethylpenicillin 250 mg capsule, 50	1	..	..	11.50	12.65	^a Cilicaine VK ^a Cilopen VK ^a Cilicaine VK	FM GN FM
1787C NP	phenoxymethylpenicillin 250 mg tablet, 25	2	..	..	*11.66	12.81	^a Cilopen VK LPV Abbecillin-VK Filmstab	GN IA QA
3360W DP	phenoxymethylpenicillin 250 mg tablet, 25	2	..	..	*11.66	12.81	Abbecillin-VK Filmstab	QA
5029Q DP	phenoxymethylpenicillin 250 mg/5 mL oral liquid: powder for, 100 mL	2	..	..	*#19.71	21.21	Phenoxymethylpenicillin-AFT	AE
8977L NP	phenoxymethylpenicillin 250 mg/5 mL oral liquid: powder for, 100 mL	2	1	..	*#19.71	21.21	Phenoxymethylpenicillin-AFT	AE
2965C NP	phenoxymethylpenicillin 500 mg capsule, 50	1	..	..	13.81	14.96	LPV	IA
3364C DP	phenoxymethylpenicillin 500 mg capsule, 50	1	..	..	13.81	14.96	^a Cilicaine VK ^a Cilopen VK ^a Cilicaine VK	FM GN FM
3028J NP	phenoxymethylpenicillin 500 mg tablet, 25	2	..	..	*14.00	15.15	^a Cilopen VK LPV Abbecillin-VK Filmstab	GN IA QA

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
3361X DP	phenoxymethylpenicillin 500 mg tablet, 25	2	..	..	*14.00	15.15	Abbocillin-VK Filmtab	QA
PHENOXYMETHYLPENICILLIN								
<u>Restricted benefit</u>								
Prophylaxis of recurrent streptococcal infections (including rheumatic fever)								
1705R NP	phenoxymethylpenicillin 250 mg capsule, 50	1	5	..	11.50	12.65	^a Cilicaine VK	FM
							^a Cilopen VK LPV	GN IA
1703P NP	phenoxymethylpenicillin 250 mg tablet, 25	2	5	..	*11.66	12.81	Abbocillin-VK Filmtab	QA
PROCAINE PENICILLIN								
1794K NP	procaine penicillin 1.5 g/3.4 mL injection, 5 x 3.4 mL syringes	1	..	..	92.56	36.90	Cilicaine	QA
3371K DP	procaine penicillin 1.5 g/3.4 mL injection, 5 x 3.4 mL syringes	1	..	..	92.56	36.90	Cilicaine	QA
<i>Beta-lactamase resistant penicillins</i>								
DICLOXACILLIN								
<u>Restricted benefit</u>								
Serious staphylococcal infections								
5096F DP	dicloxacillin 250 mg capsule, 24	1	..	..	12.44	13.59	Distaph 250	AF
8121K NP,MW	dicloxacillin 250 mg capsule, 24	1	..	..	12.44	13.59	Distaph 250	AF
5097G DP	dicloxacillin 500 mg capsule, 24	1	..	..	16.75	17.90	Distaph 500	AF
8122L NP,MW	dicloxacillin 500 mg capsule, 24	1	..	..	16.75	17.90	Distaph 500	AF
FLUCLOXACILLIN								
<u>Caution</u>								
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.								
1525G NP	flucloxacillin 1 g injection, 5 x 1 g vials	1	1	..	11.91	13.06	^a Flubiclox	GN
							^a Flucil	AS
							^a Hospira Pty Limited	HH
5095E DP	flucloxacillin 1 g injection, 5 x 1 g vials	1	..	..	11.91	13.06	^a Flubiclox	GN
							^a Flucil	AS
							^a Hospira Pty Limited	HH
1524F NP	flucloxacillin 500 mg injection, 5 x 500 mg vials	1	..	..	10.05	11.20	^a Flubiclox	GN
							^a Flucil	AS
5094D DP	flucloxacillin 500 mg injection, 5 x 500 mg vials	1	..	..	10.05	11.20	^a Flubiclox	GN
							^a Flucil	AS
FLUCLOXACILLIN								
<u>Restricted benefit</u>								
Serious staphylococcal infections								
<u>Caution</u>								
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.								
5257Q DP	flucloxacillin 125 mg/5 mL oral liquid: powder for, 100 mL	#1	..	..	#16.44	17.94	Flucil	LN
9149M NP	flucloxacillin 125 mg/5 mL oral liquid: powder for, 100 mL	#1	..	..	#16.44	17.94	Flucil	LN
1526H NP,MW	flucloxacillin 250 mg capsule, 24	1	..	..	11.53	12.68	^a Flopen	AS
							^a Staphylex 250	AF
5090X DP	flucloxacillin 250 mg capsule, 24	1	..	..	11.53	12.68	^a Flopen	AS
							^a Staphylex 250	AF

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
5258R DP	flucloxacillin 250 mg/5 mL oral liquid: powder for, 100 mL	\$1	..	..	#19.97	21.47	Flucil	LN
9150N NP	flucloxacillin 250 mg/5 mL oral liquid: powder for, 100 mL	\$1	..	..	#19.97	21.47	Flucil	LN
1527J NP,MW	flucloxacillin 500 mg capsule, 24	1	..	..	16.75	17.90	^a Flopen	AS
5091Y DP	flucloxacillin 500 mg capsule, 24	1	..	..	16.75	17.90	^a Staphylex 500 ^a Flopen	AF AS
							^a Staphylex 500	AF

Combinations of penicillins, incl. beta-lactamase inhibitors

AMOXYCILLIN + CLAVULANIC ACID

Restricted benefit

Infections where resistance to amoxycillin is suspected

Restricted benefit

Infections where resistance to amoxycillin is proven

Caution

Hepatotoxicity has been reported with this drug.

1892N NP	amoxycillin 125 mg/5 mL + clavulanic acid 31.25 mg/5 mL oral liquid: powder for, 75 mL	\$1	1	..	#10.94	12.44	^a Clamoxyl	AL
							^a Curam	SZ
				^B 3.27	#14.21	12.44	^a GA-Amclav 125/31.25	GN
							^a Augmentin	AS
5009P DP	amoxycillin 125 mg/5 mL + clavulanic acid 31.25 mg/5 mL oral liquid: powder for, 75 mL	\$1	..	..	#10.94	12.44	^a Clamoxyl	AL
							^a Curam	SZ
				^B 3.27	#14.21	12.44	^a GA-Amclav 125/31.25	GN
							^a Augmentin	AS
5011R DP	amoxycillin 400 mg/5 mL + clavulanic acid 57 mg/5 mL oral liquid: powder for, 60 mL	\$1	..	..	#11.62	13.12	^a Clamoxyl Duo 400	AL
							^a Curam Duo	SZ
							^a GA-Amclav Forte 400/57	GN
				^B 4.58	#16.20	13.12	^a Augmentin Duo 400	AS
8319W NP	amoxycillin 400 mg/5 mL + clavulanic acid 57 mg/5 mL oral liquid: powder for, 60 mL	\$1	1	..	#11.62	13.12	^a Clamoxyl Duo 400	AL
							^a Curam Duo	SZ
							^a GA-Amclav Forte 400/57	GN
				^B 4.58	#16.20	13.12	^a Augmentin Duo 400	AS
1891M NP,MW	amoxycillin 500 mg + clavulanic acid 125 mg tablet, 10	1	1	..	9.30	10.45	^a Amoxiclav AN 500/125	EA
							^a APO-Amoxycillin/Clavulanic Acid 500/125	TX
							^a Clamoxyl Duo	AL
							^a Curam Duo 500/125	SZ
							^a GA-Amclav 500/125	GN
							^a Moxiclav Duo 500/125	QA
							^a Pharmacor AmoxyClav 500/125	CR
				^B 4.57	13.87	10.45	^a Augmentin Duo	AS
5008N DP	amoxycillin 500 mg + clavulanic acid 125 mg tablet, 10	1	..	..	9.30	10.45	^a Amoxiclav AN 500/125	EA
							^a APO-Amoxycillin/Clavulanic Acid 500/125	TX
							^a Clamoxyl Duo	AL
							^a Curam Duo 500/125	SZ
							^a GA-Amclav 500/125	GN
							^a Moxiclav Duo 500/125	QA

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
5006L <i>DP</i>	amoxycillin 875 mg + clavulanic acid 125 mg tablet, 10	1	..	..	10.38	11.53	^a Pharmacor AmoxyClav 500/125	CR
							^a Augmentin Duo	AS
							^a Amoxiclav AN 875/125	EA
							^a AmoxyClav GH 875/125	GQ
							^a AmoxyClav RBX 875/125	RA
							^a APO-Amoxycillin and Clavulanic Acid	TX
							^a Chem mart Amoxycillin and Clavulanic Acid	CH
							^a Clamoxyl Duo forte	AL
							^a Clavam 875 mg/125 mg	NJ
							^a Curam Duo Forte 875/125	SZ
							^a GA-Amclav Forte 875/125	GN
							^a GenRx Amoxycillin and Clavulanic Acid	GX
							^a Moxiclav Duo Forte 875/125	QA
							^a Pharmacor AmoxyClav 875/125	CR
							^a Terry White Chemists Amoxycillin and Clavulanic Acid	TW
8254K <i>NP</i>	amoxycillin 875 mg + clavulanic acid 125 mg tablet, 10	1	1	..	10.38	11.53	^a Augmentin Duo forte	AS
							^a Amoxiclav AN 875/125	EA
							^a AmoxyClav GH 875/125	GQ
							^a AmoxyClav RBX 875/125	RA
							^a APO-Amoxycillin and Clavulanic Acid	TX
							^a Chem mart Amoxycillin and Clavulanic Acid	CH
							^a Clamoxyl Duo forte	AL
							^a Clavam 875 mg/125 mg	NJ
							^a Curam Duo Forte 875/125	SZ
							^a GA-Amclav Forte 875/125	GN
							^a GenRx Amoxycillin and Clavulanic Acid	GX
							^a Moxiclav Duo Forte 875/125	QA
							^a Pharmacor AmoxyClav 875/125	CR
							^a Terry White Chemists Amoxycillin and Clavulanic Acid	TW
							^a Augmentin Duo forte	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.

10113G <i>NP</i>	ticarcillin 3 g + clavulanic acid 100 mg injection, 1 x 3.1 g vial	10	..	..	*163.76	36.90	Timentin	AS

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
TICARCILLIN + CLAVULANIC ACID								
<u>Restricted benefit</u>								
Infections where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent								
10125X DP	ticarclillin 3 g + clavulanic acid 100 mg injection, 1 x 3.1 g vial	10	..	..	*163.76	36.90	Timentin	AS
OTHER BETA-LACTAM ANTIBACTERIALS								
<i>First-generation cephalosporins</i>								
CEPHALEXIN								
3094W NP	cephalexin 125 mg/5 mL oral liquid: powder for, 100 mL	#1	1	..	#10.74	12.24	^a APO-Cephalexin	TX
							^a Cefalexin Sandoz	SZ
							^a Chem mart Cephalexin	CH
							^a Cilex	GN
							^a Ialex	LN
							^a Ibilex 125	AF
							^a Terry White Chemists Cephalexin	TW
3319Q DP	cephalexin 125 mg/5 mL oral liquid: powder for, 100 mL	#1	..	^B 4.77	#15.51 #10.74	12.24 12.24	^a Keflex	AS
				..			^a APO-Cephalexin	TX
							^a Cefalexin Sandoz	SZ
							^a Chem mart Cephalexin	CH
							^a Cilex	GN
							^a Ialex	LN
							^a Ibilex 125	AF
							^a Terry White Chemists Cephalexin	TW
3058Y NP,MW	cephalexin 250 mg capsule, 20	1	1	^B 4.77	#15.51 7.89	12.24 9.04	^a Keflex	AS
				..			^a APO-Cephalexin	TX
							^a Cefalexin Sandoz	SZ
							^a Cephalex 250	CR
							^a Cephalexin AN	EA
							^a Cephalexin generichealth	GQ
							^a Chem mart Cephalexin	CH
							^a Cilex	GN
							^a GenRx Cephalexin	GX
							^a Ialex	LN
							^a Ibilex 250	AF
							^a Rancef	RA
							^a Terry White Chemists Cephalexin	TW
3317N DP	cephalexin 250 mg capsule, 20	1	..	^B 4.32	12.21 7.89	9.04 9.04	^a Keflex	AS
				..			^a APO-Cephalexin	TX
							^a Cefalexin Sandoz	SZ
							^a Cephalex 250	CR
							^a Cephalexin AN	EA
							^a Cephalexin generichealth	GQ
							^a Chem mart Cephalexin	CH
							^a Cilex	GN
							^a GenRx Cephalexin	GX
							^a Ialex	LN
							^a Ibilex 250	AF
							^a Rancef	RA
							^a Terry White Chemists Cephalexin	TW
3095X NP	cephalexin 250 mg/5 mL oral liquid: powder for, 100 mL	#1	1	^B 4.32	12.21 #11.39	9.04 12.89	^a Keflex	AS
				..			^a APO-Cephalexin	TX
							^a Cefalexin Sandoz	SZ

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
							a Chem mart Cephalixin CH
							a Cilex GN
							a Ialex LN
							a Ibilex 250 AF
							a Terry White Chemists Cephalixin TW
				B6.23	#17.62	12.89	a Keflex AS
3320R DP	cephalexin 250 mg/5 mL oral liquid: powder for, 100 mL	#1	..	..	#11.39	12.89	a APO-Cephalexin TX
							a Cefalexin Sandoz SZ
							a Chem mart Cephalixin CH
							a Cilex GN
							a Ialex LN
							a Ibilex 250 AF
							a Terry White Chemists Cephalixin TW
				B6.23	#17.62	12.89	a Keflex AS
3119E NP,MW	cephalexin 500 mg capsule, 20	1	1	..	8.78	9.93	a APO-Cephalexin TX
							a Cefalexin Sandoz SZ
							a Cephalax 500 NJ
							a Cephalixin AN EA
							a Cephalixin generichealth GQ
							a Chem mart Cephalixin CH
							a Cilex GN
							a GenRx Cephalixin GX
							a Ialex LN
							a Ibilex 500 AF
							a Pharmacor Cephalixin 500 CR
							a Rancef RA
							a Terry White Chemists Cephalixin TW
				B6.31	15.09	9.93	a Keflex AS
3318P DP	cephalexin 500 mg capsule, 20	1	..	..	8.78	9.93	a APO-Cephalexin TX
							a Cefalexin Sandoz SZ
							a Cephalax 500 NJ
							a Cephalixin AN EA
							a Cephalixin generichealth GQ
							a Chem mart Cephalixin CH
							a Cilex GN
							a GenRx Cephalixin GX
							a Ialex LN
							a Ibilex 500 AF
							a Pharmacor Cephalixin 500 CR
							a Rancef RA
							a Terry White Chemists Cephalixin TW
				B6.31	15.09	9.93	a Keflex AS
	CEPHALEXIN						
	<u>Authority required (STREAMLINED)</u>						
	4243						
	Prophylaxis of urinary tract infection						
2655R	cephalexin 250 mg capsule, 20	2	2	..	*9.02	10.17	a APO-Cephalexin TX
							a Cefalexin Sandoz SZ
							a Cephalax 250 CR
							a Cephalixin AN EA
							a Cephalixin generichealth GQ

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Chem mart Cephalixin	CH
							^a Cilex	GN
							^a GenRx Cephalixin	GX
							^a Ialex	LN
							^a Ibilex 250	AF
							^a Rancef	RA
							^a Terry White Chemists Cephalixin	TW
				^B 8.64	*17.66	10.17	^a Keflex	AS
CEPHALOTHIN								
2964B NP	cephalothin 1 g injection, 10 x 1 g vials	1	1	..	19.32	20.47	^a Cefalotin Sandoz	SZ
3376Q DP	cephalothin 1 g injection, 10 x 1 g vials	1	..	..	19.32	20.47	^a Hospira Pty Limited	HH
							^a Cefalotin Sandoz	SZ
							^a Hospira Pty Limited	HH
CEPHAZOLIN								
<u>Restricted benefit</u>								
Infections where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent								
<u>Restricted benefit</u>								
Septicaemia, suspected								
<u>Restricted benefit</u>								
Septicaemia, proven								
<u>Note</u>								
For item codes 1257E and 1797N, pharmaceutical benefits that have the form powder for injection 1 g are equivalent for the purposes of substitution.								
<u>Note</u>								
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.								
1257E NP	cephazolin 1 g injection, 10 x 1 g vials	1	..	..	15.27	16.42	^a Cefazolin Sandoz	SZ
1797N NP	cephazolin 1 g injection, 5 x 1 g vials	2	..	..	*15.28	16.43	^a Cefazolin-AFT	AE
							^a Hospira Pty Limited	HH
CEPHAZOLIN								
<u>Restricted benefit</u>								
Cellulitis								
<u>Note</u>								
For item codes 5478H and 1799Q, pharmaceutical benefits that have the form powder for injection 1 g are equivalent for the purposes of substitution.								
5478H NP	cephazolin 1 g injection, 10 x 1 g vials	1	..	..	15.27	16.42	^a Cefazolin Sandoz	SZ
1799Q NP	cephazolin 1 g injection, 5 x 1 g vials	2	..	..	*15.28	16.43	^a Cefazolin-AFT	AE
							^a Hospira Pty Limited	HH
CEPHAZOLIN								
<u>Restricted benefit</u>								
Cellulitis								
5479J NP	cephazolin 2 g injection, 1 x 2 g vial	10	..	..	*26.36	27.51	^a Cefazolin Sandoz	SZ
5477G NP	cephazolin 500 mg injection, 5 x 500 mg vials	2	..	..	*13.16	14.31	^a Cephalolin Alphapharm	AF
							Cefazolin-AFT	AE

CEPHAZOLIN

Restricted benefit

Infections where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent

Restricted benefit

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	Septicaemia, suspected							
	<u>Restricted benefit</u>							
	Septicaemia, proven							
	<u>Note</u>							
	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.							
9326W NP	cephazolin 2 g injection, 1 x 2 g vial	10	..	..	*26.36	27.51	^a Cefazolin Sandoz	SZ
1256D NP	cephazolin 500 mg injection, 5 x 500 mg vials	2	..	..	*13.16	14.31	^a Cephazolin Alphapharm Cefazolin-AFT	AF AE
Second-generation cephalosporins								
CEFACTOR								
<u>Caution</u>								
Serum sickness-like reactions have been reported with this drug, especially in children.								
2460L	cefactor 125 mg/5 mL oral liquid: powder for, 100 mL	£1	1	..	#12.07	13.57	^a Aclor 125	QA
							^a APO-Cefactor	TX
							^a GenRx Cefactor	GX
							^a Keflor	AF
				^b 5.86	#17.93	13.57	^a Ceclor	AS
5046N DP	cefactor 125 mg/5 mL oral liquid: powder for, 100 mL	£1	..	..	#12.07	13.57	^a Aclor 125	QA
							^a APO-Cefactor	TX
							^a GenRx Cefactor	GX
							^a Keflor	AF
				^b 5.86	#17.93	13.57	^a Ceclor	AS
2461M	cefactor 250 mg/5 mL oral liquid: powder for, 75 mL	£1	1	..	#12.28	13.78	^a Aclor 250	QA
							^a APO-Cefactor	TX
							^a GenRx Cefactor	GX
							^a Keflor	AF
				^b 6.10	#18.38	13.78	^a Ceclor	AS
5047P DP	cefactor 250 mg/5 mL oral liquid: powder for, 75 mL	£1	..	..	#12.28	13.78	^a Aclor 250	QA
							^a APO-Cefactor	TX
							^a GenRx Cefactor	GX
							^a Keflor	AF
				^b 6.10	#18.38	13.78	^a Ceclor	AS
1169M	cefactor 375 mg tablet: modified release, 10	1	1	..	10.59	11.74	^a APO-Cefactor CD	TX
							^a Cefactor-GA	GN
							^a Cefactor GH	GQ
							^a Chem mart Cefactor CD	CH
							^a GenRx Cefactor CD	GX
							^a Karlor CD	LN
							^a Keflor CD	AF
							^a Ozcef	RA
							^a Terry White Chemists Cefactor CD	TW
				^b 7.20	17.79	11.74	^a Ceclor CD	AS
5045M DP	cefactor 375 mg tablet: modified release, 10	1	..	..	10.59	11.74	^a APO-Cefactor CD	TX
							^a Cefactor-GA	GN
							^a Cefactor GH	GQ
							^a Chem mart Cefactor CD	CH
							^a GenRx Cefactor CD	GX
							^a Karlor CD	LN
							^a Keflor CD	AF
							^a Ozcef	RA
							^a Terry White Chemists	TW

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
				^a 7.20	17.79	11.74	^a Cefaclor CD Ceclor CD	AS
CEFUROXIME								
2002J DP	CEFUROXIME AXETIL Powder for oral suspension 125 mg (base) per 5 mL, 70 mL, 1	#1	..	..	#19.80	21.30	Zinnat	AS
5499K	CEFUROXIME AXETIL Powder for oral suspension 125 mg (base) per 5 mL, 70 mL, 1	#1	1	..	#19.80	21.30	Zinnat	AS
5052X DP	cefuroxime 250 mg tablet, 14	1	..	..	18.96	20.11	Zinnat	AS
8292K	cefuroxime 250 mg tablet, 14	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

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.

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.

1758M NP	CEFOTAXIME Powder for injection 1 g, 10	1	..	..	21.47	22.62	^a Hospira Pty Limited	HH
1085D NP	cefotaxime 1 g injection, 1 x 1 g vial	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 5048Q and 1768C, pharmaceutical benefits that have the form powder for injection 1 g are equivalent for the purposes of substitution.

1768C DP	CEFOTAXIME Powder for injection 1 g, 10	1	..	..	21.47	22.62	^a Hospira Pty Limited	HH
5048Q DP	cefotaxime 1 g injection, 1 x 1 g vial	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.

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.

1759N NP	CEFOTAXIME Powder for injection 2 g, 10	1	..	..	33.96	35.11	^a Hospira Pty Limited	HH
1086E	cefotaxime 2 g injection, 1 x 2 g vial	10	..	..	*34.06	35.21	^a Cefotaxime Sandoz	SZ

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
CEFOTAXIME								
<u>Restricted benefit</u>								
Infections where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent								
<u>Note</u>								
For item codes 5049R and 1769D, pharmaceutical benefits that have the form powder for injection 2 g are equivalent for the purposes of substitution.								
1769D DP	CEFOTAXIME Powder for injection 2 g, 10	1	..	..	33.96	35.11	^a Hospira Pty Limited	HH
5049R DP	cefotaxime 2 g injection, 1 x 2 g vial	10	..	..	*34.06	35.21	^a Cefotaxime Sandoz	SZ
CEFTRIAXONE								
<u>Restricted benefit</u>								
Infections where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent								
<u>Restricted benefit</u>								
Septicaemia, suspected								
<u>Restricted benefit</u>								
Septicaemia, proven								
<u>Note</u>								
For item codes 1784X and 1788D, pharmaceutical benefits that have the form powder for injection 1 g are equivalent for the purposes of substitution.								
<u>Note</u>								
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.								
1788D NP	CEFTRIAXONE Powder for injection 1 g, 5	1	..	..	15.17	16.32	^a Ceftriaxone Alphapharm	AF
							^a Max Pharma	GQ
1784X NP	ceftriaxone 1 g injection, 1 x 1 g vial	5	..	..	*15.16	16.31	^a Ceftriaxone	AE
							^a Ceftriaxone-AFT	AE
							^a Ceftriaxone ICP	PP
							^a Ceftriaxone Sandoz	SZ
							^a Hospira Ceftriaxone	HH
CEFTRIAXONE								
<u>Restricted benefit</u>								
Infections where positive bacteriological evidence confirms that this antibiotic is an appropriate therapeutic agent								
<u>Restricted benefit</u>								
Septicaemia, suspected								
<u>Restricted benefit</u>								
Septicaemia, proven								
<u>Note</u>								
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.								
1785Y NP	ceftriaxone 2 g injection, 1 x 2 g vial	5	..	..	*22.36	23.51	^a Ceftriaxone-AFT	AE
							^a Ceftriaxone Alphapharm	AF
							^a Ceftriaxone Sandoz	SZ
							^a Hospira Ceftriaxone	HH
1783W NP	ceftriaxone 500 mg injection, 1 x 500 mg vial	5	..	..	*12.16	13.31	^a Ceftriaxone-AFT	AE
							^a Ceftriaxone ICP	PP
CEFTRIAXONE								
<u>Restricted benefit</u>								
Gonorrhoea								
9058R NP	ceftriaxone 500 mg injection, 1 x 500 mg vial	1	..	..	7.84	8.99	^a Ceftriaxone-AFT	AE

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Ceftriaxone ICP	PP
Fourth-generation cephalosporins								
CEFEPIME								
<u>Authority required</u>								
Treatment of febrile neutropenia								
<u>Note</u>								
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.								
8315P NP	CEFEPIME Powder for injection 1 g (as hydrochloride), 1	10	..	..	*60.66	36.90	^a Cefepime-AFT	AE
							^a Cefepime Alphapharm	AF
							^a Cefepime Sandoz	SZ
							^a DBL Cefepime	HH
							^a Omegapharm Pty Ltd	OE
8316Q NP	CEFEPIME Powder for injection 2 g (as hydrochloride), 1	10	..	..	*109.36	36.90	^a Cefepime-AFT	AE
							^a Cefepime Alphapharm	AF
							^a Cefepime Sandoz	SZ
							^a DBL Cefepime	HH
							^a Omegapharm Pty Ltd	OE

SULFONAMIDES AND TRIMETHOPRIM

Trimethoprim and derivatives

TRIMETHOPRIM

Authority required (STREAMLINED)

4243

Prophylaxis of urinary tract infection

2666H	trimethoprim 300 mg tablet, 7	2	2	..	*10.68	11.83	^a Alprim	AF
				^B 3.78	*14.46	11.83	^a Triprim	QA
TRIMETHOPRIM								
2922T NP	trimethoprim 300 mg tablet, 7	1	1	..	8.72	9.87	^a Alprim	AF
				^B 1.89	10.61	9.87	^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.

2951H NP	trimethoprim 160 mg + sulfamethoxazole 800 mg tablet, 10	1	1	..	9.58	10.73	^a Bactrim DS	RO
				^B 3.90	13.48	10.73	^a Resprim Forte	AF
							^a Septrin Forte	QA
3390K DP	trimethoprim 160 mg + sulfamethoxazole 800 mg tablet, 10	1	..	..	9.58	10.73	^a Bactrim DS	RO
				^B 3.90	13.48	10.73	^a Resprim Forte	AF
							^a Septrin Forte	QA
3103H NP	trimethoprim 40 mg/5 mL + sulfamethoxazole 200 mg/5 mL oral liquid, 100 mL	‡1	1	..	9.27	10.42	Bactrim	RO
				^B 4.25	13.52	10.42	Septrin	QA
3391L DP	trimethoprim 40 mg/5 mL + sulfamethoxazole 200 mg/5 mL oral liquid, 100 mL	‡1	..	..	9.27	10.42	Bactrim	RO
				^B 4.25	13.52	10.42	Septrin	QA

MACROLIDES, LINCOSAMIDES AND STREPTOGRAMINS

Macrolides

AZITHROMYCIN

Restricted benefit

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	Trachoma							
	Note							
	No applications for increased maximum quantities and/or repeats will be authorised.							
8201P NP	azithromycin 200 mg/5 mL oral liquid: powder for, 15 mL	#1	..	..	#23.70	25.20	Zithromax	PF
8336R NP	azithromycin 500 mg tablet, 2	1	2	..	14.17	15.32	^a APO-Azithromycin	TX
							^a Azithromycin-GA	UA
							^a Azithromycin Sandoz	SZ
							^a Chem mart	CH
							Azithromycin	
							^a Terry White Chemists	TW
							Azithromycin	
							^a Zithromax	PF
							^a Zitrocin	GN
	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.							
8200N NP	azithromycin 500 mg tablet, 2	1	..	..	14.17	15.32	^a APO-Azithromycin	TX
							^a Azithromycin-GA	UA
							^a Azithromycin Sandoz	SZ
							^a Chem mart	CH
							Azithromycin	
							^a Terry White Chemists	TW
							Azithromycin	
							^a Zithromax	PF
							^a Zitrocin	GN
	CLARITHROMYCIN							
8318T NP	clarithromycin 250 mg tablet, 14	1	1	..	10.22	11.37	^a APO-Clarithromycin	TX
							^a Chem mart	CH
							Clarithromycin	
							^a Clarac	GN
							^a Clarihexal	HX
							^a Clarithro 250	QA
							^a Clarithromycin AN	EA
							^a Clarithromycin Sandoz	SZ
							^a Kalixocin	AF
							^a Terry White Chemists	TW
							Clarithromycin	
				^b 3.50	13.72	11.37	^a Klacid	AB
	CLARITHROMYCIN							
	Restricted benefit							
	Bordetella pertussis							
	Restricted benefit							
	Atypical mycobacterial infections							
9192T NP	clarithromycin 250 mg/5 mL oral liquid: powder for, 50 mL	#1	..	..	#27.92	29.42	Klacid	AB
	ERYTHROMYCIN							
1404X NP	erythromycin 250 mg capsule: enteric, 25	1	1	..	11.03	12.18	^a Mayne Pharma	YT
				^b 2.91	13.94	12.18	Erythromycin	
							^a Eryc	YN
3325B DP	erythromycin 250 mg capsule: enteric, 25	1	..	..	11.03	12.18	^a Mayne Pharma	YT
				^b 2.91	13.94	12.18	Erythromycin	
							^a Eryc	YN

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
ERYTHROMYCIN ETHYLSUCCINATE								
2424N NP	erythromycin (as ethylsuccinate) 200 mg/5 mL oral liquid: powder for, 100 mL	#1	1	..	#14.91	16.41	^a E-Mycin 200	AF
				^B 2.71	#17.62	16.41	^a E.E.S. 200	LM
3334L DP	erythromycin (as ethylsuccinate) 200 mg/5 mL oral liquid: powder for, 100 mL	#1	..	..	#14.91	16.41	^a E-Mycin 200	AF
				^B 2.71	#17.62	16.41	^a E.E.S. 200	LM
2750R NP	erythromycin (as ethylsuccinate) 400 mg tablet, 25	1	1	..	12.40	13.55	^a E-Mycin	AF
				^B 2.67	15.07	13.55	^a E.E.S. 400 Filmtab	LM
3336N DP	erythromycin (as ethylsuccinate) 400 mg tablet, 25	1	..	..	12.40	13.55	^a E-Mycin	AF
				^B 2.67	15.07	13.55	^a E.E.S. 400 Filmtab	LM
2428T NP	erythromycin (as ethylsuccinate) 400 mg/5 mL oral liquid: powder for, 100 mL	#1	1	..	#16.42	17.92	^a E-Mycin 400	AF
				^B 2.73	#19.15	17.92	^a E.E.S. Granules	LM
3337P DP	erythromycin (as ethylsuccinate) 400 mg/5 mL oral liquid: powder for, 100 mL	#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								
1397M NP	erythromycin (as lactobionate) 1 g injection, 1 x 1 g vial	5	..	..	*196.81	36.90	Erythrocin-I.V.	LM
5088T DP	erythromycin (as lactobionate) 1 g injection, 1 x 1 g vial	5	..	..	*196.81	36.90	Erythrocin-I.V.	LM
ROXITHROMYCIN								
1760P NP	roxithromycin 150 mg tablet, 10	1	1	..	8.96	10.11	^a APO-Roxithromycin	TX
							^a Biaxsig	AV
							^a Chem mart	CH
							^a Roxithromycin	
							^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	TW
							^a Roxithromycin	
				^B 2.12	11.08	10.11	^a Rulide	SW
5260W DP	roxithromycin 150 mg tablet, 10	1	..	..	8.96	10.11	^a APO-Roxithromycin	TX
							^a Biaxsig	AV
							^a Chem mart	CH
							^a Roxithromycin	
							^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	TW
							^a Roxithromycin	
				^B 2.12	11.08	10.11	^a Rulide	SW
5261X DP	roxithromycin 300 mg tablet, 5	1	..	..	8.96	10.11	^a APO-Roxithromycin	TX
							^a Biaxsig	AV
							^a Chem mart	CH
							^a Roxithromycin	

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
8016X NP	roxithromycin 300 mg tablet, 5	1	1	2.12 ..	11.08 8.96	10.11 10.11	a Roxar 300	QA
							a Roximycin	AF
							a Roxithromycin AN	EA
							a Roxithromycin-GA	GN
							a Roxithromycin GH	GQ
							a Roxithromycin Sandoz	SZ
							a Roxithromycin SCP 300	CR
							a Terry White Chemists Roxithromycin	TW
							a Rulide	SW
							a APO-Roxithromycin	TX
							a Biaxsig	AV
							a Chem mart Roxithromycin	CH
							a Roxar 300	QA
							a Roximycin	AF
							a Roxithromycin AN	EA
5259T DP	roxithromycin 50 mg tablet: dispersible, 10	1	..	..	13.23	14.38	a Roxithromycin-GA	GN
							a Roxithromycin GH	GQ
							a Roxithromycin Sandoz	SZ
8129W NP	roxithromycin 50 mg tablet: dispersible, 10	1	1	..	13.23	14.38	a Roxithromycin SCP 300	CR
							a Terry White Chemists Roxithromycin	TW
							a Rulide	SW
5259T DP	roxithromycin 50 mg tablet: dispersible, 10	1	..	..	13.23	14.38	a Rulide D	SW
							a Rulide D	SW
							a Rulide D	SW

Lincosamides

CLINDAMYCIN

Restricted benefit

Gram-positive coccal infections where these cannot be safely and effectively treated with a penicillin

3138E NP,MW	clindamycin 150 mg capsule, 24	1	..	..	17.96	19.11	a APO-Clindamycin	TX
							a Chem mart Clindamycin	CH
							a Cleocin	FZ
5057E DP	clindamycin 150 mg capsule, 24	1	..	1.71 ..	19.67 17.96	19.11 19.11	a Terry White Chemists Clindamycin	TW
							a Dalacin C	PF
							a APO-Clindamycin	TX
5057E DP	clindamycin 150 mg capsule, 24	1	..	1.71 ..	19.67 17.96	19.11 19.11	a Chem mart Clindamycin	CH
							a Cleocin	FZ
							a Terry White Chemists Clindamycin	TW
5057E DP	clindamycin 150 mg capsule, 24	1	..	1.71 ..	19.67 17.96	19.11 19.11	a Dalacin C	PF
							a Dalacin C	PF
							a Dalacin C	PF

LINCOMYCIN

2530E NP,MW	lincomycin 600 mg/2 mL injection, 5 x 2 mL vials	1	..	..	159.33	36.90	Lincocin	PF
5144R DP	lincomycin 600 mg/2 mL injection, 5 x 2 mL vials	1	..	..	159.33	36.90	Lincocin	PF

AMINOGLYCOSIDE ANTIBACTERIALS

Other aminoglycosides

GENTAMICIN

2824P NP	gentamicin 80 mg/2 mL injection, 10 x 2 mL ampoules	1	1	..	20.01	21.16	Pfizer Australia Pty Ltd	PF

TOBRAMYCIN

Authority required (STREAMLINED)

4456

Proven Pseudomonas aeruginosa infection

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
	<u>Note</u>							
	No increase in the maximum quantity or number of units may be authorised.							
	<u>Note</u>							
	No increase in the maximum number of repeats may be authorised.							
	<u>Note</u>							
	Special Pricing Arrangements apply.							
10066T	tobramycin 28 mg inhalation, 224 capsules	1	..	..	2549.70	36.90	TOBI podhaler	NV
	TOBRAMYCIN							
	<u>Authority required (STREAMLINED)</u>							
	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.							
	<u>Note</u>							
	No increase in the maximum quantity or number of units may be authorised.							
	<u>Note</u>							
	No increase in the maximum number of repeats may be authorised.							
	<u>Note</u>							
	Special Pricing Arrangements apply.							
10074F	tobramycin 28 mg inhalation, 224 capsules	1	2	..	2549.70	36.90	TOBI podhaler	NV
	TOBRAMYCIN							
	<u>Authority required (STREAMLINED)</u>							
	3842							
	Management of a proven Pseudomonas aeruginosa infection in a patient with cystic fibrosis							
	<u>Note</u>							
	No applications for increased maximum quantities and/or repeats will be authorised.							
	<u>Note</u>							
	Special Pricing Arrangements apply.							
5442K	tobramycin 300 mg/5 mL inhalation: solution, 56 x 5 mL ampoules	1	2	..	2137.70	36.90	Tobi	NV
	TOBRAMYCIN							
	<u>Restricted benefit</u>							
	Systemic treatment of Pseudomonas aeruginosa infection in a patient with cystic fibrosis							

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
9480Y NP	tobramycin 500 mg/5 mL injection, 10 x 5 mL vials	1	1	..	357.71	36.90	Tobra-Day	PL

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

1356J NP	tobramycin 80 mg/2 mL injection, 5 x 2 mL vials	2	1	..	*65.36	36.90	Hospira Pty Limited	HH
8872Y NP	tobramycin Injection 80 mg (base) in 2 mL (without preservative), 5	2	1	..	*65.36	36.90	Pfizer Australia Pty Ltd	PF

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

Authority required

Gonorrhoea

1208N NP	ciprofloxacin 250 mg tablet, 14	1	..	..	12.21	13.36	^a C-Flox 250	AL
							^a Ciprofloxacin-DRLA	RZ
							^a Ciprofloxacin Sandoz	SZ
							^a Ciprol 250	QA
							^a GenRx Ciprofloxacin	GX
				^b 0.42	12.63	13.36	^a Ciproxin 250	BN

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

1209P NP	ciprofloxacin 500 mg tablet, 14	1	..	..	17.42	18.57	^a C-Flox 500	AL
							^a Cifran	RA
							^a Ciprofloxacin 500	CR
							^a Ciprofloxacin AN	EA
							^a Ciprofloxacin-BW	GQ
							^a Ciprofloxacin-DRLA	RZ
							^a Ciprofloxacin-GA	GN
							^a Ciprofloxacin Sandoz	SZ
							^a Ciprol 500	QA
							^a GenRx Ciprofloxacin	GX
							^a Loxip 500	DO
				^b 0.40	17.82	18.57	^a Ciproxin 500	BN
1210Q	ciprofloxacin 750 mg tablet, 14	1	..	..	22.84	23.99	^a C-Flox 750	AL

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
NP							
							^a Cifran RA
							^a Ciprofloxacin 750 CR
							^a Ciprofloxacin AN EA
							^a Ciprofloxacin-BW GQ
							^a Ciprofloxacin-DRLA RZ
							^a Ciprofloxacin-GA GN
							^a Ciprofloxacin Sandoz SZ
							^a Ciprol 750 QA
							^a GenRx Ciprofloxacin GX
							^a Loxip 750 DO
				^b 0.40	23.24	23.99	^a Ciproxin 750 BN

NORFLOXACIN

Authority required

Acute bacterial enterocolitis

Authority required

Complicated urinary tract infection

3010K	norfloxacin 400 mg tablet, 14	1	1	..	11.38	12.53	^a GenRx Norfloxacin GX
NP							^a Norfloxacin AN EA
							^a Norfloxacin-GA GN
							^a Norfloxacin Sandoz SZ
							^a Nufloxib AF
							^a Roxin QA

OTHER ANTIBACTERIALS

Glycopeptide antibacterials

VANCOMYCIN

Restricted benefit

Prophylaxis of endocarditis in patients hypersensitive to penicillin

2269K	vancomycin 1 g injection, 1 x 1 g vial	1	..	..	10.76	11.91	^a Hospira Pty Limited HH
							^a Vancomycin AF
							^a Alphapharm
							^a Vancomycin Sandoz SZ
							^a Vycin IV GN
5083M	vancomycin 1 g injection, 1 x 1 g vial	1	..	..	10.76	11.91	^a Hospira Pty Limited HH
DP							^a Vancomycin AF
							^a Alphapharm
							^a Vancomycin Sandoz SZ
							^a Vycin IV GN
3130R	vancomycin 500 mg injection, 1 x 500 mg vial	2	..	..	*10.74	11.89	^a Hospira Pty Limited HH
							^a Vancocin CP AS
							^a Vancomycin AF
							^a Alphapharm
							^a Vancomycin Sandoz SZ
3323X	vancomycin 500 mg injection, 1 x 500 mg vial	2	..	..	*10.74	11.89	^a Hospira Pty Limited HH
DP							^a Vancocin CP AS
							^a Vancomycin AF
							^a Alphapharm
							^a Vancomycin Sandoz SZ

VANCOMYCIN

Restricted benefit

Endophthalmitis

Restricted benefit

Use initiated in a hospital for infections where vancomycin is an appropriate antibiotic

2270L	vancomycin 1 g injection, 1 x 1 g vial	3	..	..	*18.76	19.91	^a Hospira Pty Limited HH

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Vancomycin Alphapharm	AF
							^a Vancomycin Sandoz	SZ
							^a Vycin IV	GN
3131T	vancomycin 500 mg injection, 1 x 500 mg vial	5	..	..	*16.71	17.86	^a Hospira Pty Limited	HH
							^a Vancocin CP	AS
							^a Vancomycin Alphapharm	AF
							^a Vancomycin Sandoz	SZ

Steroid antibacterials

FUSIDATE

Restricted benefit

For use in combination with another antibiotic in the treatment of proven serious staphylococcal infections

2312Q	fusidate sodium 250 mg tablet, 36	1	1	..	91.23	36.90	Fucidin	CS

Imidazole derivatives

METRONIDAZOLE

1636D NP	metronidazole 200 mg tablet, 21	1	1	..	8.22	9.37	^a Metrogyl 200	AF
				^b 2.30	10.52	9.37	^a Metronide 200	AV
3339R DP	metronidazole 200 mg tablet, 21	1	..	..	8.22	9.37	^a Flagyl	SW
							^a Metrogyl 200	AF
				^b 2.30	10.52	9.37	^a Metronide 200	AV
1630T NP	metronidazole 200 mg/5 mL oral liquid, 100 mL	‡1	..	..	19.16	20.31	^a Flagyl	SW
3341W DP	metronidazole 200 mg/5 mL oral liquid, 100 mL	‡1	..	..	19.16	20.31	Flagyl S	SW
1642K NP	metronidazole 500 mg suppository, 10	‡1	..	..	23.50	24.65	Flagyl	SW
5157K DP	metronidazole 500 mg suppository, 10	‡1	..	..	23.50	24.65	Flagyl	SW

METRONIDAZOLE

Restricted benefit

Treatment of anaerobic infections

1621H NP	metronidazole 400 mg tablet, 21	1	1	..	10.19	11.34	^a Metrogyl 400	AF
				^b 2.30	12.49	11.34	^a Metronide 400	AV
5155H DP	metronidazole 400 mg tablet, 21	1	..	..	10.19	11.34	^a Flagyl	SW
							^a Metrogyl 400	AF
				^b 2.30	12.49	11.34	^a Metronide 400	AV
							^a Flagyl	SW

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.

1821W NP	metronidazole 500 mg/100 mL (0.5%) injection, 10 x 100 mL bags	1	..	..	19.25	20.40	^a DBL Metronidazole Intravenous Infusion	HH
							^a Metronidazole Sandoz	SZ

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
2277W NP	metronidazole 500 mg/100 mL (0.5%) injection, 5 x 100 mL bags	2	..	..	*19.24	20.39	^a Metronidazole-Clariv	AE
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.								
1832K DP	metronidazole 500 mg/100 mL (0.5%) injection, 10 x 100 mL bags	1	..	..	19.25	20.40	^a DBL Metronidazole Intravenous Infusion	HH
							^a Metronidazole Sandoz IV	SZ
2298Y DP	metronidazole 500 mg/100 mL (0.5%) injection, 5 x 100 mL bags	2	..	..	*19.24	20.39	^a Metronidazole-Clariv	AE
TINIDAZOLE 1465D NP tinidazole 500 mg tablet, 4								
		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.

1693D NP,MW	nitrofurantoin 100 mg capsule, 30	1	1	..	30.94	32.09	Macrochantin	PF
1692C NP,MW	nitrofurantoin 50 mg capsule, 30	1	1	..	24.00	25.15	Macrochantin	PF

Other antibacterials

HEXAMINE HIPPURATE

3124K NP	hexamine hippurate 1 g tablet, 100	1	5	..	43.59	36.90	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:

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
1472L NP	fluconazole 100 mg capsule, 28	1	5	..	44.02	36.90	^a Diflucan	PF
							^a Dizole 100	AF
							^a Fluconazole Sandoz	SZ
							^a Ozole	RA
1473M NP	fluconazole 100 mg/50 mL injection, 1 x 50 mL vial	7	..	..	*22.51	23.66	^a Fluconazole-Clarix	AE
							^a Fluconazole Hexal	HX
							^a Fluconazole Sandoz	SZ
1475P NP	fluconazole 200 mg capsule, 28	1	5	..	76.96	36.90	^a APO-Fluconazole	TX
							^a Diflucan	PF
							^a Dizole 200	AF
							^a Fluconazole Sandoz	SZ
							^a Fluzole 200	QA
							^a Ozole	RA
1474N NP	fluconazole 200 mg/100 mL injection, 1 x 100 mL vial	7	..	..	*36.44	36.90	^a Fluconazole Alphapharm	AF
							^a Fluconazole-Clarix	AE
							^a Fluconazole Hexal	HX
							^a Fluconazole Sandoz	SZ
1757L NP	fluconazole 400 mg/200 mL injection, 1 x 200 mL bag	1	..	..	13.43	14.58	Fluconazole Alphapharm	AF
1471K NP	fluconazole 50 mg capsule, 28	1	5	..	26.11	27.26	^a Diflucan	PF
							^a Dizole 50	AF
							^a Fluconazole Sandoz	SZ
							^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.

5446P NP	fluconazole 50 mg/5 mL oral liquid: powder for, 35 mL	1	..	..	#68.28	36.90	Diflucan	PF

ITRACONAZOLE

Authority required (STREAMLINED)

3607

Systemic aspergillosis

Authority required (STREAMLINED)

3608

Systemic sporotrichosis

Authority required (STREAMLINED)

3609

Systemic histoplasmosis

Authority required (STREAMLINED)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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.						
8196J NP	itraconazole 100 mg capsule, 60	1	5	..	247.13	36.90	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.						
	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.						
9360P NP	posaconazole 40 mg/mL oral liquid, 105 mL	1	..	..	733.60	36.90	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						

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
	Note							
	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.							
	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.							
10198R NP	voriconazole 200 mg tablet, 56	1	..	..	2237.86	36.90	Vfend	PF
10168E NP	voriconazole 40 mg/mL oral liquid: powder for, 70 mL	1	..	..	#593.97	36.90	Vfend	PF
10173K NP	voriconazole 50 mg tablet, 56	1	..	..	591.34	36.90	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.

9364W NP	voriconazole 200 mg tablet, 56	1	2	..	2237.86	36.90	Vfend	PF
9363T NP	voriconazole 50 mg tablet, 56	1	2	..	591.34	36.90	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

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	Clinical criteria:							
	The condition must be caused by <i>Scedosporium</i> species or <i>Fusarium</i> species.							
	<u>Authority required</u>							
	Serious <i>Candida</i> 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.							
	<u>Authority required</u>							
	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.							
	<u>Note</u>							
	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.							
	<u>Note</u>							
	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.							
9452L NP	voriconazole 40 mg/mL oral liquid: powder for, 70 mL	1	..	..	#593.97	36.90	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.

1554T NP	isoniazid 100 mg tablet, 100	1	2	..	21.83	22.98	Fawns and McAllan Proprietary Limited	FM

DRUGS FOR TREATMENT OF LEPROSY

Drugs for treatment of leprosy

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.

1272Y NP	dapsone 100 mg tablet, 100	1	1	..	114.18	36.90	Link Medical Products Pty Ltd	LM
8801F NP	dapsone 25 mg tablet, 100	1	1	..	100.92	36.90	Link Medical Products Pty Ltd	LM

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

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
arrangement with an agreed management plan. Further information can be found in the Explanatory Notes for Nurse Practitioners.								
8025J NP	rifampicin 100 mg/5 mL oral liquid, 60 mL	1	..	..	30.69	31.84	Rifadin	SW
1981G NP	rifampicin 150 mg capsule, 10	1	..	..	39.12	36.90	Rimycin 150	AF
1984K NP	rifampicin 300 mg capsule, 10	1	..	..	21.53	22.68	Rimycin 300	AF

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.

1982H NP	rifampicin 150 mg capsule, 100	1	..	..	306.14	36.90	Rimycin 150	AF
1983J NP	rifampicin 300 mg capsule, 100	1	..	..	147.98	36.90	Rimycin 300	AF

ANTIVIRALS FOR SYSTEMIC USE

DIRECT ACTING ANTIVIRALS

Nucleosides and nucleotides excl. reverse transcriptase inhibitors

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.

Note

For item codes 1003T and 1555W, pharmaceutical benefits that have the form tablet 200 mg are equivalent for the purposes of substitution.

1003T NP	aciclovir 200 mg tablet, 25	2	..	..	*32.42	33.57	^a Acihexal	SZ
							^a Acyclo-V 200	AF
							^a Lovir	GN
				^b 2.06	*34.48	33.57	^a Zovirax 200 mg	GK
1555W NP	aciclovir 200 mg tablet, 50	1	..	..	32.43	33.58	^a GenRx Aciclovir	GX

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.

1007B NP	aciclovir 200 mg tablet, 90	1	5	..	51.44	36.90	^a Aciclovir 200	CR
							^a Aciclovir GH	GQ
							^a Acihexal	SZ
							^a Acyclo-V 200	AF
							^a Chem mart Aciclovir	CH
							^a GenRx Aciclovir	GX
							^a Lovir	GN
							^a Ozvir	RA
							^a Terry White Chemists Aciclovir	TW
				^b 1.49	52.93	36.90	^a Zovirax 200 mg	GK

ACICLOVIR

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
Authority required (STREAMLINED)								
3630								
Patients with advanced HIV disease (CD4 cell counts of less than 150 million per litre)								
8234J NP	aciclovir 800 mg tablet, 120	1	5	..	190.01	36.90	^a Acihexal	SZ
							^a Acyclo-V 800	AF
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.								
Note								
No applications for repeats will be authorised.								
1052J NP	aciclovir 800 mg tablet, 35	1	..	..	60.21	36.90	^a Aciclovir 800	CR
							^a Acihexal	SZ
							^a Acyclo-V 800	AF
							^a GenRx Aciclovir	GX
				^B 0.80	61.01	36.90	^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 125 mg is not PBS-subsidised for chickenpox, herpes zoster or herpes simplex infections other than genital herpes.								
8092X NP	famciclovir 125 mg tablet, 40	1	1	..	71.91	36.90	^a APO-Famciclovir	TX
							^a Ezovir	AF
							^a Famciclovir AN	EA
							^a Famciclovir-GA	GN
							^a Famvir	NV
							^a Favic 125	QA
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.								
2274Q NP	famciclovir 250 mg tablet, 20	1	1	..	71.92	36.90	^a APO-Famciclovir	TX
							^a Ezovir	AF
							^a Famciclovir AN	EA
							^a Famciclovir-GA	GN
							^a Famciclovir Sandoz	SZ
							^a Famvir	NV
							^a Favic 250	QA
FAMCICLOVIR								
Authority required (STREAMLINED)								
3622								
Treatment of patients with herpes zoster within 72 hours of the onset of the rash								
Note								

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

Note

No applications for repeats will be authorised.

8002E NP	famciclovir 250 mg tablet, 21	1	..	..	75.19	36.90	^a APO-Famciclovir TX
							^a Auro-Famciclovir 250 DO
							^a Ezovir AF
							^a Famciclovir AN EA
							^a Famciclovir-GA GN
							^a Famciclovir GQ
							^a generichealth 250
							^a Famciclovir Sandoz SZ
							^a Famciclovir SCP 250 CR
							^a Famlo RA
							^a Famvir NV
							^a Favic 250 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.

8217L NP	famciclovir 250 mg tablet, 56	1	5	..	189.23	36.90	^a APO-Famciclovir TX
							^a Auro-Famciclovir 250 DO
							^a Ezovir AF
							^a Famciclovir AN EA
							^a Famciclovir-GA GN
							^a Famciclovir GQ
							^a generichealth 250
							^a Famciclovir Sandoz SZ
							^a Famciclovir SCP 250 CR
							^a Famlo RA
							^a Famvir NV
							^a Favic 250 QA

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.

Note

No applications for repeats will be authorised.

8897G NP	famciclovir 500 mg tablet, 30	1	..	..	104.50	36.90	^a APO-Famciclovir TX
							^a Chem mart Famciclovir CH
							^a Famciclovir AN EA
							^a Famciclovir Sandoz SZ
							^a Famvir NV
							^a Favic 500 QA
							^a Terry White Chemists TW
							Famciclovir

FAMCICLOVIR

Authority required (STREAMLINED)

3626

Episodic treatment or suppressive therapy of moderate to severe recurrent genital herpes in immunocompromised patients. Microbiological

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

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
Valaciclovir 500 mg is not PBS-subsidised for chickenpox or herpes simplex infections other than genital herpes.							
5480K NP	valaciclovir 500 mg tablet, 30	1	5	..	71.55	36.90	^a APO-Valaciclovir TX
							^a Chem mart Valaciclovir CH
							^a Shilova 500 DO
							^a Terry White Chemists Valaciclovir TW
							^a Vaclovir AF
							^a Valaciclovir Actavis VN
							^a Valaciclovir AN EA
							^a Valaciclovir GA GN
							^a Valaciclovir generichealth GQ
							^a Valaciclovir RBX RA
							^a Valaciclovir SZ HX
							^a Valacor 500 CR
							^a Valnir QA
							^a Valtrex AS
							^a Zelitrex UA

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.

8134D NP	valaciclovir 500 mg tablet, 30	1	5	..	71.55	36.90	^a APO-Valaciclovir TX
							^a Chem mart Valaciclovir CH
							^a Shilova 500 DO
							^a Terry White Chemists Valaciclovir TW
							^a Vaclovir AF
							^a Valaciclovir Actavis VN
							^a Valaciclovir AN EA
							^a Valaciclovir GA GN
							^a Valaciclovir generichealth GQ
							^a Valaciclovir RBX RA
							^a Valaciclovir Sandoz SZ
							^a Valaciclovir SZ HX
							^a Valacor 500 CR
							^a Valnir QA
							^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.

Note

No applications for repeats will be authorised.

8064K NP	valaciclovir 500 mg tablet, 42	1	..	..	97.47	36.90	^a APO-Valaciclovir TX
							^a Chem mart Valaciclovir CH
							^a Terry White Chemists TW

ANTIINFECTIVES FOR SYSTEMIC USE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							Valaciclovir	
							^a Vaclovir	AF
							^a Valaciclovir Actavis	VN
							^a Valaciclovir AN	EA
							^a Valaciclovir GA	GN
							^a Valaciclovir generichealth	GQ
							^a Valaciclovir RBX	RA
							^a Valaciclovir Sandoz	SZ
							^a Valacor 500	CR
							^a Valnir	QA
							^a Valtrex	AS
							^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

1903E NP	pneumococcal purified capsular polysaccharides 25 microgram/0.5 mL injection, 1 x 0.5 mL vial	1	..	..	47.96	36.90	Pneumovax 23	CS

Tetanus vaccines

DIPHTHERIA TOXOID + TETANUS TOXOID

Note

For immunisation of adults and children aged greater than or equal to 8 years.

8783G NP	diphtheria toxoid 2 international units/0.5 mL + tetanus toxoid 20 international units/0.5 mL injection, 5 x 0.5 mL syringes	1	..	..	75.68	36.90	ADT Booster	CS

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

ANTINEOPLASTIC AGENTS

ALKYLATING AGENTS

Nitrogen mustard analogues

CHLORAMBUCIL								
1163F	chlorambucil 2 mg tablet, 25	4	2	..	*154.12	36.90	Leukeran	AS
CYCLOPHOSPHAMIDE								
10026Q	cyclophosphamide 50 mg tablet, 50	1	2	..	83.64	36.90	Endoxan	BX
1266P	cyclophosphamide 50 mg tablet, 50	1	2	..	31.63	32.78	Cycloblastin	PF
MELPHALAN								
2547C	melfalan 2 mg tablet, 25	1	1	..	77.11	36.90	Alkeran	AS

Alkyl sulfonates

BUSULFAN								
1128J	busulfan 2 mg tablet, 100	1	..	..	96.18	36.90	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.

8898H	carmustine 7.7 mg implant, 8	†1	..	..	17539.66	36.90	Gliadel	OA

Other alkylating agents

TEMOZOLOMIDE

Authority required

Recurrence of anaplastic astrocytoma following standard therapy

Authority required

Recurrence of glioblastoma multiforme following standard therapy

Authority required

Glioblastoma multiforme following radiotherapy

8380C	temozolomide 100 mg capsule, 5	1	5	..	427.73	36.90	^a Astromide	GN
							^a Orion Temozolomide	ON
							^a Temizole 100	QA
							^a Temodal	MK
							^a Temozolomide Alphapharm	AF
							^a Temozolomide AN	EA
9362R	temozolomide 140 mg capsule, 5	1	5	..	575.53	36.90	^a Astromide	GN
							^a Orion Temozolomide	ON
							^a Temizole 140	QA
							^a Temodal	MK
							^a Temozolomide Alphapharm	AF
							^a Temozolomide AN	EA
2438H	temozolomide 180 mg capsule, 5	1	5	..	690.37	36.90	^a Astromide	GN
							^a Orion Temozolomide	ON

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
8379B	temozolomide 20 mg capsule, 5	1	5	..	111.57	36.90	^a Temodal	MK
							^a Astromide	GN
							^a Orion Temozolomide	ON
							^a Temizole 20	QA
							^a Temodal	MK
8381D	temozolomide 250 mg capsule, 5	1	5	..	1015.41	36.90	^a Temozolomide	AF
							Alphapharm	
							^a Temozolomide AN	EA
							^a Astromide	GN
							^a Orion Temozolomide	ON
8378Y	temozolomide 5 mg capsule, 5	1	5	..	43.68	36.90	^a Temizole 250	QA
							^a Temodal	MK
							^a Temozolomide	AF
							Alphapharm	
							^a Temozolomide AN	EA
8821G	temozolomide 100 mg capsule, 5	3	2	..	*1264.03	36.90	^a Astromide	GN
							^a Orion Temozolomide	ON
							^a Temizole 100	QA
							^a Temodal	MK
							^a Temozolomide	AF
9361Q	temozolomide 140 mg capsule, 5	3	2	..	*1713.07	36.90	Alphapharm	
							^a Temozolomide AN	EA
							^a Astromide	GN
							^a Orion Temozolomide	ON
							^a Temizole 140	QA
10062N	temozolomide 180 mg capsule, 5	3	2	..	*2048.71	36.90	^a Temodal	MK
							^a Temozolomide	AF
							Alphapharm	
							^a Temozolomide AN	EA
							^a Astromide	GN
8820F	temozolomide 20 mg capsule, 5	3	2	..	*310.60	36.90	^a Orion Temozolomide	ON
							^a Temodal	MK
							^a Astromide	GN
							^a Orion Temozolomide	ON
							^a Temizole 20	QA

TEMOZOLOMIDE

Authority required

Glioblastoma multiforme

Treatment criteria:

Patient must be undergoing concomitant radiotherapy.

Note

Temozolomide is not PBS-subsidised for use in conjunction with PBS-subsidised carmustine.

Note

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
8819E	temozolomide 5 mg capsule, 5	3	2	..	*113.74	36.90	^a Astromide	GN
							^a Orion Temozolomide	ON
							^a Temizole 5	QA
							^a Temodal	MK
							^a Temozolomide Alphapharm	AF
							^a Temozolomide AN	EA

ANTIMETABOLITES

Folic acid analogues

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.

1818Q	METHOTREXATE Injection 50 mg in 2 mL, 1	5	5	..	*21.76	22.91	^a Methaccord	GN
2395C	methotrexate 50 mg/2 mL injection, 5 x 2 mL vials	1	5	..	21.78	22.93	^a Hospira Pty Limited	HH

METHOTREXATE

2272N	methotrexate 10 mg tablet, 15	1	3	..	20.68	21.83	Methoblastin	PF
1622J	methotrexate 2.5 mg tablet, 30	1	5	..	13.46	14.61	^a Hospira Pty Limited	HH
2396D	methotrexate 5 mg/2 mL injection, 5 x 2 mL vials	1	..	..	22.09	23.24	^a Methoblastin Hospira Pty Limited	PF HH

METHOTREXATE

Restricted benefit

For patients requiring doses greater than 20 mg per week

1623K	methotrexate 10 mg tablet, 50	1	2	..	51.58	36.90	Methoblastin	PF

Purine analogues

FLUDARABINE

Authority required

B-cell chronic lymphocytic leukaemia in combination with cyclophosphamide where the patient has advanced disease (Binet Stage B or C) or evidence of progressive Stage A disease.

Stage A progressive disease is defined by at least one of the following: persistent rise in lymphocyte count with doubling time less than 12 months; a downward trend in haemoglobin or platelets, or both; more than 50% increase in the size of liver, spleen, or lymph nodes, or appearance of these signs if not previously present; constitutional symptoms attributable to disease.

The diagnosis of chronic lymphocytic leukaemia (CLL) must have been established based on:

(a) a lymphocytosis, with more than 5,000 million lymphocytes per L in the peripheral blood; and

(b) a clonal population of B-cells (CD5/CD19) documented by flow cytometry

9184J	fludarabine phosphate 10 mg tablet, 20	1	5	..	937.04	36.90	Fludara	GZ

MERCAPTOPURINE

1598D	mercaptopurine 50 mg tablet, 25	4	2	..	*267.12	36.90	Purinethol	AS

THIOGUANINE

1233X	thioguanine 40 mg tablet, 25	1	1	..	243.21	36.90	Lanvis	AS

Pyrimidine analogues

CAPECITABINE

Authority required

Advanced breast cancer after failure of prior therapy which includes a taxane and an anthracycline

Authority required

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
Advanced breast cancer where therapy with a taxane and/or an anthracycline is contraindicated								
Authority required								
Advanced breast cancer in combination with docetaxel after failure of prior anthracycline-containing chemotherapy								
Authority required								
Treatment of advanced or metastatic colorectal cancer								
Authority required								
Adjuvant treatment of stage III (Dukes C) colon cancer, following complete resection of the primary tumour either as:								
(a) monotherapy; or								
(b) in combination with oxaliplatin								
Authority required								
Advanced (Stage III or IV) oesophago-gastric cancer, previously untreated, in combination with a cisplatin-based regimen, in a patient with a WHO performance status of 2 or less								
Note								
In the adjuvant setting, the recommended treatment duration is 24 weeks.								
Capecitabine is not PBS-subsidised for the treatment of patients with stage II (Dukes B) colon cancer.								
Capecitabine is not PBS-subsidised for the adjuvant treatment of patients with rectal cancer.								
8361C	capecitabine 150 mg tablet, 60	1	2	..	105.47	36.90	^a Capecitabine Actavis	GN
							^a Capecitabine Alphapharm	AF
							^a Capecitabine-DRLA	RZ
							^a Capecitabine Sandoz	SZ
							^a Xelabine	QA
							^a Xeloda	RO
8362D	capecitabine 500 mg tablet, 120	1	2	..	585.31	36.90	^a Capecitabine Actavis	GN
							^a Capecitabine Alphapharm	AF
							^a Capecitabine Apotex	TX
							^a Capecitabine-DRLA	RZ
							^a Capecitabine GH	GQ
							^a Capecitabine Sandoz	SZ
							^a Xelabine	QA
							^a Xeloda	RO

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

9009E	vinorelbine 20 mg capsule, 1	20	2	..	*1579.56	36.90	Navelbine	FB
9010F	vinorelbine 30 mg capsule, 1	16	2	..	*1887.56	36.90	Navelbine	FB

Podophyllotoxin derivatives

ETOPOSIDE

1389D	etoposide 100 mg capsule, 10	1	..	..	391.07	36.90	Vepesid	BQ
1396L	etoposide 50 mg capsule, 20	1	..	..	445.28	36.90	Vepesid	BQ

CYTOTOXIC ANTIBIOTICS AND RELATED SUBSTANCES

Anthracyclines and related substances

IDARUBICIN

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
<u>Restricted benefit</u>								
Acute myelogenous leukaemia								
2448W	idarubicin hydrochloride 10 mg capsule, 1	3	..	..	*494.83	36.90	Zavedos	PF
2446R	idarubicin hydrochloride 5 mg capsule, 1	3	..	..	*267.94	36.90	Zavedos	PF

OTHER ANTINEOPLASTIC AGENTS

Protein kinase inhibitors

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.

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.

Note

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

Note

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

Note

Special Pricing Arrangements apply.

2954L	dabrafenib 50 mg capsule, 120	1	5	..	5888.15	36.90	Tafinlar	GK
10003L	dabrafenib 75 mg capsule, 120	1	5	..	8758.87	36.90	Tafinlar	GK

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.

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

Note

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

Note

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

Note

Special Pricing Arrangements apply.

2963Y	dabrafenib 50 mg capsule, 120	1	3	..	5888.15	36.90	Tafinlar	GK
2846T	dabrafenib 75 mg capsule, 120	1	3	..	8758.87	36.90	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

Note

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
1416M	dasatinib 100 mg tablet, 30	1	5	..	5004.14	36.90	Sprycel	BQ
1354G	dasatinib 20 mg tablet, 60	1	5	..	3095.79	36.90	Sprycel	BQ
1381Q	dasatinib 50 mg tablet, 60	1	5	..	5004.14	36.90	Sprycel	BQ
1415L	dasatinib 70 mg tablet, 60	1	5	..	6160.53	36.90	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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
HOBART TAS 7001								
Note 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.								
9342Q	dasatinib 100 mg tablet, 30	1	5	..	5004.14	36.90	Sprycel	BQ
2478K	dasatinib 20 mg tablet, 60	1	5	..	3095.79	36.90	Sprycel	BQ
2482P	dasatinib 50 mg tablet, 60	1	5	..	5004.14	36.90	Sprycel	BQ
2485T	dasatinib 70 mg tablet, 60	1	5	..	6160.53	36.90	Sprycel	BQ

DASATINIB

Authority required

Initial treatment, as monotherapy, of a patient with acute lymphoblastic leukaemia (ALL) bearing the Philadelphia chromosome or expressing the

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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							
	Note							
	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.							
	Note							
	No applications for increased repeats will be authorised.							
9343R	dasatinib 100 mg tablet, 30	1	2	..	5004.14	36.90	Sprycel	BQ
9125G	dasatinib 20 mg tablet, 60	1	2	..	3095.79	36.90	Sprycel	BQ
9126H	dasatinib 50 mg tablet, 60	1	2	..	5004.14	36.90	Sprycel	BQ

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
9127J	dasatinib 70 mg tablet, 60	1	2	..	6160.53	36.90	Sprycel	BQ
ERLOTINIB <u>Authority required</u> 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.								
10019H	erlotinib 100 mg tablet, 30	1	3	..	1239.13	36.90	Tarceva	RO
10025P	erlotinib 150 mg tablet, 30	1	3	..	1514.10	36.90	Tarceva	RO
10028T	erlotinib 25 mg tablet, 30	1	3	..	355.07	36.90	Tarceva	RO
ERLOTINIB <u>Authority required</u> 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.								
<u>Authority required</u> 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.								
10020J	erlotinib 100 mg tablet, 30	1	3	..	1239.13	36.90	Tarceva	RO

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
10014C	erlotinib 150 mg tablet, 30	1	3	..	1514.10	36.90	Tarceva	RO
10022L	erlotinib 25 mg tablet, 30	1	3	..	355.07	36.90	Tarceva	RO

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.

Note

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

Note

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

Note

Special Pricing Arrangements apply.

10132G	everolimus 10 mg tablet, 30	1	2	..	5546.70	36.90	Afinitor	NV
10133H	everolimus 5 mg tablet, 30	1	2	..	2846.70	36.90	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.

Note

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
No increase in the maximum quantity or number of units may be authorised.								
Note								
No increase in the maximum number of repeats may be authorised.								
Note								
Special Pricing Arrangements apply.								
10135K	everolimus 10 mg tablet, 30	1	5	..	5546.70	36.90	Afinitor	NV
10131F	everolimus 5 mg tablet, 30	1	5	..	2846.70	36.90	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.

Note

Special Pricing Arrangements apply.

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.

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 be female,

AND

Patient must be post-menopausal.

Note

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

Patients who have progressive disease with everolimus are no longer eligible for PBS-subsidised everolimus.

Note

Special Pricing Arrangements apply.

2985D	everolimus 10 mg tablet, 30	1	5	..	5546.70	36.90	Afinitor	NV
2819J	everolimus 5 mg tablet, 30	1	5	..	2846.70	36.90	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.

Note

Special Pricing Arrangements apply.

2818H	everolimus 2.5 mg tablet, 30	1	5	..	1483.50	36.90	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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	EGFR tyrosine kinase inhibitors in tumour material.							
	<u>Authority required</u>							
	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.							
8769M	gefitinib 250 mg tablet, 30	1	3	..	1514.10	36.90	Iressa	AP

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

Note

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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).								
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								
5443L	imatinib 100 mg tablet, 60	1	5	..	1963.21	36.90	Glivec	NV
5444M	imatinib 400 mg tablet, 30	1	5	..	3779.71	36.90	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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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. Note 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.) Note No applications for increased repeats will be authorised.							
9111M	imatinib 100 mg tablet, 60	1	2	..	1963.21	36.90	Glivec	NV
9112N	imatinib 400 mg tablet, 30	1	2	..	3779.71	36.90	Glivec	NV

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

Note

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	least 5 fold to a level of greater than 0.1% confirmed on a subsequent test), during ongoing tyrosine kinase inhibitor therapy.							
9113P	imatinib 100 mg tablet, 60	1	5	..	1963.21	36.90	Glivec	NV
9114Q	imatinib 400 mg tablet, 30	1	5	..	3779.71	36.90	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;

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	Aggressive systemic mastocytosis with eosinophilia.							
	Note							
	No applications for increased repeats will be authorised.							
9115R	imatinib 100 mg tablet, 60	1	2	..	1963.21	36.90	Glivec	NV
9116T	imatinib 400 mg tablet, 30	1	2	..	3779.71	36.90	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) 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

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.

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

Note

Allogeneic stem cell transplantation is the preferred therapy for eligible patients achieving a complete remission of Philadelphia positive acute lymphoblastic leukaemia.

Note

No applications for increased repeats will be authorised.

9123E	imatinib 100 mg tablet, 60	1	2	..	1963.21	36.90	Glivec	NV
9124F	imatinib 400 mg tablet, 30	1	2	..	3779.71	36.90	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.

Note

No applications for increased repeats will be authorised.

9172R	imatinib 100 mg tablet, 60	1	2	..	1963.21	36.90	Glivec	NV
9173T	imatinib 400 mg tablet, 30	1	2	..	3779.71	36.90	Glivec	NV

IMATINIB

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
	Note No applications for increased repeats will be authorised.							
9174W	imatinib 100 mg tablet, 60	1	2	..	1963.21	36.90	Glivec	NV
9175X	imatinib 400 mg tablet, 30	1	2	..	3779.71	36.90	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.

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

Note

No applications for increased repeats will be authorised.

9176Y	imatinib 100 mg tablet, 60	1	2	..	1963.21	36.90	Glivec	NV
9177B	imatinib 400 mg tablet, 30	1	2	..	3779.71	36.90	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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	(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. Note No applications for increased repeats will be authorised.							
9178C	imatinib 100 mg tablet, 60	1	2	..	1963.21	36.90	Glivec	NV
9179D	imatinib 400 mg tablet, 30	1	2	..	3779.71	36.90	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) a completed authority prescription form;
- (b) a pathology report demonstrating HER2 positivity has been demonstrated by in situ hybridisation (ISH);
- (c) date of last treatment with a taxane and total number of cycles;
- (d) a signed patient acknowledgment;
- (e) dates of treatment with trastuzumab; and
- (f) 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) a completed authority prescription form; and
- (b) a statement from the prescribing doctor that the disease has not progressed

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

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.

Note

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].

Note

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

9148L	lapatinib 250 mg tablet, 70	2	2	..	*3387.80	36.90	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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	HOBART TAS 7001						
	Note 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.						
1309X	NILOTINIB Capsule 150 mg (as hydrochloride monohydrate), 120	1	5	..	4468.21	36.90	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:

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

— 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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	Note 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.						
9171Q	NILOTINIB Capsule 200 mg (as hydrochloride monohydrate), 120	1	5	..	5872.48	36.90	Tasigna NV

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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. <u>Note</u> 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. <u>Note</u> No increase in the maximum quantity or number of units may be authorised. <u>Note</u> No increase in the maximum number of repeats may be authorised. <u>Note</u> Special Pricing Arrangements apply.							
10054E	pazopanib 200 mg tablet, 30	1	5	..	1256.59	36.90	Votrient	GK
10052C	pazopanib 400 mg tablet, 30	1	5	..	2410.34	36.90	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.

Note

Patients who have progressive disease on sunitinib are not eligible to receive PBS-subsidised pazopanib.

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.

Note

Special Pricing Arrangements apply.

2232L	pazopanib 200 mg tablet, 30	1	5	..	1256.59	36.90	Votrient	GK
2201W	pazopanib 400 mg tablet, 30	1	5	..	2410.34	36.90	Votrient	GK

PAZOPANIB

Authority required

Advanced (unresectable and/or metastatic) soft tissue sarcoma

Treatment Phase: Initial treatment

Clinical criteria:

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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; dermatofibromatosis 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. Note No increase in the maximum number of repeats may be authorised. Note Special Pricing Arrangements apply.							
10042M	pazopanib 200 mg tablet, 90	1	2	..	3542.16	36.90	Votrient	GK
10041L	pazopanib 400 mg tablet, 60	1	2	..	4673.98	36.90	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.

Note

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

Note

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

Note

Special Pricing Arrangements apply.

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
10047T	pazopanib 200 mg tablet, 90	1	5	..	3542.16	36.90	Votrient	GK
10043N	pazopanib 400 mg tablet, 60	1	5	..	4673.98	36.90	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.

Note

Patients who have progressive disease with pazopanib are no longer eligible for PBS-subsidised pazopanib.

Note

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

Note

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

Note

Special Pricing Arrangements apply.

2029T	pazopanib 200 mg tablet, 90	1	2	..	3542.16	36.90	Votrient	GK
2030W	pazopanib 400 mg tablet, 60	1	2	..	4673.98	36.90	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 with pazopanib are no longer eligible for PBS-subsidised pazopanib.

Note

Patients who have progressive disease on sunitinib are not eligible to receive PBS-subsidised pazopanib.

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.

Note

Special Pricing Arrangements apply.

Authority required

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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. Note Special Pricing Arrangements apply.								
2034C	pazopanib 200 mg tablet, 90	1	5	..	3542.16	36.90	Votrient	GK
2035D	pazopanib 400 mg tablet, 60	1	5	..	4673.98	36.90	Votrient	GK
SORAFENIB <u>Authority required (STREAMLINED)</u> 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. <u>Authority required (STREAMLINED)</u> 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. Note No increase in the maximum quantity or number of units may be authorised. Note No increase in the maximum number of repeats may be authorised. Note Special Pricing Arrangements apply.								
9380Q	sorafenib 200 mg tablet, 60	2	2	..	*6457.42	36.90	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,

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
AND								
The treatment must be as monotherapy.								
Disease progression must be documented in the patient's medical records.								
Note								
No increase in the maximum quantity or number of units may be authorised.								
Note								
No increase in the maximum number of repeats may be authorised.								
Note								
Special Pricing Arrangements apply.								
10004M	sunitinib 12.5 mg capsule, 28	1	2	..	1834.54	36.90	Sutent	PF
2959R	sunitinib 25 mg capsule, 28	1	2	..	3522.10	36.90	Sutent	PF
2837H	sunitinib 50 mg capsule, 28	1	2	..	6897.78	36.90	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 sunitinib,

AND

Patient must not have progressive disease,

AND

The treatment must be as monotherapy.

Note

Patients who have progressive disease with sunitinib are no longer eligible for PBS-subsidised sunitinib.

Note

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

Note

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

Note

Special Pricing Arrangements apply.

10009T	sunitinib 12.5 mg capsule, 28	1	5	..	1834.54	36.90	Sutent	PF
2842N	sunitinib 25 mg capsule, 28	1	5	..	3522.10	36.90	Sutent	PF
10010W	sunitinib 50 mg capsule, 28	1	5	..	6897.78	36.90	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.

Note

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

Patients who have progressive disease with sunitinib are no longer eligible for PBS-subsidised sunitinib.

Note

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

Note

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

Note

Special Pricing Arrangements apply.

9417P	sunitinib 12.5 mg capsule, 28	1	1	..	1834.54	36.90	Sutent	PF
9418Q	sunitinib 25 mg capsule, 28	1	1	..	3522.10	36.90	Sutent	PF
9419R	sunitinib 50 mg capsule, 28	1	1	..	6897.78	36.90	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.

Note

Patients who have developed progressive disease on pazopanib are not eligible to receive PBS-subsidised sunitinib.

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.

Note

Special Pricing Arrangements apply.

9420T	sunitinib 12.5 mg capsule, 28	1	3	..	1834.54	36.90	Sutent	PF
9421W	sunitinib 25 mg capsule, 28	1	3	..	3522.10	36.90	Sutent	PF
9422X	sunitinib 50 mg capsule, 28	1	3	..	6897.78	36.90	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.

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

Note

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

Note

Special Pricing Arrangements apply.

9488J	sunitinib 12.5 mg capsule, 28	1	1	..	1834.54	36.90	Sutent	PF
9489K	sunitinib 25 mg capsule, 28	1	1	..	3522.10	36.90	Sutent	PF
9490L	sunitinib 50 mg capsule, 28	1	1	..	6897.78	36.90	Sutent	PF

Other antineoplastic agents

HYDROXYUREA

3093T	hydroxyurea 500 mg capsule, 100	1	..	..	76.80	36.90	Hydrea	BQ

ENDOCRINE THERAPY

HORMONES AND RELATED AGENTS

Progestogens

MEDROXYPROGESTERONE

Restricted benefit

Hormone-dependent breast cancer

Restricted benefit

Endometrial cancer

2725K	medroxyprogesterone acetate 100 mg tablet, 100	1	2	..	103.15	36.90	Provera	PF
2316X	medroxyprogesterone acetate 200 mg tablet, 60	1	2	..	116.42	36.90	Provera	PF
2727M	medroxyprogesterone acetate 250 mg tablet, 60	1	2	..	144.38	36.90	Provera	PF

MEDROXYPROGESTERONE

Restricted benefit

Hormone-dependent advanced breast cancer

2728N	medroxyprogesterone acetate 500 mg tablet, 30	1	2	..	144.38	36.90	Provera	PF

MEGESTROL

Restricted benefit

Hormone-dependent advanced breast cancer

2734X	megestrol acetate 160 mg tablet, 30	1	2	..	83.73	36.90	Megace	QA

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
<i>Gonadotropin releasing hormone analogues</i>								
GOSERELIN								
<u>Authority required (STREAMLINED)</u>								
3229								
Locally advanced (equivalent to stage C) or metastatic (equivalent to stage D) carcinoma of the prostate								
8093Y	goserelin 10.8 mg implant, 1	1	1	..	1109.10	36.90	Zoladex 10.8 Implant	AP
GOSERELIN								
<u>Authority required</u>								
Locally advanced (equivalent to stage C) or metastatic (equivalent to stage D) carcinoma of the prostate								
<u>Authority required</u>								
Hormone-dependent locally advanced (equivalent to stage III) or metastatic (equivalent to stage IV) breast cancer in pre-menopausal women								
<u>Authority required</u>								
Short-term treatment (up to 6 months) of visually proven endometriosis (only 1 course of not more than 6 months' therapy will be authorised)								
<u>Authority required</u>								
Hormone-dependent breast cancer as an alternative to adjuvant chemotherapy in peri- or pre-menopausal women								
1454M	goserelin 3.6 mg implant, 1	1	5	..	333.34	36.90	Zoladex Implant	AP
GOSERELIN (&) BICALUTAMIDE								
<u>Authority required (STREAMLINED)</u>								
3239								
Metastatic (equivalent to stage D) prostatic carcinoma in patients for whom a combination of an antiandrogen and a GnRH (LH-RH) agonist is required								
<u>Note</u>								
No applications for increased maximum quantities and/or repeats will be authorised.								
9065D	goserelin 10.8 mg implant [1 implant] (&) bicalutamide 50 mg tablet [28 tablets], 1 pack	1	..	..	1248.63	36.90	ZolaCos CP 10.8/50(28)	AP
9066E	goserelin 10.8 mg implant [1 implant] (&) bicalutamide 50 mg tablet [84 tablets], 1 pack	1	1	..	1527.71	36.90	ZolaCos CP 10.8/50(84)	AP
9064C	goserelin 3.6 mg implant [1 implant] (&) bicalutamide 50 mg tablet [28 tablets], 1 pack	1	5	..	477.71	36.90	ZolaCos CP 3.6/50	AP
LEUPRORELIN								
<u>Authority required (STREAMLINED)</u>								
3229								
Locally advanced (equivalent to stage C) or metastatic (equivalent to stage D) carcinoma of the prostate								
8708H	leuporelin acetate 22.5 mg injection: modified release [1 syringe] (&) inert substance diluent [1 syringe], 1 pack	1	1	..	1109.10	36.90	Eligard 3 month	TL
8876E	leuporelin acetate 22.5 mg injection: modified release [1 x 22.5 mg syringe] (&) inert substance diluent [1 x 2 mL syringe], 1 pack	1	1	..	1109.10	36.90	Lucrin Depot 3 Month PDS	VE
8709J	leuporelin acetate 30 mg injection: modified release [1 syringe] (&) inert substance diluent [1 syringe], 1 pack	1	1	..	1451.67	36.90	Eligard 4 month	TL
8877F	leuporelin acetate 30 mg injection: modified release [1 x 30 mg syringe] (&) inert substance diluent [1 x 2 mL syringe], 1 pack	1	1	..	1451.67	36.90	Lucrin Depot 4 Month PDS	VE
8859G	leuporelin acetate 45 mg injection: modified release [1 syringe] (&) inert substance diluent [1 syringe], 1 pack	1	..	..	2124.32	36.90	Eligard 6 month	TL
8707G	leuporelin acetate 7.5 mg injection: modified release [1 syringe] (&) inert substance diluent [1 syringe], 1 pack	1	5	..	420.54	36.90	Eligard 1 month	TL
8875D	leuporelin acetate 7.5 mg injection: modified release [1 x 7.5 mg syringe] (&) inert substance diluent [1 x 2 mL	1	5	..	420.54	36.90	Lucrin Depot 7.5mg PDS	VE

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	syringe], 1 pack							
TRIPTORELIN								
<u>Authority required (STREAMLINED)</u>								
3229								
Locally advanced (equivalent to stage C) or metastatic (equivalent to stage D) carcinoma of the prostate								
9379P	triptorelin 11.25 mg injection [1 x 11.25 mg vial] (&) inert substance diluent [1 x 2 mL ampoule], 1 pack	1	1	..	1109.10	36.90	Diphereline	IS
5297T	triptorelin 22.5 mg injection [1 x 22.5 mg vial] (&) inert substance diluent [1 x 2 mL ampoule], 1 pack	1	..	..	2124.32	36.90	Diphereline	IS
9378N	triptorelin 3.75 mg injection [1 x 3.75 mg vial] (&) inert substance diluent [1 x 2 mL ampoule], 1 pack	1	5	..	420.54	36.90	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.

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.

2109B NP	tamoxifen 10 mg tablet, 60	1	5	..	24.22	25.37	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.

Note

For item codes 2110C and 1880Y, pharmaceutical benefits that have the form tablet 20 mg (base) are equivalent for the purposes of substitution.

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.

1880Y NP	tamoxifen 20 mg tablet, 30	2	5	^b 2.20	*39.22	36.90	^a Nolvadex-D	AP
2110C NP	tamoxifen 20 mg tablet, 60	1	5	..	37.03	36.90	^a Genox 20	AF
							^a GenRx Tamoxifen	GX
							^a Tamosin	QA
							^a Tamoxen 20 mg	GN
							^a Tamoxifen Sandoz	SZ

TOREMIFENE

Restricted benefit

Treatment of hormone-dependent metastatic breast cancer in post-menopausal patients

Note

This drug is not PBS-subsidised for primary prevention of breast cancer.

8216K	toremifene 60 mg tablet, 30	1	5	..	74.08	36.90	Fareston	MK

Anti-androgens

BICALUTAMIDE

Authority required (STREAMLINED)

3674

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
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.								
8094B NP	bicalutamide 50 mg tablet, 28	1	5	..	119.08	36.90	^a APO-Bicalutamide	TX
							^a Bicalox	ER
							^a Bicalutamide AN	EA
							^a Bicalutamide-GA	GN
							^a Calutex	QA
							^a Cosamide	AF
							^a Cosudex	AP
CYPROTERONE								
Authority required (STREAMLINED)								
1014								
Advanced carcinoma of the prostate								
Authority required (STREAMLINED)								
1404								
To reduce drive in sexual deviations in males								
8019C	cyproterone acetate 100 mg tablet, 50	1	5	..	99.89	36.90	^a Cyprocur 100	QA
							^a Cyprostat-100	SY
							^a Cyproterone AN	EA
							^a Cyproterone Sandoz	HX
							^a GenRx Cyproterone Acetate	GX
							^a Procur 100	GN
				^B 0.94	100.83	36.90	^a Androcur-100	BN
1270W	cyproterone acetate 50 mg tablet, 50	2	5	..	*126.34	36.90	^a Cyprocur 50	QA
							^a Cyprone	AF
							^a Cyprostat	SY
							^a Cyproterone AN	EA
							^a Cyproterone Sandoz	HX
							^a Cyrotone	ER
							^a GenRx Cyproterone Acetate	GX
							^a Procur	GN
				^B 2.24	*128.58	36.90	^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.

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	Note Special Pricing Arrangements apply.							
	Note No increase in the maximum quantity or number of units may be authorised.							
	Note No increase in the maximum number of repeats may be authorised.							
10174L	enzalutamide 40 mg capsule, 112	1	2	..	3700.00	36.90	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.								
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.								
1417N NP	flutamide 250 mg tablet, 100	1	5	..	181.97	36.90	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.								
8131Y NP	nilutamide 150 mg tablet, 30	1	5	..	236.90	36.90	Anandron	SW
Aromatase inhibitors								
ANASTROZOLE								
Restricted benefit								
Treatment of hormone-dependent breast cancer in post-menopausal women								
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.								
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.								
8179L NP	anastrozole 1 mg tablet, 30	1	5	..	97.24	36.90	^a Anastrozol	QA
							^a Anastrozole AN	EA
							^a Anastrozole-DRLA	RZ
							^a Anastrozole-GA	GN
							^a Anastrozole GH	GQ
							^a Anastrozole RBX	RA
							^a Anastrozole Sandoz	SZ
							^a Anzole	UA
							^a APO-Anastrozole	TX
							^a Arianna	AF
							^a Arimidex	AP
							^a Azastrole	ER

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Chem mart Anastrozole	CH
							^a Pharmacor Anastrozole 1	CR
							^a Pharmacy Choice Anastrozole	RI
							^a Terry White Chemists Anastrozole	TW
EXEMESTANE								
<u>Restricted benefit</u>								
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 be female,								
AND								
Patient must be post-menopausal.								
10103R	exemestane 25 mg tablet, 30	1	5	..	130.82	36.90	^a APO-Exemestane	TX
							^a Aromasin	PF
							^a Exaccord	RA
							^a Exemestane AN	EA
							^a Exemestane-GA	GN
							^a Exemestane GH	GQ
							^a Exemestane Pfizer	FZ
							^a Exemestane Sandoz	SZ
EXEMESTANE								
<u>Restricted benefit</u>								
Treatment of hormone-dependent advanced breast cancer in post-menopausal women with disease progression following treatment with tamoxifen citrate								
<u>Restricted benefit</u>								
Treatment of hormone-dependent early breast cancer in post-menopausal women following a minimum of 2 years' treatment with tamoxifen citrate								
<u>Note</u>								
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.								
<u>Note</u>								
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.								
8506Q NP	exemestane 25 mg tablet, 30	1	5	..	130.82	36.90	^a APO-Exemestane	TX
							^a Aromasin	PF
							^a Exaccord	RA
							^a Exemestane AN	EA
							^a Exemestane-GA	GN
							^a Exemestane GH	GQ
							^a Exemestane Pfizer	FZ
							^a Exemestane Sandoz	SZ

LETROZOLE

Restricted benefit

Treatment of hormone-dependent advanced breast cancer in post-menopausal women

Restricted benefit

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
Treatment of hormone-dependent early breast cancer in post-menopausal women							
<u>Restricted benefit</u>							
Extended adjuvant treatment of hormone-dependent early breast cancer in post-menopausal women commencing within 6 months of ceasing treatment with tamoxifen citrate							
<u>Note</u>							
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.							
This drug is not PBS-subsidised for extended adjuvant early breast cancer treatment where the total duration of letrozole (or any other aromatase inhibitor) treatment extends beyond 5 years.							
<u>Note</u>							
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.							
8245Y NP	letrozole 2.5 mg tablet, 30	1	5	..	91.52	36.90	^a APO-Letrozole TX
							^a Chem mart Letrozole CH
							^a Femara 2.5 mg NV
							^a Femolet AF
							^a Fera QA
							^a Gynotril ER
							^a Letrozole Actavis VN
							^a Letrozole AN EA
							^a Letrozole-DRLA RZ
							^a Letrozole-GA GN
							^a Letrozole generichealth GQ
							^a Letrozole RBX RA
							^a Letrozole Sandoz SZ
							^a Lezole UA
							^a Pharmacor Letrozole 2.5 CR
							^a Pharmacy Choice Letrozole RI
							^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.

2698B	abiraterone acetate 250 mg tablet, 120	1	2	..	3600.24	36.90	Zytiga	JC

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
DEGARELIX <u>Authority required (STREAMLINED)</u> 3229 Locally advanced (equivalent to stage C) or metastatic (equivalent to stage D) carcinoma of the prostate <u>Note</u> No applications for increased maximum quantities and/or repeats will be authorised for the 120 mg powder for injection.								
2785N	degarelix 120 mg injection [2 x 120 mg vials] (&) inert substance diluent [2 syringes], 1 pack	1	..	..	439.06	36.90	Firmagon 120mg	FP
DEGARELIX <u>Authority required (STREAMLINED)</u> 3229 Locally advanced (equivalent to stage C) or metastatic (equivalent to stage D) carcinoma of the prostate								
2784M	degarelix 80 mg injection [1 x 80 mg vial] (&) inert substance diluent [1 syringe], 1 pack	1	5	..	420.54	36.90	Firmagon 80mg	FP

IMMUNOSTIMULANTS

IMMUNOSTIMULANTS

Interferons

INTERFERON ALFA-2A

Authority required

Hairy cell leukaemia

Authority required

Myeloproliferative disease with excessive thrombocytosis

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.

8180M	interferon alfa-2a 3 million international units/0.5 mL injection, 1 x 0.5 mL syringe	15	4	..	*506.56	36.90	Roferon-A	RO

INTERFERON ALFA-2A

Authority required

Low grade non-Hodgkin's lymphoma with clinical features suggestive of a poor prognosis, in combination with anthracycline-based chemotherapy

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.

8181N	interferon alfa-2a 3 million international units/0.5 mL injection, 1 x 0.5 mL syringe	15	5	..	*506.56	36.90	Roferon-A	RO
8182P	interferon alfa-2a 4.5 million international units/0.5 mL injection, 1 x 0.5 mL syringe	5	5	..	*265.06	36.90	Roferon-A	RO
8183Q	interferon alfa-2a 6 million international units/0.5 mL injection, 1 x 0.5 mL syringe	5	5	..	*345.06	36.90	Roferon-A	RO
8184R	interferon alfa-2a 9 million international units/0.5 mL injection, 1 x 0.5 mL syringe	5	5	..	*506.46	36.90	Roferon-A	RO

INTERFERON ALFA-2A

Authority required

Myeloproliferative disease with excessive thrombocytosis

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.

8551C	interferon alfa-2a 4.5 million international units/0.5 mL injection, 1 x 0.5 mL syringe	5	4	..	*265.06	36.90	Roferon-A	RO
8552D	interferon alfa-2a 6 million international units/0.5 mL injection, 1 x 0.5 mL syringe	5	4	..	*345.06	36.90	Roferon-A	RO

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
8553E	international units/0.5 mL injection, 1 x 0.5 mL syringe interferon alfa-2a 9 million international units/0.5 mL injection, 1 x 0.5 mL syringe	5	4	..	*506.46	36.90	Roferon-A	RO
INTERFERON ALFA-2B								
<u>Authority required</u>								
Maintenance treatment of multiple myeloma once remission has been achieved with chemotherapy								
<u>Authority required</u>								
Low grade non-Hodgkin's lymphoma with clinical features suggestive of a poor prognosis, in combination with anthracycline-based chemotherapy								
<u>Caution</u>								
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.								
8348J	interferon alfa-2b 18 million international units/1.2 mL injection, 1 x 1.2 mL cartridge	3	5	..	*606.37	36.90	Intron A Redipen	MK
8476D	interferon alfa-2b 30 million international units/1.2 mL injection, 1 x 1.2 mL cartridge	3	5	..	*1006.09	36.90	Intron A Redipen	MK
INTERFERON ALFA-2B								
<u>Authority required</u>								
Hairy cell leukaemia								
<u>Caution</u>								
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.								
8572E	interferon alfa-2b 18 million international units/1.2 mL injection, 1 x 1.2 mL cartridge	3	4	..	*606.37	36.90	Intron A Redipen	MK
INTERFERON BETA-1A								
<u>Authority required</u>								
Initial treatment of clinically definite relapsing-remitting multiple sclerosis in ambulatory (without assistance or support) patients who have 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								
<u>Authority required</u>								
Continuing treatment of clinically definite relapsing-remitting multiple sclerosis in patients previously issued with an authority prescription for this drug who do not show continuing progression of disability while on treatment with this drug and who have 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								
8968B	INTERFERON BETA-1a Injection 44 micrograms (12,000,000 i.u.) in 0.5 mL single dose autoinjector, 12	1	5	..	1057.11	36.90	Rebif 44	SG
8289G	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	1	5	..	1057.11	36.90	Avonex	BD
8805K	interferon beta-1a 30 microgram/0.5 mL (6 million international units) injection, 4 x 0.5 mL syringes	1	5	..	1057.11	36.90	Avonex	BD
8403G	interferon beta-1a 44 microgram/0.5 mL (12 million international units) injection, 12 x 0.5 mL syringes	1	5	..	1057.11	36.90	Rebif 44	SG
9332E	interferon beta-1a 44 microgram/0.5 mL (12 million international units) injection, 4 x 1.5 mL cartridges	1	5	..	1057.11	36.90	Rebif 44	SG

INTERFERON BETA-1B

Authority required

Initial treatment of clinically definite relapsing-remitting multiple sclerosis in ambulatory (without assistance or support) patients who have 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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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							
	<u>Authority required</u>							
	Continuing treatment of clinically definite relapsing-remitting multiple sclerosis in patients previously issued with an authority prescription for this drug who do not show continuing progression of disability while on treatment with this drug and who have 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							
8101J	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	1	5	..	1001.15	36.90	Betaferon	BN
<i>Other immunostimulants</i>								
BACILLUS CALMETTE AND GUERIN-CONNAUGHT STRAIN								
<u>Restricted benefit</u>								
Treatment of carcinoma in situ of the urinary bladder								
1140B	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	3	1	..	*460.21	36.90	ImmuCyst	SW
BACILLUS CALMETTE AND GUERIN-TICE STRAIN								
<u>Restricted benefit</u>								
Primary and relapsing superficial urothelial carcinoma of the bladder								
1131M	Bacillus Calmette and Guerin-Tice strain 500 million colony forming units injection, 3 x 500 million colony forming units vials	1	1	..	556.73	36.90	OncoTICE	MK
GLATIRAMER ACETATE								
<u>Authority required</u>								
Initial treatment of clinically definite relapsing-remitting multiple sclerosis in ambulatory (without assistance or support) patients who have 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								
<u>Authority required</u>								
Continuing treatment of clinically definite relapsing-remitting multiple sclerosis in patients previously issued with an authority prescription for this drug who do not show continuing progression of disability while on treatment with this drug and who have 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								
8726G	glatiramer acetate 20 mg/mL injection, 28 x 1 mL syringes	1	5	..	1092.99	36.90	Copaxone	CS

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

[illegible]

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

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.

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

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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

requirement for concomitant treatment with methotrexate, where it applies, must be met for each bDMARD trialed.

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: 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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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. 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 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-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.						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

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.

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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. <u>Authority required</u> 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. <u>Note</u> 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						
1220F	abatacept 125 mg/mL injection, 4 x 1 mL syringes	1	3	..	1754.25	36.90	Orencia

ABATACEPT

BQ

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	<u>Authority required</u> 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. <u>Note</u> 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. <u>Note</u> 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						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

Reply Paid 9826

HOBART TAS 7001

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.

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

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:

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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							
1221G	abatacept 125 mg/mL injection, 4 x 1 mL syringes	1	5	..	1754.25	36.90	Orencia	BQ
	EVEROLIMUS							
	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							
	Caution							
	Careful monitoring of patients is mandatory.							
9352F	everolimus 1 mg tablet, 60	2	3	..	*2069.10	36.90	Certican	NV
8840G	everolimus 250 microgram tablet, 60	1	3	..	283.13	36.90	Certican	NV
8841H	everolimus 500 microgram tablet, 60	1	3	..	544.17	36.90	Certican	NV
8842J	everolimus 750 microgram tablet, 60	2	3	..	*1578.96	36.90	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.							
5262Y	fingolimod 500 microgram capsule, 28	1	5	..	2313.32	36.90	Gilenya	NV
	LEFLUNOMIDE							
	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							
	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.							
5449T	leflunomide 10 mg tablet, 30	1	5	..	56.88	36.90	^a Arabloc	AV

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
5450W	leflunomide 20 mg tablet, 30	1	5	..	83.05	36.90	^a Arava	SW
							^a Leflunomide Sandoz	SZ
							^a Arabloc	AV
							^a Arava	SW
							^a Leflunomide Sandoz	SZ

LEFLUNOMIDE

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

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.

8374R	leflunomide 10 mg tablet, 30	1	5	..	56.88	36.90	^a APO-Leflunomide	TX
							^a Arabloc	AV
							^a Arava	SW
							^a Leflunomide AN	EA
							^a Leflunomide-GA	GN
8375T	leflunomide 20 mg tablet, 30	1	5	..	83.05	36.90	^a Leflunomide GH	GQ
							^a Leflunomide Sandoz	SZ
							^a Lunava 10	ZP
							^a APO-Leflunomide	TX
							^a Arabloc	AV
							^a Arava	SW
							^a Leflunomide AN	EA
							^a Leflunomide-GA	GN
							^a Leflunomide GH	GQ
							^a Leflunomide Sandoz	SZ
							^a Lunava 20	ZP

MYCOPHENOLATE

Authority required

WHO Class III, IV or V lupus nephritis

Treatment Phase: Maintenance

Clinical criteria:

The condition must be proven by biopsy,

AND

Patient must have received initiation treatment,

AND

The treatment must be under the supervision and direction of a nephrologist reviewing the patient.

The name of the nephrologist reviewing treatment and the date of the latest review, which must be within the last 12 months, must be included in the authority application.

Caution

Careful monitoring of patients is mandatory.

2150E	mycophenolate 180 mg tablet: enteric, 120 tablets	1	5	..	135.45	36.90	Myfortic	NV
2193K	mycophenolate 360 mg tablet: enteric, 120 tablets	1	5	..	258.73	36.90	Myfortic	NV

MYCOPHENOLATE

Authority required

Maintenance therapy, following initiation and stabilisation of treatment with mycophenolate sodium 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

Caution

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

Careful monitoring of patients is mandatory.

8652J	mycophenolate 180 mg tablet: enteric, 120 tablets	1	3	..	135.45	36.90	Myfortic	NV
8653K	mycophenolate 360 mg tablet: enteric, 120 tablets	1	3	..	258.73	36.90	Myfortic	NV

MYCOPHENOLATE

Authority required

Maintenance therapy, following initiation and stabilisation of treatment with mycophenolate mofetil 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 mycophenolate mofetil 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

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.

1836P	mycophenolate Capsule 250 mg, 50	6	3	..	*317.26	36.90	^a Ceptolate	AF
8649F	mycophenolate mofetil 250 mg capsule, 100	3	3	..	*317.26	36.90	^a APO-Mycophenolate	TX
							^a CellCept	RO
							^a Mycophenolate Sandoz	SZ
							^a Pharmacor	CR
							Mycophenolate 250	

MYCOPHENOLATE

Authority required

Maintenance therapy, following initiation and stabilisation of treatment with mycophenolate mofetil 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 mycophenolate mofetil 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

Caution

Careful monitoring of patients is mandatory.

8651H	mycophenolate mofetil 1 g/5 mL oral liquid: powder for, 165 mL	1	3	..	#290.29	36.90	CellCept	RO
8650G	mycophenolate mofetil 500 mg tablet, 50	3	3	..	*317.23	36.90	^a APO-Mycophenolate	TX
							^a CellCept	RO
							^a Ceptolate	AF
							^a Mycophenolate Sandoz	SZ
							^a Pharmacor	CR
							Mycophenolate 500	

SIROLIMUS

Authority required

Maintenance therapy, following initiation and stabilisation of treatment with sirolimus 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

Caution

Careful monitoring of patients is mandatory.

8724E	sirolimus 1 mg tablet, 100	1	3	..	815.59	36.90	Rapamune	PF
8725F	sirolimus 1 mg/mL oral liquid, 60 mL	1	3	..	530.08	36.90	Rapamune	PF
8833X	sirolimus 2 mg tablet, 100	1	3	..	1584.03	36.90	Rapamune	PF

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
8984W	sirolimus 500 microgram tablet, 100	1	3	..	413.63	36.90	Rapamune	PF

TERIFLUNOMIDE

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.

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.

Note

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

Note

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

Note

Special Pricing Arrangements apply.

2898M	teriflunomide 14 mg tablet, 28	1	5	..	1847.26	36.90	Aubagio	GZ

Tumor necrosis factor alpha (TNF-) inhibitors

ADALIMUMAB

Authority required

Severe active juvenile idiopathic arthritis

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

(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.

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

Note

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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 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,

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

Note

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
	<u>Authority required</u>							
	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.							
	<u>Note</u>							
	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							
5282B	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges	1	3	..	1774.70	36.90	Humira	VE
5281Y	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes	1	3	..	1774.70	36.90	Humira	VE

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

Note

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
	<u>Note</u>							
	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							
5284D	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges	1	5	..	1774.70	36.90	Humira	VE
5283C	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes	1	5	..	1774.70	36.90	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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

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

Note

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.

[illegible]

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
	Note							
	No applications for increased maximum quantities and/or repeats will be authorised.							
8965W	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges	1	2	..	1774.70	36.90	Humira	VE
8963R	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes	1	2	..	1774.70	36.90	Humira	VE
8962Q	adalimumab 40 mg/0.8 mL injection, 6 x 0.8 mL cartridges	1	..	..	5036.70	36.90	Humira	VE
8961P	adalimumab 40 mg/0.8 mL injection, 6 x 0.8 mL syringes	1	..	..	5036.70	36.90	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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

Note

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
	Note							
	No applications for increased maximum quantities and/or repeats will be authorised.							
8966X	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges	1	5	..	1774.70	36.90	Humira	VE
8964T	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes	1	5	..	1774.70	36.90	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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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. 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. 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.						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

Special Pricing Arrangements apply

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

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

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:

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	Department of Human Services Prior Written Approval of Complex Drugs Reply Paid 9826 HOBART TAS 7001						
	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						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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							
9099X	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges	1	3	..	1774.70	36.90	Humira	VE
8737W	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes	1	3	..	1774.70	36.90	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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

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

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

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:

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	(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.						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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. <u>Authority required</u> 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. <u>Note</u> 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							
9100Y	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges	1	5	..	1774.70	36.90	Humira	VE
8741C	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes	1	5	..	1774.70	36.90	Humira	VE

ADALIMUMAB

Authority required

Initial 1

Initial PBS-subsidised treatment with adalimumab, by a rheumatologist or clinical immunologist with expertise in the management of psoriatic arthritis, of adults who:

- (1) have severe active psoriatic arthritis; and
- (2) have received no prior PBS-subsidised biological treatment for this condition in this Treatment Cycle; and
- (3) have failed to achieve an adequate response to:
 - (a) methotrexate at a dose of at least 20 mg weekly for a minimum period of 3 months; and
 - (b) sulfasalazine at a dose of at least 2 g per day for a minimum period of 3 months; or
 - (c) leflunomide at a dose of up to 20 mg daily for a minimum period of 3 months.

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.

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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, 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 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

(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 of major joints:

— elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

— 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 [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]; and

(3) a signed patient acknowledgement.

A maximum of 16 weeks treatment will be authorised under this restriction.

Where fewer than 3 repeats are requested at the time of the 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).

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 to Medicare Australia 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.

Patients who fail to demonstrate a response to treatment with adalimumab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug, in this Treatment Cycle. Patients may re-trial adalimumab 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

Authority required

Initial 2

Initial PBS-subsidised treatment with adalimumab, by a rheumatologist or clinical immunologist with expertise in the management of psoriatic arthritis, of adults who:

(1) have a documented history of severe active psoriatic arthritis; and

(2) have received prior PBS-subsidised biological treatment for this condition in this Treatment Cycle and are eligible to receive further biological therapy; and

(3) have not failed treatment with adalimumab during the current Treatment Cycle.

Applications for patients who have received PBS-subsidised treatment with adalimumab within this Treatment Cycle and who wish to re-commence 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 adalimumab treatment, within the timeframes specified below.

A maximum of 16 weeks treatment will be authorised under this restriction.

Where fewer than 3 repeats are requested at the time of the 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).

Where the most recent course of PBS-subsidised adalimumab 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), patients 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 adalimumab treatment was approved under the continuing treatment criteria, patients 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.

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 [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)].

Patients who fail to demonstrate a response to treatment with adalimumab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug, in this Treatment Cycle. Patients may re-trial adalimumab after a minimum of 5 years have elapsed between

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

Note

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, 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 the following NOTES and restrictions, it only refers to adalimumab, etanercept, golimumab and infliximab.

From 1 August 2006, all patients will be 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 5-year 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 after 1 August 2010.

(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 all agents except for infliximab, for which a maximum of 22 weeks will be authorised. 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 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, patients will be deemed to have failed to respond to treatment with that biological agent.

Grandfather patients — golimumab only.

Applications for patients who commenced treatment with golimumab prior to 1 March 2010 may apply for initial PBS-subsidised treatment as continuing therapy 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.

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	(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 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, 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.							
	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; or							
	(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.							
	Medicare Australia 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 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. 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 re-qualify 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.							
	Note							
	No applications for increased maximum quantities and/or repeats will be authorised.							
	Applications for treatment with adalimumab where the dosing frequency exceeds 40 mg per fortnight will not be approved.							
9101B	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges	1	3	..	1774.70	36.90	Humira	VE
9033K	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes	1	3	..	1774.70	36.90	Humira	VE

ADALIMUMAB

Authority required

Continuing treatment

Continuing PBS-subsidised treatment with adalimumab, by a rheumatologist or clinical immunologist with expertise in the management of psoriatic arthritis, of adults:

- (1) who have a documented history of severe active psoriatic arthritis; and
- (2) whose most recent course of PBS-subsidised biological agent for this condition in the current Treatment Cycle was with adalimumab; and
- (3) who, at the time of application, demonstrate an adequate response to treatment with adalimumab.

An adequate response to treatment with adalimumab 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:

- (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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

— 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 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 [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)].

A maximum of 24 weeks of treatment will be approved under this restriction.

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).

All applications for continuing treatment with adalimumab must include a measurement of response to the prior course of therapy. 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, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Patients who fail to demonstrate a response to treatment with adalimumab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug, in this Treatment Cycle. Patients may re-trial adalimumab 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.

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

Note

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, 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 the following NOTES and restrictions, it only refers to adalimumab, etanercept, golimumab and infliximab.

From 1 August 2006, all patients will be 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 5-year 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 after 1 August 2010.

(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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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 all agents except for infliximab, for which a maximum of 22 weeks will be authorised. 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 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, patients will be deemed to have failed to respond to treatment with that biological agent.							
	Grandfather patients — golimumab only.							
	Applications for patients who commenced treatment with golimumab prior to 1 March 2010 may apply for initial PBS-subsidised treatment as continuing therapy 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 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, 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.							
	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 trialed it on the PBS; or							
	(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.							
	Medicare Australia 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 authority 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. 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 re-qualify 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.							
	Note							
	No applications for increased maximum quantities and/or repeats will be authorised.							
	Applications for treatment with adalimumab where the dosing frequency exceeds 40 mg per fortnight will not be approved.							
9102C	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges	1	5	..	1774.70	36.90	Humira	VE
9034L	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes	1	5	..	1774.70	36.90	Humira	VE

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

Note

For details on the appropriate minimum exercise program that will be accepted for the purposes of administering this restriction, please refer to the

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

Department of Human Services website at www.humanservices.gov.au

Note

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

Note

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

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

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

Note

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

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

Note

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.

[illegible]

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
	<u>Authority required</u>							
	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.							
	<u>Note</u>							
	No increase in the maximum quantity or number of units may be authorised.							
	<u>Note</u>							
	No increase in the maximum number of repeats may be authorised.							
	<u>Note</u>							
	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							
9103D	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges	1	3	..	1774.70	36.90	Humira	VE
9077R	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes	1	3	..	1774.70	36.90	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:

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

(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

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

Note

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

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

Note

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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	(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. <u>Authority required</u> 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:						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	Must be treated by a rheumatologist.							
	Note							
	No increase in the maximum quantity or number of units may be authorised.							
	Note							
	No increase in the maximum number of repeats may 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							
9104E	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges	1	5	..	1774.70	36.90	Humira	VE
9078T	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes	1	5	..	1774.70	36.90	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.

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Note

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

Note

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

9190Q	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges	1	2	..	1774.70	36.90	Humira	VE
9188N	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes	1	2	..	1774.70	36.90	Humira	VE
9187M	adalimumab 40 mg/0.8 mL injection, 6 x 0.8 mL cartridges	1	..	..	5036.70	36.90	Humira	VE
9186L	adalimumab 40 mg/0.8 mL injection, 6 x 0.8 mL syringes	1	..	..	5036.70	36.90	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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

(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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

Note

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.

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
9191R	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges	1	5	..	1774.70	36.90	Humira	VE
9189P	adalimumab 40 mg/0.8 mL injection, 2 x	1	5	..	1774.70	36.90	Humira	VE

Note

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	0.8 mL syringes						

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:

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

(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:

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

(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).

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

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

Note

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
	Note No applications for increased maximum quantities and/or repeats will be authorised.							
	Note Special Pricing Arrangements apply.							
9426D	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges	1	4	..	1774.70	36.90	Humira	VE
9425C	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes	1	4	..	1774.70	36.90	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:

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

(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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

Note

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
	Note							
	No applications for increased maximum quantities and/or repeats will be authorised.							
	Note							
	Special Pricing Arrangements apply.							
9428F	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges	1	5	..	1774.70	36.90	Humira	VE
9427E	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes	1	5	..	1774.70	36.90	Humira	VE

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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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 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						
	Note						
	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						
	Note						
	No increase in the maximum quantity or number of units may be authorised.						
	Note						
	No increase in the maximum number of repeats may be authorised.						
	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						

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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.						
	Note						
	No increase in the maximum quantity or number of units may be authorised.						
	Note						
	No increase in the maximum number of repeats may be authorised.						
	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						
	Note						
	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.						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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 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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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.						
	<u>Note</u>						
	No increase in the maximum quantity or number of units may be authorised.						
	<u>Note</u>						
	No increase in the maximum number of repeats may be authorised.						
	<u>Note</u>						
	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						
	<u>Authority required</u>						
	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.						
	<u>Note</u>						
	No increase in the maximum quantity or number of units may be authorised.						
	<u>Note</u>						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

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

Note

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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. <u>Authority required</u> 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. <u>Note</u> No increase in the maximum quantity or number of units may be authorised. <u>Note</u> No increase in the maximum number of repeats may be authorised. <u>Note</u> 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						
10137M	certolizumab pegol 200 mg/mL injection, 2 x 1 mL syringes	1	5	..	1708.98	36.90	Cimzia UC

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)

[illegible]

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

Note

Special Pricing Arrangements apply.

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

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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

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 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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

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

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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
(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						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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 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.

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

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-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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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. <u>Authority required</u> 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. <u>Note</u> 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						
3425G	certolizumab pegol 200 mg/mL injection, 2 x 1 mL syringes	1	5	..	1708.98	36.90	Cimzia UC

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.

[illegible]

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

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

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

Note

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

Note

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

Note

Special Pricing Arrangements apply.

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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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. Note Authority approval for sufficient therapy to complete a maximum of 16 weeks of treatment may be requested by telephone by contacting the						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

Note

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

Note

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

Note

Special Pricing Arrangements apply.

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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
(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.						
	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.						
	Note 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.						
	Note 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.						
	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						
	Note No increase in the maximum quantity or number of units may be authorised.						
	Note No increase in the maximum number of repeats may be authorised.						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

Note

Special Pricing Arrangements apply.

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,

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

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

Note

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

Note

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

Note

Special Pricing Arrangements apply.

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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	(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.						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

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

Note

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

Note

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

Note

Special Pricing Arrangements apply.

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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

HOBART TAS 7001

Note

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

Note

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

Note

Special Pricing Arrangements apply.

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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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. Note 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. Note 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. 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 Note No increase in the maximum quantity or number of units may be authorised. Note No increase in the maximum number of repeats may be authorised. Note Special Pricing Arrangements apply. 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						

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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 digrams 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 Note No increase in the maximum quantity or number of units may be authorised. Note No increase in the maximum number of repeats may be authorised. Note Special Pricing Arrangements apply.							
1964J	ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1	1	3	..	1774.71	36.90	Enbrel	PF
1963H	ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1	1	3	..	1774.71	36.90	Enbrel	PF
1954W	etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack	2	3	..	*1774.70	36.90	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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

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.

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

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.

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

Note

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:

[illegible]

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

Note

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.

[illegible]

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
	<u>Authority required</u>							
	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.							
	<u>Note</u>							
	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							
3447K	ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1	1	3	..	1774.71	36.90	Enbrel	PF
3446J	ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1	1	3	..	1774.71	36.90	Enbrel	PF
3445H	etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack	2	3	..	*1774.70	36.90	Enbrel	PF

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:

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

Note

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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,

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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								
3450N	ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1	1	5	..	1774.71	36.90	Enbrel	PF
3449M	ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1	1	5	..	1774.71	36.90	Enbrel	PF
3448L	etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack	2	5	..	*1774.70	36.90	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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

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

Note

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

Note

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

Note

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

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

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

Note

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

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

Note

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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.						
	<u>Authority required</u>						
	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.						
	<u>Note</u>						
	No increase in the maximum quantity or number of units may be authorised.						
	<u>Note</u>						
	No increase in the maximum number of repeats may be authorised.						
	<u>Note</u>						
	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						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
9455P	ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1	1	3	..	1774.71	36.90	Enbrel	PF
9085E	ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1	1	3	..	1774.71	36.90	Enbrel	PF
8778B	etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack	2	3	..	*1774.70	36.90	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

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

Note

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

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

Note

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
	<u>Authority required</u>							
	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.							
	<u>Note</u>							
	No increase in the maximum quantity or number of units may be authorised.							
	<u>Note</u>							
	No increase in the maximum number of repeats may be authorised.							
	<u>Note</u>							
	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							
9456Q	ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1	1	5	..	1774.71	36.90	Enbrel	PF
9086F	ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1	1	5	..	1774.71	36.90	Enbrel	PF
8779C	etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack	2	5	..	*1774.70	36.90	Enbrel	PF

ETANERCEPT

Authority required

Initial 1

Initial PBS-subsidised treatment with etanercept, by a rheumatologist or clinical immunologist with expertise in the management of psoriatic arthritis, of adults who:

- (1) have severe active psoriatic arthritis; and
- (2) have received no prior PBS-subsidised biological treatment for this condition in this Treatment Cycle; and
- (3) have failed to achieve an adequate response to:
 - (a) methotrexate at a dose of at least 20 mg weekly for a minimum period of 3 months; and
 - (b) sulfasalazine at a dose of at least 2 g per day for a minimum period of 3 months; or
 - (c) leflunomide at a dose of up to 20 mg daily for a minimum period of 3 months.

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

[illegible]

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

subsidised treatment with this drug, in this Treatment Cycle. Patients may re-trial etanercept 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

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

Note

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, 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 the following NOTES and restrictions, it only refers to adalimumab, etanercept, golimumab and infliximab.

From 1 August 2006, all patients will be 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 5-year 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 after 1 August 2010.

(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 all agents except for infliximab, for which a maximum of 22 weeks will be authorised. 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 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, patients will be deemed to have failed to respond to treatment with that biological agent.

Grandfather patients — golimumab only.

Applications for patients who commenced treatment with golimumab prior to 1 March 2010 may apply for initial PBS-subsidised treatment as continuing therapy 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.

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	(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 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, 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.						
	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; or						
	(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.						
	Medicare Australia 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 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. 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 re-qualify 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.						
	Note						
	No applications for increased maximum quantities and/or repeats will be authorised.						
9457R	ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1	1	3	..	1774.71	36.90	Enbrel PF
9087G	ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1	1	3	..	1774.71	36.90	Enbrel PF
9035M	etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack	2	3	..	*1774.70	36.90	Enbrel PF

ETANERCEPT

Authority required

Continuing treatment

Continuing PBS-subsidised treatment with etanercept, by a rheumatologist or clinical immunologist with expertise in the management of psoriatic arthritis, of adults:

- (1) who have a documented history of severe active psoriatic arthritis; and
- (2) whose most recent course of PBS-subsidised biological agent for this condition in the current Treatment Cycle was with etanercept; and
- (3) who, at the time of application, demonstrate an adequate response to treatment with etanercept.

An adequate response to treatment with etanercept 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:

- (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%:

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

— elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

— 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 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 [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)].

A maximum of 24 weeks of treatment will be approved under this restriction.

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).

All applications for continuing treatment with etanercept must include a measurement of response to the prior course of therapy. 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, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Patients who fail to demonstrate a response to treatment with etanercept under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug, in this Treatment Cycle. Patients may re-trial etanercept 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

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

Note

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, 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 the following NOTES and restrictions, it only refers to adalimumab, etanercept, golimumab and infliximab.

From 1 August 2006, all patients will be 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 5-year 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 after 1 August 2010.

(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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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 all agents except for infliximab, for which a maximum of 22 weeks will be authorised. 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 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, patients will be deemed to have failed to respond to treatment with that biological agent.							
	Grandfather patients — golimumab only.							
	Applications for patients who commenced treatment with golimumab prior to 1 March 2010 may apply for initial PBS-subsidised treatment as continuing therapy 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 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, 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.							
	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; or							
	(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.							
	Medicare Australia 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 authority 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. 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 re-qualify 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.							
	Note							
	No applications for increased maximum quantities and/or repeats will be authorised.							
9458T	ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1	1	5	..	1774.71	36.90	Enbrel	PF
9088H	ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1	1	5	..	1774.71	36.90	Enbrel	PF
9036N	etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1	2	5	..	*1774.70	36.90	Enbrel	PF

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	
	mL syringes], 1 pack						

ETANERCEPT

Authority required

Initial 1 (new patient or patient re-commencing after a break of more than 24 months)

Initial PBS-subsidised treatment with etanercept, by a rheumatologist or clinical immunologist with expertise in the management of rheumatoid arthritis, of adults who:

- (a) have severe active rheumatoid arthritis; and
- (b) have received no PBS-subsidised treatment with a bDMARD for this condition in the previous 24 months; and
- (c) have failed, in the 24 months immediately prior to the date of application, to achieve an adequate response to 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:
 - hydroxychloroquine at a dose of at least 200 mg daily; or
 - leflunomide at a dose of at least 10 mg daily; or
 - sulfasalazine at a dose of at least 2 g daily.

If methotrexate is contraindicated according to the TGA-approved product information or cannot be tolerated at a 20 mg weekly dose, then the 6 months of intensive DMARD treatment must include at least 3 months continuous treatment with each of at least 2 of the DMARDs:

- hydroxychloroquine at a dose of at least 200 mg daily; and/or
- leflunomide at a dose of at least 10 mg daily; and/or
- sulfasalazine at a dose of at least 2 g daily.

The application must include details of the contraindication or intolerance to methotrexate. Details of the toxicities, including severity, which will be accepted for the purposes of exempting a patient from the requirement to undertake a minimum 3 month trial of methotrexate at a 20 mg weekly dose can be found on the Medicare Australia website [www.medicareaustralia.gov.au]. The maximum tolerated dose of methotrexate must be documented in the application, if applicable.

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, then one or more of the following DMARDs may be used in place of these agents in order to satisfy the requirement for a trial of 6 months of intensive DMARD therapy with at least 2 DMARDs taken continuously for at least 3 months each:

- azathioprine at a dose of at least 1 mg/kg per day; and/or
- cyclosporin at a dose of at least 2 mg/kg/day; and/or
- sodium aurothiomalate at a dose of 50 mg weekly.

The application must include details of the DMARDs trialled, their doses and duration of treatment, and all relevant contraindications and/or intolerances. Details of the toxicities, including severity, which will be accepted as a reason for substituting azathioprine, cyclosporin or sodium aurothiomalate for another DMARD as part of the 6 month intensive DMARD trial can be found on the Medicare Australia website [www.medicareaustralia.gov.au].

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. Details of the toxicities, including severity, which will be accepted for the purposes of exempting a patient from the requirement for a 6 month trial of intensive DMARD therapy can be found on the Medicare Australia website [www.medicareaustralia.gov.au].

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

- (i) a total active joint count of at least 20 active (swollen and tender) joints; or
- (ii) at least 4 active joints from the following list of major joints:
 - elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - 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 reason this criterion cannot be satisfied.

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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 [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]; and
- (3) a signed patient acknowledgement.

A maximum of 16 weeks of treatment will be authorised under this restriction.

Where fewer than 3 repeats are requested at the time of the 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 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.

Patients who fail to demonstrate a response to treatment with etanercept under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition

Authority required

Initial 2 (change or re-commencement after break of less than 24 months)

Initial course of PBS-subsidised treatment with etanercept, by a rheumatologist or clinical immunologist with expertise in the management of rheumatoid arthritis, of adults who:

- (a) have a documented history of severe active rheumatoid arthritis; and
- (b) have received prior PBS-subsidised bDMARD treatment for this condition and are eligible to receive further bDMARD therapy.

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 [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)].

Applications for patients who have received PBS-subsidised treatment with etanercept and who wish 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 etanercept treatment, within the timeframes specified below.

A maximum of 16 weeks of treatment will be authorised under this restriction.

Where fewer than 3 repeats are requested at the time of the 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).

Where the most recent course of PBS-subsidised etanercept treatment was approved under either of the initial 1 or 2 treatment restrictions, patients 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 etanercept treatment was approved under the continuing treatment criteria, patients 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 who fail to demonstrate a response to treatment with etanercept under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition

Note

- (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.

Note

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

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 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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
	Note No applications for increased maximum quantities and/or repeats will be authorised. Note Special Pricing Arrangements apply.							
9459W	ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1	1	3	..	1774.71	36.90	Enbrel	PF
9089J	ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1	1	3	..	1774.71	36.90	Enbrel	PF
8637N	etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack	2	3	..	*1774.70	36.90	Enbrel	PF

ETANERCEPT

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

Authority required

Continuing treatment

Continuing PBS-subsidised treatment with etanercept, by a rheumatologist or clinical immunologist with expertise in the management of rheumatoid arthritis, of adults:

- (a) who have a documented history of severe active rheumatoid arthritis; and
- (b) who have demonstrated an adequate response to treatment with etanercept; and
- (c) whose most recent course of PBS-subsidised bDMARD treatment was with etanercept.

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:

- (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 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 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 [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)].

A maximum of 24 weeks of treatment will be approved under this restriction.

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).

All applications for continuing treatment with etanercept must include a measurement of response to the prior course of therapy. 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, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with an initial treatment course.

Patients who fail to demonstrate a response to treatment with etanercept under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug for this condition

Note

(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.

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

Note

TREATMENT OF ADULT PATIENTS WITH SEVERE ACTIVE RHEUMATOID ARTHRITIS

[illegible]

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

Note

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

Note

Special Pricing Arrangements apply.

9460X	ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1	1	5	..	1774.71	36.90	Enbrel	PF
9090K	ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1	1	5	..	1774.71	36.90	Enbrel	PF
8638P	etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack	2	5	..	*1774.70	36.90	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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

(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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

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 700 270 (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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

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 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 700 270 (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 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 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 700 270 (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

Note

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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. Note No applications for increased maximum quantities and/or repeats will be authorised. Note Special Pricing Arrangements apply.								
9461Y	ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1	1	3	..	1774.71	36.90	Enbrel	PF
9091L	ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1	1	3	..	1774.71	36.90	Enbrel	PF
9037P	etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack	2	3	..	*1774.70	36.90	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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

Note

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.

[illegible]

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
	Note							
	No applications for increased maximum quantities and/or repeats will be authorised.							
	Note							
	Special Pricing Arrangements apply.							
9462B	ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1	1	5	..	1774.71	36.90	Enbrel	PF
9431J	ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1	1	5	..	1774.71	36.90	Enbrel	PF
9429G	etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack	2	5	..	*1774.70	36.90	Enbrel	PF

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,

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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.						
	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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

Note

Special Pricing Arrangements apply.

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

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.

[illegible]

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

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) 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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

(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.

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

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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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							
3426H	golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe	1	3	..	1777.63	36.90	Simponi	JC
3427J	golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe	1	3	..	1777.63	36.90	Simponi	JC

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

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

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

[illegible]

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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. <u>Authority required</u> 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. <u>Note</u> 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							
3428K	golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe	1	5	..	1777.63	36.90	Simponi	JC
3429L	golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe	1	5	..	1777.63	36.90	Simponi	JC

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

GOLIMUMAB

Authority required

Initial 1

Initial PBS-subsidised treatment with golimumab, by a rheumatologist or clinical immunologist with expertise in the management of psoriatic arthritis, of adults who:

- (1) have severe active psoriatic arthritis; and
- (2) have received no prior PBS-subsidised biological treatment for this condition in this Treatment Cycle; and
- (3) have failed to achieve an adequate response to:
 - (a) methotrexate at a dose of at least 20 mg weekly for a minimum period of 3 months; and
 - (b) sulfasalazine at a dose of at least 2 g per day for a minimum period of 3 months; or
 - (c) leflunomide at a dose of up to 20 mg daily for a minimum period of 3 months.

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 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, 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 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

- (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 of major joints:
 - elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - 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 [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]; and
- (3) a signed patient acknowledgement.

A maximum of 16 weeks treatment will be authorised under this restriction.

Where fewer than 3 repeats are requested at the time of the 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).

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 to Medicare Australia 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.

Patients who fail to demonstrate a response to treatment with golimumab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug, in this Treatment Cycle. Patients may re-trial golimumab 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

Authority required

Initial 2

Initial PBS-subsidised treatment with golimumab, by a rheumatologist or clinical immunologist with expertise in the management of psoriatic arthritis, of adults who:

- (1) have a documented history of severe active psoriatic arthritis; and
- (2) have received prior PBS-subsidised biological treatment for this condition in this Treatment Cycle and are eligible to receive further biological therapy; and
- (3) have not failed treatment with golimumab during the current Treatment Cycle.

Applications for patients who have received PBS-subsidised treatment with golimumab within this Treatment Cycle and who wish to re-commence 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 golimumab treatment, within the timeframes specified below.

A maximum of 16 weeks treatment will be authorised under this restriction.

Where fewer than 3 repeats are requested at the time of the 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.

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

EST Monday to Friday).

Where the most recent course of PBS-subsidised golimumab 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), patients 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 golimumab treatment was approved under the continuing treatment criteria, patients 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.

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 [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)].

Patients who fail to demonstrate a response to treatment with golimumab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug, in this Treatment Cycle. Patients may re-trial golimumab 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

Note

Any queries concerning the arrangements to prescribe golimumab 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 golimumab should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Note

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, 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 the following NOTES and restrictions, it only refers to adalimumab, etanercept, golimumab and infliximab.

From 1 August 2006, all patients will be 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 5-year 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 after 1 August 2010.

(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).

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	All applications for initial treatment for non-grandfather patients will be limited to provide for a maximum of 16 weeks of therapy for all agents except for infliximab, for which a maximum of 22 weeks will be authorised. 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 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, patients will be deemed to have failed to respond to treatment with that biological agent. Grandfather patients — golimumab only. Applications for patients who commenced treatment with golimumab prior to 1 March 2010 may apply for initial PBS-subsidised treatment as continuing therapy 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 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, 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. 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; or (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. Medicare Australia 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 authority 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. 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 re-qualify 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.						
3430M	golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe	1	3	..	1777.63	36.90	Simponi JC
3431N	golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe	1	3	..	1777.63	36.90	Simponi JC

GOLIMUMAB

Authority required

Initial 3 — grandfather golimumab patients

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	Initial PBS-subsidised supply for continuing treatment with golimumab, by a rheumatologist or clinical immunologist with expertise in the management of psoriatic arthritis, of adults who: (1) have a documented history of severe active psoriatic arthritis; and (2) were receiving treatment with golimumab prior to 1 March 2010; and (3) have demonstrated a response as specified in the criteria for continuing PBS-subsidised treatment with golimumab; and (4) are receiving treatment with golimumab at the time of application. 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 [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]; and (3) a signed patient acknowledgement. A maximum of 24 weeks of treatment with golimumab will be authorised under this restriction. 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). Patients who fail to demonstrate a response to treatment with golimumab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug, in this Treatment Cycle. Patients may re-trial golimumab 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. Patients may qualify for PBS-subsidised treatment under this restriction once only <u>Authority required</u> Continuing treatment Continuing PBS-subsidised treatment with golimumab, by a rheumatologist or clinical immunologist with expertise in the management of psoriatic arthritis, of adults: (1) who have a documented history of severe active psoriatic arthritis; and (2) whose most recent course of PBS-subsidised biological agent for this condition in the current Treatment Cycle was with golimumab; and (3) who, at the time of application, demonstrate an adequate response to treatment with golimumab. An adequate response to treatment with golimumab 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: (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 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 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 [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]. A maximum of 24 weeks of treatment will be approved under this restriction. 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). All applications for continuing treatment with golimumab must include a measurement of response to the prior course of therapy. 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 golimumab, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course. Patients who fail to demonstrate a response to treatment with golimumab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug, in this Treatment Cycle. Patients may re-trial golimumab 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 <u>Note</u> Any queries concerning the arrangements to prescribe golimumab 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 golimumab should be forwarded to: Medicare Australia						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Note

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, 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 the following NOTES and restrictions, it only refers to adalimumab, etanercept, golimumab and infliximab.

From 1 August 2006, all patients will be 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 5-year 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 after 1 August 2010.

(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 all agents except for infliximab, for which a maximum of 22 weeks will be authorised. 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 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, patients will be deemed to have failed to respond to treatment with that biological agent.

Grandfather patients — golimumab only.

Applications for patients who commenced treatment with golimumab prior to 1 March 2010 may apply for initial PBS-subsidised treatment as continuing therapy 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 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, 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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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. 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; or (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. Medicare Australia 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 authority 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. 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 re-qualify 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.						
	Note						
	No applications for increased maximum quantities and/or repeats will be authorised. Applications for treatment with golimumab where the dosing frequency exceeds 50 mg every 4 weeks will not be approved.						
3432P	golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe	1	5	..	1777.63	36.90	Simponi JC
3433Q	golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe	1	5	..	1777.63	36.90	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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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						
	Note						
	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						
	Note						
	No increase in the maximum quantity or number of units may be authorised.						
	Note						
	No increase in the maximum number of repeats may be authorised.						
	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)						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

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

Note

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

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

Note

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	Note No increase in the maximum number of repeats may be authorised.							
	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							
3434R	golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe	1	3	..	1777.63	36.90	Simponi	JC
3435T	golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe	1	3	..	1777.63	36.90	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

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

Note

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

Note

Any queries concerning the arrangements to prescribe may be directed to the Department of Human Services on 1800 700 270 (hours of operation

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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						
	Note						
	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						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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. <u>Authority required</u> 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. <u>Note</u> No increase in the maximum quantity or number of units may be authorised. <u>Note</u> No increase in the maximum number of repeats may be authorised. <u>Note</u> 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							
3436W	golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe	1	5	..	1777.63	36.90	Simponi	JC
3437X	golimumab 50 mg/0.5 mL injection, 1 x 0.5 mL syringe	1	5	..	1777.63	36.90	Simponi	JC

Interleukin inhibitors

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:

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	(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)]; (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						

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

[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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

Note

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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
	Note							
	No applications for increased repeats will be authorised.							
	Note							
	Special Pricing Arrangements apply.							
9304Q	ustekinumab 45 mg/0.5 mL injection, 1 x 0.5 mL vial	1	2	..	4601.76	36.90	Stelara	JC

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:

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

(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

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

Note

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.

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

Note

No applications for increased repeats will be authorised.

Note

Special Pricing Arrangements apply.

9305R	ustekinumab 45 mg/0.5 mL injection, 1 x 0.5 mL vial	1	1	..	4601.76	36.90	Stelara	JC

Calcineurin inhibitors

CYCLOSPORIN

Authority required

Maintenance therapy, following initiation and stabilisation of treatment with cyclosporin, of patients with organ or tissue transplants. Therapy must remain under the supervision and direction of the transplant unit reviewing the patient. 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 cyclosporin, of patients with severe atopic dermatitis for whom other systemic therapies are ineffective or inappropriate. Therapy must remain under the supervision and direction of a dermatologist, clinical immunologist or specialised unit reviewing the patient. The name of the dermatologist, clinical immunologist or specialised unit reviewing treatment and the date of the latest review must be included in the authority application

Authority required

Maintenance therapy, following initiation and stabilisation of treatment with cyclosporin, 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. Therapy must remain under the supervision and direction of a dermatologist or specialised unit reviewing the patient. The name of the dermatologist or specialised unit

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
reviewing treatment and the date of the latest review must be included in the authority application								
<u>Authority required</u>								
Maintenance therapy, following initiation and stabilisation of treatment with cyclosporin, of patients with nephrotic syndrome in whom steroids and cytostatic drugs have failed or are not tolerated or are considered inappropriate and in whom renal function is unimpaired. Therapy must remain under the supervision and direction of a nephrologist or specialised unit reviewing the patient. The name of the nephrologist or specialised unit reviewing treatment and the date of the latest review must be included in the authority application								
<u>Authority required</u>								
Maintenance therapy, following initiation and stabilisation of treatment with cyclosporin, of patients with severe active rheumatoid arthritis for whom classical slow-acting anti-rheumatic agents (including methotrexate) are ineffective or inappropriate. Therapy must remain under the supervision and direction of a rheumatologist, clinical immunologist or specialised unit reviewing the patient. The name of the rheumatologist, clinical immunologist or specialised unit reviewing treatment and the date of the latest review must be included in the authority application								
<u>Authority required</u>								
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								
<u>Authority required</u>								
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								
<u>Authority required</u>								
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								
<u>Caution</u>								
Careful monitoring of patients is mandatory.								
8657P	cyclosporin 10 mg capsule, 60	2	3	..	*94.76	36.90	Neoral 10	NV
8660T	cyclosporin 100 mg capsule, 30	2	3	..	*374.78	36.90	^a Cyclosporin Sandoz	SZ
							^a Neoral 100	NV
8661W	cyclosporin 100 mg/mL oral liquid, 50 mL	2	3	..	*713.00	36.90	Neoral	NV
8658Q	cyclosporin 25 mg capsule, 30	2	3	..	*97.58	36.90	^a Cyclosporin Sandoz	SZ
							^a Neoral 25	NV
8659R	cyclosporin 50 mg capsule, 30	2	3	..	*195.72	36.90	^a Cyclosporin Sandoz	SZ
							^a Neoral 50	NV

TACROLIMUS

Authority required

Maintenance therapy, following initiation and stabilisation of treatment with tacrolimus, of patients with organ or tissue transplants. Therapy must remain under the supervision and direction of the transplant unit reviewing the patient. 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

Caution

Careful monitoring of patients is mandatory.

8647D	tacrolimus 1 mg capsule, 100	1	3	..	377.25	36.90	^a Pharmacor Tacrolimus 1	CR
							^a Prograf	JC
							^a Tacrolimus Sandoz	SZ
5300Y	tacrolimus 1 mg capsule: modified release, 60 capsules	1	3	..	236.25	36.90	Prograf XL	JC
8648E	tacrolimus 5 mg capsule, 50	1	3	..	922.78	36.90	^a Pharmacor Tacrolimus 5	CR
							^a Prograf	JC
							^a Tacrolimus Sandoz	SZ
5451X	tacrolimus 5 mg capsule: modified release, 30 capsules	1	3	..	556.66	36.90	Prograf XL	JC
8646C	tacrolimus 500 microgram capsule, 100	1	3	..	200.64	36.90	^a Pharmacor Tacrolimus 0.5	CR
							^a Prograf	JC
							^a Tacrolimus Sandoz	SZ
5299X	tacrolimus 500 microgram capsule: modified release, 30 capsules	1	3	..	64.93	36.90	Prograf XL	JC

Other immunosuppressants

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
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.							
2688L NP	azathioprine 25 mg tablet, 100	1	5	..	26.22	27.37	^a APO-Azathioprine TX
							^a Azathioprine Sandoz SZ
							^a Imuran AS
2687K NP	azathioprine 50 mg tablet, 100	1	5	..	39.88	36.90	^a APO-Azathioprine TX
							^a Azamun GN
							^a Azapin QA
							^a Azathioprine AN EA
							^a Azathioprine Sandoz SZ
							^a GenRx Azathioprine GX
							^a Imazan ER
							^a Imuran AS
							^a Thioprine AF
METHOTREXATE							
2272N	methotrexate 10 mg tablet, 15	1	3	..	20.68	21.83	Methoblastin PF
1622J	methotrexate 2.5 mg tablet, 30	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							
1623K	methotrexate 10 mg tablet, 50	1	2	..	51.58	36.90	Methoblastin PF

MUSCULO-SKELETAL SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

MUSCULO-SKELETAL SYSTEM

ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS

ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS, NON-STERIODS

Acetic acid derivatives and related substances

DICLOFENAC

1302M NP,MW	diclofenac sodium 100 mg suppository, 20	2	3	..	*25.26	26.41	Voltaren 100	NV
5079H DP	diclofenac sodium 100 mg suppository, 20	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

1299J NP	diclofenac sodium 25 mg tablet: enteric, 50 tablets	2	3	..	*11.10	12.25	^a APO-Diclofenac	TX
							^a Chem mart Diclofenac	CH
							^a Clonac 25	QA
							^a Diclofenac AN	EA
							^a Diclofenac-GA	GN
							^a Diclofenac Sandoz	SZ
							^a Fenac 25	AF
							^a Terry White Chemists Diclofenac	TW
				^B 1.62	*12.72	12.25	^a Voltaren 25	NV
5076E DP	diclofenac sodium 25 mg tablet: enteric, 50 tablets	2	..	..	*11.10	12.25	^a APO-Diclofenac	TX
							^a Chem mart Diclofenac	CH
							^a Clonac 25	QA
							^a Diclofenac AN	EA
							^a Diclofenac-GA	GN
							^a Diclofenac Sandoz	SZ
							^a Fenac 25	AF
							^a Terry White Chemists Diclofenac	TW
				^B 1.62	*12.72	12.25	^a Voltaren 25	NV
1300K NP	diclofenac sodium 50 mg tablet: enteric, 50 tablets	1	3	..	9.78	10.93	^a APO-Diclofenac	TX
							^a Chem mart Diclofenac	CH
							^a Clonac 50	QA
							^a Diclofenac AN	EA
							^a Diclofenac-GA	GN
							^a Diclofenac Sandoz	SZ
							^a Fenac	AF
							^a Terry White Chemists Diclofenac	TW
				^B 1.61	11.39	10.93	^a Voltaren 50	NV
5077F DP	diclofenac sodium 50 mg tablet: enteric, 50 tablets	1	..	..	9.78	10.93	^a APO-Diclofenac	TX
							^a Chem mart Diclofenac	CH
							^a Clonac 50	QA
							^a Diclofenac AN	EA
							^a Diclofenac-GA	GN
							^a Diclofenac Sandoz	SZ
							^a Fenac	AF
							^a Terry White Chemists Diclofenac	TW
				^B 1.61	11.39	10.93	^a Voltaren 50	NV

INDOMETHACIN

MUSCULO-SKELETAL SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
2757D NP	indomethacin 100 mg suppository, 20	2	3	..	*22.84	23.99	Indocid	AS
5128X DP	indomethacin 100 mg suppository, 20	2	..	..	*22.84	23.99	Indocid	AS
INDOMETHACIN								
<u>Restricted benefit</u>								
Chronic arthropathies (including osteoarthritis) with an inflammatory component								
<u>Restricted benefit</u>								
Bone pain due to malignant disease								
2454E NP	indomethacin 25 mg capsule, 50	2	3	..	*13.20	14.35	^a Arthrexin	AF
				^b 4.64	*17.84	14.35	^a Indocid	AS
5126T DP	indomethacin 25 mg capsule, 50	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.

Note

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.

8888T NP	meloxicam 15 mg capsule, 30	1	3	..	14.66	15.81	^a APO-Meloxicam	TX
							^a Chem mart Meloxicam	CH
							^a Melox 15	GN
							^a Meloxicam Sandoz	SZ
							^a Movalis 15	QA
							^a Terry White Chemists Meloxicam	TW
				^b 2.50	17.16	15.81	^a Mobic	BY
8562P NP	meloxicam 15 mg tablet, 30	1	3	..	14.66	15.81	^a APO-Meloxicam	TX
							^a Chem mart Meloxicam 15 mg	CH
							^a GenRx Meloxicam	GX
							^a Meloxiauro 15	DO
							^a Meloxibell	GQ
							^a Meloxicam AN	EA
							^a Meloxicam-GA	GN
							^a Meloxicam Ranbaxy	RA
							^a Meloxicam Sandoz	SZ
							^a Movalis 15	QA
							^a Moxicam 15	AF
							^a Pharmacor Meloxicam 15	CR
							^a Terry White Chemists Meloxicam 15 mg	TW
				^b 2.50	17.16	15.81	^a Mobic	BY

MELOXICAM

Restricted benefit

Symptomatic treatment of osteoarthritis

Restricted benefit

MUSCULO-SKELETAL SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
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.							
Note							
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.							
8887R NP	meloxicam 7.5 mg capsule, 30	1	3	..	12.18	13.33	^a APO-Meloxicam TX
							^a Chem mart Meloxicam CH
							^a Melox 7.5 GN
							^a Meloxicam Sandoz SZ
							^a Movalis 7.5 QA
							^a Terry White Chemists Meloxicam TW
				^b 2.50	14.68	13.33	^a Mobic BY
8561N NP	meloxicam 7.5 mg tablet, 30	1	3	..	12.18	13.33	^a APO-Meloxicam TX
							^a Chem mart Meloxicam 7.5 mg CH
							^a GenRx Meloxicam GX
							^a Meloxiauro 7.5 DO
							^a Meloxibell GQ
							^a Meloxicam AN EA
							^a Meloxicam-GA GN
							^a Meloxicam Ranbaxy RA
							^a Meloxicam Sandoz SZ
							^a Movalis 7.5 QA
							^a Moxicam 7.5 AF
							^a Pharmacor Meloxicam 7.5 CR
							^a Terry White Chemists Meloxicam 7.5 mg TW
				^b 2.50	14.68	13.33	^a Mobic BY
PIROXICAM							
Restricted benefit							
Chronic arthropathies (including osteoarthritis) with an inflammatory component							
1897W NP	piroxicam 10 mg capsule, 50	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
5203W DP	piroxicam 10 mg capsule, 50	1	..	..	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
1895R NP	piroxicam 10 mg tablet: dispersible, 50	1	3	..	12.54	13.69	Mobilis D-10 AF
5201R DP	piroxicam 10 mg tablet: dispersible, 50	1	..	..	12.54	13.69	Mobilis D-10 AF
1898X NP	piroxicam 20 mg capsule, 25	1	3	..	12.26	13.41	^a Chem mart Piroxicam CH
							^a GenRx Piroxicam GX
							^a Mobilis 20 AF
							^a Terry White Chemists Piroxicam TW

MUSCULO-SKELETAL SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
5204X DP	piroxicam 20 mg capsule, 25	1	..	^B 2.86 ..	15.12 12.26	13.41 13.41	^a Feldene ^a Chem mart Piroxicam	PF CH
							^a GenRx Piroxicam ^a Mobilis 20 ^a Terry White Chemists Piroxicam	GX AF TW
1896T NP	piroxicam 20 mg tablet: dispersible, 25	1	3	^B 2.86 ..	15.12 12.26	13.41 13.41	^a Feldene ^a Mobilis D-20	PF AF
5202T DP	piroxicam 20 mg tablet: dispersible, 25	1	..	^B 3.86 ..	16.12 12.26	13.41 13.41	^a Feldene-D ^a Mobilis D-20	PF AF
				^B 3.86	16.12	13.41	^a Feldene-D	PF
Propionic acid derivatives								
IBUPROFEN								
<u>Restricted benefit</u>								
Chronic arthropathies (including osteoarthritis) with an inflammatory component								
<u>Restricted benefit</u>								
Bone pain due to malignant disease								
3190X NP	ibuprofen 400 mg tablet, 30	3	3	..	*15.07	16.22	Brufen	AB
5123P DP	ibuprofen 400 mg tablet, 30	3	..	..	*15.07	16.22	Brufen	AB
IBUPROFEN								
3192B NP,MW	ibuprofen 400 mg tablet, 30	1	..	..	9.53	10.68	Brufen	AB
5124Q DP	ibuprofen 400 mg tablet, 30	1	..	..	9.53	10.68	Brufen	AB
KETOPROFEN								
1588N NP	ketoprofen 100 mg suppository, 20	2	3	..	*25.64	26.79	Orudis	SW
5139L DP	ketoprofen 100 mg suppository, 20	2	..	..	*25.64	26.79	Orudis	SW
KETOPROFEN								
<u>Restricted benefit</u>								
Chronic arthropathies (including osteoarthritis) with an inflammatory component								
1590Q NP	ketoprofen 200 mg capsule: modified release, 28 capsules	1	3	..	19.44	20.59	^a Oruvail SR	AV
				^B 2.21	21.65	20.59	^a Orudis SR 200	SW
5136H DP	ketoprofen 200 mg capsule: modified release, 28 capsules	1	..	..	19.44	20.59	^a Oruvail SR	AV
				^B 2.21	21.65	20.59	^a Orudis SR 200	SW
NAPROXEN								
<u>Restricted benefit</u>								
Chronic arthropathies (including osteoarthritis) with an inflammatory component								
<u>Restricted benefit</u>								
Bone pain due to malignant disease								
1615B NP	naproxen 1 g tablet: modified release, 28	1	3	..	14.30	15.45	^a Proxen SR 1000	MD
				^B 1.29	15.59	15.45	^a Naprosyn SR1000	RO
5179N DP	naproxen 1 g tablet: modified release, 28	1	..	..	14.30	15.45	^a Proxen SR 1000	MD
				^B 1.29	15.59	15.45	^a Naprosyn SR1000	RO
1674D NP	naproxen 250 mg tablet, 50	2	3	..	*13.68	14.83	^a Inza 250	AF
				^B 2.24	*15.92	14.83	^a Naprosyn	RO
5176K DP	naproxen 250 mg tablet, 50	2	..	..	*13.68	14.83	^a Inza 250	AF
				^B 2.24	*15.92	14.83	^a Naprosyn	RO
1659H	naproxen 500 mg tablet, 50	1	3	..	12.94	14.09	^a Inza 500	AF

MUSCULO-SKELETAL SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
<i>NP</i>				^B 1.28	14.22	14.09	^a Naprosyn	RO
5177L	naproxen 500 mg tablet, 50	1	..	..	12.94	14.09	^a Inza 500	AF
<i>DP</i>				^B 1.28	14.22	14.09	^a Naprosyn	RO
1614Y	naproxen 750 mg tablet: modified release, 28 tablets	1	3	..	12.42	13.57	^a Proxen SR 750	MD
<i>NP</i>				^B 1.22	13.64	13.57	^a Naprosyn SR750	RO
5178M	naproxen 750 mg tablet: modified release, 28 tablets	1	..	..	12.42	13.57	^a Proxen SR 750	MD
<i>DP</i>				^B 1.22	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.

1658G	naproxen 125 mg/5 mL oral liquid, 474 mL	1	3	..	127.96	36.90	Phebra Naproxen Suspension	PL

NP

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.

1795L	naproxen sodium 550 mg tablet, 50	1	3	..	13.11	14.26	^a Crysanal	MD
<i>NP</i>				^B 2.17	15.28	14.26	^a Anaprox 550	RO
5186Y	naproxen sodium 550 mg tablet, 50	1	..	..	13.11	14.26	^a Crysanal	MD
<i>DP</i>				^B 2.17	15.28	14.26	^a Anaprox 550	RO

Fenamates

MEFENAMIC ACID

Restricted benefit

Dysmenorrhoea

Restricted benefit

Menorrhagia

1824B	mefenamic acid 250 mg capsule, 50	1	2	..	18.50	19.65	Ponstan	PF

NP

Coxibs

CELECOXIB

Restricted benefit

Symptomatic treatment of osteoarthritis

Restricted benefit

Symptomatic treatment of rheumatoid arthritis

Note

The use of celecoxib for the treatment of the following conditions is not subsidised through the PBS:

MUSCULO-SKELETAL SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	(a) acute pain;						
	(b) soft tissue injury;						
	(c) arthrosis without an inflammatory component.						
8439E NP	celecoxib 100 mg capsule, 60	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
8440F NP	celecoxib 200 mg capsule, 30	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.

1512N NP	hydroxychloroquine sulfate 200 mg tablet, 100	1	1	..	32.93	34.08	^a APO-Hydroxychloroquine TX
							^a Chem mart Hydroxychloroquine CH
							^a Hydroxychloroquine GN
							^a Actavis SW
							^a Plaquenil TW
							^a Terry White Chemists Hydroxychloroquine

Gold preparations

AURANOFIN

Caution

Regular blood and urine checks are essential.

2022K NP	AURANOFIN Capsule 3 mg, 60	1	5	..	779.33	36.90	Ridaura GH

AURANOFIN

Caution

Regular blood and urine checks are essential.

Note

MUSCULO-SKELETAL SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
1095P NP	auranofin 3 mg tablet, 60	1	5	..	63.89	36.90	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.								
2016D NP	aurothiomalate sodium 10 mg/0.5 mL injection, 10 x 0.5 mL ampoules	1	..	..	83.64	36.90	Myocrisin	SW
2017E NP	aurothiomalate sodium 20 mg/0.5 mL injection, 10 x 0.5 mL ampoules	1	1	..	125.03	36.90	Myocrisin	SW
2018F NP	aurothiomalate sodium 50 mg/0.5 mL injection, 10 x 0.5 mL ampoules	1	1	..	152.81	36.90	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.

2721F NP	penicillamine 125 mg tablet, 100	1	1	..	31.97	33.12	D-Penamine	AL
2838J NP	penicillamine 250 mg tablet, 100	1	1	..	53.63	36.90	D-Penamine	AL

MUSCLE RELAXANTS

MUSCLE RELAXANTS, CENTRALLY ACTING AGENTS

Other centrally acting agents

BACLOFEN

2729P NP	baclofen 10 mg tablet, 100	1	5	..	19.59	20.74	^a Clofen 10	AF
							^a Lioresal 10	NV
							^a Stelax 10	QA
2730Q NP	baclofen 25 mg tablet, 100	1	5	..	34.81	35.96	^a Clofen 25	AF
							^a Lioresal 25	NV
							^a Stelax 25	QA
							^a Terry White Chemists Baclofen	TW

MUSCLE RELAXANTS, DIRECTLY ACTING AGENTS

Dantrolene and derivatives

DANTROLENE

Restricted benefit

Treatment of chronic spasticity

1779P NP	dantrolene sodium 25 mg capsule, 100	1	2	..	81.53	36.90	Dantrium	PF
1780Q NP	dantrolene sodium 50 mg capsule, 100	1	2	..	82.15	36.90	Dantrium	PF

ANTIGOUT PREPARATIONS

ANTIGOUT PREPARATIONS

Preparations inhibiting uric acid production

MUSCULO-SKELETAL SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
ALLOPURINOL								
Note								
The dose should be adjusted in accordance with renal function.								
Note								
For item codes 2600W and 1557Y, pharmaceutical benefits that have the form tablet 100 mg are equivalent for the purposes of substitution.								
1557Y NP	allopurinol 100 mg tablet, 100	2	2	..	*11.32	12.47	^a Progout 100	AF
2600W NP	allopurinol 100 mg tablet, 200	1	2	..	11.31	12.46	^a Allopurinol Sandoz	SZ
							^a Allosig	FM
							^a Chem mart Allopurinol	CH
							^a GenRx Allopurinol	GX
							^a Terry White Chemists	TW
				^b 3.44	14.75	12.46	^a Allopurinol Zyloprim	QA
ALLOPURINOL								
Note								
The dose should be adjusted in accordance with renal function.								
2604C NP	allopurinol 300 mg tablet, 60	1	2	..	9.43	10.58	^a Allopurinol Sandoz	SZ
							^a Allosig	FM
							^a Chem mart Allopurinol	CH
							^a GenRx Allopurinol	GX
							^a Progout 300	AF
							^a Terry White Chemists	TW
				^b 3.43	12.86	10.58	^a Allopurinol Zyloprim	QA
Preparations increasing uric acid excretion								
PROBENECID								
1940D NP	probenecid 500 mg tablet, 100	1	5	..	76.03	36.90	Pro-Cid	PL
Preparations with no effect on uric acid metabolism								
COLCHICINE								
3410L NP	colchicine 500 microgram tablet, 30	1	5	..	11.34	12.49	^a Lengout	LN
				^b 3.33	14.67	12.49	^a Colgout	AS

DRUGS FOR TREATMENT OF BONE DISEASES

DRUGS AFFECTING BONE STRUCTURE AND MINERALIZATION

Bisphosphonates

ALENDRONATE

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:

MUSCULO-SKELETAL SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
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. <u>Authority required (STREAMLINED)</u> 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. <u>Note</u> Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride, strontium ranelate and zoledronic acid.							
8511Y NP	alendronate 70 mg tablet, 4	1	5	..	14.93	16.08	^a Alendrobell 70mg GQ ^a Alendronate AN EA ^a Alendronate-GA GN ^a Alendronate Sandoz SZ ^a Alendro Once Weekly QA ^a APO-Alendronate TX ^a Chem mart CH Alendronate 70mg ^a Densate 70 DO ^a Fonat AL ^a Ossmax 70mg RA ^a Terry White Chemists TW Alendronate 70mg
CLODRONATE <u>Restricted benefit</u> Maintenance treatment of hypercalcaemia of malignancy refractory to anti-neoplastic therapy <u>Restricted benefit</u> Multiple myeloma <u>Restricted benefit</u> Bone metastases from breast cancer <u>Note</u> 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.							
8132B NP	clodronate sodium 400 mg capsule, 100	1	2	..	334.42	36.90	Bonefos BN
8265B NP	clodronate sodium 800 mg tablet, 60	1	2	..	391.78	36.90	Bonefos 800 mg BN

IBANDRONIC ACID

Restricted benefit

Bone metastases from breast cancer

Note

Continuing Therapy Only:

MUSCULO-SKELETAL SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
9357L NP	ibandronic acid 50 mg tablet, 28	1	2	..	342.68	36.90	Bondronat	RO

PAMIDRONATE DISODIUM

Authority required (STREAMLINED)

4422

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.

8461H NP	pamidronate disodium 15 mg/5 mL injection, 1 x 5 mL vial	4	..	..	*102.16	36.90	Pamisol	HH
8463K NP	pamidronate disodium 60 mg/10 mL injection, 1 x 10 mL vial	1	..	..	102.13	36.90	Pamisol	HH

PAMIDRONATE DISODIUM

Authority required (STREAMLINED)

4420

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.

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.

8209C NP	pamidronate disodium 30 mg injection [2 x 30 mg vials] (& inert substance diluent [2 x 10 mL ampoules], 1 pack	1	..	..	102.14	36.90 ^a	Aredia 30 mg	NV
8462J NP	pamidronate disodium 30 mg/10 mL injection, 1 x 10 mL vial	2	..	..	*102.16	36.90 ^a	Pamisol	HH

RISEDRONATE

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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
8972F NP	RISEDRONATE SODIUM Tablet 35 mg (enteric coated), 4	1	5	..	42.11	36.90	Actonel EC	SW
9391G NP	risedronate sodium 150 mg tablet, 1	1	5	..	44.69	36.90	^a Acris Once-a-Month	AF
							^a Actonel Once-a-Month	SW
							^a APO-Risedronate	TX
							^a Chem mart Risedronate	CH
							^a Terry White Chemists Risedronate	TW
8621R NP	risedronate sodium 35 mg tablet, 4	1	5	..	42.11	36.90	^a Acris Once-a-Week	AF
							^a APO-Risedronate	TX
							^a Risedronate AN	EA
							^a Risedronate-GA	GN
							^a Risedronate Sandoz	SZ
							^a Risedro once a week	QA
8481J NP	risedronate sodium 5 mg tablet, 28	1	5	..	42.11	36.90	Actonel	SW
RISEDRONATE								
Authority required (STREAMLINED)								
3256								
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.								
8482K NP	risedronate sodium 30 mg tablet, 28	1	1	..	235.41	36.90	Actonel	SW
TILUDRONATE								
Authority required (STREAMLINED)								
3256								
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.								
8267D NP	tiludronate 200 mg tablet, 56	1	2	..	304.96	36.90	Skelid	SW
ZOLEDRONIC ACID								
Authority required (STREAMLINED)								
4100								
Corticosteroid-induced osteoporosis								

MUSCULO-SKELETAL SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

9288W	zoledronic acid 5 mg/100 mL injection, 1 x 100 mL vial	1	..	..	589.51	36.90	Aclasta	NV

ZOLEDRONIC ACID
Authority required

Symptomatic Paget disease of bone.

Only 1 treatment each year per patient will be PBS-subsidised

9350D	zoledronic acid 5 mg/100 mL injection, 1 x 100 mL vial	1	..	..	589.51	36.90	Aclasta	NV

Bisphosphonates, combinations
ALENDRONATE + COLECALCIFEROL
Authority required (STREAMLINED)

4122

MUSCULO-SKELETAL SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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. <u>Authority required (STREAMLINED)</u> 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. <u>Authority required (STREAMLINED)</u> 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. <u>Note</u> Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride, strontium ranelate and zoledronic acid.						
9183H NP	alendronate 70 mg + colecalciferol 140 microgram tablet, 4	1	5	..	45.51	36.90	^a Alendronate plus D3-DRLA ^a Dronalen Plus ^a Fonat Plus ^a Fosamax Plus 70 mg/140 mcg
				^b 2.49	48.00	36.90	

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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
<u>Authority required (STREAMLINED)</u>							
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.							
<u>Authority required (STREAMLINED)</u>							
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.							
<u>Note</u>							
Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride, strontium ranelate and zoledronic acid.							
<u>Note</u>							
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.							
9012H NP	alendronate 70 mg + colecalciferol 70 microgram tablet, 4	1	5	..	45.51	36.90	^a Alendronate plus D3-DRLA ^a FonatPlus ^a Fosamax Plus RZ AF MK
ALENDRONATE + COLECALCIFEROL (&) CALCIUM CARBONATE							
<u>Authority required (STREAMLINED)</u>							
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.							
<u>Authority required (STREAMLINED)</u>							
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:							

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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. <u>Authority required (STREAMLINED)</u> 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. <u>Note</u> Anti-resorptive agents in established osteoporosis include alendronate sodium, risedronate sodium, denosumab, raloxifene hydrochloride, strontium ranelate and zoledronic acid.						
9351E NP	alendronate 70 mg + colecalciferol 140 microgram tablet [4] (&) calcium (as carbonate) 500 mg tablet [48], 1 pack	#1	5	..	45.51	36.90 ^a	Dronalen Plus D-Cal FR ^a Fosamax Plus D-Cal MK
	RISEDRONATE (&) CALCIUM CARBONATE <u>Authority required (STREAMLINED)</u> 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. <u>Authority required (STREAMLINED)</u> 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. <u>Authority required (STREAMLINED)</u> 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						

MUSCULO-SKELETAL SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

8973G NP	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	¥1	5	..	45.73	36.90 ^a	Actonel EC Combi	SW
8899J NP	risedronate sodium 35 mg tablet [4] (& calcium (as carbonate) 500 mg tablet [24], 28	¥1	5	..	45.73	36.90 ^a	Risedronate Winthrop EC Combi Acris Combi	WA 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,

MUSCULO-SKELETAL SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
8974H NP	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	1	5	..	45.73	36.90	^a Actonel EC Combi D	SW
							^a Risedronate Winthrop EC Combi D	WA

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

2502Q NP	calcitriol 0.25 microgram capsule, 100	1	3	..	30.62	31.77	^a Calciprox	ER
							^a Calcitriol AN	EA
							^a Calcitriol-GA	UA
							^a Calcitriol Sandoz	SZ
							^a GenRx Calcitriol	GX
							^a Kosteo	QA
							^a Rocaltrol	RO
							^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.

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.

MUSCULO-SKELETAL SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
10061M NP	denosumab 120 mg/1.7 mL injection, 1 x 1.7 mL vial	1	5	..	532.31	36.90	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.

5110Y NP	denosumab 120 mg/1.7 mL injection, 1 x 1.7 mL vial	1	5	..	532.31	36.90	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.

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.

5457F NP	denosumab 60 mg/mL injection, 1 x 1 mL syringe	1	..	..	296.00	36.90	Prolia	AN

RALOXIFENE

Authority required (STREAMLINED)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
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.						
8363E NP	raloxifene hydrochloride 60 mg tablet, 28	1	5	..	50.55	36.90	^a APO-Raloxifene TX
						^a	Chem mart Raloxifene CH
						^a	Evifyne EL
						^a	Evista LY
						^a	Raloxifene AN EA
						^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.						
3036T	strontium ranelate 2 g granules, 28 x 2 g sachets	1	5	..	52.00	36.90	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						

MUSCULO-SKELETAL SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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. <u>Note</u> Details of accepted toxicities including severity can be found on the Department of Human Services website at www.humanservices.gov.au. <u>Note</u> No increase in the maximum quantity or number of units may be authorised. <u>Note</u> No increase in the maximum number of repeats may be authorised. <u>Note</u> Special Pricing Arrangements apply. <u>Authority required</u> 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. <u>Note</u> Up to a maximum of 18 pens will be reimbursed through the PBS. <u>Note</u> No increase in the maximum quantity or number of units may be authorised. <u>Note</u> No increase in the maximum number of repeats may be authorised. <u>Note</u> Special Pricing Arrangements apply.						
9411H	teriparatide 20 microgram/dose injection, 1 x 2.4 mL cartridge	1	5	..	438.71	36.90	Forteo LY

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

NERVOUS SYSTEM

ANALGESICS

OPIOIDS

Natural opium alkaloids

CODEINE

1214X NP	codeine phosphate 30 mg tablet, 20	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.

5063L DP	codeine phosphate 30 mg tablet, 20	1	..	..	17.21	18.36	Fawns and McAllan Proprietary Limited	FM

HYDROMORPHONE

Restricted benefit

Severe disabling pain not responding to non-narcotic analgesics

Caution

The risk of drug dependence is high.

Note

Prescribing of drugs of addiction by dentists is not permitted in some States/Territories.

5132D DP	hydromorphone hydrochloride 1 mg/mL oral liquid, 473 mL	1	..	..	64.04	36.90	Dilaudid	MF
5115F DP	hydromorphone hydrochloride 2 mg tablet, 20	1	..	..	17.45	18.60	Dilaudid	MF
5116G DP	hydromorphone hydrochloride 4 mg tablet, 20	1	..	..	20.19	21.34	Dilaudid	MF
5117H DP	hydromorphone hydrochloride 8 mg tablet, 20	1	..	..	30.37	31.52	Dilaudid	MF

HYDROMORPHONE

Restricted benefit

Severe disabling pain not responding to non-narcotic analgesics

Caution

The risk of drug dependence is high.

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.

8424J NP	hydromorphone hydrochloride 1 mg/mL oral liquid, 473 mL	1	..	..	64.04	36.90	Dilaudid	MF
8541M NP	hydromorphone hydrochloride 2 mg tablet, 20	1	..	..	17.45	18.60	Dilaudid	MF
8542N NP	hydromorphone hydrochloride 4 mg tablet, 20	1	..	..	20.19	21.34	Dilaudid	MF
8543P NP	hydromorphone hydrochloride 8 mg tablet, 20	1	..	..	30.37	31.52	Dilaudid	MF

HYDROMORPHONE

Caution

The risk of drug dependence is high.

8421F	hydromorphone hydrochloride 10	1	..	..	29.31	30.46	Dilaudid-HP	MF

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
NP	mg/mL injection, 5 x 1 mL ampoules							
8420E	hydromorphone hydrochloride 2	1	..	..	23.18	24.33	Dilaudid	MF
NP	mg/mL injection, 5 x 1 mL ampoules							
8422G	hydromorphone hydrochloride 50 mg/5	1	..	..	52.34	36.90	Dilaudid-HP	MF
NP	mL injection, 5 x 5 mL ampoules							
8423H	hydromorphone hydrochloride 500	1	..	..	75.75	36.90	Dilaudid-HP	MF
NP	mg/50 mL injection, 1 x 50 mL vial							

HYDROMORPHONE

Restricted benefit

Chronic severe disabling pain not responding to non-narcotic analgesics

Caution

The risk of drug dependence is high.

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.

9407D	hydromorphone hydrochloride 16 mg	1	..	..	53.16	36.90	Jurnista	JC
NP	tablet: modified release, 14 tablets							
9408E	hydromorphone hydrochloride 32 mg	1	..	..	89.04	36.90	Jurnista	JC
NP	tablet: modified release, 14 tablets							
9299K	hydromorphone hydrochloride 4 mg	1	..	..	31.29	32.44	Jurnista	JC
NP	tablet: modified release, 14 tablets							
9409F	hydromorphone hydrochloride 64 mg	1	..	..	149.72	36.90	Jurnista	JC
NP	tablet: modified release, 14 tablets							
9406C	hydromorphone hydrochloride 8 mg	1	..	..	36.75	36.90	Jurnista	JC
NP	tablet: modified release, 14 tablets							

MORPHINE

Restricted benefit

Chronic severe disabling pain not responding to non-narcotic analgesics

Caution

The risk of drug dependence is high.

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.

8349K	morphine Capsule 10 mg (containing	1	..	..	20.37	21.52	Kapanol	YN
NP	sustained release pellets), 28							
2841M	morphine Capsule 100 mg (containing	1	..	..	70.81	36.90	Kapanol	YN
NP	sustained release pellets), 28							
2839K	morphine Capsule 20 mg (containing	1	..	..	25.35	26.50	Kapanol	YN
NP	sustained release pellets), 28							
2840L	morphine Capsule 50 mg (containing	1	..	..	43.65	36.90	Kapanol	YN
NP	sustained release pellets), 28							
8146R	morphine Sachet containing controlled	1	..	..	62.41	36.90	MS Contin Suspension	MF
NP	release granules for oral suspension, 30 mg per sachet, 28						30 mg	

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
8305D NP	morphine Sachet containing controlled release granules for oral suspension, 60 mg per sachet, 28	1	..	..	70.21	36.90	MS Contin Suspension 60 mg	MF
1653B NP	morphine sulfate 10 mg tablet: modified release, 28 tablets	1	..	..	20.38	21.53	^a Momex SR 10	QA
							^a MORPHINE MR APOTEX	TX
							^a MS Contin	MF
8306E NP	morphine sulfate 100 mg granules: modified release, 28 sachets	1	..	..	86.71	36.90	MS Contin Suspension 100 mg	MF
1656E NP	morphine sulfate 100 mg tablet: modified release, 28 tablets	1	..	..	72.85	36.90	^a APOTEX-MORPHINE MR	TX
							^a Momex SR 100	QA
							^a MS Contin	MF
8494C NP	morphine sulfate 120 mg capsule: modified release, 14 capsules	1	..	..	54.81	36.90	MS Mono	MF
8489T NP	morphine sulfate 15 mg tablet: modified release, 28 tablets	1	..	..	24.57	25.72	MS Contin	MF
8490W NP	morphine sulfate 20 mg granules: modified release, 28 sachets	1	..	..	60.63	36.90	MS Contin Suspension 20 mg	MF
8491X NP	morphine sulfate 30 mg capsule: modified release, 14 capsules	1	..	..	24.56	25.71	MS Mono	MF
1654C NP	morphine sulfate 30 mg tablet: modified release, 28 tablets	1	..	..	36.23	36.90	^a Momex SR 30	QA
							^a MORPHINE MR APOTEX	TX
							^a MS Contin	MF
8035X NP	morphine sulfate 5 mg tablet: modified release, 28 tablets	1	..	..	17.95	19.10	MS Contin	MF
8492Y NP	morphine sulfate 60 mg capsule: modified release, 14 capsules	1	..	..	36.21	36.90	MS Mono	MF
1655D NP	morphine sulfate 60 mg tablet: modified release, 28 tablets	1	..	..	54.82	36.90	^a APOTEX-MORPHINE MR	TX
							^a Momex SR 60	QA
							^a MS Contin	MF
8493B NP	morphine sulfate 90 mg capsule: modified release, 14 capsules	1	..	..	41.76	36.90	MS Mono	MF

MORPHINE

Restricted benefit

Severe disabling pain not responding to non-narcotic analgesics

Caution

The risk of drug dependence is high.

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.

2124T NP	morphine hydrochloride 10 mg/mL oral liquid, 200 mL	1	..	..	27.20	28.35	Ordine 10	MF
2122Q NP	morphine hydrochloride 2 mg/mL oral liquid, 200 mL	1	..	..	20.67	21.82	Ordine 2	MF
2123R NP	morphine hydrochloride 5 mg/mL oral liquid, 200 mL	1	..	..	23.07	24.22	Ordine 5	MF
1646P NP	morphine sulfate 30 mg tablet, 20	1	..	..	14.37	15.52	Anamorph	FM

MORPHINE

Restricted benefit

Severe disabling pain not responding to non-narcotic analgesics

Caution

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	The risk of drug dependence is high.							
	Note							
	Prescribing of drugs of addiction by dentists is not permitted in some States/Territories.							
5239R DP	morphine hydrochloride 10 mg/mL oral liquid, 200 mL	1	..	..	27.20	28.35	Ordine 10	MF
5237P DP	morphine hydrochloride 2 mg/mL oral liquid, 200 mL	1	..	..	20.67	21.82	Ordine 2	MF
5238Q DP	morphine hydrochloride 5 mg/mL oral liquid, 200 mL	1	..	..	23.07	24.22	Ordine 5	MF
5163R DP	morphine sulfate 30 mg tablet, 20	1	..	..	14.37	15.52	Anamorph	FM
	MORPHINE							
	Restricted benefit							
	Severe disabling pain due to cancer not responding to non-narcotic analgesics							
	Caution							
	The risk of drug dependence is high.							
8669G NP	morphine sulfate 10 mg tablet, 20	1	..	..	14.66	15.81	Sevredol	MF
8670H NP	morphine sulfate 20 mg tablet, 20	1	..	..	15.60	16.75	Sevredol	MF
	MORPHINE							
	Caution							
	The risk of drug dependence is high.							
1644M NP,MW	morphine sulfate 10 mg/mL injection, 5 x 1 mL ampoules	1	..	..	16.76	17.91	Hospira Pty Limited	HH
1645N NP,MW	morphine sulfate 15 mg/mL injection, 5 x 1 mL ampoules	1	..	..	17.30	18.45	Hospira Pty Limited	HH
1647Q NP	morphine sulfate 30 mg/mL injection, 5 x 1 mL ampoules	1	..	..	19.43	20.58	Hospira Pty Limited	HH
1607N NP	morphine tartrate 120 mg/1.5 mL injection, 5 x 1.5 mL ampoules	1	..	..	39.62	36.90	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.							
5168B DP	morphine sulfate 10 mg/mL injection, 5 x 1 mL ampoules	1	..	..	16.76	17.91	Hospira Pty Limited	HH
5169C DP	morphine sulfate 15 mg/mL injection, 5 x 1 mL ampoules	1	..	..	17.30	18.45	Hospira Pty Limited	HH
5170D DP	morphine sulfate 30 mg/mL injection, 5 x 1 mL ampoules	1	..	..	19.43	20.58	Hospira Pty Limited	HH
	MORPHINE							
	Authority required							
	Chronic severe disabling pain due to cancer							
	Caution							
	The risk of drug dependence is high.							
8454Y NP	morphine sulfate 200 mg granules: modified release, 28 sachets	1	..	..	164.09	36.90	MS Contin Suspension 200 mg	MF
8453X NP	morphine sulfate 200 mg tablet: modified release, 28 tablets	1	..	..	122.20	36.90	MS Contin	MF

OXYCODONE

Restricted benefit

Severe disabling pain not responding to non-narcotic analgesics

Caution

The risk of drug dependence is high.

Note

Authorities for increased maximum quantities and/or repeats will be granted only for:

- (i) severe disabling pain associated with proven malignant neoplasia; or

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	(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.							
2481N NP	oxycodone 30 mg suppository, 12	1	..	..	44.00	36.90	Proladone	PL
8501K NP	oxycodone hydrochloride 10 mg capsule, 20	1	..	..	14.76	15.91	OxyNorm	MF
8502L NP	oxycodone hydrochloride 20 mg capsule, 20	1	..	..	18.72	19.87	OxyNorm	MF
8464L NP	oxycodone hydrochloride 5 mg capsule, 20	1	..	..	12.14	13.29	OxyNorm	MF
2622B NP	oxycodone hydrochloride 5 mg tablet, 20	1	..	..	12.14	13.29	Endone	QA
8644Y NP	oxycodone hydrochloride 5 mg/5 mL oral liquid, 250 mL	1	..	..	21.07	22.22	OxyNorm Liquid 5mg/5mL	MF

OXYCODONE

Restricted benefit

Severe disabling pain not responding to non-narcotic analgesics

Caution

The risk of drug dependence is high.

Note

Prescribing of drugs of addiction by dentists is not permitted in some States/Territories.

5194J DP	oxycodone 30 mg suppository, 12	1	..	..	44.00	36.90	Proladone	PL
5197M DP	oxycodone hydrochloride 10 mg capsule, 20	1	..	..	14.76	15.91	OxyNorm	MF
5191F DP	oxycodone hydrochloride 5 mg capsule, 20	1	..	..	12.14	13.29	OxyNorm	MF
5195K DP	oxycodone hydrochloride 5 mg tablet, 20	1	..	..	12.14	13.29	Endone	QA
5190E DP	oxycodone hydrochloride 5 mg/5 mL oral liquid, 250 mL	1	..	..	21.07	22.22	OxyNorm Liquid 5mg/5mL	MF

OXYCODONE

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

The condition must be unresponsive to non-narcotic analgesics.

Caution

The risk of drug dependence is high.

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.

Note

OxyContin modified release tablets are intended to be crush-deterrent and to reduce the rapid release of oxycodone upon accidental or intentional misuse.

8385H NP	oxycodone hydrochloride 10 mg tablet: modified release, 28 tablets	1	..	..	24.57	25.72 ^a	Oxycodone Sandoz	SZ

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
9399Q	oxycodone hydrochloride 15 mg tablet:	1	..	..	31.60	32.75	^a OxyContin	MF
NP	modified release, 28 tablets						OxyContin	MF
8386J	oxycodone hydrochloride 20 mg tablet:	1	..	..	36.22	36.90	^a Oxycodone Sandoz	SZ
NP	modified release, 28 tablets							
9400R	oxycodone hydrochloride 30 mg tablet:	1	..	..	46.79	36.90	^a OxyContin	MF
NP	modified release, 28 tablets						OxyContin	MF
8387K	oxycodone hydrochloride 40 mg tablet:	1	..	..	54.81	36.90	^a Oxycodone Sandoz	SZ
NP	modified release, 28 tablets							
8388L	oxycodone hydrochloride 80 mg tablet:	1	..	..	83.05	36.90	^a OxyContin	MF
NP	modified release, 28 tablets						^a Oxycodone Sandoz	SZ
							^a OxyContin	MF

OXYCODONE + NALOXONE

Restricted benefit

Chronic severe disabling pain not responding to non-narcotic analgesics

Caution

The risk of drug dependence is high.

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.

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.

8934F	oxycodone hydrochloride 10 mg + naloxone hydrochloride 5 mg tablet:	1	..	..	31.01	32.16	Targin 10/5mg	MF
NP	modified release, 28 tablets							
8935G	oxycodone hydrochloride 20 mg + naloxone hydrochloride 10 mg tablet:	1	..	..	47.19	36.90	Targin 20/10mg	MF
NP	modified release, 28 tablets							
8936H	oxycodone hydrochloride 40 mg + naloxone hydrochloride 20 mg tablet:	1	..	..	73.62	36.90	Targin 40/20mg	MF
NP	modified release, 28 tablets							
8000C	oxycodone hydrochloride 5 mg + naloxone hydrochloride 2.5 mg tablet:	1	..	..	29.71	30.86	Targin 5/2.5mg	MF
NP	modified release, 28 tablets							

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 below.

1215Y	CODEINE PHOSPHATE with PARACETAMOL Tablet 30 mg-500 mg, 20	1	..	..	7.68	8.83	^a APO-Paracetamol/Codeine 500/30	TX
NP							^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

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
3316M DP	CODEINE PHOSPHATE with PARACETAMOL Tablet 30 mg-500 mg, 20	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 not responding 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.

8785J NP	CODEINE PHOSPHATE with PARACETAMOL Tablet 30 mg-500 mg, 20	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

Restricted benefit

Chronic severe disabling pain not responding to non-narcotic analgesics

Caution

The risk of drug dependence is high.

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.

Note

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 forms fentanyl transdermal patch 16.5 mg, fentanyl transdermal patch 10.20 mg and fentanyl transdermal patch 16.8 mg (all releasing approximately 100 micrograms per hour) are equivalent for the purposes of substitution.

5280X NP	fentanyl 100 microgram/hour patch, 5	1	..	..	84.81	36.90	^a Denpax	AF
5441J NP	fentanyl 100 microgram/hour patch, 5	1	..	..	84.81	36.90	^a Dutran 100	GN
							^a Fenpatch 100	ZP
8894D NP	fentanyl 100 microgram/hour patch, 5	1	..	..	84.81	36.90	^a Durogesic 100	JC
							^a Fentanyl Sandoz	SZ

FENTANYL

Restricted benefit

Chronic severe disabling pain not responding to non-narcotic analgesics

Caution

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
The risk of drug dependence is high.							
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.							
Note							
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 forms fentanyl transdermal patch 2.063 mg, fentanyl transdermal patch 1.28 mg and fentanyl transdermal patch 2.1 mg (all releasing approximately 12 micrograms per hour) are equivalent for the purposes of substitution.							
5265D NP	fentanyl 12 microgram/hour patch, 5	1	..	..	29.30	30.45 ^a	Denpax AF
5437E NP	fentanyl 12 microgram/hour patch, 5	1	..	..	29.30	30.45 ^a	Dutran 12 GN
8878G NP	fentanyl 12 microgram/hour patch, 5	1	..	..	29.30	30.45 ^a	Fenpatch 12 ZP
						30.45 ^a	Durogesic 12 JC
						30.45 ^a	Fentanyl Sandoz SZ

FENTANYL

Restricted benefit

Chronic severe disabling pain not responding to non-narcotic analgesics

Caution

The risk of drug dependence is high.

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.

Note

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 forms fentanyl transdermal patch 4.125 mg, fentanyl transdermal patch 2.55 mg and fentanyl transdermal patch 4.2 mg (all releasing approximately 25 micrograms per hour) are equivalent for the purposes of substitution.

5277R NP	fentanyl 25 microgram/hour patch, 5	1	..	..	34.67	35.82 ^a	Denpax AF
5438F NP	fentanyl 25 microgram/hour patch, 5	1	..	..	34.67	35.82 ^a	Dutran 25 GN
8891Y NP	fentanyl 25 microgram/hour patch, 5	1	..	..	34.67	35.82 ^a	Fenpatch 25 ZP
						35.82 ^a	Durogesic 25 JC
						35.82 ^a	Fentanyl Sandoz SZ

FENTANYL

Restricted benefit

Chronic severe disabling pain not responding to non-narcotic analgesics

Caution

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
The risk of drug dependence is high.							
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.							
Note							
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 forms fentanyl transdermal patch 8.25 mg, fentanyl transdermal patch 5.10 mg and fentanyl transdermal patch 8.4 mg (all releasing approximately 50 micrograms per hour) are equivalent for the purposes of substitution.							
5278T NP	fentanyl 50 microgram/hour patch, 5	1	..	..	54.25	36.90	^a Denpax AF
5439G NP	fentanyl 50 microgram/hour patch, 5	1	..	..	54.25	36.90	^a Dutran 50 GN
8892B NP	fentanyl 50 microgram/hour patch, 5	1	..	..	54.25	36.90	^a Fenpatch 50 ZP
							^a Durogesic 50 JC
							^a Fentanyl Sandoz SZ

FENTANYL

Restricted benefit

Chronic severe disabling pain not responding to non-narcotic analgesics

Caution

The risk of drug dependence is high.

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.

Note

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 forms fentanyl transdermal patch 12.375 mg, fentanyl transdermal patch 7.65 mg and fentanyl transdermal patch 12.6 mg (all releasing approximately 75 micrograms per hour) are equivalent for the purposes of substitution.

5279W NP	fentanyl 75 microgram/hour patch, 5	1	..	..	70.18	36.90	^a Denpax AF
5440H NP	fentanyl 75 microgram/hour patch, 5	1	..	..	70.18	36.90	^a Dutran 75 GN
8893C NP	fentanyl 75 microgram/hour patch, 5	1	..	..	70.18	36.90	^a Fenpatch 75 ZP
							^a Durogesic 75 JC
							^a Fentanyl Sandoz SZ

Diphenylpropylamine derivatives

METHADONE

Restricted benefit

Severe disabling pain not responding to non-narcotic analgesics

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
Caution								
The risk of drug dependence is high.								
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.								
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.								
1609Q NP	methadone hydrochloride 10 mg tablet, 20	1	..	..	15.57	16.72	Physeptone	QA
1606M NP	methadone hydrochloride 10 mg/mL injection, 5 x 1 mL ampoules	1	..	..	49.65	36.90	Physeptone	QA

Oripavine derivatives

BUPRENORPHINE

Restricted benefit

Chronic severe disabling pain not responding to non-narcotic analgesics

Caution

The risk of drug dependence is high.

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.

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.

8866P NP	buprenorphine 10 microgram/hour patch, 2	1	..	..	41.11	36.90	Norspan	MF
8867Q NP	buprenorphine 20 microgram/hour patch, 2	1	..	..	56.42	36.90	Norspan	MF
8865N NP	buprenorphine 5 microgram/hour patch, 2	1	..	..	27.04	28.19	Norspan	MF

Other opioids

TAPENTADOL

Restricted benefit

Chronic severe disabling pain

Clinical criteria:

The condition must be unresponsive to non-narcotic analgesics.

Caution

The risk of drug dependence is high.

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
10094G NP	tapentadol 100 mg tablet: modified release, 28	1	..	..	31.65	32.80	Palexia SR	CS
10100N NP	tapentadol 150 mg tablet: modified release, 28	1	..	..	40.35	36.90	Palexia SR	CS
10091D NP	tapentadol 200 mg tablet: modified release, 28	1	..	..	47.49	36.90	Palexia SR	CS
10092E NP	tapentadol 250 mg tablet: modified release, 28	1	..	..	53.15	36.90	Palexia SR	CS
10096J NP	tapentadol 50 mg tablet: modified release, 28	1	..	..	22.60	23.75	Palexia SR	CS
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.								
8523N NP	tramadol hydrochloride 100 mg tablet: modified release, 20 tablets	1	..	..	10.42	11.57	^a APO-Tramadol SR	TX
							^a Chem mart Tramadol SR	CH
							^a GA Tramadol SR 100mg	GN
							^a Lodam SR 100	ZP
							^a Terry White Chemists Tramadol SR	TW
							^a Tramadol AN SR	EA
							^a Tramadol Sandoz SR	SZ
							^a Tramadol SR generichealth	GQ
							^a Tramedo SR 100	AF
				^b 4.49	14.91	11.57	^a Zydol SR 100	QA
							^a Tramal SR 100	CS
8843K NP	tramadol hydrochloride 100 mg/mL oral liquid, 10 mL	±1	..	..	14.05	15.20	Tramal	CS
8524P NP	tramadol hydrochloride 150 mg tablet: modified release, 20 tablets	1	..	..	11.68	12.83	^a APO-Tramadol SR	TX
							^a Chem mart Tramadol SR	CH
							^a GA Tramadol SR 150mg	GN
							^a Lodam SR 150	ZP
							^a Terry White Chemists Tramadol SR	TW
							^a Tramadol AN SR	EA
							^a Tramadol Sandoz SR	SZ
							^a Tramadol SR generichealth	GQ
							^a Tramedo SR 150	AF
				^b 5.37	17.05	12.83	^a Zydol SR 150	QA
8525Q NP	tramadol hydrochloride 200 mg tablet: modified release, 20 tablets	1	..	..	12.75	13.90	^a Tramal SR 150	CS
							^a APO-Tramadol SR	TX
							^a Chem mart Tramadol SR	CH
							^a GA Tramadol SR 200mg	GN

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Lodam SR 200	ZP
							^a Terry White Chemists Tramadol SR	TW
							^a Tramadol AN SR	EA
							^a Tramadol Sandoz SR	SZ
							^a Tramadol SR generichealth	GQ
							^a Tramedo SR 200	AF
				^b 6.09	18.84	13.90	^a Zydol SR 200	QA
2527B NP	tramadol hydrochloride 50 mg tablet: modified release, 20 tablets	1	..	..	10.38	11.53	^a Tramal SR 200	CS
							^a Tramal SR 50	CS
	TRAMADOL							
	<u>Restricted benefit</u>							
	Short-term treatment of acute pain							
5231H DP	tramadol hydrochloride 100 mg/2 mL injection, 5 x 2 mL ampoules	1	..	..	12.51	13.66	^a Tramadol ACT	GN
							^a Tramadol Sandoz	SZ
							^a Tramal 100	CS
	TRAMADOL							
	<u>Restricted benefit</u>							
	Short-term treatment of acute pain							
	<u>Note</u>							
	No applications for increased maximum quantities and/or repeats will be authorised.							
8582Q NP	tramadol hydrochloride 100 mg/2 mL injection, 5 x 2 mL ampoules	1	..	..	12.51	13.66	^a Tramadol ACT	GN
							^a Tramadol Sandoz	SZ
							^a Tramal 100	CS
	TRAMADOL							
	<u>Restricted benefit</u>							
	For pain where aspirin and/or paracetamol alone are inappropriate or have failed							
5150C DP	tramadol hydrochloride 100 mg/mL oral liquid, 10 mL	#1	..	..	14.05	15.20	Tramal	CS
	TRAMADOL							
	<u>Restricted benefit</u>							
	For acute pain where aspirin and/or paracetamol alone are inappropriate or have failed							
	<u>Restricted benefit</u>							
	For dosage titration in chronic pain where aspirin and/or paracetamol alone are inappropriate or have failed							
5232J DP	tramadol hydrochloride 50 mg capsule, 20	1	..	..	8.11	9.26	^a APO-Tramadol	TX
							^a Chem mart Tramadol	CH
							^a GA Tramadol 50mg	GN
							^a Terry White Chemists Tramadol	TW
							^a Tramadol Actavis	UA
							^a Tramadol AN	EA
							^a Tramadol Sandoz	SZ
							^a Tramadol SCP	CR
							^a Tramedo	AF
							^a Zydol	QA
				^b 2.41	10.52	9.26	^a Tramal	CS
	TRAMADOL							
	<u>Restricted benefit</u>							
	For acute pain where aspirin and/or paracetamol alone are inappropriate or have failed							
	<u>Note</u>							
	No applications for increased maximum quantities and/or repeats will be authorised.							
8455B NP	tramadol hydrochloride 50 mg capsule, 20	1	..	..	8.11	9.26	^a APO-Tramadol	TX
							^a Chem mart Tramadol	CH

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a GA Tramadol 50mg	GN
							^a Terry White Chemists Tramadol	TW
							^a Tramadol Actavis	UA
							^a Tramadol AN	EA
							^a Tramadol Sandoz	SZ
							^a Tramadol SCP	CR
							^a Tramedo	AF
							^a Zydol	QA
				^b 2.41	10.52	9.26	^a Tramal	CS

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.

8611F NP	tramadol hydrochloride 50 mg capsule, 20	1	2	..	8.11	9.26	^a APO-Tramadol	TX
							^a Chem mart Tramadol	CH
							^a GA Tramadol 50mg	GN
							^a Terry White Chemists Tramadol	TW
							^a Tramadol Actavis	UA
							^a Tramadol AN	EA
							^a Tramadol Sandoz	SZ
							^a Tramadol SCP	CR
							^a Tramedo	AF
							^a Zydol	QA
				^b 2.41	10.52	9.26	^a Tramal	CS

OTHER ANALGESICS AND ANTIPYRETICS

Salicylic acid and derivatives

ASPIRIN

1010E NP	aspirin 300 mg tablet: effervescent, 96	1	1	..	8.51	9.66	Solprin	RC
5018D DP	aspirin 300 mg tablet: effervescent, 96	1	..	..	8.51	9.66	Solprin	RC

Anilides

PARACETAMOL

1747Y NP	paracetamol 120 mg/5 mL oral liquid, 100 mL	1	2	..	9.72	10.87	Panamax	SW
3348F DP	paracetamol 120 mg/5 mL oral liquid, 100 mL	1	..	..	9.72	10.87	Panamax	SW
1770E NP	paracetamol 240 mg/5 mL oral liquid, 200 mL	1	2	..	11.02	12.17	Panamax 240 Elixir	SW
3349G DP	paracetamol 240 mg/5 mL oral liquid, 200 mL	1	..	..	11.02	12.17	Panamax 240 Elixir	SW
1746X NP	paracetamol 500 mg tablet, 100	1	1	..	8.66	9.81	^a APO-Paracetamol	TX
							^a Febridol	GN
							^a Generic Health Pty Ltd	GQ
							^a Panamax	SW
							^a Paracetamol (Sandoz)	SZ
							^a Paralgin	FM
							^a Parapane	AF
5196L DP	paracetamol 500 mg tablet, 100	1	..	..	8.66	9.81	^a APO-Paracetamol	TX
							^a Febridol	GN
							^a Generic Health Pty Ltd	GQ
							^a Panamax	SW
							^a Paracetamol (Sandoz)	SZ
							^a Paralgin	FM
							^a Parapane	AF

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
PARACETAMOL <u>Restricted benefit</u> Chronic arthropathies								
5224Y DP	paracetamol 500 mg tablet, 100	3	..	..	*12.46	13.61	^a APO-Paracetamol	TX
							^a Febridol	GN
							^a Generic Health Pty Ltd	GQ
							^a Panamax	SW
							^a Paracetamol (Sandoz)	SZ
							^a Paralgin	FM
							^a Parapane	AF
8784H NP	paracetamol 500 mg tablet, 100	3	4	..	*12.46	13.61	^a APO-Paracetamol	TX
							^a Febridol	GN
							^a Generic Health Pty Ltd	GQ
							^a Panamax	SW
							^a Paracetamol (Sandoz)	SZ
							^a Paralgin	FM
							^a Parapane	AF
PARACETAMOL <u>Restricted benefit</u> Relief of persistent pain associated with osteoarthritis								
8814X NP	paracetamol 665 mg tablet: modified release, 96 tablets	2	5	..	*15.34	16.49	^a APO-Osteo Paracetamol 665 mg	TX
							^a Blooms the Chemist Osteo Pain Relief Paracetamol 665 mg	IB
							^a Chem mart Pharmacy Osteo Relief Paracetamol 665 mg	CH
							^a Osteomol 665 Paracetamol	CR
							^a Terry White Chemists Osteo Relief Paracetamol 665 mg	TW
				^B 1.64	*16.98	16.49	^a Panadol Osteo	GC

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.

2355Y NP	pregabalin 150 mg capsule, 56	1	5	..	70.63	36.90	Lyrica	PF
2348N NP	pregabalin 25 mg capsule, 56	1	5	..	26.44	27.59	Lyrica	PF
2363J NP	pregabalin 300 mg capsule, 56	1	5	..	102.05	36.90	Lyrica	PF
2335X NP	pregabalin 75 mg capsule, 56	1	5	..	49.11	36.90	Lyrica	PF

ANTIMIGRAINE PREPARATIONS

Selective serotonin (5HT₁) agonists

ELETRIPTAN

Authority required (STREAMLINED)

4573

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	Migraine attack							
	Clinical criteria:							
	The condition must have usually failed to respond to analgesics in the past.							
	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.							
	Note							
	No increase in the maximum quantity or number of units may be authorised.							
	Note							
	No increase in the maximum number of repeats may 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.							
5290K NP	eletriptan 40 mg tablet, 4	1	5	..	25.10	26.25	Relpax	PF
5291L NP	eletriptan 80 mg tablet, 4	1	5	..	25.10	26.25	Relpax	PF

NARATRIPTAN

Authority required

Migraine attack

Clinical criteria:

The condition must have usually failed to respond to analgesics in the past.

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.

Note

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

Note

No increase in the maximum number of repeats may 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.

8298R NP	naratriptan 2.5 mg tablet, 2	2	5	^s 2.78	*29.02	27.39	Naramig	AS

NARATRIPTAN

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

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.

Note

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

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
9734H NP	naratriptan 2.5 mg tablet, 2	2	5	..	*29.02	30.17	Naramig	AS
RIZATRIPTAN Authority required (STREAMLINED) 4573 Migraine attack Clinical criteria: The condition must have usually failed to respond to analgesics in the past. 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. Note No increase in the maximum quantity or number of units may be authorised. Note No increase in the maximum number of repeats may 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.								
9313E NP	rizatriptan 10 mg wafer, 2	2	5	..	*25.46	26.61	Maxalt	MK
SUMATRIPTAN Authority required (STREAMLINED) 4558 Migraine attack Clinical criteria: The condition must have usually failed to respond to analgesics in the past. 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. Note No increase in the maximum quantity or number of units may be authorised. Note No increase in the maximum number of repeats may be authorised. Note 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. 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.								
8885P NP	SUMATRIPTAN Tablet (fast disintegrating) 50 mg (as succinate), 2	2	5	^B 2.48	*18.78	17.45	^a Imigran FDT	AS
8144P NP	SUMATRIPTAN Tablet 50 mg (as succinate), 2	2	5	..	*16.30	17.45	^a APO-Sumatriptan	TX
							^a Chem mart Sumatriptan	CH
							^a Sumagran Aspen 50	AS
							^a Sumatab	AF
							^a Sumatran	QA
							^a Sumatriptan Sandoz	SZ
							^a Terry White Chemists Sumatriptan	TW
				^B 2.48	*18.78	17.45	^a Imigran	LN
8341B	sumatriptan 20 mg/actuation nasal	1	5	..	19.59	20.74	Imigran	AS

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
NP	spray, 2 actuations							
1849H	sumatriptan 50 mg tablet, 4	1	5	..	16.31	17.46	^a APO-Sumatriptan	TX
NP							^a Chem mart Sumatriptan	CH
							^a Pharmacor Sumatriptan 50	CR
							^a Sumatran	QA
							^a Sumatriptan AN	EA
							^a Sumatriptan-GA	GN
							^a Sumatriptan generichealth	GQ
							^a Sumatriptan RBX	RA
							^a Sumatriptan Sandoz	SZ
							^a Terry White Chemists Sumatriptan	TW

ZOLMITRIPTAN

Authority required (STREAMLINED)

4573

Migraine attack

Clinical criteria:

The condition must have usually failed to respond to analgesics in the past.

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.

Note

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

Note

No increase in the maximum number of repeats may 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.

8266C	zolmitriptan 2.5 mg tablet, 2	2	5	..	*26.18	27.33	^a APO-Zolmitriptan	TX
NP							^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.

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.

1798P	cyproheptadine hydrochloride 4 mg tablet, 100	1	2	..	14.53	15.68	Periactin	AS
NP								

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.

3074T	pizotifen 500 microgram tablet, 100	1	2	..	22.09	23.24	Sandomigran 0.5	NV
NP								

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

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.

1850J NP	phenobarbitone 30 mg tablet, 200	1	4	..	16.94	18.09	Aspen Pharma Pty Ltd	QA
2138M NP	phenobarbitone sodium 219 mg/mL injection, 5 x 1 mL ampoules	1	..	..	39.36	36.90	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.

1939C NP	primidone 250 mg tablet, 200	1	2	..	83.83	36.90	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.

2692Q NP	phenytoin 30 mg/5 mL oral liquid, 500 mL	1	3	..	30.62	31.77	Dilantin	PF
1249R NP	phenytoin 50 mg tablet: chewable, 200	1	2	..	48.49	36.90	Dilantin Infatabs	PF
1874P NP	phenytoin sodium 100 mg capsule, 200	1	2	..	30.46	31.61	Dilantin Sodium	PF
1873N NP	phenytoin sodium 30 mg capsule, 200	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.

1413J NP	ethosuximide 250 mg capsule, 200	1	2	..	66.18	36.90	Zarontin	PF
1414K NP	ethosuximide 250 mg/5 mL oral liquid, 200 mL	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.

1807D NP	clonazepam 1 mg/mL injection [5 x 1 mL ampoules] (&) inert substance diluent [5 x 1 mL ampoules], 1 pack	1	..	..	18.92	20.07	Rivotril	RO

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
CLONAZEPAM								
<u>Authority required</u>								
Neurologically proven epilepsy								
<u>Caution</u>								
Abuse of clonazepam has been reported. Refer to the current product information.								
<u>Note</u>								
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.								
1806C NP	clonazepam 2 mg tablet, 100	2	2	..	*31.40	32.55	^a Paxam 2	AF
				^b 3.86	*35.26	32.55	^a Rivotril	RO
1808E NP	clonazepam 2.5 mg/mL oral liquid, 10 mL	2	..	..	*15.38	16.53	Rivotril	RO
1805B NP	clonazepam 500 microgram tablet, 100	2	2	..	*19.84	20.99	^a Paxam 0.5	AF
				^b 3.42	*23.26	20.99	^a Rivotril	RO
NITRAZEPAM								
<u>Authority required</u>								
Myoclonic epilepsy								
<u>Authority required</u>								
Malignant neoplasia (late stage)								
<u>Authority required</u>								
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								
<u>Authority required</u>								
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								
<u>Note</u>								
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.								
2732T NP	nitrazepam 5 mg tablet, 25	2	5	..	*9.94	11.09	^a Alodorm	AF
				^b 2.48	*12.42	11.09	^a Mogadon	IA

Carboxamide derivatives

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.

2422L NP	CARBAMAZEPINE Tablet 100 mg, 100	2	2	..	*18.84	19.99	^a Carbamazepine Sandoz	SZ
				^b 2.96	*21.80	19.99	^a Tegretol 100	NV
CARBAMAZEPINE								
5039F DP	CARBAMAZEPINE Tablet 100 mg, 100	2	..	..	*18.84	19.99	^a Carbamazepine Sandoz	SZ
				^b 2.96	*21.80	19.99	^a Tegretol 100	NV
5041H DP	carbamazepine 100 mg/5 mL oral liquid, 300 mL	1	..	..	21.69	22.84	Tegretol Liquid	NV
5038E DP	carbamazepine 200 mg tablet: modified release, 200 tablets	1	..	..	29.82	30.97	Tegretol CR 200	NV
5037D DP	carbamazepine 400 mg tablet: modified release, 200 tablets	1	..	..	49.37	36.90	Tegretol CR 400	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.

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
1706T NP	CARBAMAZEPINE Tablet 200 mg, 100	2	2	..	*29.34	30.49 ^a	Carbamazepine Sandoz	SZ
				^b 2.96	*32.30	30.49 ^a	Tegretol 200	NV
2419H NP	carbamazepine 200 mg tablet, 200	1	2	..	29.33	30.48 ^a	Teril	AF
CARBAMAZEPINE								
Note								
For item codes 5040G and 1724R, pharmaceutical benefits that have the form tablet 200 mg are equivalent for the purposes of substitution.								
1724R DP	CARBAMAZEPINE Tablet 200 mg, 100	2	..	..	*29.34	30.49 ^a	Carbamazepine Sandoz	SZ
				^b 2.96	*32.30	30.49 ^a	Tegretol 200	NV
5040G DP	carbamazepine 200 mg tablet, 200	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.								
2427R NP	carbamazepine 100 mg/5 mL oral liquid, 300 mL	1	5	..	21.69	22.84	Tegretol Liquid	NV
2426Q NP	carbamazepine 200 mg tablet: modified release, 200 tablets	1	2	..	29.82	30.97	Tegretol CR 200	NV
2431Y NP	carbamazepine 400 mg tablet: modified release, 200 tablets	1	2	..	49.37	36.90	Tegretol CR 400	NV
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.								
8584T NP	oxcarbazepine 150 mg tablet, 100	1	5	..	72.61	36.90	Trileptal	NV
8585W NP	oxcarbazepine 300 mg tablet, 100	1	5	..	115.42	36.90	Trileptal	NV
8588B NP	oxcarbazepine 60 mg/mL oral liquid, 250 mL	2	5	..	*138.46	36.90	Trileptal	NV
8586X NP	oxcarbazepine 600 mg tablet, 100	1	5	..	188.32	36.90	Trileptal	NV
Fatty acid derivatives								
TIAGABINE								
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.								
8222R NP	tiagabine 10 mg tablet, 50	2	5	..	*139.18	36.90	Gabitril	OA
8223T NP	tiagabine 15 mg tablet, 50	2	5	..	*197.24	36.90	Gabitril	OA
8221Q NP	tiagabine 5 mg tablet, 50	2	5	..	*72.96	36.90	Gabitril	OA

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
VALPROATE								
<u>Caution</u>								
There are reports of fatal hepatotoxicity, particularly in children.								
There is increasing evidence of dose-related teratogenesis from this drug.								
<u>Note</u>								
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.								
2294R NP	valproate sodium 100 mg tablet, 100	2	2	..	*32.34	33.49	Epilim	SW
2289L NP	valproate sodium 200 mg tablet: enteric, 100	2	2	..	*25.46	26.61	^a Sodium Valproate Sandoz	SZ
							^a Valprease 200	QA
							^a Valpro 200	AF
							^a Valproate Winthrop EC 200	WA
				^b 2.00	*27.46	26.61	^a Epilim EC	SW
2293Q NP	valproate sodium 200 mg/5 mL oral liquid, 300 mL	2	2	..	*38.92	36.90	Epilim Liquid	SW
2295T NP	valproate sodium 200 mg/5 mL oral liquid, 300 mL	2	2	..	*38.92	36.90	Epilim Syrup	SW
2290M NP	valproate sodium 500 mg tablet: enteric, 100	2	2	..	*43.42	36.90	^a Sodium Valproate Sandoz	SZ
							^a Valprease 500	QA
							^a Valpro 500	AF
							^a Valproate Winthrop EC 500	WA
				^b 2.00	*45.42	36.90	^a Epilim EC	SW

VIGABATRIN**Authority required (STREAMLINED)****1426**

Treatment of epileptic seizures which are not controlled satisfactorily by other anti-epileptic drugs

Caution

Visual field defects have been reported 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.

2668K NP	vigabatrin 500 mg oral liquid: powder for, 60 x 500 mg sachets	1	5	..	79.48	36.90	Sabril	SW
2667J NP	vigabatrin 500 mg tablet, 100	1	5	..	119.11	36.90	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.

8505P NP	gabapentin 100 mg capsule, 100	1	5	..	14.01	15.16	^a APO-Gabapentin	TX
							^a Gabacor	NJ
							^a Gabapentin Aspen 100	FM
							^a Gabatine 100	QA
							^a Neurontin	PF
							^a Nupentin 100	AF
1834M NP	gabapentin 300 mg capsule, 100	1	5	..	30.97	32.12	^a Gabacor	NJ

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
1835N NP	gabapentin 400 mg capsule, 100	1	5	..	39.79	36.90	^a Gabapentin 300 CR
							^a Gabapentin Aspen 300 FM
							^a Gabapentin-GA UA
							^a Gabapentin Sandoz SZ
							^a Gabatine 300 QA
							^a Gantin GN
							^a GenRx Gabapentin GX
							^a Neurontin PF
							^a Nupentin 300 AF
							^a Gabacor NJ
8559L NP	gabapentin 600 mg tablet, 100	1	5	..	56.90	36.90	^a Gabapentin 400 CR
							^a Gabapentin Aspen 400 FM
							^a Gabapentin Sandoz SZ
							^a Gabatine 400 QA
							^a Gantin GN
							^a GenRx Gabapentin GX
							^a Neurontin PF
							^a Nupentin 400 AF
							^a Gabapentin AN EA
							^a Gabapentin Aspen 600 FM
8389M NP	gabapentin 800 mg tablet, 100	1	5	..	73.60	36.90	^a Gabaran RA
							^a Gabatine 600 QA
							^a GenRx Gabapentin GX
							^a Neurontin PF
							^a Nupentin Tabs AF
							^a Pharmacor Gabapentin 600 CR
							^a Gabapentin AN EA
							^a Gabapentin Aspen 800 FM
							^a Gabaran RA
							^a Gabatine 800 QA
							^a Gantin GN
							^a GenRx Gabapentin GX
							^a Neurontin PF
							^a Nupentin Tabs AF
							^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.

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
9334G NP	lacosamide 100 mg tablet, 14	1	1	..	52.63	36.90	Vimpat	UC
9336J NP	lacosamide 150 mg tablet, 14	1	1	..	75.03	36.90	Vimpat	UC
9333F NP	lacosamide 50 mg tablet, 14	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.

9335H NP	lacosamide 100 mg tablet, 56	1	5	..	188.80	36.90	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.

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
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.								
9337K NP	lacosamide 150 mg tablet, 56	1	5	..	273.00	36.90	Vimpat	UC
9338L NP	lacosamide 200 mg tablet, 56	1	5	..	355.72	36.90	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.								
2850B NP	lamotrigine 100 mg tablet, 56	1	5	..	39.12	36.90	^a APO-Lamotrigine	TX
							^a GenRx Lamotrigine	GX
							^a Lamidus	RA
							^a Lamogine	AF
							^a Lamotrigine AN	EA
							^a Lamotrigine Aspen 100	FM
							^a Lamotrigine-GA	GN
							^a Lamotrigine generichealth	GQ
							^a Lamotrigine Sandoz	SZ
							^a Lamotruster 100	CR
							^a Reedos 100	DO
							^a Seaze 100	QA
							^a Torlemo DT 100	UA
				^b 3.00	42.12	36.90	^a Lamictal	AS
2851C NP	lamotrigine 200 mg tablet, 56	1	5	..	58.77	36.90	^a APO-Lamotrigine	TX
							^a GenRx Lamotrigine	GX
							^a Lamidus	RA
							^a Lamogine	AF
							^a Lamotrigine AN	EA
							^a Lamotrigine Aspen 200	FM
							^a Lamotrigine-GA	GN
							^a Lamotrigine generichealth	GQ
							^a Lamotrigine Sandoz	SZ
							^a Lamotruster 200	CR
							^a Reedos 200	DO
							^a Seaze 200	QA
							^a Torlemo DT 200	UA
				^b 3.00	61.77	36.90	^a Lamictal	AS
2848X NP	lamotrigine 25 mg tablet, 56	1	5	..	18.41	19.56	^a APO-Lamotrigine	TX
							^a GenRx Lamotrigine	GX
							^a Lamidus	RA
							^a Lamogine	AF
							^a Lamotrigine AN	EA
							^a Lamotrigine Aspen 25	FM
							^a Lamotrigine-GA	GN
							^a Lamotrigine generichealth	GQ

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
8063J NP	lamotrigine 5 mg tablet, 56	1	5	..	11.99	13.14	^a Lamotrigine Sandoz SZ
							^a Lamotruster 25 CR
							^a Reedos 25 DO
							^a Seaze 25 QA
							^a Torlemo DT 25 UA
							^a Lamictal AS
							^a Lamogine AF
							^a Lamotrigine Aspen 5 FM
							^a Seaze 5 QA
							^a Lamictal AS
2849Y NP	lamotrigine 50 mg tablet, 56	1	5	..	26.18	27.33	^a APO-Lamotrigine TX
							^a GenRx Lamotrigine GX
							^a Lamidus RA
							^a Lamogine AF
							^a Lamotrigine AN EA
							^a Lamotrigine Aspen 50 FM
							^a Lamotrigine-GA GN
							^a Lamotrigine GQ
							^a generichealth
							^a Lamotrigine Sandoz SZ
							^a Lamotruster 50 CR
							^a Reedos 50 DO
							^a Seaze 50 QA
							^a Torlemo DT 50 UA
							^a Lamictal AS
							^b 3.38 21.79 19.56
							^b 2.33 14.32 13.14
							^b 3.01 29.19 27.33

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.

8656N NP	levetiracetam 1 g tablet, 60	1	5	..	96.25	36.90	^a APO-Levetiracetam TX
							^a Chem mart CH
							^a Levetiracetam
							^a Kepcet GN
							^a Keppra UC
							^a Kerron 1000 DO
							^a Kevtam AF
							^a Levactam ER
							^a Levecetam 1000 RZ
							^a Levetiracetam AN EA
							^a Levetiracetam GQ
							^a generichealth
							^a Levetiracetam SZ
							^a Levi 1000 FM
							^a Levitaccord RA
							^a Levitam 1000 QA
							^a Terry White Chemists TW
8654L NP	levetiracetam 250 mg tablet, 60	1	5	..	40.44	36.90	^a APO-Levetiracetam TX
							^a Chem mart CH
							^a Levetiracetam
							^a Kepcet GN
							^a Keppra UC
							^a Kerron 250 DO
							^a Kevtam AF
							^a Levactam ER

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Levecetam 250	RZ
							^a Levetiracetam AN	EA
							^a Levetiracetam generichealth	GQ
							^a Levetiracetam SZ	SZ
							^a Levi 250	FM
							^a Levitaccord	RA
							^a Levitam 250	QA
							^a Terry White Chemists Levetiracetam	TW
8655M NP	levetiracetam 500 mg tablet, 60	1	5	..	60.46	36.90	^a APO-Levetiracetam	TX
							^a Chem mart Levetiracetam	CH
							^a Kepcet	GN
							^a Keppra	UC
							^a Kerron 500	DO
							^a Kevtam	AF
							^a Levactam	ER
							^a Levecetam 500	RZ
							^a Levetiracetam AN	EA
							^a Levetiracetam generichealth	GQ
							^a Levetiracetam SZ	SZ
							^a Levi 500	FM
							^a Levitaccord	RA
							^a Levitam 500	QA
							^a Terry White Chemists Levetiracetam	TW

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.

9169N NP	levetiracetam 100 mg/mL oral liquid, 300 mL	1	5	..	111.76	36.90	Keppra	UC

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.

10151G NP	perampanel 10 mg tablet, 28	1	5	..	355.72	36.90	Fycompa	EI
10159Q NP	perampanel 12 mg tablet, 28	1	5	..	355.72	36.90	Fycompa	EI
10162W NP	perampanel 4 mg tablets, 28	1	5	..	188.80	36.90	Fycompa	EI
10163X NP	perampanel 6 mg tablet, 28	1	5	..	273.00	36.90	Fycompa	EI
10160R NP	perampanel 8 mg tablet, 28	1	5	..	355.72	36.90	Fycompa	EI

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

10157N	perampanel 2 mg tablet, 7	2	1	..	*52.64	36.90	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.

2100M	sulthiame 200 mg tablet, 200	1	2	..	206.33	36.90	Ospolot	PL

NP

2099L	sulthiame 50 mg tablet, 200	1	2	..	82.81	36.90	Ospolot	PL

NP

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.

8165R	topiramate 100 mg tablet, 60	1	5	..	55.63	36.90	^a APO-Topiramate	TX
							^a Epiramax 100	QA
							^a RBX Topiramate	RA
							^a Tamate	AF
							^a Topamax	JC
							^a Topiramate GH	GQ
							^a Topiramate Sandoz	SZ
							^a APO-Topiramate	TX
							^a Epiramax 200	QA
							^a RBX Topiramate	RA
							^a Tamate	AF
							^a Topamax	JC
							^a Topiramate GH	GQ
							^a Topiramate Sandoz	SZ

8166T

NP

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.

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
8371N NP	topiramate 15 mg capsule, 60	1	5	..	21.14	22.29	Topamax Sprinkle	JC
8372P NP	topiramate 25 mg capsule, 60	1	5	..	26.20	27.35	Topamax Sprinkle	JC
8520K NP	topiramate 50 mg capsule, 60	1	5	..	39.16	36.90	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.

8163P NP	topiramate 25 mg tablet, 60	1	5	..	26.52	27.67	^a APO-Topiramate	TX
							^a Epiramax 25	QA
							^a RBX Topiramate	RA
							^a Tamate	AF
							^a Topamax	JC
							^a Topiramate GH	GQ
							^a Topiramate Sandoz	SZ
8164Q NP	topiramate 50 mg tablet, 60	1	5	..	39.20	36.90	^a APO-Topiramate	TX
							^a Epiramax 50	QA
							^a RBX Topiramate	RA
							^a Tamate	AF
							^a Topamax	JC
							^a Topiramate GH	GQ
							^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.

9390F NP	zonisamide 100 mg capsule, 56	2	5	..	*93.80	36.90	Zonegran	SA
9388D NP	zonisamide 25 mg capsule, 56	1	5	..	23.14	24.29	Zonegran	SA
9389E NP	zonisamide 50 mg capsule, 56	1	5	..	34.06	35.21	Zonegran	SA

ANTI-PARKINSON DRUGS

ANTICHOLINERGIC AGENTS

Tertiary amines

BENZHEXOL

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
1109J NP	benzhexol hydrochloride 2 mg tablet, 200	1	2	..	15.66	16.81	Artane	QA
1110K NP	benzhexol hydrochloride 5 mg tablet, 200	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.

2544X NP	biperiden hydrochloride 2 mg tablet, 100	2	2	..	*21.22	22.37	Akineton	LM

Ethers of tropine or tropine derivatives

BENZTROPINE

2362H NP	benztropine mesylate 2 mg tablet, 60	1	2	..	15.47	16.62	Benztrop	PL
10013B NP	benztropine mesylate 2 mg/2 mL injection, 10 x 2 mL vials	1	..	..	287.65	36.90	Benztropine Omega	FK
10027R DP	benztropine mesylate 2 mg/2 mL injection, 10 x 2 mL vials	1	..	..	287.65	36.90	Benztropine Omega	FK
3038X NP	benztropine mesylate 2 mg/2 mL injection, 5 x 2 mL ampoules	1	..	..	103.93	36.90	Cogentin	FK
5031T DP	benztropine mesylate 2 mg/2 mL injection, 5 x 2 mL ampoules	1	..	..	103.93	36.90	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.

8219N NP	LEVODOPA with BENSERAZIDE Dispersible tablet 100 mg-25 mg, 100	1	5	..	39.26	36.90	Madopar Rapid 125	RO
8218M NP	LEVODOPA with BENSERAZIDE Dispersible tablet 50 mg-12.5 mg, 100	1	5	..	23.34	24.49	Madopar Rapid 62.5	RO
2225D NP	levodopa 100 mg + benserazide 25 mg capsule, 100	1	5	..	39.26	36.90	Madopar 125	RO
2231K NP	levodopa 100 mg + benserazide 25 mg capsule: modified release, 100 capsules	1	5	..	42.34	36.90	Madopar HBS	RO
2229H NP	levodopa 100 mg + benserazide 25 mg tablet, 100	1	5	..	39.26	36.90	Madopar 125	RO
2226E NP	levodopa 200 mg + benserazide 50 mg capsule, 100	1	5	..	50.35	36.90	Madopar	RO
2228G NP	levodopa 200 mg + benserazide 50 mg tablet, 100	1	5	..	50.35	36.90	Madopar	RO
2227F NP	levodopa 50 mg + benserazide 12.5 mg capsule, 100	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.

1242J NP	levodopa 100 mg + carbidopa anhydrous 25 mg tablet, 100	1	5	..	38.63	36.90	^a Kinson	AF
				^b 5.19	43.82	36.90	^a Sinemet 100/25	MK
1245M NP	levodopa 250 mg + carbidopa anhydrous 25 mg tablet, 100	1	5	..	45.43	36.90	^a Levo/Carbidopa Sandoz	SZ
				^b 2.92	48.35	36.90	^a Sinemet	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

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
	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.							
8970D NP	levodopa 20 mg/mL + carbidopa monohydrate 5 mg/mL gel: intestinal, 7 x 100 mL bags	8	5	..	*11682.68	36.90	Duodopa	VE
	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.							
1255C NP	levodopa 200 mg + carbidopa anhydrous 50 mg tablet: modified release, 100 tablets	1	5	..	68.21	36.90	Sinemet CR	MK
	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.							
8798C NP	levodopa 100 mg + carbidopa anhydrous 25 mg + entacapone 200 mg tablet, 100	2	4	..	*342.26	36.90	Stalevo 100/25/200mg	NV
9345W NP	levodopa 125 mg + carbidopa anhydrous 31.25 mg + entacapone 200 mg tablet, 100	2	4	..	*354.30	36.90	Stalevo 125/31.25/200mg	NV
8799D NP	levodopa 150 mg + carbidopa anhydrous 37.5 mg + entacapone 200 mg tablet, 100	2	4	..	*372.30	36.90	Stalevo 150/37.5/200mg	NV
9292C NP	levodopa 200 mg + carbidopa anhydrous 50 mg + entacapone 200 mg tablet, 100	2	4	..	*399.96	36.90	Stalevo 200/50/200mg	NV
8797B NP	levodopa 50 mg + carbidopa anhydrous 12.5 mg + entacapone 200 mg tablet, 100	2	4	..	*312.22	36.90	Stalevo 50/12.5/200mg	NV
9344T NP	levodopa 75 mg + carbidopa anhydrous 18.75 mg + entacapone 200 mg tablet, 100	2	4	..	*325.46	36.90	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.

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
3016R NP	amantadine hydrochloride 100 mg capsule, 100	1	5	..	44.64	36.90	Symmetrel 100	NV
Dopamine agonists								
BROMOCRIPTINE								
<u>Restricted benefit</u>								
Acromegaly								
<u>Restricted benefit</u>								
Parkinson's disease								
<u>Restricted benefit</u>								
Pathological hyperprolactinaemia where surgery is not indicated								
<u>Restricted benefit</u>								
Pathological hyperprolactinaemia where surgery has already been used with incomplete resolution								
<u>Restricted benefit</u>								
Pathological hyperprolactinaemia where radiotherapy is not indicated								
<u>Restricted benefit</u>								
Pathological hyperprolactinaemia where radiotherapy has already been used with incomplete resolution								
<u>Note</u>								
Care should be taken when treating patients with advanced age and significant cognitive impairment with dopamine agonists.								
<u>Note</u>								
For item codes 1443Y and 1559C, pharmaceutical benefits that have the form tablet 2.5 mg (base) are equivalent for the purposes of substitution.								
1443Y	bromocriptine 2.5 mg tablet, 30	2	5	..	*31.76	32.91	^a Parlodel	NV
1559C	bromocriptine 2.5 mg tablet, 60	1	5	..	31.76	32.91	^a Krypton 2.5	AF
CABERGOLINE								
<u>Restricted benefit</u>								
Parkinson's disease								
<u>Note</u>								
Care should be taken when treating patients with advanced age and significant cognitive impairment with dopamine agonists.								
<u>Note</u>								
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.								
8393R NP	cabergoline 1 mg tablet, 30	1	5	..	60.12	36.90	^a Cabaser	PF
8394T NP	cabergoline 2 mg tablet, 30	1	5	..	78.28	36.90	^a Cobasol	GN
							^a Cabaser	PF
							^a Cobasol	GN
PRAMIPEXOLE								
<u>Restricted benefit</u>								
Parkinson disease								
<u>Caution</u>								
Episodes of sudden onset of sleep without warning, during activity, have been reported with this drug.								
<u>Note</u>								
Care should be taken when treating patients with advanced age and significant cognitive impairment with dopamine agonists.								
<u>Note</u>								
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.								
9153R NP	pramipexole hydrochloride monohydrate 1 mg tablet, 100	1	5	..	129.16	36.90	^a Pramipexole AN	EA
9151P NP	pramipexole hydrochloride monohydrate 125 microgram tablet,	1	..	..	11.23	12.38	^a Sifrol	BY
							^a Simipex 1	QA
							^a Simpral	AF
							^a Pramipexole AN	EA

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	30							
							^a Sifrol	BY
							^a Simipex 0.125	QA
							^a Simpral	AF
9152Q NP	pramipexole hydrochloride monohydrate 250 microgram tablet, 100	1	5	..	36.07	36.90	^a Pramipexole AN	EA
							^a Sifrol	BY
							^a Simipex 0.25	QA
							^a Simpral	AF

PRAMIPEXOLE

Restricted benefit

Parkinson disease

Caution

Episodes of sudden onset of sleep without warning, during activity, have been reported with this drug.

Note

Care should be taken when treating patients with advanced age and significant cognitive impairment with dopamine agonists.

Note

No applications for increased maximum quantities and/or repeats will be approved for extended release pramipexole formulations.

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.

3420B NP	pramipexole hydrochloride monohydrate 1.5 mg tablet: modified release, 30 tablets	1	5	..	57.24	36.90	Sifrol ER	BY
5143Q NP	pramipexole hydrochloride monohydrate 2.25 mg tablet: modified release, 30 tablets	1	5	..	82.50	36.90	Sifrol ER	BY
3421C NP	pramipexole hydrochloride monohydrate 3 mg tablet: modified release, 30 tablets	1	5	..	116.91	36.90	Sifrol ER	BY
5145T NP	pramipexole hydrochloride monohydrate 3.75 mg tablet: modified release, 30 tablets	1	5	..	142.16	36.90	Sifrol ER	BY
3418X NP	pramipexole hydrochloride monohydrate 375 microgram tablet: modified release, 30 tablets	1	5	..	20.18	21.33	Sifrol ER	BY
3422D NP	pramipexole hydrochloride monohydrate 4.5 mg tablet: modified release, 30 tablets	1	5	..	172.00	36.90	Sifrol ER	BY
3419Y NP	pramipexole hydrochloride monohydrate 750 microgram tablet: modified release, 30 tablets	1	5	..	33.14	34.29	Sifrol ER	BY

PRAMIPEXOLE

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:

- An urge to move the legs usually accompanied or caused by unpleasant sensations in the legs; and
- The urge to move or unpleasant sensations begin or worsen during periods of rest or inactivity such as lying or sitting; and
- 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
- 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

Caution

Episodes of sudden onset of sleep without warning, during activity, have been reported with this drug.

Note

Care should be taken when treating patients with advanced age and significant cognitive impairment with dopamine agonists.

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
Note No applications for increased maximum quantities and/or 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.								
9393J NP	pramipexole hydrochloride monohydrate 125 microgram tablet, 30	1	2	..	11.23	12.38 ^a	Sifrol	BY
9394K NP	pramipexole hydrochloride monohydrate 250 microgram tablet, 100	1	2	..	36.07	36.90 ^a	Simpral Sifrol	AF BY
						^a	Simpral	AF
ROTIGOTINE Restricted benefit Parkinson disease Clinical criteria: The treatment must be as adjunctive therapy to a levodopa-decarboxylase inhibitor combination.								
2385M	rotigotine 2 mg/24 hours patch, 28	1	5	..	77.59	36.90	Neupro	UC
ROTIGOTINE Restricted benefit Parkinson disease Clinical criteria: The treatment must be as adjunctive therapy to a levodopa-decarboxylase inhibitor combination.								
2384L	rotigotine 4 mg/24 hours patch, 28	1	5	..	101.20	36.90	Neupro	UC
2410W	rotigotine 6 mg/24 hours patch, 28	1	5	..	113.92	36.90	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.								
1952R NP	RASAGILINE Tablet 1 mg (as mesilate), 30	1	5	..	121.93	36.90	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.								
1973W NP	selegiline hydrochloride 5 mg tablet, 100	1	5	..	53.30	36.90 ^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

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
8367J NP	entacapone 200 mg tablet, 100	2	4	..	*282.16	36.90	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.

1196Y NP	chlorpromazine hydrochloride 10 mg tablet, 100	1	5	..	11.21	12.36	Largactil	SW
1199D NP	chlorpromazine hydrochloride 100 mg tablet, 100	1	5	..	17.78	18.93	Largactil	SW
1197B NP	chlorpromazine hydrochloride 25 mg tablet, 100	1	5	..	11.83	12.98	Largactil	SW
1201F NP	chlorpromazine hydrochloride 5 mg/mL oral liquid, 100 mL	1	5	..	13.13	14.28	Largactil	SW
1195X NP	chlorpromazine hydrochloride 50 mg/2 mL injection, 10 x 2 mL ampoules	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.

1046C NP	fluphenazine decanoate 12.5 mg/0.5 mL injection, 5 x 0.5 mL ampoules	1	..	..	19.56	20.71	Modectate	BQ
3098C NP	fluphenazine decanoate 25 mg/mL injection, 5 x 1 mL ampoules	1	..	..	26.72	27.87	Modectate	BQ
1001Q NP	fluphenazine decanoate 50 mg/2 mL injection, 5 x 2 mL ampoules	1	..	..	37.99	36.90	Modectate	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.

2185B NP	trifluoperazine 1 mg tablet, 100	1	5	..	16.85	18.00	Stelazine	GH
2386N NP	trifluoperazine 2 mg tablet, 100	1	5	..	21.78	22.93	Stelazine	GH
2186C NP	trifluoperazine 5 mg tablet, 100	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.

3053Q NP	pericyazine 10 mg tablet, 100	1	5	..	15.53	16.68	Neulactil	SW
3052P NP	pericyazine 2.5 mg tablet, 100	1	5	..	11.03	12.18	Neulactil	SW

Butyrophenone derivatives

HALOPERIDOL

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
2767P NP	haloperidol 1.5 mg tablet, 100	1	5	..	11.25	12.40	Serenace	QA
2763K NP	haloperidol 2 mg/mL oral liquid, 100 mL	1	5	..	20.79	21.94	Serenace	QA
2770T NP	haloperidol 5 mg tablet, 50	1	5	..	11.02	12.17	Serenace	QA
2768Q NP	haloperidol 5 mg/mL injection, 10 x 1 mL ampoules	1	..	..	22.62	23.77	Serenace	QA
2761H NP	haloperidol 500 microgram tablet, 100	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.

2766N NP	haloperidol (as decanoate) 150 mg/3 mL injection, 5 x 3 mL ampoules	1	..	..	51.87	36.90	Haldol decanoate	JC
2765M NP	haloperidol (as decanoate) 50 mg/mL injection, 5 x 1 mL vials	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.

9070J NP	ziprasidone 20 mg capsule, 60	1	5	..	77.49	36.90	^a APO-Ziprasidone	TX
9071K NP	ziprasidone 40 mg capsule, 60	1	5	..	148.45	36.90	^a Zeldox ^a APO-Ziprasidone	PF TX
9072L NP	ziprasidone 60 mg capsule, 60	1	5	..	217.30	36.90	^a Zeldox ^a APO-Ziprasidone	PF TX
9073M NP	ziprasidone 80 mg capsule, 60	1	5	..	281.81	36.90	^a Zeldox ^a APO-Ziprasidone	PF 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.

2257T NP	flupenthixol decanoate 100 mg/mL injection, 5 x 1 mL ampoules	1	..	..	48.61	36.90	Fluanxol Concentrated Depot	LU
2255Q NP	flupenthixol decanoate 20 mg/mL injection, 5 x 1 mL ampoules	1	..	..	20.85	22.00	Fluanxol Depot	LU

ZUCLOPENTHIXOL DECANOATE

Note

Shared Care Model:

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
8097E NP	zuclopenthixol decanoate 200 mg/mL injection, 5 x 1 mL ampoules	1	..	..	27.58	28.73	Clopixol Depot	LU
<i>Diazepines, oxazepines, thiazepines and oxepines</i>								
ASENAPINE								
<u>Authority required (STREAMLINED)</u>								
1589								
Schizophrenia								
<u>Authority required (STREAMLINED)</u>								
3935								
Treatment, for up to 6 months, of an episode of acute mania or mixed episodes associated with bipolar I disorder								
<u>Authority required (STREAMLINED)</u>								
3936								
Maintenance treatment, as monotherapy, of bipolar I disorder								
<u>Note</u>								
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.								
5141N NP	asenapine 10 mg wafer: sublingual, 60 wafers	1	5	..	253.06	36.90	Saphris	LU
5140M NP	asenapine 5 mg wafer: sublingual, 60 wafers	1	5	..	157.41	36.90	Saphris	LU
OLANZAPINE								
<u>Authority required (STREAMLINED)</u>								
1589								
Schizophrenia								
<u>Authority required (STREAMLINED)</u>								
2044								
Maintenance treatment of bipolar I disorder								
<u>Note</u>								
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.								
3382B NP	OLANZAPINE Tablet 10 mg (orally disintegrating), 28	1	5	..	63.16	36.90	^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								
<u>Authority required (STREAMLINED)</u>								
1589								
Schizophrenia								
<u>Authority required (STREAMLINED)</u>								
2044								
Maintenance treatment of bipolar I disorder								
<u>Note</u>								
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.								
3381Y NP	OLANZAPINE Tablet 5 mg (orally disintegrating), 28	1	5	..	35.94	36.90	^a APO-Olanzapine ODT	TX

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^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 and pharmaceutical benefits that have the form olanzapine tablet 10 mg (as benzoate) are equivalent for the purposes of substitution.

1042W NP	olanzapine 10 mg tablet, 28	1	5	..	63.16	36.90	^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 10 mg and pharmaceutical benefits that have the form olanzapine tablet 10 mg (as benzoate) are equivalent for the purposes of substitution.

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.

8187X NP	olanzapine 10 mg tablet, 28	1	5	..	63.16	36.90	^a APO-Olanzapine	TX
							^a Chem mart Olanzapine	CH
							^a Lanzek	EL
							^a Olanzapine AN	EA
							^a Olanzapine-DRLA	RZ
							^a Olanzapine-GA	GN
							^a Olanzapine GH	GQ
							^a Olanzapine RBX	RA
							^a Olanzapine Sandoz	SZ
							^a Ozin 10	DO
							^a Pharmacor Olanzapine 10	CR
							^a Pharmacy Choice Olanzapine	RI
							^a Terry White Chemists Olanzapine	TW
							^a Zypine	AF
							^a Zyprexa	LY

OLANZAPINE

Authority required (STREAMLINED)

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	1589 Schizophrenia <u>Authority required (STREAMLINED)</u> 2044 Maintenance treatment of bipolar I disorder <u>Note</u> 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. <u>Note</u> 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.							
8434X NP	olanzapine 10 mg wafer, 28	1	5	..	63.16	36.90	^a Lanzek Zydis ^a Zypine ODT ^a Zyprexa Zydis	EL AF LY
	OLANZAPINE <u>Authority required (STREAMLINED)</u> 1589 Schizophrenia <u>Authority required (STREAMLINED)</u> 2044 Maintenance treatment of bipolar I disorder <u>Note</u> 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.							
3384D NP	olanzapine 15 mg tablet, 28	1	5	..	91.35	36.90	^a APO-Olanzapine ODT ^a Chem mart Olanzapine ODT ^a Olanzapine AN ODT ^a Terry White Chemists Olanzapine ODT	TX CH EA TW
	OLANZAPINE <u>Authority required (STREAMLINED)</u> 1589 Schizophrenia <u>Authority required (STREAMLINED)</u> 2044 Maintenance treatment of bipolar I disorder <u>Note</u> 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. <u>Note</u> 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.							
8952E NP	olanzapine 15 mg wafer, 28	1	5	..	91.35	36.90	^a Zypine ODT ^a Zyprexa Zydis	AF LY
	OLANZAPINE <u>Authority required (STREAMLINED)</u> 1589 Schizophrenia <u>Authority required (STREAMLINED)</u> 2044 Maintenance treatment of bipolar I disorder <u>Note</u> Pharmaceutical benefits that have the form olanzapine tablet 2.5 mg and pharmaceutical benefits that have the form olanzapine tablet 2.5 mg (as							

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
1024X NP	benzoate) are equivalent for the purposes of substitution. olanzapine 2.5 mg tablet, 28	1	5	..	21.50	22.65	^a Olanzapine generichealth 2.5	GQ
OLANZAPINE <u>Authority required (STREAMLINED)</u> 1589 Schizophrenia <u>Authority required (STREAMLINED)</u> 2044 Maintenance treatment of bipolar I disorder <u>Note</u> 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. <u>Note</u> 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.								
8170B NP	olanzapine 2.5 mg tablet, 28	1	5	..	21.50	22.65	^a APO-Olanzapine	TX
							^a Chem mart Olanzapine	CH
							^a Lanzek	EL
							^a Olanzapine AN	EA
							^a Olanzapine-DRLA	RZ
							^a Olanzapine-GA	GN
							^a Olanzapine RBX	RA
							^a Olanzapine Sandoz	SZ
							^a Ozin 2.5	DO
							^a Pharmacor Olanzapine 2.5	CR
							^a Pharmacy Choice Olanzapine	RI
							^a Terry White Chemists Olanzapine	TW
							^a Zypine	AF
							^a Zyprexa	LY
OLANZAPINE <u>Authority required (STREAMLINED)</u> 1589 Schizophrenia <u>Authority required (STREAMLINED)</u> 2044 Maintenance treatment of bipolar I disorder <u>Note</u> 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.								
3385E NP	olanzapine 20 mg tablet, 28	1	5	..	119.54	36.90	^a APO-Olanzapine ODT	TX
							^a Chem mart Olanzapine ODT	CH
							^a Olanzapine AN ODT	EA
							^a Terry White Chemists Olanzapine ODT	TW
OLANZAPINE <u>Authority required (STREAMLINED)</u> 1589 Schizophrenia <u>Authority required (STREAMLINED)</u> 2044 Maintenance treatment of bipolar I disorder <u>Note</u>								

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

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.

8953F NP	olanzapine 20 mg wafer, 28	1	5	..	119.54	36.90	^a Zypine ODT	AF
							^a Zyprexa Zydis	LY

OLANZAPINE

Authority required (STREAMLINED)

4304

Schizophrenia

Caution

Monitor for post-injection syndrome for at least two hours after each injection.

Note

Special Pricing Arrangements apply.

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.

9294E NP	olanzapine 210 mg injection: modified release [1 x 210 mg vial] (&) inert substance diluent [1 x 3 mL vial], 1 pack	2	5	..	*500.12	36.90	Zyprexa Relprevv	LY
9295F NP	olanzapine 300 mg injection: modified release [1 x 300 mg vial] (&) inert substance diluent [1 x 3 mL vial], 1 pack	2	5	..	*809.60	36.90	Zyprexa Relprevv	LY
9303P NP	olanzapine 405 mg injection: modified release [1 x 405 mg vial] (&) inert substance diluent [1 x 3 mL vial], 1 pack	1	5	..	500.12	36.90	Zyprexa Relprevv	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.

1037N NP	olanzapine 5 mg tablet, 28	1	5	..	35.94	36.90	^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 5 mg and pharmaceutical benefits that have the form olanzapine tablet 5 mg (as benzoate) are equivalent for the purposes of substitution.

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.

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
8185T NP	olanzapine 5 mg tablet, 28	1	5	..	35.94	36.90	^a APO-Olanzapine	TX
							^a Chem mart Olanzapine	CH
							^a Lanzek	EL
							^a Olanzapine AN	EA
							^a Olanzapine-DRLA	RZ
							^a Olanzapine-GA	GN
							^a Olanzapine GH	GQ
							^a Olanzapine RBX	RA
							^a Olanzapine Sandoz	SZ
							^a Ozin 5	DO
							^a Pharmacor Olanzapine 5	CR
							^a Pharmacy Choice Olanzapine	RI
							^a Terry White Chemists Olanzapine	TW
							^a Zypine	AF
							^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 (orally disintegrating) and pharmaceutical benefits that have the form olanzapine wafer 5 mg are equivalent for the purposes of substitution.

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.

8433W NP	olanzapine 5 mg wafer, 28	1	5	..	35.94	36.90	^a Lanzek Zydis	EL
							^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 7.5 mg and pharmaceutical benefits that have the form olanzapine tablet 7.5 mg (as benzoate) are equivalent for the purposes of substitution.

1041T NP	olanzapine 7.5 mg tablet, 28	1	5	..	49.72	36.90	^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 7.5 mg and pharmaceutical benefits that have the form olanzapine tablet 7.5 mg (as benzoate) are equivalent for the purposes of substitution.

Note

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
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.							
8186W NP	olanzapine 7.5 mg tablet, 28	1	5	..	49.72	36.90	^a APO-Olanzapine TX ^a Chem mart Olanzapine CH ^a Lanzek EL ^a Olanzapine AN EA ^a Olanzapine-DRLA RZ ^a Olanzapine-GA GN ^a Olanzapine GH GQ ^a Olanzapine RBX RA ^a Olanzapine Sandoz SZ ^a Ozin 7.5 DO ^a Pharmacor Olanzapine 7.5 CR ^a Pharmacy Choice Olanzapine RI ^a Terry White Chemists Olanzapine TW ^a Zypine AF ^a Zyprexa LY
QUETIAPINE <u>Authority required (STREAMLINED)</u> 1589 Schizophrenia <u>Authority required (STREAMLINED)</u> 2765 Monotherapy, for up to 6 months, of an episode of acute mania associated with bipolar I disorder <u>Authority required (STREAMLINED)</u> 2044 Maintenance treatment of bipolar I disorder <u>Note</u> 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.							
8457D NP	quetiapine 100 mg tablet, 90	1	5	..	67.59	36.90	^a APO-Quetiapine TX ^a Chem mart Quetiapine CH ^a Delucon 100 DO ^a Kaptan ER ^a Pharmacor Quetiapine 100 CR ^a Pharmacy Choice Quetiapine RI ^a Quetia 100 FM ^a Quetiaccord UA ^a Quetiapine Actavis 100 VN ^a Quetiapine AN EA ^a Quetiapine-DRLA RZ ^a Quetiapine-GA GN ^a Quetiapine GH 100 GQ ^a Quetiapine RBX RA ^a Quetiapine Sandoz SZ ^a Sequase PM ^a Seronia 100 QA ^a Seroquel AP ^a Syquet AF ^a Terry White Chemists Quetiapine TW Seroquel XR AP
5458G NP	quetiapine 150 mg tablet: modified release, 60 tablets	1	5	..	67.59	36.90	
8458E	quetiapine 200 mg tablet, 60	1	5	..	89.63	36.90	^a APO-Quetiapine TX

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
NP							
							^a Chem mart Quetiapine CH
							^a Delucon 200 DO
							^a Kaptan ER
							^a Pharmacor Quetiapine 200 CR
							^a Pharmacy Choice Quetiapine RI
							^a Quetia 200 FM
							^a Quetiaccord UA
							^a Quetiapine Actavis 200 VN
							^a Quetiapine AN EA
							^a Quetiapine-DRLA RZ
							^a Quetiapine-GA GN
							^a Quetiapine GH 200 GQ
							^a Quetiapine RBX RA
							^a Quetiapine Sandoz SZ
							^a Sequase PM
							^a Seronia 200 QA
							^a Seroquel AP
							^a Syquet AF
							^a Terry White Chemists Quetiapine TW
9203J	quetiapine 200 mg tablet: modified release, 60 tablets	1	5	..	89.63	36.90	Seroquel XR AP
NP							
8580N	quetiapine 300 mg tablet, 60	1	5	..	128.35	36.90	^a APO-Quetiapine TX
NP							
							^a Chem mart Quetiapine CH
							^a Delucon 300 DO
							^a Kaptan ER
							^a Pharmacor Quetiapine 300 CR
							^a Pharmacy Choice Quetiapine RI
							^a Quetia 300 FM
							^a Quetiaccord UA
							^a Quetiapine Actavis 300 VN
							^a Quetiapine AN EA
							^a Quetiapine-DRLA RZ
							^a Quetiapine-GA GN
							^a Quetiapine GH 300 GQ
							^a Quetiapine RBX RA
							^a Quetiapine Sandoz SZ
							^a Sequase PM
							^a Seronia 300 QA
							^a Seroquel AP
							^a Syquet AF
							^a Terry White Chemists Quetiapine TW
9204K	quetiapine 300 mg tablet: modified release, 60 tablets	1	5	..	128.35	36.90	Seroquel XR AP
NP							
9205L	quetiapine 400 mg tablet: modified release, 60 tablets	1	5	..	172.51	36.90	Seroquel XR AP
NP							
9202H	quetiapine 50 mg tablet: modified release, 60 tablets	1	5	..	50.33	36.90	Seroquel XR AP
NP							

QUETIAPINE

Authority required (STREAMLINED)

4391

Schizophrenia

Clinical criteria:

The treatment must be for dose titration purposes.

Authority required (STREAMLINED)

4396

Acute mania

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
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.							
<u>Authority required (STREAMLINED)</u>							
4385							
Bipolar I disorder							
Clinical criteria:							
The treatment must be maintenance therapy,							
AND							
The treatment must be for dose titration purposes.							
<u>Note</u>							
No increase in the maximum quantity or number of units may be authorised.							
<u>Note</u>							
No increase in the maximum number of repeats may be authorised.							
<u>Note</u>							
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.							
8456C NP	quetiapine 25 mg tablet, 60	1	..	..	29.23	30.38	^a APO-Quetiapine TX
							^a Chem mart Quetiapine CH
							^a Delucon 25 DO
							^a Kaptan ER
							^a Pharmacor Quetiapine 25 CR
							^a Pharmacy Choice Quetiapine RI
							^a Quetia 25 FM
							^a Quetiaccord UA
							^a Quetiapine Actavis 25 VN
							^a Quetiapine AN EA
							^a Quetiapine-DRLA RZ
							^a Quetiapine-GA GN
							^a Quetiapine GH 25 GQ
							^a Quetiapine RBX RA
							^a Quetiapine Sandoz SZ
							^a Sequase PM
							^a Seronia 25 QA
							^a Seroquel AP
							^a Syquet AF
							^a Terry White Chemists Quetiapine TW

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.

8594H NP	amisulpride 100 mg tablet, 30	1	5	..	21.27	22.42	^a Amisulpride 100 Winthrop WA
							^a Amisulpride Sandoz SZ
							^a APO-Amisulpride TX
							^a Solian 100 SW

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
8736T NP	amisulpride 100 mg/mL oral liquid, 60 mL	2	5	..	*149.08	36.90	^a Sulprix Solian Solution	AF SW
8595J NP	amisulpride 200 mg tablet, 60	1	5	..	66.58	36.90	^a Amisulpride 200 Winthrop	WA
							^a Amisulpride Sandoz	SZ
							^a APO-Amisulpride	TX
							^a Solian 200	SW
							^a Sulprix	AF
8596K NP	amisulpride 400 mg tablet, 60	1	5	..	115.25	36.90	^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

ARIPIPRAZOLE

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.

8717T NP	aripiprazole 10 mg tablet, 30	1	5	..	152.59	36.90	Abilify	BQ
8718W NP	aripiprazole 15 mg tablet, 30	1	5	..	212.90	36.90	Abilify	BQ
8719X NP	aripiprazole 20 mg tablet, 30	1	5	..	253.77	36.90	Abilify	BQ
8720Y NP	aripiprazole 30 mg tablet, 30	1	5	..	303.83	36.90	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.

5107T NP	paliperidone 100 mg injection: modified release, 1 syringe	1	5	..	441.03	36.90	Invega Sustenna	JC
5109X NP	paliperidone 150 mg injection: modified release, 1 syringe	1	5	..	441.03	36.90	Invega Sustenna	JC
5100K NP	paliperidone 25 mg injection: modified release, 1 syringe	1	5	..	149.97	36.90	Invega Sustenna	JC
9140C NP	paliperidone 3 mg tablet: modified release, 28 tablets	1	5	..	79.93	36.90	Invega	JC
5102M NP	paliperidone 50 mg injection: modified release, 1 syringe	1	5	..	285.14	36.90	Invega Sustenna	JC
9141D NP	paliperidone 6 mg tablet: modified release, 28 tablets	1	5	..	154.60	36.90	Invega	JC
5103N NP	paliperidone 75 mg injection: modified release, 1 syringe	1	5	..	363.48	36.90	Invega Sustenna	JC
9142E NP	paliperidone 9 mg tablet: modified release, 28 tablets	1	5	..	226.35	36.90	Invega	JC

RISPERIDONE

Authority required (STREAMLINED)

1589

Schizophrenia

Authority required (STREAMLINED)

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
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.							
3169T NP	risperidone 1 mg tablet, 60	1	5	..	21.57	22.72	^a APO-Risperidone TX
							^a Ozidal RA
							^a Rispa QA
							^a Risperdal JC
							^a Rispericor 1 CR
							^a Risperidone AN EA
							^a Risperidone-DRLA RZ
							^a Risperidone-GA GN
							^a Risperidone generichealth GQ
							^a Risperidone Sandoz SZ
							^a Rispernia ER
							^a Rixadone AF
8792R NP	risperidone 1 mg tablet: orally disintegrating, 28	2	5	..	*23.94	25.09	Risperdal Quicklet JC
8100H NP	risperidone 1 mg/mL oral liquid, 100 mL	1	5	..	118.37	36.90	Risperdal JC
3170W NP	risperidone 2 mg tablet, 60	1	5	..	40.64	36.90	^a APO-Risperidone TX
							^a Ozidal RA
							^a Rispa QA
							^a Risperdal JC
							^a Rispericor 2 CR
							^a Risperidone Actavis 2 UA
							^a Risperidone AN EA
							^a Risperidone-DRLA RZ
							^a Risperidone-GA GN
							^a Risperidone generichealth GQ
							^a Risperidone Sandoz SZ
							^a Rispernia ER
							^a Rixadone AF
8794W NP	risperidone 2 mg tablet: orally disintegrating, 28	2	5	..	*41.30	36.90	Risperdal Quicklet JC
3171X NP	risperidone 3 mg tablet, 60	1	5	..	56.73	36.90	^a APO-Risperidone TX
							^a Ozidal RA
							^a Rispa QA
							^a Risperdal JC
							^a Rispericor 3 CR
							^a Risperidone Actavis 3 UA
							^a Risperidone AN EA
							^a Risperidone-DRLA RZ
							^a Risperidone-GA GN
							^a Risperidone generichealth GQ
							^a Risperidone Sandoz SZ
							^a Rispernia ER
							^a Rixadone AF
9075P NP	risperidone 3 mg tablet: orally disintegrating, 28	2	5	..	*55.90	36.90	Risperdal Quicklet JC
3172Y NP	risperidone 4 mg tablet, 60	1	5	..	74.22	36.90	^a APO-Risperidone TX
							^a Ozidal RA
							^a Rispa QA
							^a Risperdal JC
							^a Rispericor 4 CR

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Risperidone AN	EA
							^a Risperidone-DRLA	RZ
							^a Risperidone-GA	GN
							^a Risperidone generichealth	GQ
							^a Risperidone Sandoz	SZ
							^a Rispernia	ER
							^a Rixadone	AF
9076Q NP	risperidone 4 mg tablet: orally disintegrating, 28	2	5	..	*72.16	36.90	Risperdal Quicklet	JC
RISPERIDONE								
<u>Authority required (STREAMLINED)</u>								
2061								
Behavioural disturbances characterised by psychotic symptoms and aggression in patients with dementia where non-pharmacological methods have been unsuccessful								
<u>Authority required (STREAMLINED)</u>								
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								
<u>Caution</u>								
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.								
<u>Note</u>								
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.								
8789N NP	risperidone 1 mg tablet, 60	1	2	..	21.57	22.72	^a APO-Risperidone	TX
							^a Ozidal	RA
							^a Rispa	QA
							^a Risperdal	JC
							^a Rispericor 1	CR
							^a Risperidone AN	EA
							^a Risperidone-DRLA	RZ
							^a Risperidone-GA	GN
							^a Risperidone generichealth	GQ
							^a Risperidone Sandoz	SZ
							^a Rispernia	ER
							^a Rixadone	AF
8790P NP	risperidone 1 mg tablet: orally disintegrating, 28	2	2	..	*23.94	25.09	Risperdal Quicklet	JC
9293D NP	risperidone 1 mg/mL oral liquid, 100 mL	#1	2	..	118.37	36.90	Risperdal	JC
8788M NP	risperidone 500 microgram tablet: orally disintegrating, 28	2	2	..	*15.36	16.51	Risperdal Quicklet	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

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
9079W NP	risperidone 2 mg tablet, 60	1	2	..	40.64	36.90	^a APO-Risperidone	TX
							^a Ozidal	RA
							^a Rispa	QA
							^a Risperdal	JC
							^a Rispericor 2	CR
							^a Risperidone Actavis 2	UA
							^a Risperidone AN	EA
							^a Risperidone-DRLA	RZ
							^a Risperidone-GA	GN
							^a Risperidone generichealth	GQ
							^a Risperidone Sandoz	SZ
							^a Rispernia	ER
							^a Rixadone	AF
9080X NP	risperidone 2 mg tablet: orally disintegrating, 28	2	2	..	*41.30	36.90	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.

8780D NP	risperidone 25 mg injection: modified release [1 x 25 mg vial] (&) inert substance diluent [1 x 2 mL syringe], 1 pack	2	5	..	*277.44	36.90	Risperdal Consta	JC
8781E NP	risperidone 37.5 mg injection: modified release [1 x 37.5 mg vial] (&) inert substance diluent [1 x 2 mL syringe], 1 pack	2	5	..	*353.78	36.90	Risperdal Consta	JC
8782F NP	risperidone 50 mg injection: modified release [1 x 50 mg vial] (&) inert substance diluent [1 x 2 mL syringe], 1 pack	2	5	..	*429.32	36.90	Risperdal Consta	JC

RISPERIDONE

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.

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

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.

Note

For item codes 8787L and 1842Y, pharmaceutical benefits that have the form tablet 0.5 mg are equivalent for the purposes of substitution.

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.

1842Y NP	risperidone 500 microgram tablet, 20	3	2	..	*14.44	15.59	^a	APO-Risperidone	TX
							^a	Risperdal	JC
8787L NP	risperidone 500 microgram tablet, 60	1	2	..	14.44	15.59	^a	Ozidal	RA
							^a	Rispa	QA
							^a	Rispericor 0.5	CR
							^a	Risperidone AN	EA
							^a	Risperidone-DRLA	RZ
							^a	Risperidone-GA	GN
							^a	Risperidone GH	GQ
							^a	Risperidone Sandoz	SZ
							^a	Rispernia	ER
							^a	Rixadone	AF

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.

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.

1846E NP	risperidone 500 microgram tablet, 20	3	5	..	*14.44	15.59	^a	APO-Risperidone	TX
							^a	Risperdal	JC
8869T NP	risperidone 500 microgram tablet, 60	1	5	..	14.44	15.59	^a	Ozidal	RA
							^a	Rispa	QA
							^a	Rispericor 0.5	CR
							^a	Risperidone AN	EA
							^a	Risperidone-DRLA	RZ
							^a	Risperidone-GA	GN
							^a	Risperidone GH	GQ
							^a	Risperidone Sandoz	SZ
							^a	Rispernia	ER
							^a	Rixadone	AF

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.

8870W NP	risperidone 500 microgram tablet: orally disintegrating, 28	2	5	..	*15.36	16.51		Risperdal Quicklet	JC

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
ANXIOLYTICS								
<i>Benzodiazepine derivatives</i>								
ALPRAZOLAM								
<u>Authority required</u>								
Panic disorder where other treatments have failed or are inappropriate								
2132F NP	alprazolam 1 mg tablet, 50	1	2	..	14.75	15.90	^a Alprax 1	QA
							^a Chem mart Alprazolam	CH
							^a GenRx Alprazolam	GX
							^a Kalma 1	AF
							^a Terry White Chemists Alprazolam	TW
8118G NP	alprazolam 2 mg tablet, 50	1	2	..	17.66	18.81	^a Alprax 2	QA
							^a Chem mart Alprazolam	CH
							^a GenRx Alprazolam	GX
							^a Kalma 2	AF
							^a Terry White Chemists Alprazolam	TW
2130D NP	alprazolam 250 microgram tablet, 50	1	..	..	11.34	12.49	^a Alprax 0.25	QA
							^a Kalma 0.25	AF
2131E NP	alprazolam 500 microgram tablet, 50	1	..	..	12.51	13.66	^a Alprax 0.5	QA
							^a Kalma 0.5	AF
DIAZEPAM								
<u>Authority required</u>								
Chronic spasticity								
Population criteria:								
Patient must be under 18 years of age.								
2669L NP	diazepam 1 mg/mL oral liquid, 100 mL	\$1	..	..	43.12	36.90	Diazepam Elixir	ON
DIAZEPAM								
<u>Note</u>								
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.								
2558P NP	diazepam 10 mg/2 mL injection, 5 x 2 mL ampoules	1	..	..	13.68	14.83	Hospira Pty Limited	HH
3161J NP	diazepam 2 mg tablet, 50	1	..	..	7.92	9.07	^a Antenex 2	AF
							^a APO-Diazepam	TX
							^a Ranzepam	RA
							^a Valpam 2	QA
3162K NP	diazepam 5 mg tablet, 50	1	..	..	8.04	9.19	^a Antenex 5	AF
							^a APO-Diazepam	TX
							^a Diazepam-GA	GN
							^a Ranzepam	RA
							^a Valpam 5	QA
				^b 0.76	8.80	9.19	^a Valium	RO
DIAZEPAM								
5073B	diazepam 10 mg/2 mL injection, 5 x 2	1	..	..	13.68	14.83	Hospira Pty Limited	HH

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
<i>DP</i> 5071X	mL ampoules diazepam 2 mg tablet, 50	1	..	..	7.92	9.07	^a Antenex 2	AF
<i>DP</i>							^a APO-Diazepam	TX
							^a Ranzepam	RA
							^a Valpam 2	QA
5072Y	diazepam 5 mg tablet, 50	1	..	..	8.04	9.19	^a Antenex 5	AF
<i>DP</i>							^a APO-Diazepam	TX
							^a Diazepam-GA	GN
							^a Ranzepam	RA
							^a Valpam 5	QA
				^b 0.76	8.80	9.19	^a Valium	RO

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.

3132W	oxazepam 15 mg tablet, 25	1	..	..	8.00	9.15	^a Alepam 15	AF
<i>NP</i>				^b 2.68	10.68	9.15	^a Serepax	QA
3133X	oxazepam 30 mg tablet, 25	1	..	..	8.00	9.15	^a Alepam 30	AF
<i>NP</i>							^a APO-Oxazepam	TX
							^a Murelax	FM
				^b 2.68	10.68	9.15	^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

3134Y	oxazepam 15 mg tablet, 25	2	5	..	*9.24	10.39	^a Alepam 15	AF
<i>NP</i>				^b 5.36	*14.60	10.39	^a Serepax	QA
3135B	oxazepam 30 mg tablet, 25	2	5	..	*9.24	10.39	^a Alepam 30	AF
<i>NP</i>							^a APO-Oxazepam	TX
							^a Murelax	FM
				^b 5.36	*14.60	10.39	^a Serepax	QA

OXAZEPAM

5192G	oxazepam 15 mg tablet, 25	1	..	..	8.00	9.15	^a Alepam 15	AF
<i>DP</i>				^b 2.68	10.68	9.15	^a Serepax	QA
5193H	oxazepam 30 mg tablet, 25	1	..	..	8.00	9.15	^a Alepam 30	AF
<i>DP</i>							^a APO-Oxazepam	TX
							^a Murelax	FM
				^b 2.68	10.68	9.15	^a Serepax	QA

HYPNOTICS AND SEDATIVES

Benzodiazepine derivatives

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.

2723H	nitrazepam 5 mg tablet, 25	1	..	..	8.35	9.50	^a Alodorm	AF
<i>NP</i>				^b 1.24	9.59	9.50	^a Mogadon	IA

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
NITRAZEPAM								
<u>Authority required</u>								
Myoclonic epilepsy								
<u>Authority required</u>								
Malignant neoplasia (late stage)								
<u>Authority required</u>								
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								
<u>Authority required</u>								
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								
<u>Note</u>								
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.								
2732T NP	nitrazepam 5 mg tablet, 25	2	5	..	*9.94	11.09	^a Alodorm	AF
				^b 2.48	*12.42	11.09	^a Mogadon	IA
NITRAZEPAM								
5189D DP	nitrazepam 5 mg tablet, 25	1	..	..	8.35	9.50	^a Alodorm	AF
				^b 1.24	9.59	9.50	^a Mogadon	IA
TEMAZEPAM								
<u>Authority required</u>								
Malignant neoplasia (late stage)								
<u>Authority required</u>								
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								
<u>Authority required</u>								
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								
<u>Note</u>								
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.								
2088X NP	temazepam 10 mg tablet, 25	2	5	..	*8.62	9.77	^a APO-Temazepam	TX
							^a Temaze	AF
							^a Temtabs	FM
				^b 8.00	*16.62	9.77	^a Normison	QA
TEMAZEPAM								
<u>Note</u>								
Authorities for increased maximum quantities and/or repeats will not be granted except as detailed under the 'Authority required' listing of temazepam below.								
2089Y NP	temazepam 10 mg tablet, 25	1	..	..	7.69	8.84	^a APO-Temazepam	TX
							^a Temaze	AF
							^a Temtabs	FM
				^b 4.00	11.69	8.84	^a Normison	QA
TEMAZEPAM								
5221T DP	temazepam 10 mg tablet, 25	1	..	..	7.69	8.84	^a APO-Temazepam	TX
							^a Temaze	AF
							^a Temtabs	FM
				^b 4.00	11.69	8.84	^a Normison	QA

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

2417F NP	amitriptyline hydrochloride 10 mg tablet, 50	1	2	..	9.65	10.80	Endep 10	AF
2418G NP	amitriptyline hydrochloride 25 mg tablet, 50	1	2	..	9.87	11.02	Endep 25	AF
2429W NP	amitriptyline hydrochloride 50 mg tablet, 50	1	2	..	10.33	11.48	Endep 50	AF

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.

1561E NP	clomipramine hydrochloride 25 mg tablet, 50	1	2	..	14.49	15.64	^a Chem mart Clomipramine	CH
							^a GenRx Clomipramine	GX
							^a Placil	AF
							^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.

1357K NP	dothiepin hydrochloride 25 mg capsule, 50	1	2	..	9.72	10.87	Dothep 25	AF
1358L NP	dothiepin hydrochloride 75 mg tablet, 30	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.

1011F NP	doxepin 10 mg capsule, 50	1	2	..	10.26	11.41	Deptran 10	AF
				^b 2.86	13.12	11.41	Sinequan	PF
1013H NP	doxepin 25 mg capsule, 50	1	2	..	10.39	11.54	Deptran 25	AF
				^b 2.73	13.12	11.54	Sinequan	PF
1012G NP	doxepin 50 mg tablet, 50	1	2	..	11.36	12.51	Deptran 50	AF

IMIPRAMINE

Note

Continuing Therapy Only:

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
2420J NP	imipramine hydrochloride 10 mg tablet, 50	1	2	..	8.88	10.03	^a Tolerade 10	PQ
				^B 2.79	11.67	10.03	^a Tofranil 10	LM
2421K NP	imipramine hydrochloride 25 mg tablet, 50	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.

2522R NP	nortriptyline 10 mg tablet, 50	1	2	..	13.66	14.81	Allegron	AS
2523T NP	nortriptyline 25 mg tablet, 50	1	2	..	15.44	16.59	Allegron	AS

Selective serotonin reuptake inhibitors

CITALOPRAM

Restricted benefit

Major depressive disorders

8702B NP	citalopram 10 mg tablet, 28	1	5	..	8.39	9.54	^a Celapram	AF
							^a Citalopram Actavis	UA
							^a Citalopram-GA	GN
8220P NP	citalopram 20 mg tablet, 28	1	5	..	9.23	10.38	^a APO-Citalopram	TX
							^a Auro-Citalopram 20	DO
							^a Celapram	AF
							^a Celica	RA
							^a Chem mart Citalopram	CH
							^a Ciazil	UA
							^a Citalopram AN	EA
							^a Citalopram-GA	GN
							^a Citalopram generichealth	GQ
							^a Citalopram Sandoz	SZ
							^a Pharmacor Citalo 20	CR
							^a Talam	QA
							^a Terry White Chemists Citalopram	TW
8703C NP	citalopram 40 mg tablet, 28	1	5	^B 3.66	12.89	10.38	^a Cipramil	LU
				..	10.95	12.10	^a APO-Citalopram	TX
							^a Auro-Citalopram 40	DO
							^a Celapram	AF
							^a Citalopram AN	EA
							^a Citalopram-GA	GN
							^a Citalopram Sandoz	SZ

ESCITALOPRAM

Restricted benefit

Major depressive disorders

8700X NP	escitalopram 10 mg tablet, 28	1	5	..	12.59	13.74	^a APO-Escitalopram	TX
							^a Chem mart Escitalopram	CH
							^a Cilopam-S	ER

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
8701Y NP	escitalopram 20 mg tablet, 28	1	5	..	12.65	13.80	^a Escicor 10	RA
							^a Escitalopram AN	EA
							^a Escitalopram-DRLA	RZ
							^a Escitalopram GA	GN
							^a Escitalopram generichealth	GQ
							^a Esipram	UA
							^a Esitalo	SZ
							^a Lexam 10	QA
							^a LoxaLate	AF
							^a Pharmacor	CR
							^a Escitalopram 10	
							^a Terry White Chemists	TW
							^a Escitalopram	
							^a Lexapro	LU
							^a APO-Escitalopram	TX
							^a Chem mart	CH
							^a Escitalopram	
							^a Cilopam-S	ER
							^a Escicor 20	RA
							^a Escitalopram AN	EA
							^a Escitalopram-DRLA	RZ
							^a Escitalopram GA	GN
							^a Escitalopram generichealth	GQ
							^a Esipram	UA
							^a Esitalo	SZ
							^a Lexam 20	QA
							^a LoxaLate	AF
							^a Pharmacor	CR
							^a Escitalopram 20	
							^a Terry White Chemists	TW
							^a Escitalopram	
							^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,

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
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.							
<u>Restricted benefit</u>							
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.							
9432K NP	escitalopram 10 mg tablet, 28	1	5	..	12.59	13.74 ^a	Esipram UA
				^B 5.96	18.55	13.74 ^a	Lexapro LU
9433L NP	escitalopram 20 mg tablet, 28	1	5	..	12.65	13.80 ^a	Esipram UA
				^B 6.86	19.51	13.80 ^a	Lexapro LU
ESCITALOPRAM							
<u>Restricted benefit</u>							
Major depressive disorders							
<u>Restricted benefit</u>							
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.							
<u>Restricted benefit</u>							
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.							
<u>Restricted benefit</u>							
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.							
<u>Restricted benefit</u>							
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							

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	Patient must have been assessed by a psychiatrist.							
8849R NP	escitalopram 10 mg/mL oral liquid, 28 mL	#1	5	..	34.64	35.79	Lexapro	LU
10181W NP	escitalopram 20 mg/mL oral liquid, 15 mL	#1	5	..	36.63	36.90	Lexapro	LU
	FLUOXETINE							
	<u>Restricted benefit</u>							
	Major depressive disorders							
	<u>Restricted benefit</u>							
	Obsessive-compulsive disorder							
1434L NP	fluoxetine 20 mg capsule, 28	1	5	..	13.21	14.36	^a Auscap Aspen	QA
							^a Chem mart Fluoxetine	CH
							^a Fluoxetine 20	CR
							^a Fluoxetine AN	EA
							^a Fluoxetine-GA	GN
							^a Fluoxetine generichealth	GQ
							^a Fluoxetine RBX	RA
							^a Fluoxetine Sandoz	SZ
							^a GenRx Fluoxetine	GX
							^a Lovan	AL
							^a Terry White Chemists Fluoxetine	TW
							^a Zactin	AF
				^B 2.06	15.27	14.36	^a Prozac 20	LY
8270G NP	fluoxetine 20 mg tablet: dispersible, 28	1	5	..	13.21	14.36	^a Lovan 20 Tab	AL
							^a Zactin Tablet	AF
				^B 2.06	15.27	14.36	^a Prozac Tab	LY
	FLUVOXAMINE							
	<u>Restricted benefit</u>							
	Major depressive disorders							
	<u>Restricted benefit</u>							
	Obsessive-compulsive disorder							
8174F NP	fluvoxamine maleate 100 mg tablet, 30	1	5	..	19.33	20.48	^a APO-Fluvoxamine	TX
							^a Faverin 100	QA
							^a Fluvoxamine GA	GN
							^a Movox 100	AF
							^a Voxam	SZ
				^B 3.50	22.83	20.48	^a Luvox	AB
8512B NP	fluvoxamine maleate 50 mg tablet, 30	1	5	..	15.05	16.20	^a APO-Fluvoxamine	TX
							^a Faverin 50	QA
							^a Fluvoxamine GA	GN
							^a Movox 50	AL
							^a Voxam	SZ
				^B 3.50	18.55	16.20	^a Luvox	AB
	PAROXETINE							
	<u>Restricted benefit</u>							
	Major depressive disorders							
	<u>Restricted benefit</u>							
	Obsessive-compulsive disorder							
	<u>Restricted benefit</u>							
	Panic disorder							
	<u>Note</u>							
	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.							
2242B	paroxetine 20 mg tablet, 30	1	5	..	12.44	13.59	^a Chem mart Paroxetine	CH

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
NP							
							^a Extine 20 QA
							^a GenRx Paroxetine GX
							^a Paroxetine AN EA
							^a Paroxetine-GA GN
							^a Paroxetine Sandoz SZ
							^a Paxtine AF
							^a Roxet 20 DO
							^a Terry White Chemists Paroxetine TW
				^b 2.52	14.96	13.59	^a Aropax AS
9197C NP	paroxetine 20 mg tablet, 30	1	5	..	12.44	13.59	^a Paroxetine generichealth GQ
	SERTRALINE						
	<u>Restricted benefit</u>						
	Major depressive disorders						
2237R NP	sertraline 100 mg tablet, 30	1	5	..	10.16	11.31	^a APO-Sertraline TX
							^a Auro-Sertraline 100 DO
							^a Chem mart Sertraline CH
							^a Eleva 100 AF
							^a GenRx Sertraline GX
							^a Sertra 100 QA
							^a Sertracor 100 CR
							^a Sertraline Actavis UA
							^a Sertraline AN EA
							^a Sertraline-DRLA RZ
							^a Sertraline generichealth GQ
							^a Sertraline Sandoz SZ
							^a Setrona RA
							^a Terry White Chemists Sertraline TW
							^a Xydep 100 GN
				^b 0.71	10.87	11.31	^a Zoloft PF
2236Q NP	sertraline 50 mg tablet, 30	1	5	..	10.16	11.31	^a APO-Sertraline TX
							^a Auro-Sertraline 50 DO
							^a Chem mart Sertraline CH
							^a Eleva 50 AF
							^a GenRx Sertraline GX
							^a Sertra 50 QA
							^a Sertracor 50 CR
							^a Sertraline Actavis UA
							^a Sertraline AN EA
							^a Sertraline-DRLA RZ
							^a Sertraline generichealth GQ
							^a Sertraline Sandoz SZ
							^a Setrona RA
							^a Terry White Chemists Sertraline TW
							^a Xydep 50 GN
				^b 0.71	10.87	11.31	^a Zoloft PF
	SERTRALINE						
	<u>Restricted benefit</u>						
	Obsessive-compulsive disorder						
	<u>Restricted benefit</u>						
	Panic disorder where other treatments have failed or are inappropriate						
8837D NP	sertraline 100 mg tablet, 30	1	5	..	10.16	11.31	^a Auro-Sertraline 100 DO
							^a Eleva 100 AF
							^a Sertraline Actavis UA
							^a Sertraline AN EA

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
8836C NP	sertraline 50 mg tablet, 30	1	5	^B 0.71	10.87	11.31	^a Xydep 100	GN
				..	10.16	11.31	^a Zoloft	PF
							^a Auro-Sertraline 50	DO
							^a Eleva 50	AF
							^a Sertraline Actavis	UA
							^a Sertraline AN	EA
							^a Xydep 50	GN
				^B 0.71	10.87	11.31	^a Zoloft	PF

Monoamine oxidase inhibitors, non-selective

PHENELZINE

Restricted benefit

Depression where all other anti-depressant therapy has failed or is inappropriate

Caution

This drug is an irreversible monoamine oxidase inhibitor.

2856H	phenelzine 15 mg tablet, 100	1	1	..	100.44	36.90	Nardil	LM

TRANLYCYPROMINE

Caution

This drug is an irreversible monoamine oxidase inhibitor.

2444P	tranylcypromine 10 mg tablet, 50	1	2	..	58.66	36.90	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.

1900B NP	moclobemide 150 mg tablet, 60	1	5	..	13.89	15.04	^a Amira 150	AF
							^a Chem mart	CH
							Moclobemide	
							^a Clobemix	GN
							^a GenRx Moclobemide	GX
							^a Moclobemide AN	EA
							^a Moclobemide Sandoz	SZ
							^a Mohexal	HX
8003F NP	moclobemide 300 mg tablet, 60	1	5	..	20.50	21.65	^a Terry White Chemists	TW
							Moclobemide	
							^a Aurorix	HM
							^a Amira 300	AF
							^a Chem mart	CH
							Moclobemide	
							^a Clobemix	GN
							^a GenRx Moclobemide	GX
							^a Moclobemide AN	EA
							^a Moclobemide Sandoz	SZ
							^a Terry White Chemists	TW
							Moclobemide	
				^B 0.83	21.33	21.65	^a Aurorix 300 mg	HM

Other antidepressants

DESVENLAFAXINE

Restricted benefit

Major depressive disorders

Note

Continuing Therapy Only:

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

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.

9367B NP	desvenlafaxine 100 mg tablet: modified release, 28 tablets	1	5	..	48.75	36.90	Pristiq	PF
9366Y NP	desvenlafaxine 50 mg tablet: modified release, 28 tablets	1	5	..	41.78	36.90	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.

9155W NP	duloxetine 30 mg capsule: enteric, 28	1	..	..	23.90	25.05	^a Andepra	EL
							^a APO-Duloxetine	TX
							^a Chem mart Duloxetine	CH
							^a Coperin	AF
							^a Cymbalta	LY
							^a Deotine 30	SZ
							^a Drulox	GN
							^a Duloxetine AN	EA
							^a Duloxetine-DRLA	RZ
							^a Duloxetine GH	GQ
							^a Duloxetine RBX	RA
							^a Pharmacor Duloxetine 30	CR
							^a Terry White Chemists Duloxetine	TW
9156X NP	duloxetine 60 mg capsule: enteric, 28	1	5	..	31.24	32.39	^a Andepra	EL
							^a APO-Duloxetine	TX
							^a Chem mart Duloxetine	CH
							^a Coperin	AF
							^a Cymbalta	LY
							^a Deotine 60	SZ
							^a Drulox	GN
							^a Duloxetine AN	EA
							^a Duloxetine-DRLA	RZ
							^a Duloxetine GH	GQ
							^a Duloxetine RBX	RA
							^a Pharmacor Duloxetine 60	CR
							^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.

3059B NP	lithium carbonate 250 mg tablet, 200	1	2	..	17.23	18.38	Lithicarb	AS
8290H NP	lithium carbonate 450 mg tablet: modified release, 100 tablets	2	2	..	*34.64	35.79	Quilonum SR	AS

MIANSERIN

Restricted benefit

Severe depression

Caution

Neutropenia and agranulocytosis are more frequent in the elderly, especially in the early months of therapy.

Note

Continuing Therapy Only:

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
1627P NP	mianserin hydrochloride 10 mg tablet, 50	1	5	..	15.73	16.88	^a Lumin 10	AF
				^B 3.29	19.02	16.88	^a Tolvon	MK
1628Q NP	mianserin hydrochloride 20 mg tablet, 50	1	5	..	25.68	26.83	Lumin 20	AF
MIRTAZAPINE								
<u>Restricted benefit</u>								
Major depressive disorders								
<u>Note</u>								
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.								
8855C NP	MIRTAZAPINE Tablet 15 mg (orally disintegrating), 30	1	5	..	14.70	15.85	^a Milivin OD 15	DO
							^a Mirtazapine AN ODT	EA
							^a Mirtazapine Sandoz ODT 15	SZ
				^B 1.20	15.90	15.85	^a Remeron SolTab	FR
8856D NP	MIRTAZAPINE Tablet 30 mg (orally disintegrating), 30	1	5	..	17.34	18.49	^a Avanza SolTab	MK
							^a Milivin OD 30	DO
							^a Mirtazapine AN ODT	EA
							^a Mirtazapine Sandoz ODT 30	SZ
				^B 1.20	18.54	18.49	^a Remeron SolTab	FR
8857E NP	MIRTAZAPINE Tablet 45 mg (orally disintegrating), 30	1	5	..	22.71	23.86	^a Avanza SolTab	MK
							^a Milivin OD 45	DO
							^a Mirtazapine AN ODT	EA
							^a Mirtazapine Sandoz ODT 45	SZ
				^B 1.20	23.91	23.86	^a Remeron SolTab	FR
9365X NP	mirtazapine 15 mg tablet, 30	1	5	..	11.36	12.51	^a Avanza SolTab	MK
							^a APO-Mirtazapine	TX
							^a Axit 15	AF
8513C NP	mirtazapine 30 mg tablet, 30	1	5	..	13.66	14.81	^a Mirtazapine AN	EA
							^a APO-Mirtazapine	TX
							^a Aurozapine 30	DO
							^a Axit 30	AF
							^a Chem mart Mirtazapine	CH
							^a GenRx Mirtazapine	GX
							^a Mirtazapine AN	EA
							^a Mirtazapine-GA	GN
							^a Mirtazapine GH	GQ
							^a Mirtazapine Sandoz	SZ
							^a Mirtazon	QA
							^a Terry White Chemists Mirtazapine	TW
				^B 3.50	17.16	14.81	^a Avanza	MK
8883M NP	mirtazapine 45 mg tablet, 30	1	5	..	18.27	19.42	^a APO-Mirtazapine	TX
							^a Aurozapine 45	DO
							^a Axit 45	AF
							^a Chem mart Mirtazapine	CH
							^a Mirtazapine AN	EA
							^a Mirtazapine-GA	GN
							^a Mirtazapine GH	GQ
							^a Mirtazapine Sandoz	SZ
							^a Mirtazon	QA
							^a Terry White Chemists	TW

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
				^a 3.50	21.77	19.42	^a Mirtazapine Avanza	MK
REBOXETINE								
<u>Restricted benefit</u>								
Major depressive disorders								
<u>Note</u>								
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.								
8583R NP	reboxetine 4 mg tablet, 60	1	5	..	39.10	36.90	Edronax	PF
VENLAFAXINE								
<u>Restricted benefit</u>								
Major depressive disorders								
<u>Note</u>								
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.								
8302Y NP	venlafaxine 150 mg capsule: modified release, 28 capsules	1	5	..	22.25	23.40	^a Altven	FZ
							^a APO-Venlafaxine XR	TX
							^a Chem mart Venlafaxine XR	CH
							^a Efexor-XR	PF
							^a Elaxine SR 150	ZP
							^a Enlafax-XR	AF
							^a Terry White Chemists Venlafaxine XR	TW
							^a Venlafaxine Actavis XR	UA
							^a Venlafaxine AN SR	EA
							^a Venlafaxine generichealth XR	GQ
							^a Venlafaxine Sandoz XR	SZ
							^a Venlafaxine SR SCP 150	CR
							^a Venla RBX	RA
							^a Venlexor XR	GN
8868R NP	venlafaxine 37.5 mg capsule: modified release, 28 capsules	1	..	..	13.96	15.11	^a Altven	FZ
							^a Efexor-XR	PF
							^a Elaxine SR 37.5	ZP
							^a Venlafaxine Actavis XR	UA
							^a Venlafaxine AN SR	EA
8301X NP	venlafaxine 75 mg capsule: modified release, 28 capsules	1	5	..	19.46	20.61	^a Altven	FZ
							^a APO-Venlafaxine XR	TX
							^a Chem mart Venlafaxine XR	CH
							^a Efexor-XR	PF
							^a Elaxine SR 75	ZP
							^a Enlafax-XR	AF
							^a Terry White Chemists Venlafaxine XR	TW
							^a Venlafaxine Actavis XR	UA
							^a Venlafaxine AN SR	EA
							^a Venlafaxine generichealth XR	GQ
							^a Venlafaxine Sandoz XR	SZ
							^a Venlafaxine SR SCP 75	CR
							^a Venla RBX	RA
							^a Venlexor XR	GN

PSYCHOSTIMULANTS, AGENTS USED FOR ADHD AND NOOTROPICS

Centrally acting sympathomimetics

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
ATOMOXETINE							
<u>Authority required (STREAMLINED)</u>							
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.							
<u>Authority required (STREAMLINED)</u>							
4578							
Attention deficit hyperactivity disorder							
Treatment Phase: Continuing treatment							
Clinical criteria:							
Patient must have previously been issued with an authority prescription for this drug.							
<u>Note</u>							
No increase in the maximum quantity or number of units may be authorised.							
<u>Note</u>							
No increase in the maximum number of repeats may be authorised.							
9092M	atomoxetine 10 mg capsule, 28	2	5	..	*221.52	36.90	Strattera LY
9290Y	atomoxetine 100 mg capsule, 28	1	5	..	147.45	36.90	Strattera LY
9093N	atomoxetine 18 mg capsule, 28	2	5	..	*221.52	36.90	Strattera LY
9094P	atomoxetine 25 mg capsule, 28	2	5	..	*221.52	36.90	Strattera LY
9095Q	atomoxetine 40 mg capsule, 28	2	5	..	*221.52	36.90	Strattera LY
9096R	atomoxetine 60 mg capsule, 28	2	5	..	*221.52	36.90	Strattera LY
9289X	atomoxetine 80 mg capsule, 28	1	5	..	147.45	36.90	Strattera LY
DEXAMPHETAMINE							
<u>Authority required</u>							
Use in attention deficit hyperactivity disorder, in accordance with State/Territory law							
<u>Authority required</u>							
Narcolepsy							
<u>Note</u>							
Care must be taken to comply with the provisions of State/Territory law when prescribing dexamphetamine.							
<u>Note</u>							
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.							
1165H NP	dexamphetamine sulfate 5 mg tablet, 100	1	5	..	18.53	19.68	Aspen Pharma Pty Ltd QA
METHYLPHENIDATE							
<u>Authority required</u>							

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.

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.

3440C NP	methylphenidate hydrochloride 10 mg capsule: modified release, 30 capsules	1	5	..	34.39	35.54	Ritalin LA	NV
2276T NP	methylphenidate hydrochloride 20 mg capsule: modified release, 30 capsules	1	5	..	44.91	36.90	Ritalin LA	NV
2280B NP	methylphenidate hydrochloride 30 mg capsule: modified release, 30 capsules	1	5	..	52.37	36.90	Ritalin LA	NV
2283E NP	methylphenidate hydrochloride 40 mg capsule: modified release, 30 capsules	1	5	..	54.90	36.90	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.

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.

8839F NP	methylphenidate hydrochloride 10 mg tablet, 100	1	5	..	17.23	18.38	Ritalin 10	NV

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.

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.

2387P NP	methylphenidate hydrochloride 18 mg tablet: modified release, 30 tablets	1	5	..	51.66	36.90	Concerta	JC
2172H NP	methylphenidate hydrochloride 27 mg tablet: modified release, 30 tablets	1	5	..	55.80	36.90	Concerta	JC
2388Q NP	methylphenidate hydrochloride 36 mg tablet: modified release, 30 tablets	1	5	..	60.03	36.90	Concerta	JC
2432B NP	methylphenidate hydrochloride 54 mg tablet: modified release, 30 tablets	1	5	..	70.09	36.90	Concerta	JC

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.

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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 <u>Authority required</u> Continuing treatment of narcolepsy, where the patient has previously been issued with an authority prescription for this drug <u>Note</u> 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. <u>Note</u> Modafinil is not PBS-subsidised when used in combination with PBS-subsidised dexamphetamine sulfate.						
8816B	modafinil 100 mg tablet, 60	2	5	..	*347.32	36.90	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:

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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.						
2479L NP	donepezil hydrochloride 10 mg tablet, 28	1	5	..	39.64	36.90	a APO-Donepezil TX a Arazil AF a Aricept PF a Aridon 10 QA a Aridon APN 10 FM a Chem mart Donepezil CH a Donepezil AN EA a Donepezil-DRLA RZ a Donepezil-GA GN a Donepezil GQ generichealth a Donepezil RBX RA a Donepezil Sandoz SZ a Pharmacor Donepezil 10 CR a Terry White Chemists Donepezil TW
2532G NP	donepezil hydrochloride 5 mg tablet, 28	1	5	..	39.64	36.90	a APO-Donepezil TX a Arazil AF a Aricept PF a Aridon 5 QA a Aridon APN 5 FM a Chem mart Donepezil CH a Donepezil AN EA a Donepezil-DRLA RZ a Donepezil-GA GN a Donepezil GQ generichealth a Donepezil RBX RA a Donepezil Sandoz SZ a Pharmacor Donepezil 5 CR 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.

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
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.							
8496E NP	donepezil hydrochloride 10 mg tablet, 28	1	5	..	39.64	36.90	a APO-Donepezil TX a Arazil AF a Aricept PF a Aridon 10 QA a Aridon APN 10 FM a Chem mart Donepezil CH a Donepezil AN EA a Donepezil-DRLA RZ a Donepezil-GA GN a Donepezil generichealth GQ a Donepezil RBX RA a Donepezil Sandoz SZ a Pharmacor Donepezil 10 CR a Terry White Chemists Donepezil TW
8495D NP	donepezil hydrochloride 5 mg tablet, 28	1	5	..	39.64	36.90	a APO-Donepezil TX a Arazil AF a Aricept PF a Aridon 5 QA a Aridon APN 5 FM a Chem mart Donepezil CH a Donepezil AN EA a Donepezil-DRLA RZ a Donepezil-GA GN a Donepezil generichealth GQ

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Donepezil RBX	RA
							^a Donepezil Sandoz	SZ
							^a Pharmacor Donepezil 5	CR
							^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.

2537M NP	galantamine 16 mg capsule: modified release, 28 capsules	1	5	..	51.20	36.90	^a APO-Galantamine MR	TX
							^a Galantamine AN SR	EA
							^a Galantyl	AF
							^a Gamine XR	QA
							^a Reminyl	JC
2531F NP	galantamine 24 mg capsule: modified release, 28 capsules	1	5	..	59.12	36.90	^a APO-Galantamine MR	TX
							^a Galantamine AN SR	EA
							^a Galantyl	AF
							^a Gamine XR	QA
							^a Reminyl	JC
2463P NP	galantamine 8 mg capsule: modified release, 28 capsules	1	5	..	43.91	36.90	^a APO-Galantamine MR	TX
							^a Galantamine AN SR	EA
							^a Galantyl	AF
							^a Gamine XR	QA
							^a Reminyl	JC

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.

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
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. <u>Authority required</u> 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. <u>Note</u> 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.							
8771P NP	galantamine 16 mg capsule: modified release, 28 capsules	1	5	..	51.20	36.90	^a APO-Galantamine MR TX ^a Galantamine AN SR EA ^a Galantyl AF ^a Gamine XR QA ^a Reminyl JC
8772Q NP	galantamine 24 mg capsule: modified release, 28 capsules	1	5	..	59.12	36.90	^a APO-Galantamine MR TX ^a Galantamine AN SR EA ^a Galantyl AF ^a Gamine XR QA ^a Reminyl JC
8770N NP	galantamine 8 mg capsule: modified release, 28 capsules	1	5	..	43.91	36.90	^a APO-Galantamine MR TX ^a Galantamine AN SR EA ^a Galantyl AF ^a Gamine XR QA ^a Reminyl JC

RIVASTIGMINE

Authority required (STREAMLINED)

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.							
2475G NP	rivastigmine 1.5 mg capsule, 56	1	5	..	96.18	36.90	Exelon	NV
2476H NP	rivastigmine 2 mg/mL oral liquid, 120 mL	1	5	..	96.18	36.90	Exelon	NV
2493F NP	rivastigmine 3 mg capsule, 56	1	5	..	96.18	36.90	Exelon	NV
2494G NP	rivastigmine 4.5 mg capsule, 56	1	5	..	96.18	36.90	Exelon	NV
2477J NP	rivastigmine 4.6 mg/24 hours patch, 30	1	5	..	102.56	36.90	Exelon Patch 5	NV
2526Y NP	rivastigmine 6 mg capsule, 56	1	5	..	96.18	36.90	Exelon	NV
2551G NP	rivastigmine 9.5 mg/24 hours patch, 30	1	5	..	102.56	36.90	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

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
8497F NP	rivastigmine 1.5 mg capsule, 56	1	5	..	96.18	36.90	Exelon	NV
8563Q NP	rivastigmine 2 mg/mL oral liquid, 120 mL	1	5	..	96.18	36.90	Exelon	NV
8498G NP	rivastigmine 3 mg capsule, 56	1	5	..	96.18	36.90	Exelon	NV
8499H NP	rivastigmine 4.5 mg capsule, 56	1	5	..	96.18	36.90	Exelon	NV
9161E NP	rivastigmine 4.6 mg/24 hours patch, 30	1	5	..	102.56	36.90	Exelon Patch 5	NV
8500J NP	rivastigmine 6 mg capsule, 56	1	5	..	96.18	36.90	Exelon	NV
9162F NP	rivastigmine 9.5 mg/24 hours patch, 30	1	5	..	102.56	36.90	Exelon Patch 10	NV

Other anti-dementia drugs

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.

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
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.							
1956Y NP	memantine hydrochloride 10 mg tablet, 56	1	5	..	67.08	36.90	^a APO-Memantine TX
							^a Ebixa LU
							^a Memantine generichealth GQ
							^a Memanxa QA
9306T NP	memantine hydrochloride 20 mg tablet, 28	1	5	..	67.08	36.90	^a APO-Memantine TX
							^a Ebixa LU
							^a Memantine generichealth GQ

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.

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
2492E NP	memantine hydrochloride 10 mg tablet, 56	1	5	..	67.08	36.90	^a APO-Memantine	TX
							^a Ebixa	LU
							^a Memantine generichealth	GQ
							^a Memanxa	QA
2513G NP	memantine hydrochloride 20 mg tablet, 28	1	5	..	67.08	36.90	^a APO-Memantine	TX
							^a Ebixa	LU
							^a Memantine generichealth	GQ

OTHER NERVOUS SYSTEM DRUGS

PARASYMPATHOMIMETICS

Anticholinesterases

PYRIDOSTIGMINE

2724J	PYRIDOSTIGMINE BROMIDE Tablet 10 mg, 50	2	5	..	*23.34	24.49	Mestinon	IA
2608G	pyridostigmine bromide 180 mg tablet: modified release, 50 tablets	2	5	..	*149.56	36.90	Mestinon Timespan	IA
1959D	pyridostigmine bromide 60 mg tablet, 150	1	5	..	71.66	36.90	Mestinon	IA

Choline esters

BETHANECHOL

1062X NP	bethanechol chloride 10 mg tablet, 100	1	2	..	33.87	35.02	Uro-Carb	YN

DRUGS USED IN ADDICTIVE DISORDERS

Drugs used in nicotine dependence

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.

8465M NP	bupropion hydrochloride 150 mg tablet: modified release, 30 tablets	1	..	..	63.34	36.90	^a Prexaton	GN
				^b 0.80	64.14	36.90	^a Zyban	AS

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

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
8710K NP	bupropion hydrochloride 150 mg tablet: modified release, 90 tablets	1	..	..	176.50	36.90	^a Prexaton	GN
				^b 0.96	177.46	36.90	^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.

Note

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

5572G NP	nicotine 14 mg/24 hours patch, 28	1	2	..	55.56	36.90	Nicotinell Step 2	NC
3414Q NP	nicotine 21 mg/24 hours patch, 28	1	2	..	55.56	36.90	Nicotinell Step 1	NC
5573H NP	nicotine 7 mg/24 hours patch, 28	1	2	..	55.56	36.90	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.

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	<u>Note</u> No increase in the maximum quantity or number of units may be authorised.							
	<u>Note</u> No increase in the maximum number of repeats may be authorised.							
	<u>Authority required (STREAMLINED)</u> 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.							
	<u>Note</u> No increase in the maximum quantity or number of units may be authorised.							
	<u>Note</u> No increase in the maximum number of repeats may be authorised.							
	<u>Authority required (STREAMLINED)</u> 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.							
	<u>Note</u> No increase in the maximum quantity or number of units may be authorised.							
	<u>Note</u> No increase in the maximum number of repeats may be authorised.							
5465P NP	nicotine 21 mg/24 hours patch, 28	1	2	..	55.56	36.90	Nicabate P	GC
10076H NP	nicotine 25 mg/16 hours patch, 28	1	2	..	55.56	36.90	nicorette 16hr Invisipatch	JT

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.

Note

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

Note

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
No increase in the maximum number of repeats may be authorised.								
5571F NP	nicotine 21 mg/24 hours patch, 28	1	2	..	55.56	36.90	Nicotinell Step 1	NC

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 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.

Note

A patient may only qualify for PBS-subsidised treatment under this treatment phase restriction once during a short-term course of treatment.

Note

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

Note

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

5469W NP	varenicline 1 mg tablet, 56	1	2	..	120.76	36.90	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.

Note

A patient may only qualify for PBS-subsidised treatment under this treatment phase restriction once during a short-term course of treatment.

Note

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

Note

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

9129L NP	varenicline 1 mg tablet, 56	2	..	..	*232.04	36.90	Champix	PF

VARENICLINE

Authority required

Nicotine dependence

Treatment Phase: Commencement of a short-term (12 weeks or 24 weeks) course of treatment

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
Note								
The period between commencing varenicline and bupropion or a new course of varenicline must be at least 6 months.								
Note								
A patient may only qualify for PBS-subsidised treatment under this treatment phase restriction once during a short-term course of treatment.								
Note								
No increase in the maximum quantity or number of units may be authorised.								
Note								
No increase in the maximum number of repeats may be authorised.								
9128K NP	varenicline 500 microgram tablet [11 tablets] (&) varenicline 1 mg tablet [42 tablets], 53	\$1	..	..	103.46	36.90	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.

8357W NP	acamprosate calcium 333 mg tablet: enteric, 180 tablets	1	1	..	166.92	36.90	Campral	AF

NALTREXONE

Authority required

For use within a comprehensive treatment program for alcohol dependence with the goal of maintaining abstinence

Caution

Naltrexone hydrochloride is contraindicated in patients receiving opioid drugs.

Note

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

8370M NP	naltrexone hydrochloride 50 mg tablet, 30	1	1	..	136.01	36.90	^a Naltrexone GH	GQ
							^a ReVia	BQ

OTHER NERVOUS SYSTEM DRUGS

Other nervous system drugs

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,

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

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.

Note

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

Note

Special Pricing Arrangements apply.

2896K	dimethyl fumarate 120 mg capsule, 14	1	..	..	491.31	36.90	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

Special Pricing Arrangements apply.

2943X	dimethyl fumarate 120 mg capsule, 14	1	..	..	491.31	36.90	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.

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer	
					Price for Max. Qty \$	Recordable Value for Safety Net \$		

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.

Note

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

Note

Special Pricing Arrangements apply.

2966D	dimethyl fumarate 240 mg capsule, 56	1	5	..	1880.00	36.90	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.

8664B NP	riluzole 50 mg tablet, 56	1	5	..	451.50	36.90	^a APO-Riluzole	TX
							^a Pharmacor Riluzole	CR
							^a Rilutek	SW
							^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.

1330B NP	tetrabenazine 25 mg tablet, 112	1	5	..	364.25	36.90	iNova Pharmaceuticals (Australia) Pty Ltd	IA

ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

8300W NP	atovaquone 750 mg/5 mL oral liquid, 210 mL	\$1	..	..	1034.91	36.90	Wellvone	AS

PYRIMETHAMINE

1966L NP	pyrimethamine 25 mg tablet, 50	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.

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.

9439T NP	atovaquone 250 mg + proguanil hydrochloride 100 mg tablet, 12	1	..	..	67.34	36.90	Malarone	GK

Methanolquinolines

QUININE

Authority required (STREAMLINED)

2142

Malaria

Caution

Severe thrombocytopenia has been reported with this drug.

1975Y NP	quinine sulfate 300 mg tablet, 50	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*

Note

Artemether with lumefantrine is not PBS-subsidised for prophylaxis of malaria.

9498X	artemether 20 mg + lumefantrine 120 mg tablet, 24	1	..	..	97.24	36.90	Riamet	NV

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

ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	lumefantrine							
	Note Artemether with lumefantrine is not PBS-subsidised for prophylaxis of malaria.							
5296R	artemether 20 mg + lumefantrine 120 mg tablet: dispersible, 18	1	..	..	97.24	36.90	Riamet 20mg/120mg Dispersible	NV

ANTHELMINTICS

ANTITREMATODALS

Quinoline derivatives and related substances

PRAZIQUANTEL

Authority required (STREAMLINED)

3147

Schistosomiasis

9447F NP	praziquantel 600 mg tablet, 8	1	..	..	41.19	36.90	Biltricide	BN

ANTINEMATODAL AGENTS

Benzimidazole derivatives

ALBENDAZOLE

Authority required (STREAMLINED)

1525

Treatment of tapeworm infestation

8503M NP	albendazole 200 mg tablet: chewable, 6	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

9047E NP	albendazole 200 mg tablet: chewable, 6	1	..	..	33.44	34.59	Zentel	AS

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

8459F	albendazole 400 mg tablet: chewable, 60	1	2	..	185.59	36.90	Eskazole	AS

Tetrahydropyrimidine derivatives

PYRANTEL

3047J NP	pyrantel 125 mg tablet, 6	1	..	..	14.94	16.09	Anthel 125	AF

3048K NP	pyrantel 250 mg tablet, 6	1	..	..	23.11	24.26	Anthel 250	AF

Avermectines

IVERMECTIN

Authority required (STREAMLINED)

4328

Strongyloidiasis

Authority required (STREAMLINED)

4565

Crusted (Norwegian) scabies

Clinical criteria:

ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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. <u>Authority required (STREAMLINED)</u> 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. <u>Note</u> This drug is not PBS-subsidised for first line treatment of typical scabies.						
2868Y NP	ivermectin 3 mg tablet, 4	2	2	..	*54.54	36.90	Stromectol MK
	IVERMECTIN <u>Authority required (STREAMLINED)</u> 4319 Onchocerciasis						
8359Y NP	ivermectin 3 mg tablet, 4	1	..	..	31.65	32.80	Stromectol MK

ECTOPARASITICIDES, INCL. SCABICIDES, INSECTICIDES AND REPELLENTS

ECTOPARASITICIDES, INCL. SCABICIDES

Pyrethrines, incl. synthetic compounds

PERMETHRIN								
3054R NP	permethrin 5% cream, 30 g	†1	1	..	17.11	18.26	Lyclear	JT

RESPIRATORY SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

9440W NP	mupirocin 2% (20 mg/g) ointment, 3 g	\$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

8136F NP	eformoterol fumarate dihydrate 12 microgram inhalation: powder for, 60 capsules	1	5	..	37.67	36.90	Foradile	NV
8240Q NP	eformoterol fumarate dihydrate 12 microgram/actuation inhalation: powder for, 60 actuations	\$1	5	..	36.78	36.90	Oxis Turbuhaler	AP
8239P NP	eformoterol fumarate dihydrate 6 microgram/actuation inhalation: powder for, 60 actuations	\$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.

5134F NP	indacaterol 150 microgram inhalation: powder for, 30 capsules	1	5	..	62.73	36.90	Onbrez	NV
5137J NP	indacaterol 300 microgram inhalation: powder for, 30 capsules	1	5	..	62.73	36.90	Onbrez	NV

SALBUTAMOL

8288F NP	salbutamol 100 microgram/actuation inhalation: pressurised, 200	2	5	..	*14.14	15.29	^a APO-Salbutamol Inhaler	TX
				^b 2.34	*16.48	15.29	^a Asmol CFC-free	AL
10143W NP	salbutamol 200 microgram inhalation: powder for, 128 capsules	2	4	..	*19.12	20.27	^a Ventolin CFC-free Ventolin Rotacaps	GK GK

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

2000G NP	salbutamol 2.5 mg/2.5 mL inhalation: solution, 30 x 2.5 mL ampoules	2	5	..	*15.96	17.11	^a APO-Salbutamol	TX
							^a Asmol 2.5 uni-dose	AF
							^a Butamol 2.5	QA

RESPIRATORY SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
2001H NP	salbutamol 5 mg/2.5 mL inhalation: solution, 30 x 2.5 mL ampoules	2	5	1.20 ..	*17.16 *16.44	17.11 17.59	^a GenRx Salbutamol	GX
							^a Pharmacor Salbutamol 2.5	CR
							^a Salbutamol Actavis	UA
							^a Salbutamol-GA	GN
							^a Salbutamol Sandoz	SZ
							^a Ventolin Nebules	GK
							^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
				^b 1.16	*17.60	17.59	^a Ventolin Nebules	GK

SALBUTAMOL

Restricted benefit

Patients unable to achieve co-ordinated use of other metered dose inhalers containing this drug

8354Q NP	salbutamol Oral pressurised inhalation in breath actuated device 100 micrograms (base) per dose (200 doses), CFC-free formulation, 1	2	5	..	*38.94	36.90	Airomir Autohaler	IA

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

8141L NP	salmeterol 50 microgram/actuation inhalation: powder for, 60 actuations	1	5	..	37.67	36.90	Serevent Accuhaler	GK

TERBUTALINE

2817G NP	terbutaline sulfate 500 microgram/actuation inhalation: powder for, 100 actuations	2	5	..	*18.20	19.35	Bricanyl Turbuhaler	AP

Adrenergics and other drugs for obstructive airway diseases

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.

10015D NP	budesonide 100 microgram/actuation + eformoterol fumarate dihydrate 3 microgram/actuation inhalation: pressurised, 120 actuations	2	5	..	*59.10	36.90	Symbicort Rapihaler 100/3	AP
10024N NP	budesonide 50 microgram/actuation + eformoterol fumarate dihydrate 3 microgram/actuation inhalation: pressurised, 120 actuations	2	5	..	*54.80	36.90	Symbicort Rapihaler 50/3	AP

BUDESONIDE + EFORMOTEROL

Restricted benefit

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
8796Y NP	budesonide 100 microgram/actuation + eformoterol fumarate dihydrate 6 microgram/actuation inhalation: powder for, 120 actuations	#1	5	..	54.81	36.90	Symbicort Turbuhaler 100/6	AP
8625Y NP	budesonide 200 microgram/actuation + eformoterol fumarate dihydrate 6 microgram/actuation inhalation: powder for, 120 actuations	#1	5	..	59.11	36.90	Symbicort Turbuhaler 200/6	AP
	BUDESONIDE + EFORMOTEROL							
	<u>Restricted benefit</u>							
	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.							
	<u>Note</u>							
	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.							
	<u>Restricted benefit</u>							
	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.							
	<u>Note</u>							
	Patient must not be on a concomitant single agent long-acting beta-2 agonist.							
	<u>Note</u>							
	This product is not indicated for the initiation of bronchodilator therapy in COPD.							
10018G NP	budesonide 200 microgram/actuation + eformoterol fumarate dihydrate 6 microgram/actuation inhalation: pressurised, 120 actuations	2	5	..	*89.40	36.90	Symbicort Rapihaler 200/6	AP
	BUDESONIDE + EFORMOTEROL							
	<u>Restricted benefit</u>							
	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.							
	<u>Note</u>							

RESPIRATORY SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	Symbicort 400/12 is not recommended nor PBS-subsidised for use as 'maintenance and reliever' therapy.							
	<u>Restricted benefit</u>							
	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.							
	<u>Note</u>							
	Patient must not be on a concomitant single agent long-acting beta-2 agonist.							
	<u>Note</u>							
	This product is not indicated for the initiation of bronchodilator therapy in COPD.							
8750M NP	budesonide 400 microgram/actuation + eformoterol fumarate dihydrate 12 microgram/actuation inhalation: powder for, 120 actuations	1	5	..	89.37	36.90	Symbicort Turbuhaler 400/12	AP
	FLUTICASONE + EFORMOTEROL							
	<u>Restricted benefit</u>							
	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.							
	<u>Note</u>							
	Flutiform is not recommended nor PBS-subsidised for use as 'maintenance and reliever' therapy.							
	<u>Note</u>							
	Flutiform is not indicated or PBS-subsidised for bronchodilator therapy in COPD.							
10007Q NP	fluticasone propionate 125 microgram/actuation + eformoterol fumarate dihydrate 5 microgram/actuation inhalation: pressurised, 120 actuations	1	5	..	56.71	36.90	flutiform 125/5	MF
10008R NP	fluticasone propionate 250 microgram/actuation + eformoterol fumarate dihydrate 10 microgram/actuation inhalation: pressurised, 120 actuations	1	5	..	78.78	36.90	flutiform 250/10	MF
2827T NP	fluticasone propionate 50 microgram/actuation + eformoterol fumarate dihydrate 5 microgram/actuation inhalation: pressurised, 120 actuations	1	5	..	45.96	36.90	flutiform 50/5	MF
	FLUTICASONE + SALMETEROL							
	<u>Restricted benefit</u>							
	Asthma							
	Clinical criteria:							
	Patient must have previously had frequent episodes of asthma while receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids,							
	AND							
	Patient must have been stabilised on concomitant inhaled salmeterol xinafoate and fluticasone propionate if aged less than 12 years.							
8430Q NP	fluticasone propionate 100 microgram/actuation + salmeterol 50 microgram/actuation inhalation: powder for, 60 actuations	1	5	..	47.54	36.90	Seretide Accuhaler 100/50	GK

RESPIRATORY SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
8518H NP	fluticasone propionate 125 microgram/actuation + salmeterol 25 microgram/actuation inhalation: pressurised, 120 actuations	¥1	5	..	59.65	36.90	Seretide MDI 125/25	GK
8431R NP	fluticasone propionate 250 microgram/actuation + salmeterol 50 microgram/actuation inhalation: powder for, 60 actuations	¥1	5	..	59.65	36.90	Seretide Accuhaler 250/50	GK
8517G NP	fluticasone propionate 50 microgram/actuation + salmeterol 25 microgram/actuation inhalation: pressurised, 120 actuations	¥1	5	..	47.54	36.90	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,

AND

Patient must have been stabilised on concomitant inhaled salmeterol xinafoate and fluticasone propionate if aged less than 12 years.

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.

Note

This product is not indicated for the initiation of bronchodilator therapy in COPD.

8519J NP	fluticasone propionate 250 microgram/actuation + salmeterol 25 microgram/actuation inhalation: pressurised, 120 actuations	¥1	5	..	78.02	36.90	Seretide MDI 250/25	GK
8432T NP	fluticasone propionate 500 microgram/actuation + salmeterol 50 microgram/actuation inhalation: powder for, 60 actuations	¥1	5	..	78.02	36.90	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.

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

RESPIRATORY SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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. Note This product is not indicated for the initiation of bronchodilator therapy in COPD.							
10199T NP	fluticasone furoate 100 microgram/actuation + vilanterol 25 microgram/actuation inhalation: powder for, 30 actuations	\$1	5	..	56.29	36.90	Breo Ellipta 100/25	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. Note This drug is not PBS-subsidised for the treatment of chronic obstructive pulmonary disease (COPD).							
10167D NP	fluticasone furoate 200 microgram/actuation + vilanterol 25 microgram/actuation inhalation: powder for, 30 actuations	\$1	5	..	73.34	36.90	Breo Ellipta 200/25	GK
	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. Note A LAMA includes tiotropium, glycopyrronium, aclidinium or umeclidinium. Note A LABA includes indacaterol, salmeterol or eformoterol. Note This product is not PBS-subsidised for the treatment of asthma. Note This product is not indicated for the initiation of bronchodilator therapy in COPD.							
10156M NP	indacaterol 110 microgram + glycopyrronium 50 microgram	1	5	..	96.38	36.90	ultibro breezhaler 110/50	NV

RESPIRATORY SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

inhalation: powder for, 30 capsules

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.

Note

A LAMA includes tiotropium, glycopyrronium, aclidinium or umeclidinium.

Note

A LABA includes indacaterol, salmeterol or formoterol.

Note

This product is not PBS-subsidised for the treatment of asthma.

Note

This product is not indicated for the initiation of bronchodilator therapy in COPD.

10188F NP	umeclidinium 62.5 microgram/actuation + vilanterol 25 microgram/actuation inhalation: powder for, 30 actuations	\$1	5	..	96.38	36.90	Anoro Ellipta 62.5/25	GK

OTHER DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES, INHALANTS

Glucocorticoids

BECLOMETHASONE

Restricted benefit

Patients unable to achieve co-ordinated use of other metered dose inhalers containing this drug

8409N NP	BECLOMETHASONE DIPROPIONATE Oral pressurised inhalation in breath actuated device 100 micrograms per dose (200 doses), CFC-free formulation, 1	\$1	5	..	39.47	36.90	Qvar 100 Autohaler	IA
8408M NP	BECLOMETHASONE DIPROPIONATE Oral pressurised inhalation in breath actuated device 50 micrograms per dose (200 doses), CFC-free formulation, 1	\$1	5	..	28.21	29.36	Qvar 50 Autohaler	IA
8407L NP	BECLOMETHASONE beclomethasone dipropionate 100 microgram/actuation inhalation: pressurised, 200	\$1	5	..	33.80	34.95	Qvar 100	IA
8406K NP	beclomethasone dipropionate 50 microgram/actuation inhalation: pressurised, 200	\$1	5	..	19.63	20.78	Qvar 50	IA

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

2066R NP	budesonide 1 mg/2 mL inhalation: solution, 30 x 2 mL ampoules	\$1	5	..	49.34	36.90	Pulmicort Respules	AP

RESPIRATORY SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
2065Q NP	budesonide 500 microgram/2 mL inhalation: solution, 30 x 2 mL ampoules	\$1	5	..	38.20	36.90	Pulmicort Respules	AP
BUDESONIDE								
2070Y NP	budesonide 100 microgram/actuation inhalation: powder for, 200 actuations	\$1	5	..	23.68	24.83	Pulmicort Turbuhaler	AP
2071B NP	budesonide 200 microgram/actuation inhalation: powder for, 200 actuations	\$1	5	..	31.42	32.57	Pulmicort Turbuhaler	AP
2072C NP	budesonide 400 microgram/actuation inhalation: powder for, 200 actuations	\$1	5	..	46.18	36.90	Pulmicort Turbuhaler	AP
CICLESONIDE								
8854B NP	ciclesonide 160 microgram/actuation inhalation: pressurised, 120 actuations	\$1	5	..	42.59	36.90	Alvesco 160	NQ
8853Y NP	ciclesonide 80 microgram/actuation inhalation: pressurised, 120 actuations	\$1	5	..	26.49	27.64	Alvesco 80	NQ
FLUTICASONE								
8147T NP	fluticasone propionate 100 microgram/actuation inhalation: powder for, 60 actuations	\$1	5	..	17.43	18.58	Flixotide Junior Accuhaler	GK
8345F NP	fluticasone propionate 125 microgram/actuation inhalation: pressurised, 120 actuations	\$1	5	..	31.00	32.15	Flixotide	GK
8148W NP	fluticasone propionate 250 microgram/actuation inhalation: powder for, 60 actuations	\$1	5	..	31.00	32.15	Flixotide Accuhaler	GK
8346G NP	fluticasone propionate 250 microgram/actuation inhalation: pressurised, 120 actuations	\$1	1	..	50.06	36.90	Flixotide	GK
8516F NP	fluticasone propionate 50 microgram/actuation inhalation: pressurised, 120	\$1	5	..	17.43	18.58	Flixotide Junior	GK
8149X NP	fluticasone propionate 500 microgram/actuation inhalation: powder for, 60 actuations	\$1	1	..	50.06	36.90	Flixotide Accuhaler	GK
Anticholinergics								
ACLIDINIUM								
<u>Restricted benefit</u>								
Chronic obstructive pulmonary disease (COPD)								
10124W NP	acclidinium 322 microgram/actuation inhalation: powder for, 60 actuations	\$1	5	..	62.73	36.90	Bretaris Genuair	FK
GLYCOPYRRONIUM								
<u>Restricted benefit</u>								
Chronic obstructive pulmonary disease (COPD)								
10059K NP	glycopyrronium 50 microgram inhalation, 30 capsules	1	5	..	62.73	36.90	seebri breezhaler	NV
IPRATROPIUM								
8671J NP	ipratropium bromide 20 microgram/actuation inhalation: pressurised, 200 actuations	2	5	..	*34.18	35.33	Atrovent	BY
IPRATROPIUM								
<u>Restricted benefit</u>								
Asthma in patients unable to use this drug delivered from an oral pressurised inhalation device via a spacer								
<u>Restricted benefit</u>								
Chronic obstructive pulmonary disease in patients unable to use this drug delivered from an oral pressurised inhalation device via a spacer								
1542E NP	ipratropium bromide 250 microgram/mL inhalation: solution, 30 x 1 mL ampoules	2	5	..	*28.28	29.43	^a Aeron 250	QA
							^a APO-Ipratropium	TX
							^a Ipratrin	AF

RESPIRATORY SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
8238N	ipratropium bromide 500 microgram/mL inhalation: solution, 30 x 1 mL ampoules	2	5	^b 0.52	*28.80	29.43	^a Atrovent	BY
NP				..	*32.20	33.35	^a Aeron 500	QA
							^a APO-Ipratropium	TX
							^a Ipratrin Adult	AF
				^b 0.48	*32.68	33.35	^a Atrovent Adult	BY

TIOTROPIUM

Restricted benefit

Chronic obstructive pulmonary disease

8626B	tiotropium 18 microgram inhalation: powder for, 30 capsules	1	5	..	62.73	36.90	Spiriva	BY
NP								

UMECLIDINIUM

Restricted benefit

Chronic obstructive pulmonary disease (COPD)

10187E	umeclidinium 62.5 microgram/actuation inhalation: powder for, 30 actuations	1	5	..	62.73	36.90	Incruse Ellipta	GK
NP								

Antiallergic agents, excl. corticosteroids

CROMOGLYCATE

8767K	cromoglycate sodium 1 mg/actuation inhalation: pressurised, 200	1	5	..	33.84	34.99	Intal CFC-Free	SW
NP								
2878L	cromoglycate sodium 20 mg inhalation: powder for, 100 capsules	1	5	..	31.75	32.90	Intal Spincaps	GN
NP								
8334P	cromoglycate sodium 5 mg/actuation inhalation: pressurised, 112	1	5	..	38.65	36.90	Intal Forte CFC-Free	SW
NP								

NEDOCROMIL

8365G	nedocromil sodium 2 mg/actuation inhalation: pressurised, 112 actuations	1	5	..	40.20	36.90	Tilade CFC-Free	SW
NP								

ADRENERGICS FOR SYSTEMIC USE

Alpha- and beta-adrenoreceptor agonists

ADRENALINE

1016L	adrenaline 1 in 1000 (1 mg/mL) injection, 5 x 1 mL ampoules	1	1	..	20.68	21.83	Link Medical Products Pty Ltd	LM
NP								
5004J	adrenaline 1 in 1000 (1 mg/mL) injection, 5 x 1 mL ampoules	1	..	..	20.68	21.83	Link Medical Products Pty Ltd	LM
DP								

ADRENALINE

Authority required

Initial sole PBS-subsidised supply for anticipated emergency treatment of acute allergic reactions with anaphylaxis in a patient who has been assessed to be at significant risk of anaphylaxis by, or in consultation with, a clinical immunologist, allergist, paediatrician or respiratory physician. The name of the specialist consulted must be provided at the time of application for initial supply

Authority required

Initial sole PBS-subsidised supply for anticipated emergency treatment of acute allergic reactions with anaphylaxis in a patient who has been discharged from hospital or an emergency department after treatment with adrenaline for acute allergic reaction with anaphylaxis

Authority required

Continuing sole PBS-subsidised supply for anticipated emergency treatment of acute allergic reactions with anaphylaxis, where the patient has previously been issued with an authority prescription for this drug

Caution

EpiPen and Anapen products have different administration techniques and should not be prescribed to the same patient without training in their use.

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.)

Note

Authority approvals will be limited to a maximum quantity of 2 auto-injectors (Anapen or EpiPen) at any one time.

No repeats will be issued.

RESPIRATORY SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
3408J NP	adrenaline 150 microgram/0.3 mL injection, 1 x 0.3 mL syringe	1	..	..	106.34	36.90	Anapen Junior	LM
8697R NP	adrenaline 150 microgram/0.3 mL injection, 1 x 0.3 mL syringe	1	..	..	106.34	36.90	EpiPen Jr.	AL
3409K NP	adrenaline 300 microgram/0.3 mL injection, 1 x 0.3 mL syringe	1	..	..	106.34	36.90	Anapen	LM
8698T NP	adrenaline 300 microgram/0.3 mL injection, 1 x 0.3 mL syringe	1	..	..	106.34	36.90	EpiPen	AL

Selective beta-2-adrenoreceptor agonists

SALBUTAMOL

1103C NP	salbutamol 2 mg/5 mL oral liquid, 150 mL	2	5	..	*22.54	23.69	Ventolin	GK

TERBUTALINE

1034K NP	terbutaline sulfate 500 microgram/mL injection, 5 x 1 mL ampoules	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.

2614N NP	theophylline 133.3 mg/25 mL oral liquid, 500 mL	1	5	..	12.65	13.80	Nuelin	IA
8230E NP	theophylline 200 mg tablet: modified release, 100 tablets	1	5	..	12.50	13.65	Nuelin-SR 200	IA
2634P NP	theophylline 250 mg tablet: modified release, 100 tablets	1	5	..	13.66	14.81	Nuelin-SR 250	IA
8231F NP	theophylline 300 mg tablet: modified release, 100 tablets	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.

Note

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

8627C NP	montelukast 4 mg tablet: chewable, 28	1	5	..	32.03	33.18	^a APO-Montelukast	TX
							^a Auro-Montelukast Tabs 4	DO
							^a Chem mart Montelukast	CH
							^a Lukair	FR
							^a Montair 4	GN
							^a Montelukast AN	EA
							^a Montelukast GH	GQ
							^a Montelukast RBX	RA
							^a Montelukast Sandoz 4	SZ
							^a Pharmacor Montelukast 4	CR
							^a Respikast 4	QA

RESPIRATORY SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Singulair	MK
							^a Terry White Chemists Montelukast	TW
							^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.

Note

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

8628D NP	montelukast 5 mg tablet: chewable, 28	1	5	..	30.51	31.66	^a APO-Montelukast	TX
							^a Auro-Montelukast Tabs 5	DO
							^a Chem mart Montelukast	CH
							^a Lukair	FR
							^a Montair 5	GN
							^a Montelukast AN	EA
							^a Montelukast GH	GQ
							^a Montelukast RBX	RA
							^a Montelukast Sandoz 5	SZ
							^a Pharmacor Montelukast 5	CR
							^a Respikast 5	QA
							^a Singulair	MK
							^a Terry White Chemists Montelukast	TW
							^a T Lukast	AF

COUGH AND COLD PREPARATIONS

COUGH SUPPRESSANTS, EXCL. COMBINATIONS WITH EXPECTORANTS

Opium alkaloids and derivatives

CODEINE

1214X NP	codeine phosphate 30 mg tablet, 20	1	..	..	17.21	18.36	Fawns and McAllan Proprietary Limited	FM

ANTI-HISTAMINES FOR SYSTEMIC USE

ANTI-HISTAMINES FOR SYSTEMIC USE

Phenothiazine derivatives

PROMETHAZINE

1948M NP	promethazine hydrochloride 50 mg/2 mL injection, 5 x 2 mL ampoules	2	..	..	*30.58	31.73	Hospira Pty Limited	HH

SENSORY ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

SENSORY ORGANS

OPHTHALMOLOGICALS

ANTIINFECTIVES

Antibiotics

AZITHROMYCIN

Restricted benefit

Trachoma

Note

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

8201P NP	azithromycin 200 mg/5 mL oral liquid: powder for, 15 mL	#1	..	..	#23.70	25.20	Zithromax	PF
8336R NP	azithromycin 500 mg tablet, 2	1	2	..	14.17	15.32	^a APO-Azithromycin	TX
							^a Azithromycin-GA	UA
							^a Azithromycin Sandoz	SZ
							^a Chem mart	CH
							^a Azithromycin	
							^a Terry White Chemists	TW
							^a Azithromycin	
							^a Zithromax	PF
							^a Zitrocin	GN

CHLORAMPHENICOL

2360F NP,MW	chloramphenicol 0.5% eye drops, 10 mL	#1	2	..	11.34	12.49	Chloromycetin	PF
5055C DP	chloramphenicol 0.5% eye drops, 10 mL	#1	..	..	11.34	12.49	Chlorsig	QA
							Chloromycetin	PF
5512D OP	chloramphenicol 0.5% eye drops, 10 mL	#1	2	..	11.34	12.49	Chlorsig	QA
							Chloromycetin	PF
1171P NP,MW	chloramphenicol 1% eye ointment, 4 g	#1	..	..	10.10	11.25	Chlorsig	QA
							Chloromycetin	PF
5511C OP	chloramphenicol 1% eye ointment, 4 g	#1	..	..	10.10	11.25	Chlorsig	QA
							Chloromycetin	PF
							Chlorsig	QA

GENTAMICIN

Restricted benefit

Invasive ocular infection

Restricted benefit

Perioperative use in ophthalmic surgery

Restricted benefit

Suspected pseudomonal eye infection

1441W	gentamicin 0.3% eye drops, 5 mL	#1	2	..	18.63	19.78	Genoptic	AG

GENTAMICIN

Restricted benefit

Perioperative use in ophthalmic surgery

Restricted benefit

Suspected pseudomonal eye infection

5566Y OP	gentamicin 0.3% eye drops, 5 mL	#1	2	..	18.63	19.78	Genoptic	AG

TOBRAMYCIN

Restricted benefit

Invasive ocular infection

SENSORY ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	Restricted benefit Perioperative use in ophthalmic surgery							
	Restricted benefit Suspected pseudomonal eye infection							
2328M	tobramycin 0.3% (3 mg/mL) eye drops, 5 mL	\$1	2	..	19.62	20.77	Tobrex	AQ
2329N	tobramycin 0.3% eye ointment, 3.5 g	\$1	..	..	22.72	23.87	Tobrex	AQ
	TOBRAMYCIN							
	Restricted benefit Perioperative use in ophthalmic surgery							
	Restricted benefit Suspected pseudomonal eye infection							
5569D OP	tobramycin 0.3% (3 mg/mL) eye drops, 5 mL	\$1	2	..	19.62	20.77	Tobrex	AQ
5570E OP	tobramycin 0.3% eye ointment, 3.5 g	\$1	..	..	22.72	23.87	Tobrex	AQ
	Antivirals							
	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.							
1002R NP	aciclovir 3% eye ointment, 4.5 g	\$1	..	..	37.80	36.90	Zovirax	GK
	ACICLOVIR							
	Restricted benefit Herpes simplex keratitis							
5501M OP	aciclovir 3% eye ointment, 4.5 g	\$1	..	..	37.80	36.90	Zovirax	GK
	Fluoroquinolones							
	CIPROFLOXACIN							
	Authority required Bacterial keratitis							
	Treatment criteria: Must be treated by an ophthalmologist or in consultation with an ophthalmologist.							
1217C	ciprofloxacin 0.3% eye drops, 5 mL	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.							
5564W OP	ciprofloxacin 0.3% eye drops, 5 mL	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.							
5567B	ofloxacin 0.3% (3 mg/mL) eye drops, 5	2	..	..	*35.64	36.79	Ocuflox	AG

SENSORY ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
OP	mL							
	OFLOXACIN							
	<u>Authority required</u>							
	Bacterial keratitis							
	Treatment criteria:							
	Must be treated by an ophthalmologist or in consultation with an ophthalmologist.							
8383F	ofloxacin 0.3% (3 mg/mL) eye drops, 5 mL	2	..	..	*35.64	36.79	Ocuflox	AG
ANTIINFLAMMATORY AGENTS								
<i>Corticosteroids, plain</i>								
	DEXAMETHASONE							
1288T NP	DEXAMETHASONE Eye drops 1 mg per mL (0.1%), 5 mL, 1	\$1	2	..	10.95	12.10	Maxidex	AQ
	DEXAMETHASONE							
	<u>Note</u>							
	No applications for increased maximum quantities and/or repeats will be authorised.							
5565X OP	DEXAMETHASONE Eye drops 1 mg per mL (0.1%), 5 mL, 1	\$1	..	..	10.95	12.10	Maxidex	AQ
	FLUOROMETHOLONE							
1204J NP	fluorometholone 0.1% eye drops, 5 mL	\$1	5	..	10.95	12.10	Flucon	AQ
							FML Liquifilm	AG
	FLUOROMETHOLONE							
	<u>Note</u>							
	No applications for increased maximum quantities and/or repeats will be authorised.							
5513E OP	fluorometholone 0.1% eye drops, 5 mL	\$1	..	..	10.95	12.10	Flucon	AQ
							FML Liquifilm	AG
	FLUOROMETHOLONE ACETATE							
1438Q NP	fluorometholone acetate 0.1% eye drops, 5 mL	\$1	2	..	10.95	12.10	Flarex	AQ
	FLUOROMETHOLONE ACETATE							
	<u>Note</u>							
	No applications for increased maximum quantities and/or repeats will be authorised.							
5533F OP	fluorometholone acetate 0.1% eye drops, 5 mL	\$1	..	..	10.95	12.10	Flarex	AQ
	HYDROCORTISONE ACETATE							
2441L NP	hydrocortisone acetate 1% eye ointment, 5 g	\$1	..	..	13.03	14.18	Hycor	QA
	HYDROCORTISONE ACETATE							
	<u>Note</u>							
	No applications for increased maximum quantities and/or repeats will be authorised.							
5516H OP	hydrocortisone acetate 1% eye ointment, 5 g	\$1	..	..	13.03	14.18	Hycor	QA
<i>Corticosteroids and mydriatics in combination</i>								
	PHENYLEPHRINE + PREDNISOLONE ACETATE							
	<u>Restricted benefit</u>							
	Corneal grafts							
	<u>Restricted benefit</u>							
	Uveitis							
3112T NP	phenylephrine hydrochloride 0.12% + prednisolone acetate 1% eye drops, 10 mL	\$1	2	..	26.16	27.31	Prednefrin Forte	AG
	PHENYLEPHRINE + PREDNISOLONE ACETATE							

SENSORY ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	<u>Restricted benefit</u>							
	Uveitis							
	<u>Note</u>							
	No applications for increased maximum quantities and/or repeats will be authorised.							
5568C OP	phenylephrine hydrochloride 0.12% + prednisolone acetate 1% eye drops, 10 mL	£1	..	..	26.16	27.31	Prednefrin Forte	AG
	<i>Antiinflammatory agents, non-steroids</i>							
	FLURBIPROFEN							
5514F OP	flurbiprofen sodium 0.03% (120 microgram/0.4 mL) eye drops, 5 x 0.4 mL ampoules	1	..	..	17.16	18.31	Ocufen	AG
8699W NP	flurbiprofen sodium 0.03% (120 microgram/0.4 mL) eye drops, 5 x 0.4 mL ampoules	1	..	..	17.16	18.31	Ocufen	AG
	ANTIGLAUCOMA PREPARATIONS AND MIOTICS							
	<i>Sympathomimetics in glaucoma therapy</i>							
	APRACLOPIDINE							
	<u>Restricted benefit</u>							
	Short-term reduction of intra-ocular pressure in patients already on maximally tolerated anti-glaucoma therapy							
8083K	apraclopidine 0.5% eye drops, 10 mL	£1	2	..	42.11	36.90	Iopidine 0.5%	AQ
	BRIMONIDINE							
5298W	brimonidine tartrate 0.15% eye drops, 5 mL	£1	5	..	20.48	21.63	Alphagan P 1.5	AG
8351M	brimonidine tartrate 0.2% eye drops, 5 mL	£1	5	..	20.48	21.63	^a Enidin	PE
				^b 1.63	22.11	21.63	^a Alphagan	AG
	BRIMONIDINE							
	<u>Note</u>							
	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.							
5563T OP	brimonidine tartrate 0.15% eye drops, 5 mL	£1	5	..	20.48	21.63	Alphagan P 1.5	AG
5534G OP	brimonidine tartrate 0.2% eye drops, 5 mL	£1	5	..	20.48	21.63	^a Enidin	PE
				^b 1.63	22.11	21.63	^a Alphagan	AG
	BRIMONIDINE + TIMOLOL							
	<u>Restricted benefit</u>							
	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.							
	<u>Note</u>							
	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.							
5535H OP	brimonidine tartrate 0.2% + timolol 0.5% eye drops, 5 mL	£1	5	..	26.37	27.52	Combigan	AG
	BRIMONIDINE + TIMOLOL							
	<u>Restricted benefit</u>							
	Elevated intra-ocular pressure							
	Clinical criteria:							

SENSORY ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
The condition must have been inadequately controlled with monotherapy,								
AND								
Patient must have open-angle glaucoma; OR								
Patient must have ocular hypertension.								
8826M	brimonidine tartrate 0.2% + timolol 0.5% eye drops, 5 mL	\$1	5	..	26.37	27.52	Combigan	AQ
Parasympathomimetics								
PILOCARPINE								
2595N	pilocarpine hydrochloride 1% eye drops, 15 mL	\$1	5	..	12.87	14.02	Isopto Carpine	AQ
2596P	pilocarpine hydrochloride 2% eye drops, 15 mL	\$1	5	..	14.12	15.27	Isopto Carpine	AQ
2598R	pilocarpine hydrochloride 4% eye drops, 15 mL	\$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.								
5536J OP	pilocarpine hydrochloride 1% eye drops, 15 mL	\$1	5	..	12.87	14.02	Isopto Carpine	AQ
5537K OP	pilocarpine hydrochloride 2% eye drops, 15 mL	\$1	5	..	14.12	15.27	Isopto Carpine	AQ
5538L OP	pilocarpine hydrochloride 4% eye drops, 15 mL	\$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.								
1004W NP	acetazolamide 250 mg tablet, 100	1	3	..	24.13	25.28	Diamox	QA
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.								
5540N OP	brinzolamide 1% eye drops, 5 mL	\$1	5	..	23.11	24.26 ^a	BrinzoQuin	IQ
				^B 1.18	24.29	24.26 ^a	Azopt	AQ
BRINZOLAMIDE								
8483L	brinzolamide 1% eye drops, 5 mL	\$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.								
3438Y	brinzolamide 1% + timolol 0.5% eye drops, 5 mL	\$1	5	..	27.22	28.37	Azarga	AQ

SENSORY ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
BRINZOLAMIDE + TIMOLOL <u>Restricted benefit</u> 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. <u>Note</u> 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.								
5562R OP	brinzolamide 1% + timolol 0.5% eye drops, 5 mL	1	5	..	27.22	28.37	Azarga	AQ
DORZOLAMIDE <u>Note</u> 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.								
5541P OP	dorzolamide 2% (20 mg/mL) eye drops, 5 mL	1	5	..	21.63	22.78	Trusopt	MK
8488R	dorzolamide 2% (20 mg/mL) eye drops, 5 mL	1	5	..	21.63	22.78	Trusopt	MK
DORZOLAMIDE + TIMOLOL <u>Restricted benefit</u> 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. <u>Note</u> 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.								
5542Q OP	dorzolamide 2% + timolol 0.5% eye drops, 5 mL	1	5	..	24.19	25.34	^a Cosopt	MK
							^a Dorzolamide/Timolol Sandoz 20/5	SZ
DORZOLAMIDE + TIMOLOL <u>Restricted benefit</u> 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.								
8567X	dorzolamide 2% + timolol 0.5% eye drops, 5 mL	1	5	..	24.19	25.34	^a Cosopt	MK
							^a Dorzolamide/Timolol Sandoz 20/5	SZ

Beta blocking agents

SENSORY ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
BETAXOLOL								
2811Y	betaxolol 0.25% eye drops, 5 mL	£1	5	..	15.11	16.26	Betoptic S	AQ
2825Q	betaxolol 0.5% eye drops, 5 mL	£1	5	..	15.11	16.26	^a BetoQuin	IQ
				^b 2.08	17.19	16.26	^a Betoptic	AQ
BETAXOLOL								
<u>Note</u>								
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.								
5543R	betaxolol 0.25% eye drops, 5 mL	£1	5	..	15.11	16.26	Betoptic S	AQ
5544T	betaxolol 0.5% eye drops, 5 mL	£1	5	..	15.11	16.26	^a BetoQuin	IQ
				^b 2.08	17.19	16.26	^a Betoptic	AQ
TIMOLOL								
<u>Note</u>								
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.								
5546X	timolol 0.1% eye gel, 5 g	£1	5	..	13.21	14.36	Nyogel	AS
5549C	timolol 0.25% (2.5 mg/mL) eye drops, 2.5 mL	£1	5	..	11.88	13.03	Timoptol XE	MK
5550D	timolol 0.5% (5 mg/mL) eye drops, 2.5 mL	£1	5	..	12.65	13.80	Timoptol XE	MK
5548B	timolol 0.5% (5 mg/mL) eye drops, 5 mL	£1	5	..	12.65	13.80	^a Tenopt	QA
				^b 3.03	15.68	13.80	^a Timoptol	FR
TIMOLOL								
8803H	timolol 0.1% eye gel, 5 g	£1	5	..	13.21	14.36	Nyogel	AS
1925H	timolol 0.25% (2.5 mg/mL) eye drops, 2.5 mL	£1	5	..	11.88	13.03	Timoptol XE	MK
1926J	timolol 0.5% (5 mg/mL) eye drops, 2.5 mL	£1	5	..	12.65	13.80	Timoptol XE	MK
1279H	timolol 0.5% (5 mg/mL) eye drops, 5 mL	£1	5	..	12.65	13.80	^a Tenopt	QA
				^b 3.03	15.68	13.80	^a Timoptol	FR

Prostaglandin analogues

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.

5551E	bimatoprost 0.03% eye drops, 3 mL	£1	5	..	42.48	36.90	Lumigan	AG
10053D	bimatoprost 0.03% eye drops, 30 x 0.4 mL unit doses	£1	5	..	36.91	36.90	Lumigan PF	AG
BIMATOPROST								
8620Q	bimatoprost 0.03% eye drops, 3 mL	£1	5	..	42.48	36.90	Lumigan	AG
10046R	bimatoprost 0.03% eye drops, 30 x 0.4 mL unit doses	£1	5	..	36.91	36.90	Lumigan PF	AG

BIMATOPROST + TIMOLOL

Restricted benefit

Elevated intra-ocular pressure

SENSORY ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
5558M OP	bimatoprost 0.03% + timolol 0.5% eye drops, 3 mL	\$1	5	..	46.94	36.90	Ganfort 0.3/5	AG
10108B OP	bimatoprost 0.03% + timolol 0.5% eye drops, 30 x 0.4 mL unit doses	\$1	5	..	41.21	36.90	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.								
9464D	bimatoprost 0.03% + timolol 0.5% eye drops, 3 mL	\$1	5	..	46.94	36.90	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.								
10107Y	bimatoprost 0.03% + timolol 0.5% eye drops, 30 x 0.4 mL unit doses	\$1	5	..	41.21	36.90	GANfort PF 0.3/5	AG
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.								
5552F OP	latanoprost 0.005% eye drops, 2.5 mL	\$1	5	..	29.27	30.42	^a APO-Latanoprost	TX
							^a Chem mart Latanoprost	CH
							^a Latanoprost Actavis	GN
							^a Latanoprost GH	GQ
							^a Latanoprost Pfizer	FZ
							^a Latanoprost Sandoz	SZ
							^a Terry White Chemists	TW
							Latanoprost	
							^a Xalatan	PF
LATANOPROST								
8243W	latanoprost 0.005% eye drops, 2.5 mL	\$1	5	..	29.27	30.42	^a APO-Latanoprost	TX
							^a Chem mart Latanoprost	CH
							^a Latanoprost Actavis	GN
							^a Latanoprost GH	GQ
							^a Latanoprost Pfizer	FZ

SENSORY ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Latanoprost Sandoz	SZ
							^a Terry White Chemists Latanoprost	TW
							^a Xalatan	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.

5553G OP	latanoprost 0.005% + timolol 0.5% eye drops, 2.5 mL	£1	5	..	41.21	36.90	^a APO- Latanoprost/Timolol 0.05/5	TX
							^a Latanocom	FZ
							^a Latanoprost/Timolol Sandoz 50/5	SZ
							^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.

8895E	latanoprost 0.005% + timolol 0.5% eye drops, 2.5 mL	£1	5	..	41.21	36.90	^a APO- Latanoprost/Timolol 0.05/5	TX
							^a Latanocom	FZ
							^a Latanoprost/Timolol Sandoz 50/5	SZ
							^a Xalacom	PF

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.

2748P OP	tafluprost 0.0015% eye drops, 30 x 0.3 mL unit doses	£1	5	..	34.16	35.31	Saflutan	MK

TAFLUPROST

2755B	tafluprost 0.0015% eye drops, 30 x 0.3 mL unit doses	£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

OCULAR VASCULAR DISORDER AGENTS

Antineovascularisation agents

Treatment Phase: Initial treatment

SENSORY ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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. Note Authority approvals will be administered by the Complex Drugs Unit of the Department of Human Services. 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 Note Special Pricing Arrangements apply. 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. 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).						

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	Note No increase in the maximum number of repeats may be authorised. Note Special Pricing Arrangements apply.						
2168D	afibercept 4 mg/0.1 mL injection, 1 x 0.1 mL vial	1	2	..	1431.50	36.90	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. 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 Note Special Pricing Arrangements apply. 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.						

SENSORY ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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).								
Note								
Special Pricing Arrangements apply.								
10138N	ranibizumab 1.65 mg/0.165 mL injection, 1 x 0.165 mL syringe	1	2	..	1431.50	36.90	Lucentis	NV
1382R	ranibizumab 2.3 mg/0.23 mL injection, 1 x 0.23 mL vial	1	2	..	1431.50	36.90	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

SENSORY ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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							
	<u>Authority required</u>							
	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)							
1349B	verteporfin 15 mg injection, 1 x 15 mg vial	1	..	..	2246.70	36.90	Visudyne	NV

OTHER OPHTHALMOLOGICALS

Other ophthalmologicals

CARBOMER + TRIGLYCERIDE LIPIDS

Authority required (STREAMLINED)

1359

Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops

2058H NP	carbomer 0.2% + triglyceride lipids 1% eye gel, 30 x 600 mg unit doses	3	5	..	*36.43	36.90	Artelac	BU

CARBOMER + TRIGLYCERIDE LIPIDS

Authority required

Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops

2090B OP	carbomer 0.2% + triglyceride lipids 1% eye gel, 30 x 600 mg unit doses	3	5	..	*36.43	36.90	Artelac	BU

CARBOMER-974

Authority required

Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops

5502N OP	carbomer-974 0.3% eye gel, 30 x 500 mg unit doses	3	5	..	*36.40	36.90	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

8514D NP	carbomer-974 0.3% eye gel, 30 x 500 mg unit doses	3	5	..	*36.40	36.90	Poly Gel	AQ

CARBOMER-980

Authority required

Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops

5504Q OP	carbomer-980 0.2% (2 mg/g) eye drops, 30 x 0.6 mL unit doses	3	5	..	*36.43	36.90	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

8578L NP	carbomer-980 0.2% (2 mg/g) eye drops, 30 x 0.6 mL unit doses	3	5	..	*36.43	36.90	Viscotears Gel PF	AQ

CARBOMER-980

Restricted benefit

SENSORY ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
Severe dry eye syndrome, including Sjogren's syndrome								
5503P OP	carbomer-980 0.2% eye gel, 10 g	‡1	5	..	10.00	11.15	^a Optifresh eye gel	PP
				^B 1.84	11.84	11.15	^a PAA	IQ
8384G NP	carbomer-980 0.2% eye gel, 10 g	‡1	5	..	10.00	11.15	^a Viscotears	AQ
				^B 1.84	11.84	11.15	^a Optifresh eye gel	PP
							^a PAA	IQ
							^a Viscotears	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.

9210R	carbomer-980 0.2% eye gel, 10 g	‡1	11	..	10.00	11.15	^a Optifresh eye gel	PP
				^B 1.84	11.84	11.15	^a PAA	IQ
							^a Viscotears	AQ

CARMELLOSE SODIUM

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

5508X OP	carmellose sodium 1% (10 mg/mL) eye drops, 15 mL	‡1	5	..	10.93	12.08	Refresh Liquigel	AG
8593G NP	carmellose sodium 1% (10 mg/mL) eye drops, 15 mL	‡1	5	..	10.93	12.08	Refresh Liquigel	AG
5507W OP	carmellose sodium 0.5% (5 mg/mL) eye drops, 15 mL	‡1	5	..	10.93	12.08	Refresh Tears Plus	AG
8548X NP	carmellose sodium 0.5% (5 mg/mL) eye drops, 15 mL	‡1	5	..	10.93	12.08	Refresh Tears Plus	AG

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.

9212W	carmellose sodium 1% (10 mg/mL) eye drops, 15 mL	‡1	11	..	10.93	12.08	Refresh Liquigel	AG
9211T	carmellose sodium 0.5% (5 mg/mL) eye drops, 15 mL	‡1	11	..	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

2324H NP	carmellose sodium 1% (4 mg/0.4 mL) eye drops, 30 x 0.4 mL unit doses	3	5	..	*31.63	32.78	^a Optifresh Plus	PP
				^B 4.77	*36.40	32.78	^a Celluvisc	AG
8823J NP	carmellose sodium 0.25% (1.5 mg/0.6 mL) eye drops, 24 x 0.6 mL unit doses	4	5	..	*40.76	36.90	TheraTears	CX
2338C NP	carmellose sodium 0.5% (2 mg/0.4 mL) eye drops, 30 x 0.4 mL unit doses	3	5	..	*31.63	32.78	^a Optifresh Tears	PP
				^B 4.77	*36.40	32.78	^a Cellufresh	AG
8824K NP	carmellose sodium 1% (6 mg/0.6 mL) eye gel, 28 x 0.6 mL unit doses	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

5505R OP	carmellose sodium 1% (4 mg/0.4 mL) eye drops, 30 x 0.4 mL unit doses	3	5	..	*31.63	32.78	^a Optifresh Plus	PP
				^B 4.77	*36.40	32.78	^a Celluvisc	AG

SENSORY ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
5509Y OP	carmellose sodium 0.25% (1.5 mg/0.6 mL) eye drops, 24 x 0.6 mL unit doses	4	5	..	*40.76	36.90	TheraTears	CX
5506T OP	carmellose sodium 0.5% (2 mg/0.4 mL) eye drops, 30 x 0.4 mL unit doses	3	5	..	*31.63	32.78	^a Optifresh Tears	PP
				^b 4.77	*36.40	32.78	^a Cellufresh	AG
5510B OP	carmellose sodium 1% (6 mg/0.6 mL) eye gel, 28 x 0.6 mL unit doses	3	5	..	*34.42	35.57	TheraTears	CX

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.

5556K OP	carmellose sodium 0.5% + glycerol 0.9% eye drops, 15 mL	£1	3	..	10.93	12.08	Optive	AG
9355J NP	carmellose sodium 0.5% + glycerol 0.9% eye drops, 15 mL	£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.

Note

The in-use shelf life of Optive is 6 months from the date of opening.

9356K	carmellose sodium 0.5% + glycerol 0.9% eye drops, 15 mL	£1	7	..	10.93	12.08	Optive	AG

CARMELLOSE SODIUM + GLYCEROL

Authority required

Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops

5561Q OP	carmellose sodium 0.5% + glycerol 0.9% eye drops, 30 x 0.4 mL unit doses	3	5	..	*36.40	36.90	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

9307W NP	carmellose sodium 0.5% + glycerol 0.9% eye drops, 30 x 0.4 mL unit doses	3	5	..	*36.40	36.90	Optive	AG

DEXTRAN-70 + HYPROMELLOSE

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

1509K NP	dextran-70 0.1% + hypromellose 0.3% eye drops, 15 mL	£1	5	..	10.83	11.98	^a Poly-Tears	IQ
				^b 2.04	12.87	11.98	^a Tears Naturale	AQ
5520M OP	dextran-70 0.1% + hypromellose 0.3% eye drops, 15 mL	£1	5	..	10.83	11.98	^a Poly-Tears	IQ
				^b 2.04	12.87	11.98	^a Tears Naturale	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.

9216C	dextran-70 0.1% + hypromellose 0.3% eye drops, 15 mL	£1	11	..	10.83	11.98	^a Poly-Tears	IQ
				^b 2.04	12.87	11.98	^a Tears Naturale	AQ

DEXTRAN-70 + HYPROMELLOSE

Authority required

SENSORY ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops								
5521N OP	dextran-70 0.1% + hypromellose 0.3% eye drops, 28 x 0.4 mL unit doses	3	5	..	*35.41	36.56	Bion Tears	AQ
DEXTRAN-70 + HYPROMELLOSE								
<u>Authority required (STREAMLINED)</u>								
1359								
Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops								
8299T NP	dextran-70 0.1% + hypromellose 0.3% eye drops, 28 x 0.4 mL unit doses	3	5	..	*35.41	36.56	Bion Tears	AQ
HYPROMELLOSE								
<u>Restricted benefit</u>								
Severe dry eye syndrome, including Sjogren's syndrome								
5518K OP	HYPROMELLOSE Eye drops 3 mg per mL (0.3%), 15 mL (contains sodium perborate as preservative), 1	\$1	5	..	10.61	11.76	^a In a Wink Moisturising	IQ
				^B 1.95	12.56	11.76	^a Genteal	AQ
8287E NP	HYPROMELLOSE Eye drops 3 mg per mL (0.3%), 15 mL (contains sodium perborate as preservative), 1	\$1	5	..	10.61	11.76	^a In a Wink Moisturising	IQ
				^B 1.95	12.56	11.76	^a Genteal	AQ
2956N NP	HYPROMELLOSE Eye drops 5 mg per mL (0.5%), 15 mL, 1	\$1	5	..	10.61	11.76	Methopt	QA
5517J OP	HYPROMELLOSE Eye drops 5 mg per mL (0.5%), 15 mL, 1	\$1	5	..	10.61	11.76	Methopt	QA
HYPROMELLOSE								
<u>Restricted benefit</u>								
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								
<u>Note</u>								
No applications for increased maximum quantities and/or repeats will be authorised.								
9213X	HYPROMELLOSE Eye drops 3 mg per mL (0.3%), 15 mL (contains sodium perborate as preservative), 1	\$1	11	..	10.61	11.76	^a In a Wink Moisturising	IQ
				^B 1.95	12.56	11.76	^a Genteal	AQ
9214Y	HYPROMELLOSE Eye drops 5 mg per mL (0.5%), 15 mL, 1	\$1	11	..	10.61	11.76	Methopt	QA
HYPROMELLOSE + CARBOMER-980								
<u>Restricted benefit</u>								
Severe dry eye syndrome, including Sjogren's syndrome								
5519L OP	hypromellose 0.3% + carbomer-980 0.2% eye gel, 10 g	\$1	5	..	10.61	11.76	^a HPMC PAA	IQ
				^B 1.95	12.56	11.76	^a Genteal gel	AQ
8564R NP	hypromellose 0.3% + carbomer-980 0.2% eye gel, 10 g	\$1	5	..	10.61	11.76	^a HPMC PAA	IQ
				^B 1.95	12.56	11.76	^a Genteal gel	AQ
HYPROMELLOSE + CARBOMER-980								
<u>Restricted benefit</u>								
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								
<u>Note</u>								
No applications for increased maximum quantities and/or repeats will be authorised.								
9215B	hypromellose 0.3% + carbomer-980 0.2% eye gel, 10 g	\$1	11	..	10.61	11.76	^a HPMC PAA	IQ
				^B 1.95	12.56	11.76	^a Genteal gel	AQ
PARAFFIN								
1750D NP	paraffin 1 g/g eye ointment, 2 x 3.5 g tubes	\$1	5	..	20.94	22.09	^a Ircal	PE
				^B 2.12	23.06	22.09	^a Poly Visc Refresh Night Time	IQ AG

SENSORY ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
5522P OP	paraffin 1 g/g eye ointment, 2 x 3.5 g tubes	1	5	..	20.94	22.09	Poly Visc	IQ
				^B 2.12	23.06	22.09	^a Ircal	PE
1754H NP	paraffin 1 g/g eye ointment, 3.5 g	2	5	..	*21.58	22.73	^a Refresh Night Time	AG
				^B 2.54	*24.12	22.73	^a Poly Visc	IQ
5523Q OP	paraffin 1 g/g eye ointment, 3.5 g	2	5	..	*21.58	22.73	^a Duratears	AQ
				^B 2.54	*24.12	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.

9218E	paraffin 1 g/g eye ointment, 2 x 3.5 g tubes	1	11	..	20.94	22.09	^a Ircal	PE
				^B 2.12	23.06	22.09	^a Poly Visc	IQ
9217D	paraffin 1 g/g eye ointment, 3.5 g	2	11	..	*21.58	22.73	^a Refresh Night Time	AG
				^B 2.54	*24.12	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.

2167C OP	paraffin + retinyl palmitate 138 microgram/g (equivalent to 250 units/g vitamin A) eye ointment, 5 g	2	5	..	*21.58	22.73	VitA-POS	AE
2222Y NP	paraffin + retinyl palmitate 138 microgram/g (equivalent to 250 units/g vitamin A) eye ointment, 5 g	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.

Note

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

Note

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

2202X	paraffin + retinyl palmitate 138 microgram/g (equivalent to 250 units/g vitamin A) eye ointment, 5 g	2	11	..	*21.58	22.73	VitA-POS	AE

POLYETHYLENE GLYCOL-400 + PROPYLENE GLYCOL

Restricted benefit

Severe dry eye syndrome, including Sjogren's syndrome

5524R OP	polyethylene glycol-400 0.4% + propylene glycol 0.3% eye drops, 15 mL	1	5	..	10.93	12.08	Systane	AQ
8676P NP	polyethylene glycol-400 0.4% + propylene glycol 0.3% eye drops, 15 mL	1	5	..	10.93	12.08	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

SENSORY ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	No applications for increased maximum quantities and/or repeats will be authorised.							
9219F	polyethylene glycol-400 0.4% + propylene glycol 0.3% eye drops, 15 mL	#1	11	..	10.93	12.08	Systane	AQ
	POLYETHYLENE GLYCOL-400 + PROPYLENE GLYCOL							
	<u>Authority required</u>							
	Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops							
5532E OP	polyethylene glycol-400 0.4% + propylene glycol 0.3% eye drops, 28 x 0.8 mL unit doses	2	5	..	*34.42	35.57	Systane	AQ
	POLYETHYLENE GLYCOL-400 + PROPYLENE GLYCOL							
	<u>Authority required (STREAMLINED)</u>							
	1359							
	Severe dry eye syndrome in patients who are sensitive to preservatives in multi-dose eye drops							
9170P NP	polyethylene glycol-400 0.4% + propylene glycol 0.3% eye drops, 28 x 0.8 mL unit doses	2	5	..	*34.42	35.57	Systane	AQ
	POLYVINYL ALCOHOL							
	<u>Restricted benefit</u>							
	Severe dry eye syndrome, including Sjogren's syndrome							
2682E NP	polyvinyl alcohol 1.4% eye drops, 15 mL	#1	5	..	10.61	11.76	^a PVA Tears	PE
				^b 1.60	12.21	11.76	^a Liquifilm Tears	AG
5526W OP	polyvinyl alcohol 1.4% eye drops, 15 mL	#1	5	..	10.61	11.76	^a PVA Tears	PE
				^b 1.60	12.21	11.76	^a Liquifilm Tears	AG
5527X OP	polyvinyl alcohol 1.4% eye drops, 15 mL	#1	5	..	10.61	11.76	Vistil	AE
8831T NP	polyvinyl alcohol 1.4% eye drops, 15 mL	#1	5	..	10.61	11.76	Vistil	AE
2681D NP	polyvinyl alcohol 3% eye drops, 15 mL	#1	5	..	10.61	11.76	^a PVA Forte	PE
				^b 5.59	16.20	11.76	^a Liquifilm Forte	AG
5525T OP	polyvinyl alcohol 3% eye drops, 15 mL	#1	5	..	10.61	11.76	^a PVA Forte	PE
				^b 5.59	16.20	11.76	^a Liquifilm Forte	AG
5528Y OP	polyvinyl alcohol 3% eye drops, 15 mL	#1	5	..	10.61	11.76	Vistil Forte	AE
8832W NP	polyvinyl alcohol 3% eye drops, 15 mL	#1	5	..	10.61	11.76	Vistil Forte	AE
	POLYVINYL ALCOHOL							
	<u>Restricted benefit</u>							
	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							
	<u>Note</u>							
	No applications for increased maximum quantities and/or repeats will be authorised.							
9220G	polyvinyl alcohol 1.4% eye drops, 15 mL	#1	11	..	10.61	11.76	^a PVA Tears	PE
				^b 1.60	12.21	11.76	^a Liquifilm Tears	AG
9221H	polyvinyl alcohol 1.4% eye drops, 15 mL	#1	11	..	10.61	11.76	Vistil	AE
9222J	polyvinyl alcohol 3% eye drops, 15 mL	#1	11	..	10.61	11.76	^a PVA Forte	PE
				^b 5.59	16.20	11.76	^a Liquifilm Forte	AG
9223K	polyvinyl alcohol 3% eye drops, 15 mL	#1	11	..	10.61	11.76	Vistil Forte	AE
	SODIUM HYALURONATE							
	<u>Authority required (STREAMLINED)</u>							
	4105							
	Severe dry eye syndrome							

SENSORY ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
2181T NP	sodium hyaluronate 0.1% (1 mg/mL) eye drops, 10 mL	\$1	5	..	33.96	35.11	Hylo-Fresh	AE
2253N NP	sodium hyaluronate 0.2% (2 mg/mL) eye drops, 10 mL	\$1	5	..	33.96	35.11	Hylo-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.								
2184Y OP	sodium hyaluronate 0.1% (1 mg/mL) eye drops, 10 mL	\$1	5	..	33.96	35.11	Hylo-Fresh	AE
2171G OP	sodium hyaluronate 0.2% (2 mg/mL) eye drops, 10 mL	\$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								
5545W OP	soy lecithin 1% (10 mg/mL) + tocopherols 0.002% (20 microgram/mL) + vitamin A palmitate 0.025% (250 microgram/mL) eye spray, 100 actuations	2	5	..	*36.40	36.90	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								
9448G NP	soy lecithin 1% (10 mg/mL) + tocopherols 0.002% (20 microgram/mL) + vitamin A palmitate 0.025% (250 microgram/mL) eye spray, 100 actuations	2	5	..	*36.40	36.90	tearsagain	RB

OTOLOGICALS

ANTIINFECTIVES

Antiinfectives

CHLORAMPHENICOL

1172Q NP	chloramphenicol 0.5% ear drops, 5 mL	\$1	2	..	11.39	12.54	Chloromycetin	PF

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

2480M NP	ciprofloxacin 0.3% ear drops, 5 mL	\$1	1	..	19.62	20.77	Ciloxan	AQ

CORTICOSTEROIDS AND ANTIINFECTIVES IN COMBINATION

Corticosteroids and antiinfectives in combination

DEXAMETHASONE + FRAMYCETIN SULFATE + GRAMICIDIN

2781J NP	dexamethasone 0.05% (500 microgram/mL) + framycetin sulfate	\$1	2	..	10.28	11.43 ^a	Otodex	AV

SENSORY ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	0.5% (5 mg/mL) + gramicidin 0.005% (50 microgram/mL) ear drops, 8 mL			^B 1.91	12.19	11.43	^a Sofradex	SW
2974M NP	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	#1	2	..	8.52	9.67	^a Otocomb Otic	FM
2971J NP	triamcinolone acetate 0.1% + neomycin sulfate 0.25% + gramicidin 0.025% + nystatin 100 000 international units/mL ear drops, 7.5 mL	#1	2	..	11.43	12.58	^a Otocomb Otic	QA FM
				^B 1.95	13.38	12.58	^a Kenacomb Otic	QA

OPHTHALMOLOGICAL AND OTOLOGICAL PREPARATIONS

ANTIINFECTIVES

Antiinfectives

1440T NP,MW	FRAMYCETIN SULFATE framycetin sulfate 0.5% (5 mg/mL) eye/ear drops, 8 mL	#1	2	..	11.08	12.23	Soframycin	SW
5557L OP	framycetin sulfate 0.5% (5 mg/mL) eye/ear drops, 8 mL	#1	2	..	11.08	12.23	Soframycin	SW

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

VARIOUS

ALLERGENS

ALLERGENS

*Allergen extracts***BEE VENOM**

2886X	bee venom 550 microgram injection [1 x 550 microgram vial] (&) inert substance diluent [4 vials], 1 pack	1	..	..	238.72	36.90	Albey Bee Venom	HL

PAPER WASP VENOM**Note**

Paper wasp venom is not European wasp venom.

2918N	paper wasp venom 550 microgram injection [1 x 550 microgram vial] (&) inert substance diluent [4 vials], 1 pack	1	..	..	238.72	36.90	Albey Paper Wasp Venom	HL

VESPUULA SPP VENOM

2883R	vespula spp venom 550 microgram injection [1 x 550 microgram vial] (&) inert substance diluent [4 vials], 1 pack	1	..	..	238.72	36.90	Albey Yellow Jacket Venom	HL

ALL OTHER THERAPEUTIC PRODUCTS

ALL OTHER THERAPEUTIC PRODUCTS

*Antidotes***NALOXONE**

2192J NP	naloxone hydrochloride 400 microgram/mL injection, 1 x 1 mL syringe	5	..	..	*105.16	36.90	Naloxone minijet	UC
2196N DP	naloxone hydrochloride 400 microgram/mL injection, 1 x 1 mL syringe	5	..	..	*105.16	36.90	Naloxone minijet	UC

*Drugs for treatment of hyperkalemia and hyperphosphatemia***LANTHANUM****Authority required (STREAMLINED)****3546**

Maintenance therapy, following initiation and stabilisation of treatment with lanthanum carbonate, of hyperphosphataemia in a patient with chronic kidney disease on dialysis whose serum phosphate is not controlled on calcium and where serum phosphate is greater than 1.6 mmol per L at the commencement of therapy

Authority required (STREAMLINED)**3547**

Maintenance therapy, following initiation and stabilisation of treatment with lanthanum carbonate, of hyperphosphataemia in a patient with chronic kidney disease on dialysis whose serum phosphate is not controlled on calcium and where the serum calcium times phosphate product is greater than 4.0 at the commencement of therapy

Note

Not to be used in combination with sevelamer.

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.

9405B NP	LANTHANUM Tablet, chewable, 1000 mg (as carbonate hydrate), 90	1	5	..	504.37	36.90	Fosrenol	ZI
9403X NP	LANTHANUM Tablet, chewable, 500 mg (as carbonate hydrate), 90	1	5	..	306.22	36.90	Fosrenol	ZI
9404Y NP	LANTHANUM Tablet, chewable, 750 mg (as carbonate hydrate), 90	1	5	..	449.77	36.90	Fosrenol	ZI

SEVELAMER

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
<u>Authority required (STREAMLINED)</u>								
3548								
Maintenance therapy, following initiation and stabilisation of treatment with sevelamer hydrochloride, of hyperphosphataemia in a patient with chronic kidney disease on dialysis whose serum phosphate is not controlled on calcium and where serum phosphate is greater than 1.6 mmol per L at the commencement of therapy								
<u>Authority required (STREAMLINED)</u>								
3549								
Maintenance therapy, following initiation and stabilisation of treatment with sevelamer hydrochloride, of hyperphosphataemia in a patient with chronic kidney disease on dialysis whose serum phosphate is not controlled on calcium and where the serum calcium times phosphate product is greater than 4.0 at the commencement of therapy								
<u>Note</u>								
Not to be used in combination with lanthanum.								
<u>Note</u>								
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.								
2142R NP	sevelamer hydrochloride 800 mg tablet, 180	1	5	..	358.07	36.90	Renagel	GZ
<i>Detoxifying agents for antineoplastic treatment</i>								
FOLINIC ACID								
8969C	folinic acid 1 g/100 mL injection, 1 x 100 mL vial	1	1	..	63.06	36.90	Calcium Folate Ebewe	SZ
9041W	folinic acid 300 mg/30 mL injection, 1 x 30 mL vial	4	1	..	*72.68	36.90	^a Calcium Folate Ebewe	SZ
							^a Leucovorin Calcium (Hospira Pty Limited)	HH
FOLINIC ACID								
<u>Note</u>								
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.								
8812T	folinic acid 100 mg/10 mL injection, 1 x 10 mL vial	10	1	..	*63.06	36.90	^a Calcium Folate Ebewe	SZ
1704Q	folinic acid 100 mg/10 mL injection, 10 x 10 mL ampoules	1	1	..	63.06	36.90	^a Leucovorin Calcium (Pfizer Australia Pty Ltd)	PF
FOLINIC ACID								
<u>Restricted benefit</u>								
Antidote to folic acid antagonists								
2308L	folinic acid 15 mg tablet, 10	1	..	..	96.65	36.90	Leucovorin Calcium (Hospira Pty Limited)	HH
FOLINIC ACID								
<u>Note</u>								
For item codes 8740B, 1575X 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.								
8740B	folinic acid 50 mg/5 mL injection, 1 x 5 mL vial	10	2	..	*67.86	36.90	^a Leucovorin Calcium (Hospira Pty Limited)	HH
1610R	folinic acid 50 mg/5 mL injection, 10 x 5 mL ampoules	1	2	..	67.79	36.90	^a Leucovorin Calcium (Pfizer Australia Pty Ltd)	PF
1575X	folinic acid 50 mg/5 mL injection, 5 x 5 mL ampoules	2	2	..	*67.78	36.90	^a Calcium Folate Ebewe	SZ
MESNA								
<u>Restricted benefit</u>								
Adjunctive therapy for use with ifosfamide or high dose cyclophosphamide								
8079F	mesna 1 g/10 mL injection, 15 x 10 mL ampoules	1	5	..	224.15	36.90	Uromitexan	BX
8078E	mesna 400 mg/4 mL injection, 15 x 4 mL ampoules	1	5	..	103.62	36.90	Uromitexan	BX

Drugs for treatment of hypercalcemia

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	PHOSPHORUS							
	<u>Authority required (STREAMLINED)</u>							
	1099							
	Familial hypophosphataemia							
	<u>Authority required (STREAMLINED)</u>							
	1157							
	Hypercalcaemia							
	<u>Authority required (STREAMLINED)</u>							
	1167							
	Hypophosphataemic rickets							
	<u>Authority required (STREAMLINED)</u>							
	1467							
	Vitamin D-resistant rickets							
2946C NP	phosphorus 500 mg tablet: effervescent, 100	1	5	..	81.97	36.90	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).

Note

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

9475Q	polylactic acid 150 mg injection, 1 x 150 mg vial	2	4	..	*446.80	36.90	Sculptra	SW

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).

Note

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.

9476R	polylactic acid 150 mg injection, 1 x 150 mg vial	2	..	..	*446.80	36.90	Sculptra	SW

DIAGNOSTIC AGENTS

URINE TESTS

GLUCOSE AND KETONE INDICATOR URINE

3106L NP	glucose and ketone indicator urine strip: diagnostic, 50 diagnostic strips	2	2	..	*17.64	18.79	Keto-Diabur- Test 5000	RD
3107M NP	glucose and ketone indicator urine strip: diagnostic, 50 diagnostic strips	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.

9254C	glucose and ketone indicator urine	2	4	..	*17.64	18.79	Keto-Diabur- Test 5000	RD

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
9255D	strip: diagnostic, 50 diagnostic strips glucose and ketone indicator urine strip: diagnostic, 50 diagnostic strips	2	4	..	*17.76	18.91	Keto-Diastix	BN
GLUCOSE INDICATOR URINE								
3104J NP	glucose indicator urine strip: diagnostic, 50 diagnostic strips	2	2	..	*20.16	21.31	Diastix	BN
GLUCOSE INDICATOR URINE								
<u>Restricted benefit</u>								
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								
<u>Note</u>								
No applications for increased maximum quantities and/or repeats will be authorised.								
9253B	glucose indicator urine strip: diagnostic, 50 diagnostic strips	2	4	..	*20.16	21.31	Diastix	BN

OTHER DIAGNOSTIC AGENTS

Tests for diabetes

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.

Note

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

10099M	glucose indicator blood strip: diagnostic, 100	#1	11	..	53.50	36.90	GoodLife	JN
10141R	glucose indicator blood strip: diagnostic, 100	#1	11	..	53.50	36.90	EasyMate II	WI
10164Y	glucose indicator blood strip: diagnostic, 100	#1	11	..	53.50	36.90	Contour next	IK
1518X	glucose indicator blood strip: diagnostic, 100	#1	11	..	53.50	36.90	Contour	IK
1520B	glucose indicator blood strip: diagnostic, 100	#1	11	..	53.50	36.90	BGStar	SW
2568E	glucose indicator blood strip: diagnostic, 100	#1	11	..	53.50	36.90	TRUEresult	NX
2571H	glucose indicator blood strip: diagnostic, 100	#1	11	..	53.50	36.90	TRUEbalance	NX
2602Y	glucose indicator blood strip: diagnostic, 100	#1	11	..	53.50	36.90	TRUEtrack	NX
3412N	glucose indicator blood strip: diagnostic, 100	#1	11	..	53.50	36.90	Accu-Chek Advantage/Sensor Comfort	RD
9257F	glucose indicator blood strip: diagnostic, 100	#1	11	..	53.50	36.90	Accu-Chek Performa	RD
9269W	glucose indicator blood strip: diagnostic, 100	#1	11	..	53.50	36.90	FreeStyle Lite	MS
9270X	glucose indicator blood strip: diagnostic, 100	#1	11	..	53.50	36.90	FreeStyle Optium	MS
9273C	glucose indicator blood strip: diagnostic, 100	#1	11	..	53.50	36.90	Accu-Chek Active	RD
10139P	glucose indicator blood strip: diagnostic, 50	2	11	..	*53.52	36.90	EasyMate II	WI
2697Y	glucose indicator blood strip: diagnostic, 50	2	11	..	*53.52	36.90	OneTouch Select	JJ
3407H	glucose indicator blood strip: diagnostic, 50	2	11	..	*53.52	36.90	CareSens N	LB

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
3442E	glucose indicator blood strip: diagnostic, 50	2	11	..	*53.52	36.90	OneTouch Verio	JJ
5053Y	glucose indicator blood strip: diagnostic, 50	2	11	..	*53.52	36.90	Accu-Chek Aviva	RD
9263M	glucose indicator blood strip: diagnostic, 50	2	11	..	*53.52	36.90	GlucoDr	OZ
9267R	glucose indicator blood strip: diagnostic, 50	2	11	..	*53.52	36.90	Optium Omega	MS
9274D	glucose indicator blood strip: diagnostic, 50	2	11	..	*53.52	36.90	Accu-Chek Go	RD
9276F	glucose indicator blood strip: diagnostic, 50	2	11	..	*53.52	36.90	Betachek	NA
9277G	glucose indicator blood strip: diagnostic, 50	2	11	..	*53.52	36.90	Betachek G5	NA
9278H	glucose indicator blood strip: diagnostic, 50	2	11	..	*53.52	36.90	CareSens	LB
9279J	glucose indicator blood strip: diagnostic, 50	2	11	..	*46.24	36.90	Glucoflex-R	NA
9281L	glucose indicator blood strip: diagnostic, 50	2	11	..	*53.52	36.90	SensoCard	PX
9297H	glucose indicator blood strip: diagnostic, 50	2	11	..	*53.52	36.90	Bionime Rightest	QB
9472M	glucose indicator blood strip: diagnostic, 50	2	11	..	*53.52	36.90	MyGlucoHealth	EH
9486G	glucose indicator blood strip: diagnostic, 50	2	11	..	*53.52	36.90	Lifeline Attest	OI
9275E	glucose indicator blood strip: diagnostic, 51 diagnostic strips	2	11	..	*53.52	36.90	Accu-Chek Integra	RD
GLUCOSE INDICATOR BLOOD								
10101P NP	glucose indicator blood strip: diagnostic, 100	#1	5	..	53.50	36.90	GoodLife	JN
10145Y NP	glucose indicator blood strip: diagnostic, 100	#1	5	..	53.50	36.90	EasyMate II	WI
10153J NP	glucose indicator blood strip: diagnostic, 100	#1	5	..	53.50	36.90	Contour next	IK
1503D NP	glucose indicator blood strip: diagnostic, 100	#1	5	..	53.50	36.90	Contour	IK
1519Y NP	glucose indicator blood strip: diagnostic, 100	#1	5	..	53.50	36.90	BGStar	SW
2562W NP	glucose indicator blood strip: diagnostic, 100	#1	5	..	53.50	36.90	TRUEbalance	NX
2575M NP	glucose indicator blood strip: diagnostic, 100	#1	5	..	53.50	36.90	TRUEtrack	NX
2624D NP	glucose indicator blood strip: diagnostic, 100	#1	5	..	53.50	36.90	TRUEresult	NX
2979T NP	glucose indicator blood strip: diagnostic, 100	#1	5	..	53.50	36.90	Accu-Chek Performa	RD
3411M NP	glucose indicator blood strip: diagnostic, 100	#1	5	..	53.50	36.90	Accu-Chek Advantage/Sensor Comfort	RD
8190C NP	glucose indicator blood strip: diagnostic, 100	#1	5	..	53.50	36.90	Accu-Chek Active	RD
8522M NP	glucose indicator blood strip: diagnostic, 100	#1	5	..	53.50	36.90	FreeStyle Optium	MS
9154T NP	glucose indicator blood strip: diagnostic, 100	#1	5	..	53.50	36.90	FreeStyle Lite	MS
10147C NP	glucose indicator blood strip: diagnostic, 50	2	5	..	*53.52	36.90	EasyMate II	WI
2263D NP	glucose indicator blood strip: diagnostic, 50	2	5	..	*53.52	36.90	Optium Omega	MS
2673Q NP	glucose indicator blood strip: diagnostic, 50	2	5	..	*53.52	36.90	OneTouch Select	JJ
2860M NP	glucose indicator blood strip: diagnostic, 50	2	5	..	*53.52	36.90	Betachek G5	NA
2890D NP	glucose indicator blood strip: diagnostic, 50	2	5	..	*53.52	36.90	Betachek	NA

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
2914J NP	glucose indicator blood strip: diagnostic, 50	2	5	..	*46.24	36.90	Glucoflex-R	NA
3406G NP	glucose indicator blood strip: diagnostic, 50	2	5	..	*53.52	36.90	CareSens N	LB
3441D NP	glucose indicator blood strip: diagnostic, 50	2	5	..	*53.52	36.90	OneTouch Verio	JJ
5043K NP	glucose indicator blood strip: diagnostic, 50	2	5	..	*53.52	36.90	Accu-Chek Aviva	RD
8739Y NP	glucose indicator blood strip: diagnostic, 50	2	5	..	*53.52	36.90	Accu-Chek Go	RD
8749L NP	glucose indicator blood strip: diagnostic, 50	2	5	..	*53.52	36.90	GlucoDr	OZ
8759B NP	glucose indicator blood strip: diagnostic, 50	2	5	..	*53.52	36.90	CareSens	LB
8795X NP	glucose indicator blood strip: diagnostic, 50	2	5	..	*53.52	36.90	SensoCard	PX
9298J NP	glucose indicator blood strip: diagnostic, 50	2	5	..	*53.52	36.90	Bionime Rightest	QB
9471L NP	glucose indicator blood strip: diagnostic, 50	2	5	..	*53.52	36.90	MyGlucoHealth	EH
9485F NP	glucose indicator blood strip: diagnostic, 50	2	5	..	*53.52	36.90	Lifeline Attest	OI
8806L NP	glucose indicator blood strip: diagnostic, 51 diagnostic strips	2	5	..	*53.52	36.90	Accu-Chek Integra	RD

GLUCOSE INDICATOR BLOOD

Restricted benefit

For use in patients on insulin therapy

9300L NP	glucose indicator blood strip: diagnostic, 100	\$1	5	..	53.50	36.90	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.

9301M	glucose indicator blood strip: diagnostic, 100	\$1	11	..	53.50	36.90	Accu-Chek Mobile	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.

10037G NP	triglycerides long chain oral liquid, 18 x 250 mL cartons	2	5	..	*300.16	36.90	carbzero	VF

TRIGLYCERIDES MEDIUM CHAIN

Authority required

Chylous ascites

Authority required

Chyllothorax

Authority required

Fat malabsorption due to liver disease, short gut syndrome, cystic fibrosis and gastrointestinal disorders

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	<u>Authority required</u>							
	Hyperlipoproteinaemia type 1							
	<u>Authority required</u>							
	Intractable childhood epilepsy or cerebrospinal fluid glucose transporter defect, requiring a ketogenic diet							
	<u>Authority required</u>							
	Long chain fatty acid oxidation disorders							
	<u>Note</u>							
	No applications for increased maximum quantities and/or repeats will be authorised.							
3128P	triglycerides medium chain oil: oral, 500 mL	2	5	..	*52.72	36.90	MCT Oil	SB
NP								
9327X	triglycerides medium chain oral liquid, 1 x 250 mL bottle	8	5	..	*214.76	36.90	Liquigen	SB
NP								
	TRIGLYCERIDES MEDIUM CHAIN							
	<u>Authority required</u>							
	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.							
	<u>Authority required</u>							
	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.							
	<u>Note</u>							
	No increase in the maximum quantity or number of units may be authorised.							
	<u>Note</u>							
	No increase in the maximum number of repeats may be authorised.							
10049X	triglycerides medium chain oral liquid, 18 x 250 mL cartons	2	5	..	*383.86	36.90	betaquik	VF
NP								

Fat/carbohydrates/proteins/minerals/vitamins, combinations**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.

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

Note

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

1180D NP	amino acid synthetic formula oral liquid: powder for, 400 g	8	5	..	*361.48	36.90	Neocate Advance Vanilla	SB
8574G NP	amino acid synthetic formula oral liquid: powder for, 400 g	8	5	..	*361.48	36.90	EleCare	AB
8754R NP	amino acid synthetic formula oral liquid: powder for, 400 g	8	5	..	*361.48	36.90	Neocate Advance	SB

AMINO ACID SYNTHETIC FORMULA

Authority required

Cows' milk anaphylaxis

Population criteria:

Patient must be up to the age of 24 months.

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

1192R NP	amino acid synthetic formula oral liquid: powder for, 400 g	8	5	..	*361.48	36.90	Neocate Advance Vanilla	SB
8575H NP	amino acid synthetic formula oral liquid: powder for, 400 g	8	5	..	*361.48	36.90	EleCare	AB
8755T NP	amino acid synthetic formula oral liquid: powder for, 400 g	8	5	..	*361.48	36.90	Neocate Advance	SB

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:

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
1521C NP	amino acid synthetic formula oral liquid: powder for, 400 g	12	5	..	*532.00	36.90	Neocate Advance Vanilla	SB
2250K NP	amino acid synthetic formula oral liquid: powder for, 400 g	12	5	..	*532.00	36.90	EleCare	AB

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:

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

Note

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

2246F NP	amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids oral liquid: powder for, 400 g	8	5	..	*368.20	36.90	Neocate LCP	SB
9339M NP	amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids oral liquid: powder for, 400 g	8	5	..	*368.20	36.90	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.

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

2560R	amino acid synthetic formula	8	5	..	*368.20	36.90	Neocate LCP	SB

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
NP	supplemented with long chain polyunsaturated fatty acids oral liquid: powder for, 400 g							
9340N	amino acid synthetic formula	8	5	..	*368.20	36.90	EleCare LCP	AB
NP	supplemented with long chain polyunsaturated fatty acids oral liquid: powder for, 400 g							

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.

1545H	amino acid synthetic formula	12	5	..	*542.56	36.90	Neocate Gold	SB
NP	supplemented with long chain polyunsaturated fatty acids and medium chain triglycerides oral liquid: powder for, 400 g							

AMINO ACID SYNTHETIC FORMULA SUPPLEMENTED WITH LONG CHAIN POLYUNSATURATED FATTY ACIDS AND MEDIUM CHAIN TRIGLYCERIDES

Authority required

Cows' milk protein enteropathy

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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. <u>Authority required</u> 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. <u>Authority required</u> 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. <u>Authority required</u> 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.						

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

2900P NP	amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids and medium chain triglycerides oral liquid: powder for, 400 g	8	5	..	*368.20	36.90	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.

[illegible]

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

5467R NP	amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids and medium chain triglycerides oral liquid: powder for, 400 g	8	5	..	*368.20	36.90	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.

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	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.						
	<u>Authority required</u> 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.						
	<u>Authority required</u> 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.						
	<u>Authority required</u> Biliary atresia						
	<u>Authority required</u> Chronic liver failure with fat malabsorption						
	<u>Authority required</u> Chylous ascites						
	<u>Authority required</u> Cystic fibrosis						
	<u>Authority required</u> Enterokinase deficiency						
	<u>Authority required</u> Proven fat malabsorption						
	<u>Authority required</u> 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.						
	<u>Authority required</u> Severe intestinal malabsorption including short bowel syndrome						
	<u>Authority required</u> Chylothorax						
	<u>Note</u> No increase in the maximum quantity or number of units may be authorised.						
	<u>Note</u> No increase in the maximum number of repeats may be authorised.						
2676W NP	protein hydrolysate formula with medium chain triglycerides oral liquid:	8	5	..	*172.28	36.90	Alfaré NT

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
	powder for, 400 g						

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.

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

Note

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

8259Q NP	protein hydrolysate formula with medium chain triglycerides oral liquid: powder for, 450 g	8	5	..	*110.20	36.90	Karicare Aptamil Pepti-Junior Gold	NU

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.

Note

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

Note

Not indicated for the treatment of intractable childhood epilepsy or cerebrospinal fluid glucose transporter defect requiring a ketogenic diet.

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
10152H NP	triglycerides medium chain formula oral liquid: powder for, 400 g	8	5	..	*421.64	36.90	Monogen	SB
10154K NP	triglycerides medium chain formula oral liquid: powder for, 400 g	8	5	..	*411.80	36.90	Peptamen Junior	NT
10155L NP	triglycerides medium chain formula oral liquid: powder for, 400 g	8	5	..	*443.16	36.90	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

Chyllothorax

Note

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

Note

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

Note

Not indicated for the treatment of intractable childhood epilepsy or cerebrospinal fluid glucose transporter defect requiring a ketogenic diet.

1938B NP	triglycerides medium chain formula oral liquid: powder for, 400 g	8	5	..	*443.16	36.90	Lipistart	VF
8478F NP	triglycerides medium chain formula oral liquid: powder for, 400 g	8	5	..	*421.64	36.90	Monogen	SB

Carbohydrates**AMYLOPECTIN MODIFIED LONG CHAIN****Restricted benefit**

Glycogen storage disease

9386B NP	amylopectin modified long chain oral liquid: powder for, 30 x 60 g sachets	4	5	..	*752.64	36.90	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.

8282X NP	milk powder lactose free formula oral liquid: powder for, 900 g	5	..	..	*113.21	36.90	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.

8283Y NP	milk powder lactose free formula oral liquid: powder for, 900 g	5	5	..	*113.21	36.90	S-26 LF	AS

MILK POWDER LACTOSE FREE FORMULA PREDIGESTED**Authority required**

Acute lactose intolerance

Population criteria:

Patient must be up to the age of 12 months.

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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.

Note

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

Note

No more than 1 application per patient will be authorised.

2975N NP	milk powder lactose free formula predigested oral liquid: powder for, 900 g	5	..	..	*95.76	36.90	Karicare Aptamil Gold De-Lact	NU

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.

Note

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

2989H NP	milk powder lactose free formula predigested oral liquid: powder for, 900 g	5	5	..	*95.76	36.90	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.

2357C NP	milk powder lactose modified predigested oral liquid: powder for, 900 g	3	10	..	*73.15	36.90	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.

2358D NP	milk powder lactose modified predigested oral liquid: powder for,	3	1	..	*73.15	36.90	Digestelact	SJ

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	900 g							
	MILK POWDER SYNTHETIC LOW CALCIUM							
	<u>Authority required</u>							
	Hypercalcaemia in children under the age of 4 years							
	<u>Note</u>							
	No applications for increased maximum quantities and/or repeats will be authorised.							
3092R NP	milk powder synthetic low calcium oral liquid: powder for, 400 g	8	5	..	*381.72	36.90	Locasol	SB
	<i>Other combinations of nutrients</i>							
	AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS AND TRACE ELEMENTS WITHOUT METHIONINE AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID							
	<u>Restricted benefit</u>							
	Pyridoxine non-responsive homocystinuria							
3417W NP	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	4	5	..	*2508.32	36.90	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							
	<u>Restricted benefit</u>							
	Tyrosinaemia							
9330C NP	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	4	5	..	*2508.32	36.90	TYR Anamix junior LQ	SB
	AMINO ACID FORMULA WITHOUT PHENYLALANINE							
	<u>Restricted benefit</u>							
	Phenylketonuria							
8678R NP	amino acid formula without phenylalanine 1 g tablet, 75	24	5	..	*1427.32	36.90	Phlexy-10	SB
8554F NP	amino acid formula without phenylalanine 500 mg capsule, 200	16	5	..	*1276.68	36.90	Phlexy-10	SB
2347M NP	amino acid formula without phenylalanine oral liquid: powder for, 30 x 20 g sachets	7	5	..	*1463.25	36.90	Phlexy-10 Drink Mix	SB
	AMINO ACID FORMULA WITHOUT VALINE, LEUCINE AND ISOLEUCINE							
	<u>Restricted benefit</u>							
	Maple syrup urine disease							
10161T NP	amino acid formula without valine, leucine and isoleucine containing 5 g of protein equivalent oral liquid: powder for, 30 x 6 g sachets	12	5	..	*3098.68	36.90	MSUD amino5	VF
	AMINO ACID FORMULA WITH VITAMINS, MINERALS AND LONG CHAIN POLYUNSATURATED FATTY ACIDS WITHOUT PHENYLALANINE							
	<u>Restricted benefit</u>							
	Phenylketonuria							
8479G NP	amino acid formula with vitamins, minerals and long chain polyunsaturated fatty acids without phenylalanine oral liquid: powder for, 400 g	8	5	..	*703.96	36.90	PKU Anamix infant	SB
	AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT LYSINE AND LOW IN TRYPTOPHAN							
	<u>Restricted benefit</u>							
	A child aged from 6 months up to 10 years with proven glutaric aciduria type 1							
9438R	amino acid formula with vitamins and	4	5	..	*2114.72	36.90	GA gel	VF

VARIOUS

	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
NP	minerals without lysine and low in tryptophan oral liquid: powder for, 30 x 24 g sachets							
AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT LYSINE AND LOW IN TRYPTOPHAN								
<u>Restricted benefit</u>								
A patient aged 3 years or older with proven glutaric aciduria type 1								
5484P NP	amino acid formula with vitamins and minerals without lysine and low in tryptophan oral liquid: powder for, 30 x 25 g sachets	4	5	..	*3154.76	36.90	GA express 15	VF
AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT LYSINE AND LOW IN TRYPTOPHAN								
<u>Restricted benefit</u>								
An infant or young child with proven glutaric aciduria type 1								
2650L NP	amino acid formula with vitamins and minerals without lysine and low in tryptophan oral liquid: powder for, 400 g	8	5	..	*769.64	36.90	GA1 Anamax infant	SB
AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT LYSINE AND LOW IN TRYPTOPHAN								
<u>Restricted benefit</u>								
A child aged less than 9 years with proven glutaric aciduria type 1								
2646G NP	amino acid formula with vitamins and minerals without lysine and low in tryptophan oral liquid: powder for, 500 g	8	5	..	*1785.08	36.90	XLYS, LOW TRY Maxamaid	SB
AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT METHIONINE								
<u>Restricted benefit</u>								
Pyridoxine non-responsive homocystinuria								
1548L NP	AMINO ACID FORMULA with VITAMINS and MINERALS without METHIONINE Oral liquid 125 mL, 30, 1	3	5	..	*3098.68	36.90	HCU Lophlex LQ 20	SB
9133Q NP	amino acid formula with vitamins and minerals without methionine oral liquid, 30 x 130 mL cans	4	5	..	*3098.72	36.90	HCU cooler 15	VF
2640Y NP	amino acid formula with vitamins and minerals without methionine oral liquid, 30 x 174 mL pouches	4	5	..	*4082.72	36.90	HCU cooler 20	VF
2639X NP	amino acid formula with vitamins and minerals without methionine oral liquid, 30 x 87 mL pouches	4	5	..	*2114.72	36.90	HCU cooler 10	VF
8677Q NP	amino acid formula with vitamins and minerals without methionine oral liquid: powder for, 30 x 24 g sachets	4	5	..	*2114.72	36.90	HCU gel	VF
8744F NP	amino acid formula with vitamins and minerals without methionine oral liquid: powder for, 30 x 25 g sachets	4	5	..	*3098.72	36.90	HCU express 15	VF
8328H NP	amino acid formula with vitamins and minerals without methionine oral liquid: powder for, 500 g	8	5	..	*1785.08	36.90	XMET Maxamaid	SB
8416Y NP	amino acid formula with vitamins and minerals without methionine oral liquid: powder for, 500 g	8	5	..	*2705.08	36.90	XMET Maxamum	SB
AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT METHIONINE								
<u>Restricted benefit</u>								
For infants and very young children with pyridoxine non-responsive homocystinuria								
8417B NP	amino acid formula with vitamins and minerals without methionine oral liquid: powder for, 400 g	8	5	..	*769.64	36.90	HCU Anamax infant	SB
AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT METHIONINE, THREONINE AND VALINE AND LOW IN Isoleucine								
<u>Restricted benefit</u>								
Methylmalonic acidaemia								

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
<u>Restricted benefit</u>								
Propionic acidaemia								
1923F NP	AMINO ACID FORMULA with VITAMINS and MINERALS without METHIONINE, THREONINE and VALINE and low in ISOLEUCINE Oral liquid 130 mL, 30, 1	4	5	..	*3098.72	36.90	MMA/PA cooler 15	VF
3444G NP	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	4	5	..	*2114.72	36.90	MMA/PA gel	VF
3443F NP	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	4	5	..	*3098.72	36.90	MMA/PA express 15	VF
8058D NP	amino acid formula with vitamins and minerals without methionine, threonine and valine and low in isoleucine oral liquid: powder for, 400 g	8	5	..	*769.64	36.90	MMA/PA Anamix infant	SB
8059E NP	amino acid formula with vitamins and minerals without methionine, threonine and valine and low in isoleucine oral liquid: powder for, 500 g	8	5	..	*1785.08	36.90	XMTVI Maxamaid	SB
8061G NP	amino acid formula with vitamins and minerals without methionine, threonine and valine and low in isoleucine oral liquid: powder for, 500 g	8	5	..	*2705.08	36.90	XMTVI Maxamum	SB
AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT PHENYLALANINE								
<u>Restricted benefit</u>								
Phenylketonuria								
1411G NP	AMINO ACID FORMULA with VITAMINS and MINERALS without PHENYLALANINE Sachets 18.2 g, 60, 1	3	5	..	*1640.41	36.90	add-ins	SB
1909L NP	AMINO ACID FORMULA with VITAMINS and MINERALS without PHENYLALANINE Sachets 34 g, 30, 1	4	5	..	*2054.36	36.90	PKU express 20	VF
8746H NP	amino acid formula with vitamins and minerals without phenylalanine oral liquid, 18 x 250 mL cans	5	5	..	*1313.61	36.90	Easiphen	SB
9021T NP	amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 125 mL cans	3	5	..	*1549.78	36.90	PKU Lophlex LQ 20	SB
8846N NP	amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 130 mL cans	4	5	..	*1548.68	36.90	PKU Cooler 15	VF
2474F NP	amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 174 mL cans	4	5	..	*2054.36	36.90	PKU Cooler 20	VF
5483N NP	amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 85 g sachets	4	5	..	*1058.96	36.90	PKU squeezie	VF
2382J NP	amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 87 mL cans	4	5	..	*1035.12	36.90	PKU Cooler 10	VF
9396M NP	amino acid formula with vitamins and minerals without phenylalanine oral liquid, 36 x 125 mL cans	4	5	..	*1270.20	36.90	PKU Anamix Junior LQ	SB
9397N NP	amino acid formula with vitamins and minerals without phenylalanine oral liquid, 60 x 62.5 mL cans	2	5	..	*1059.70	36.90	PKU Lophlex LQ 10	SB
8555G NP	amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 30 x 24 g sachets	4	5	..	*1058.96	36.90	PKU gel	VF
8591E	amino acid formula with vitamins and	4	5	..	*1549.48	36.90	PKU express 15	VF

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
NP	minerals without phenylalanine oral liquid: powder for, 30 x 25 g sachets							
8804J	amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 30 x 27.8 g sachets	3	5	..	*1549.78	36.90	Lophlex	SB
NP								
8613H	amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 30 x 29 g sachets	4	5	..	*892.44	36.90	PKU Anamix Junior	SB
NP								
8727H	amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 30 x 50 g sachets	3	5	..	*1512.40	36.90	XP Maxamum	SB
NP								
2738D	amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 500 g	8	5	..	*884.36	36.90	XP Maxamaid	SB
NP								
2739E	amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 500 g	8	5	..	*1352.76	36.90	XP Maxamum	SB
NP								
2806Q	amino acid formula with vitamins and minerals without phenylalanine oral semi-solid, 36 x 109 g jars	3	5	..	*1853.08	36.90	PKU Lophlex Sensation 20	SB
NP								

AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT PHENYLALANINE AND TYROSINE

Restricted benefit

Tyrosinaemia

1547K	AMINO ACID FORMULA with VITAMINS and MINERALS without PHENYLALANINE and TYROSINE Oral liquid 125 mL, 30, 1	3	5	..	*3098.68	36.90	TYR Lophlex LQ 20	SB
NP								
9132P	amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid, 30 x 130 mL cans	4	5	..	*3098.72	36.90	TYR cooler 15	VF
NP								
2701E	amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid, 30 x 174 mL pouches	4	5	..	*4082.72	36.90	TYR cooler 20	VF
NP								
2674R	amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid, 30 x 87 mL pouches	4	5	..	*2114.72	36.90	TYR cooler 10	VF
NP								
8631G	amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid: powder for, 30 x 24 g sachets	4	5	..	*2114.72	36.90	TYR gel	VF
NP								
8667E	amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid: powder for, 30 x 25 g sachets	4	5	..	*3098.72	36.90	TYR express 15	VF
NP								
9395L	amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid: powder for, 30 x 29 g sachets	4	5	..	*1800.80	36.90	TYR Anamix Junior	SB
NP								
8445L	amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid: powder for, 400 g	8	5	..	*769.64	36.90	TYR Anamix infant	SB
NP								
3078B	amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid: powder for, 500 g	8	5	..	*2705.08	36.90	XPhen, Tyr Maxamum	SB
NP								
8446M	amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid: powder for, 500 g	8	5	..	*1785.08	36.90	XPhen, Tyr Maxamaid	SB
NP								

AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT VALINE, LEUCINE AND ISOLEUCINE

Restricted benefit

Maple syrup urine disease

1546J	AMINO ACID FORMULA with VITAMINS and MINERALS without VALINE, LEUCINE and ISOLEUCINE Oral liquid 125 mL, 30, 1	3	5	..	*3098.68	36.90	MSUD Lophlex LQ 20	SB
NP								
1914R	AMINO ACID FORMULA with VITAMINS	4	5	..	*4094.48	36.90	MSUD express 20	VF

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
<i>NP</i>	and MINERALS without VALINE, LEUCINE and ISOLEUCINE Sachets 34 g, 30, 1							
2375B <i>NP</i>	amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid, 30 x 130 mL cans	4	5	..	*3098.72	36.90	MSUD cooler 15	VF
2654Q <i>NP</i>	amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid, 30 x 174 mL pouches	4	5	..	*4082.72	36.90	MSUD cooler 20	VF
2651M <i>NP</i>	amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid, 30 x 87 mL pouches	4	5	..	*2114.72	36.90	MSUD cooler 10	VF
8592F <i>NP</i>	amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 30 x 24 g sachets	4	5	..	*2114.72	36.90	MSUD gel	VF
8632H <i>NP</i>	amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 30 x 25 g sachets	4	5	..	*3098.72	36.90	MSUD express 15	VF
8745G <i>NP</i>	amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 30 x 29 g sachets	4	5	..	*1800.80	36.90	MSUD Anamix Junior	SB
2380G <i>NP</i>	amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 400 g	8	5	..	*769.64	36.90	MSUD Anamix infant	SB
8057C <i>NP</i>	amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 500 g	8	5	..	*2705.08	36.90	MSUD Maxamum	SB
8260R <i>NP</i>	amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 500 g	8	5	..	*1785.08	36.90	MSUD Maxamaid	SB
8310J <i>NP</i>	amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 500 g	4	5	..	*2672.32	36.90	MSUD AID III	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

9499Y <i>NP</i>	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	4	5	..	*2508.32	36.90	MSUD Anamix Junior LQ	SB

ARACHIDONIC ACID AND DOCOSAHEXAENOIC ACID WITH CARBOHYDRATE

Authority required

Peroxisomal biogenesis disorders

10036F <i>NP</i>	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	4	5	..	*371.16	36.90	keyomega	VF

ARGININE WITH CARBOHYDRATE

Restricted benefit

Urea cycle disorders

Note

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
Arginine with carbohydrate is not indicated for the treatment of arginase deficiency and other inborn errors of protein metabolism.								
5482M NP	arginine with carbohydrate containing 2 g arginine oral liquid: powder for, 30 x 4 g sachets	4	5	..	*771.16	36.90	Arginine 2000	VF
10093F NP	arginine with carbohydrate containing 5 g arginine oral liquid: powder for, 30 x 7.6 g sachets	4	5	..	*1023.44	36.90	Arginine 5000	VF
9437Q NP	arginine with carbohydrate containing 500 mg arginine oral liquid: powder for, 30 x 4 g sachets	4	5	..	*516.36	36.90	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.

8369L NP	carbohydrate, fat, vitamins, minerals and trace elements oral liquid: powder for, 400 g	8	5	..	*318.52	36.90	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.

10050Y NP	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	4	5	..	*248.60	36.90	basecal 100	VF
10039J NP	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	4	5	..	*472.48	36.90	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.

5481L NP	citrulline with carbohydrate containing 1 g citrulline oral liquid: powder for, 30 x 4 g sachets	4	5	..	*516.36	36.90	Citrulline 1000	VF

CYSTINE WITH CARBOHYDRATE

Restricted benefit

Pyridoxine non-responsive homocystinuria

9164H NP	cystine with carbohydrate containing 500 mg cystine oral liquid: powder for, 30 x 4 g sachets	4	5	..	*516.36	36.90	Cystine 500	VF

DOCOSAHEXAENOIC ACID WITH CARBOHYDRATE

Authority required

Peroxisomal biogenesis disorders

10040K NP	docosahexaenoic acid with carbohydrate containing 200 mg docosahexaenoic acid oral liquid: powder for, 30 x 4g sachets	4	5	..	*371.16	36.90	docomega	VF

ESSENTIAL AMINO ACIDS FORMULA

Restricted benefit

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	Gyrate atrophy of the choroid and retina							
	<u>Restricted benefit</u>							
	Urea cycle disorders							
9329B NP	essential amino acids formula oral liquid: powder for, 2 x 200 g cans	6	5	..	*1200.88	36.90	Essential Amino Acid Mix	SB
	ESSENTIAL AMINO ACIDS FORMULA WITH MINERALS AND VITAMIN C							
	<u>Restricted benefit</u>							
	Gyrate atrophy of the choroid and retina							
	<u>Restricted benefit</u>							
	Urea cycle disorders							
2027Q NP	essential amino acids formula with minerals and vitamin C oral liquid: powder for, 400 g	5	5	..	*634.51	36.90	Dialamine	SB
	ESSENTIAL AMINO ACIDS FORMULA WITH VITAMINS AND MINERALS							
	<u>Restricted benefit</u>							
	Gyrate atrophy of the choroid and retina							
	<u>Restricted benefit</u>							
	Urea cycle disorders							
9385Y NP	essential amino acids formula with vitamins and minerals oral liquid: powder for, 50 x 12.5 g sachets	4	5	..	*1516.84	36.90	EAA Supplement	VF
	GLYCINE WITH CARBOHYDRATE							
	<u>Restricted benefit</u>							
	Isovaleric acidaemia							
10195N NP	glycine with carbohydrate containing 500 mg of glycine oral liquid: powder for, 30 x 4 g sachets	4	5	..	*516.36	36.90	Glycine500	VF
	GLYCOMACROPEPTIDE AND ESSENTIAL AMINO ACIDS							
	<u>Restricted benefit</u>							
	Phenylketonuria							
2712R NP	glycomacropeptide and essential amino acids oral liquid, 12 x 500 mL bottles	12	5	..	*1270.48	36.90	Camino Pro Restore	QH
	GLYCOMACROPEPTIDE AND ESSENTIAL AMINO ACIDS WITH VITAMINS AND MINERALS							
	<u>Restricted benefit</u>							
	Phenylketonuria							
2696X NP	glycomacropeptide and essential amino acids with vitamins and minerals bar, 7 x 54 g	14	5	..	*866.78	36.90	Camino Pro Complete	QH
2644E NP	glycomacropeptide and essential amino acids with vitamins and minerals bar, 7 x 81 g	14	5	..	*1296.86	36.90	Camino Pro Complete	QH
2685H NP	glycomacropeptide and essential amino acids with vitamins and minerals oral liquid: powder for, 28 x 49 g sachets	4	5	..	*1480.12	36.90	Camino Pro Bettermilk	QH
	HIGH FAT FORMULA WITH VITAMINS, MINERALS AND TRACE ELEMENTS AND LOW IN PROTEIN AND CARBOHYDRATE							
	<u>Restricted benefit</u>							
	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.							
	<u>Note</u>							
	Authorities for increased maximum quantities, up to a maximum of 48, may be authorised.							
2652N NP	high fat formula with vitamins, minerals and trace elements and low in protein and carbohydrate (3:1 ratio long chain	24	5	..	*1037.80	36.90	KetoCal 3:1	SB

PHENYLALANINE WITH CARBOHYDRATE

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
<u>Restricted benefit</u>								
Tyrosinaemia								
9384X NP	phenylalanine with carbohydrate containing 50 mg phenylalanine oral liquid: powder for, 30 x 4 g sachets	4	5	..	*516.36	36.90	Phenylalanine 50	VF
SOY PROTEIN AND FAT FORMULA WITH VITAMINS AND MINERALS CARBOHYDRATE FREE								
<u>Restricted benefit</u>								
Patients with intractable seizures requiring treatment with a ketogenic diet								
<u>Restricted benefit</u>								
Glucose transport protein defects								
<u>Restricted benefit</u>								
Pyruvate dehydrogenase deficiency								
<u>Restricted benefit</u>								
Infants and young children with glucose-galactose intolerance and multiple monosaccharide intolerance								
8577K NP	soy protein and fat formula with vitamins and minerals carbohydrate free oral liquid, 1 x 384 mL can	120	5	..	*670.36	36.90	RCF	AB
TRIGLYCERIDES LONG CHAIN WITH GLUCOSE POLYMER								
<u>Restricted benefit</u>								
Patients with proven inborn errors of protein metabolism who are unable to meet their energy requirements with permitted food and formulae								
9308X NP	triglycerides long chain with glucose polymer oral liquid, 18 x 250 mL cans	6	5	..	*340.12	36.90	ProZero	VF
9309Y NP	triglycerides long chain with glucose polymer oral liquid, 6 x 1000 mL bottles	4	5	..	*304.36	36.90	ProZero	VF
TRIGLYCERIDES LONG CHAIN WITH GLUCOSE POLYMER								
<u>Restricted benefit</u>								
Proven inborn errors of protein metabolism								
Clinical criteria:								
Patient must be unable to meet their energy requirements with permitted food and formulae.								
10189G NP	triglycerides long chain with glucose polymer oral liquid, 27 x 200 mL cartons	2	5	..	*192.18	36.90	Sno-Pro	SB
TRIGLYCERIDES MEDIUM CHAIN AND LONG CHAIN WITH GLUCOSE POLYMER								
<u>Restricted benefit</u>								
Patients with proven inborn errors of protein metabolism who are unable to meet their energy requirements with permitted food and formulae								
3136C NP	triglycerides medium chain and long chain with glucose polymer oral liquid: powder for, 400 g	8	5	..	*295.88	36.90	Duocal	SB
TRIGLYCERIDES MEDIUM CHAIN FORMULA								
<u>Authority required</u>								
Chylous ascites								
<u>Authority required</u>								
Chylothorax								
<u>Authority required</u>								
Fat malabsorption due to liver disease, short gut syndrome, cystic fibrosis and gastrointestinal disorders								
<u>Authority required</u>								
Hyperlipoproteinaemia type 1								
<u>Authority required</u>								
Long chain fatty acid oxidation disorders								
<u>Note</u>								
No applications for increased maximum quantities and/or repeats will be authorised.								
<u>Note</u>								
MCT Pro-Cal is not indicated for the treatment of intractable childhood epilepsy or cerebrospinal fluid glucose transporter defect requiring a ketogenic diet.								
9383W NP	triglycerides medium chain formula oral liquid: powder for, 30 x 16 g sachets	4	5	..	*253.96	36.90	MCT Pro-Cal	VF

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
TYROSINE WITH CARBOHYDRATE								
<u>Restricted benefit</u>								
Phenylketonuria								
9165J NP	tyrosine with carbohydrate containing 1 g tyrosine oral liquid: powder for, 30 x 4 g sachets	4	5	..	*516.36	36.90	Tyrosine 1000	VF
VALINE WITH CARBOHYDRATE								
<u>Restricted benefit</u>								
Maple syrup urine disease								
9434M NP	valine with carbohydrate containing 1 g valine oral liquid: powder for, 30 x 4 g sachets	4	5	..	*567.32	36.90	Valine 1000	VF
9135T NP	valine with carbohydrate containing 50 mg valine oral liquid: powder for, 30 x 4 g sachets	4	5	..	*516.36	36.90	Valine 50	VF
VITAMINS, MINERALS AND TRACE ELEMENTS WITH CARBOHYDRATE								
<u>Authority required</u>								
Infants and children whose vitamin and mineral intake is insufficient due to a specific diagnosis requiring a highly restrictive therapeutic diet, and whose vitamin, mineral and trace element needs cannot be adequately met with other proprietary vitamin and mineral preparations								
<u>Note</u>								
Paediatric Seravit should only be used under strict supervision of a dietitian and a paediatrician.								
9328Y NP	vitamins, minerals and trace elements with carbohydrate oral liquid: powder for, 200 g	6	5	..	*390.76	36.90	Paediatric Seravit	SB
VITAMINS, MINERALS AND TRACE ELEMENTS WITH CARBOHYDRATE								
<u>Authority required</u>								
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.								
<u>Note</u>								
FruitiVits must only be used under strict supervision of a dietitian and a paediatrician.								
10149E NP	vitamins, minerals and trace elements with carbohydrate oral liquid: powder for, 30 x 6 g sachets	1	5	..	299.25	36.90	FruitiVits	VF
WHEY PROTEIN FORMULA SUPPLEMENTED WITH AMINO ACIDS, LONG CHAIN POLYUNSATURATED FATTY ACIDS, VITAMINS AND MINERALS, LOW IN PROTEIN, PHOSPHATE, POTASSIUM AND LACTOSE								
<u>Authority required</u>								
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.								
9382T NP	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	9	5	..	*1485.91	36.90	RenaStart	VF
2870C NP	whey protein formula supplemented with amino acids, long chain polyunsaturated fatty acids, vitamins	4	5	..	*1584.60	36.90	Renastart	VF

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	and minerals, low in protein, phosphate, potassium and lactose oral liquid: powder for, 6 x 400 g cans							
	WHEY PROTEIN FORMULA SUPPLEMENTED WITH AMINO ACIDS, VITAMINS AND MINERALS, AND LOW IN PROTEIN, PHOSPHATE, POTASSIUM AND LACTOSE							
	<u>Authority required</u>							
	Infants and young children with chronic renal failure requiring treatment with a low protein and a low phosphorus diet, or a low protein, a low phosphorus and a low potassium diet							
8587Y NP	whey protein formula supplemented with amino acids, vitamins and minerals, and low in protein, phosphate, potassium and lactose oral liquid: powder for, 400 g	16	5	..	*1066.28	36.90	Kindergen	SB

Pharmaceutical Benefits for Palliative Care

PREPARATIONS WHICH MAY BE PRESCRIBED FOR PATIENTS RECEIVING PALLIATIVE CARE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

5385K NP	benzydamine hydrochloride 0.15% mouthwash, 500 mL	£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.

5386L NP	benzydamine hydrochloride 0.15% mouthwash, 500 mL	£1	..	..	22.60	23.75	Difflam	IA

CARMELLOSE SODIUM

Authority required (STREAMLINED)

3636

Initial supply, for up to 4 months, for a palliative care patient where dry mouth is a symptom

5334R NP	carmellose sodium 10 mg/mL oral spray, 100 mL	£1	3	..	13.49	14.64	Aquae	IA
5333Q NP	carmellose sodium 10 mg/mL oral spray, 25 mL	£1	3	..	11.64	12.79	Aquae	IA

CARMELLOSE SODIUM

Authority required (STREAMLINED)

3637

Continuing supply for a palliative care patient where dry mouth 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.

5336W NP	carmellose sodium 10 mg/mL oral spray, 100 mL	£1	..	..	13.49	14.64	Aquae	IA
5335T NP	carmellose sodium 10 mg/mL oral spray, 25 mL	£1	..	..	11.64	12.79	Aquae	IA

HYPROMELLOSE

Authority required (STREAMLINED)

3636

Initial supply, for up to 4 months, for a palliative care patient where dry mouth is a symptom

5421H NP	HYPROMELLOSE Oral gel 20 mg per g, 100 g, 1	£1	3	..	12.73	13.88	Aquae Gel	IA

HYPROMELLOSE

Authority required (STREAMLINED)

3637

Continuing supply for a palliative care patient where dry mouth 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.

5422J NP	HYPROMELLOSE Oral gel 20 mg per g, 100 g, 1	£1	..	..	12.73	13.88	Aquae Gel	IA

PREPARATIONS WHICH MAY BE PRESCRIBED FOR PATIENTS RECEIVING PALLIATIVE CARE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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

5317W NP	hyoscine butylbromide 20 mg/mL injection, 5 x 1 mL ampoules	6	3	..	*108.88	36.90	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.

5318X NP	hyoscine butylbromide 20 mg/mL injection, 5 x 1 mL ampoules	6	..	..	*108.88	36.90	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

5303D NP	bisacodyl 10 mg suppository, 10	3	3	..	*21.28	22.43	^a Petrus Bisacodyl Suppositories	PP
				^B 1.50	*22.78	22.43	^a Dulcolax	BY
5304E NP	bisacodyl 10 mg suppository, 12	3	3	..	*18.67	19.82	Petrus Bisacodyl Suppositories	PP
5301B NP	bisacodyl 5 mg tablet: enteric, 200 tablets	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.

5307H NP	bisacodyl 10 mg suppository, 10	3	..	..	*21.28	22.43	^a Petrus Bisacodyl Suppositories	PP
				^B 1.50	*22.78	22.43	^a Dulcolax	BY
5308J NP	bisacodyl 10 mg suppository, 12	3	..	..	*18.67	19.82	Petrus Bisacodyl Suppositories	PP
5305F NP	bisacodyl 5 mg tablet: enteric, 200 tablets	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

5322D NP	rhamnus frangula 80 mg/g + sterculia 620 mg/g granules, 500 g	#1	3	..	26.71	27.86	Normacol Plus	NE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$		Brand Name and Manufacturer	
	RHAMNUS FRANGULA + STERCULIA								
	<u>Authority required (STREAMLINED)</u>								
	3643								
	Continuing supply for a palliative care patient where constipation is a problem								
	<u>Note</u>								
	Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.								
5324F NP	rhamnus frangula 80 mg/g + sterculia 620 mg/g granules, 500 g	#1	..	..	26.71	27.86		Normacol Plus	NE
	Osmotically acting laxatives								
	LACTULOSE								
	<u>Authority required (STREAMLINED)</u>								
	3642								
	Initial supply, for up to 4 months, for a palliative care patient where constipation is a problem								
5387M NP	LACTULOSE Mixture 3.34 g per 5 mL, 500 mL, 1	3	3	.. ^B 2.67	*18.58 *21.25	19.73 19.73	^a ^a	Genlac Actilax	QA AF
	LACTULOSE								
	<u>Authority required (STREAMLINED)</u>								
	3643								
	Continuing supply for a palliative care patient where constipation is a problem								
	<u>Note</u>								
	Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.								
5388N NP	LACTULOSE Mixture 3.34 g per 5 mL, 500 mL, 1	3	..	.. ^B 2.67	*18.58 *21.25	19.73 19.73	^a ^a	Genlac Actilax	QA AF
	MACROGOL-3350								
	<u>Authority required (STREAMLINED)</u>								
	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.								
	<u>Note</u>								
	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.								
2351R NP	macrogol-3350 1 g/g oral liquid: powder for, 30 x 17 g sachets	2	3	..	*35.02	36.17	^a	MediHealth ClearLax	ON
5426N NP	macrogol-3350 1 g/g oral liquid: powder for, 510 g	2	3	..	*35.02	36.17	^a	OsmoLax	KY
	MACROGOL-3350								
	<u>Authority required (STREAMLINED)</u>								
	4170								
	Constipation								
	Treatment Phase: Continuing treatment								
	Clinical criteria:								
	Patient must be receiving palliative care.								
	<u>Note</u>								
	Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.								
	<u>Note</u>								
	Pharmaceutical benefits that have the form macrogol-3350 1 g/g oral liquid: powder for, 510 g and pharmaceutical benefits that have the form								

PREPARATIONS WHICH MAY BE PRESCRIBED FOR PATIENTS RECEIVING PALLIATIVE CARE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	macrogol-3350 1 g/g oral liquid: powder for, 30 x 17 g sachets are equivalent for the purposes of substitution.							
2353W NP	macrogol-3350 1 g/g oral liquid: powder for, 30 x 17 g sachets	2	..	..	*35.02	36.17	^a MediHealth ClearLax	ON
5427P NP	macrogol-3350 1 g/g oral liquid: powder for, 510 g	2	..	..	*35.02	36.17	^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.

5389P NP	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	2	3	..	*35.02	36.17	^a APO-MACROGOL plus ELECTROLYTES	TX
							^a LaxaCon	GN
							^a lax-sachets	AE
							^a Macrovic	QA
							^a Molaxole	HM
							^a Movicol	NE
10127B NP	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	2	3	..	*25.60	26.75	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.

5390Q NP	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	2	..	..	*35.02	36.17	^a APO-MACROGOL plus ELECTROLYTES	TX
							^a LaxaCon	GN
							^a lax-sachets	AE
							^a Macrovic	QA
							^a Molaxole	HM
							^a Movicol	NE
10112F NP	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	2	..	..	*25.60	26.75	Movicol Liquid	NE

Enemas

BISACODYL

Authority required (STREAMLINED)

PREPARATIONS WHICH MAY BE PRESCRIBED FOR PATIENTS RECEIVING PALLIATIVE CARE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
3642								
Initial supply, for up to 4 months, for a palliative care patient where constipation is a problem								
5302C NP	bisacodyl 10 mg/5 mL enema, 25 x 5 mL	\$1	3	..	38.28	36.90	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.								
5306G NP	bisacodyl 10 mg/5 mL enema, 25 x 5 mL	\$1	..	..	38.28	36.90	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								
5331N NP	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	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.								
5332P NP	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	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.

Note

Special Pricing Arrangements apply.

5424L NP	METHYLNALTREXONE Solution for injection containing methylnaltrexone bromide 12 mg in 0.6 mL, 7	1	..	..	288.18	36.90	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.

Note

Special Pricing Arrangements apply.

5423K NP	methylnaltrexone bromide 12 mg/0.6 mL injection, 1 x 0.6 mL vial	3	..	..	*130.93	36.90	Relistor	LM

Other drugs for constipation

PREPARATIONS WHICH MAY BE PRESCRIBED FOR PATIENTS RECEIVING PALLIATIVE CARE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
GLYCEROL								
<u>Authority required (STREAMLINED)</u>								
3642								
Initial supply, for up to 4 months, for a palliative care patient where constipation is a problem								
5312N NP	glycerol 1.4 g suppository, 12	3	3	..	*20.23	21.38	Petrus Pharmaceuticals Pty Ltd	PP
5313P NP	glycerol 2.8 g suppository, 12	3	3	..	*20.74	21.89	Petrus Pharmaceuticals Pty Ltd	PP
5311M NP	glycerol 700 mg suppository, 12	3	3	..	*19.81	20.96	Petrus Pharmaceuticals Pty Ltd	PP
GLYCEROL								
<u>Authority required (STREAMLINED)</u>								
3643								
Continuing supply for a palliative care patient where constipation is a problem								
<u>Note</u>								
Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.								
5315R NP	glycerol 1.4 g suppository, 12	3	..	..	*20.23	21.38	Petrus Pharmaceuticals Pty Ltd	PP
5316T NP	glycerol 2.8 g suppository, 12	3	..	..	*20.74	21.89	Petrus Pharmaceuticals Pty Ltd	PP
5314Q NP	glycerol 700 mg suppository, 12	3	..	..	*19.81	20.96	Petrus Pharmaceuticals Pty Ltd	PP

PREPARATIONS WHICH MAY BE PRESCRIBED FOR PATIENTS RECEIVING PALLIATIVE CARE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

MUSCULO-SKELETAL SYSTEM

ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS

ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS, NON-STERIODS

Acetic acid derivatives and related substances

DICLOFENAC

Authority required

Initial supply, for up to 4 months, for a palliative care patient where severe pain is a problem

5363G NP	diclofenac sodium 100 mg suppository, 20	2	3	..	*25.26	26.41	Voltaren 100	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.

5366K NP	diclofenac sodium 100 mg suppository, 20	2	..	..	*25.26	26.41	Voltaren 100	NV

DICLOFENAC

Authority required (STREAMLINED)

3645

Initial supply, for up to 4 months, for a palliative care patient where severe pain is a problem

5361E NP	diclofenac sodium 25 mg tablet: enteric, 50 tablets	2	3	..	*11.10	12.25	^a APO-Diclofenac	TX
							^a Chem mart Diclofenac	CH
							^a Clonac 25	QA
							^a Diclofenac AN	EA
							^a Diclofenac-GA	GN
							^a Diclofenac Sandoz	SZ
							^a Fenac 25	AF
							^a Terry White Chemists Diclofenac	TW
				^B 1.62	*12.72	12.25	^a Voltaren 25	NV
5362F NP	diclofenac sodium 50 mg tablet: enteric, 50 tablets	1	3	..	9.78	10.93	^a APO-Diclofenac	TX
							^a Chem mart Diclofenac	CH
							^a Clonac 50	QA
							^a Diclofenac AN	EA
							^a Diclofenac-GA	GN
							^a Diclofenac Sandoz	SZ
							^a Fenac	AF
							^a Terry White Chemists Diclofenac	TW
				^B 1.61	11.39	10.93	^a Voltaren 50	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.

5364H NP	diclofenac sodium 25 mg tablet: enteric, 50 tablets	2	..	..	*11.10	12.25	^a APO-Diclofenac	TX
							^a Chem mart Diclofenac	CH
							^a Clonac 25	QA
							^a Diclofenac AN	EA

PREPARATIONS WHICH MAY BE PRESCRIBED FOR PATIENTS RECEIVING PALLIATIVE CARE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
5365J NP	diclofenac sodium 50 mg tablet: enteric, 50 tablets	1	..	..	9.78	10.93	^a Diclofenac-GA	GN
							^a Diclofenac Sandoz	SZ
							^a Fenac 25	AF
							^a Terry White Chemists Diclofenac	TW
							^a Voltaren 25	NV
							^a APO-Diclofenac	TX
							^a Chem mart Diclofenac	CH
							^a Clonac 50	QA
							^a Diclofenac AN	EA
							^a Diclofenac-GA	GN
							^a Diclofenac Sandoz	SZ
							^a Fenac	AF
							^a Terry White Chemists Diclofenac	TW
							^B 1.62	*12.72
			^B 1.61	11.39	10.93			
INDOMETHACIN								
<u>Authority required</u>								
Initial supply, for up to 4 months, for a palliative care patient where severe pain is a problem								
5378C NP	indomethacin 100 mg suppository, 20	2	3	..	*22.84	23.99	Indocid	AS
INDOMETHACIN								
<u>Authority required</u>								
Continuing supply for a palliative care patient where severe pain is a problem								
<u>Note</u>								
Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.								
5380E NP	indomethacin 100 mg suppository, 20	2	..	..	*22.84	23.99	Indocid	AS
INDOMETHACIN								
<u>Authority required (STREAMLINED)</u>								
3645								
Initial supply, for up to 4 months, for a palliative care patient where severe pain is a problem								
5377B NP	indomethacin 25 mg capsule, 50	2	3	..	*13.20	14.35	^a Arthrexin	AF
				^B 4.64	*17.84	14.35	^a Indocid	AS
INDOMETHACIN								
<u>Authority required (STREAMLINED)</u>								
3646								
Continuing supply for a palliative care patient where severe pain is a problem								
<u>Note</u>								
Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.								
5379D NP	indomethacin 25 mg capsule, 50	2	..	..	*13.20	14.35	^a Arthrexin	AF
				^B 4.64	*17.84	14.35	^a Indocid	AS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$		Brand Name and Manufacturer	
	Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.								
5370P NP	ibuprofen 400 mg tablet, 30	3	..	..	*15.07	16.22		Brufen	AB
	NAPROXEN								
	<u>Authority required (STREAMLINED)</u>								
	3645								
	Initial supply, for up to 4 months, for a palliative care patient where severe pain is a problem								
5348L NP	naproxen 1 g tablet: modified release, 28	1	3	.. ^B 1.29	14.30 15.59	15.45	^a	Proxen SR 1000	MD
5345H NP	naproxen 250 mg tablet, 50	2	3	.. ^B 2.24	*13.68 *15.92	14.83	^a	Naprosyn SR1000 Inza 250	RO AF
5346J NP	naproxen 500 mg tablet, 50	1	3	.. ^B 1.28	12.94 14.22	14.09	^a	Naprosyn Inza 500	RO AF
5347K NP	naproxen 750 mg tablet: modified release, 28 tablets	1	3	.. ^B 1.22	12.42 13.64	13.57	^a	Naprosyn Proxen SR 750 Naprosyn SR750	RO MD RO
	NAPROXEN								
	<u>Authority required (STREAMLINED)</u>								
	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.								
5352Q NP	naproxen 1 g tablet: modified release, 28	1	..	.. ^B 1.29	14.30 15.59	15.45	^a	Proxen SR 1000	MD
5349M NP	naproxen 250 mg tablet, 50	2	..	.. ^B 2.24	*13.68 *15.92	14.83	^a	Naprosyn SR1000 Inza 250	RO AF
5350N NP	naproxen 500 mg tablet, 50	1	..	.. ^B 1.28	12.94 14.22	14.09	^a	Naprosyn Inza 500	RO AF
5351P NP	naproxen 750 mg tablet: modified release, 28 tablets	1	..	.. ^B 1.22	12.42 13.64	13.57	^a	Naprosyn Proxen SR 750 Naprosyn SR750	RO MD RO
	NAPROXEN								
	<u>Authority required (STREAMLINED)</u>								
	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.								
5397C NP	naproxen 125 mg/5 mL oral liquid, 474 mL	#1	3	..	127.96	36.90		Phebra Naproxen Suspension	PL
	NAPROXEN								
	<u>Authority required (STREAMLINED)</u>								
	4129								
	Severe pain								
	Treatment Phase: Continuing treatment								

PREPARATIONS WHICH MAY BE PRESCRIBED FOR PATIENTS RECEIVING PALLIATIVE CARE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
5398D NP	naproxen 125 mg/5 mL oral liquid, 474 mL	\$1	..	..	127.96	36.90	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								
Note								
Naproxen sodium 550 mg is approximately equivalent to 500 mg of naproxen acid.								
5353R NP	naproxen sodium 550 mg tablet, 50	1	3	..	13.11	14.26	^a Crysanal	MD
				^b 2.17	15.28	14.26	^a Anaprox 550	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.								
Note								
Naproxen sodium 550 mg is approximately equivalent to 500 mg of naproxen acid.								
5354T NP	naproxen sodium 550 mg tablet, 50	1	..	..	13.11	14.26	^a Crysanal	MD
				^b 2.17	15.28	14.26	^a Anaprox 550	RO

PREPARATIONS WHICH MAY BE PRESCRIBED FOR PATIENTS RECEIVING PALLIATIVE CARE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

NERVOUS SYSTEM

ANALGESICS

OPIOIDS

Natural opium alkaloids

MORPHINE

Authority required

Initial supply, for up to 3 months, for a palliative care patient with severe disabling pain not responding to non-narcotic analgesics

Caution

The risk of drug dependence is high.

Note

Telephone approvals are limited to 1 month's therapy.

5393W NP	morphine sulfate 10 mg tablet, 20	1	2	..	14.66	15.81	Sevredol	MF
5394X NP	morphine sulfate 20 mg tablet, 20	1	2	..	15.60	16.75	Sevredol	MF

MORPHINE

Authority required

Continuing supply for a palliative care patient with severe disabling pain not responding to non-narcotic analgesics

Caution

The risk of drug dependence is high.

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.

5395Y NP	morphine sulfate 10 mg tablet, 20	1	..	..	14.66	15.81	Sevredol	MF
5396B NP	morphine sulfate 20 mg tablet, 20	1	..	..	15.60	16.75	Sevredol	MF

MORPHINE

Authority required

Initial supply, for up to 3 months, for a palliative care patient with chronic severe disabling pain not responding to non-narcotic analgesics

Caution

The risk of drug dependence is high.

Note

Telephone approvals are limited to 1 month's therapy.

5391R NP	morphine sulfate 200 mg tablet: modified release, 28 tablets	1	2	..	122.20	36.90	MS Contin	MF

MORPHINE

Authority required

Continuing supply for a palliative care patient with chronic severe disabling pain not responding to non-narcotic analgesics

Caution

The risk of drug dependence is high.

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.

5392T NP	morphine sulfate 200 mg tablet: modified release, 28 tablets	1	..	..	122.20	36.90	MS Contin	MF

Phenylpiperidine derivatives

FENTANYL

Authority required

Breakthrough pain

PREPARATIONS WHICH MAY BE PRESCRIBED FOR PATIENTS RECEIVING PALLIATIVE CARE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
Caution								
The risk of drug dependence is high.								
Note								
For first continuing supply, applications for increased repeats for up to 3 months' supply may be authorised.								
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.								
Note								
Telephone approvals are limited to 1 months' 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.								
5411T NP	FENTANYL Lozenge 1200 micrograms (as citrate), 30	2	..	..	*579.77	36.90	Actiq	OA
5412W NP	FENTANYL Lozenge 1600 micrograms (as citrate), 30	2	..	..	*579.77	36.90	Actiq	OA
5407N NP	FENTANYL Lozenge 200 micrograms (as citrate), 30	2	..	..	*579.77	36.90	Actiq	OA
5408P NP	FENTANYL Lozenge 400 micrograms (as citrate), 30	2	..	..	*579.77	36.90	Actiq	OA
5409Q NP	FENTANYL Lozenge 600 micrograms (as citrate), 30	2	..	..	*579.77	36.90	Actiq	OA
5410R NP	FENTANYL Lozenge 800 micrograms (as citrate), 30	2	..	..	*579.77	36.90	Actiq	OA
FENTANYL								
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.								
Caution								
The risk of drug dependence is high.								
Note								
No increase in the maximum number of repeats may be authorised.								
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.								
5405L	FENTANYL Lozenge 1200 micrograms	1	..	..	99.95	36.90	Actiq	OA

PREPARATIONS WHICH MAY BE PRESCRIBED FOR PATIENTS RECEIVING PALLIATIVE CARE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
NP	(as citrate), 9							
5406M	FENTANYL Lozenge 1600 micrograms	1	..	..	99.95	36.90	Actiq	OA
NP	(as citrate), 9							
5401G	FENTANYL Lozenge 200 micrograms (as citrate), 9	1	..	..	99.95	36.90	Actiq	OA
NP								
5402H	FENTANYL Lozenge 400 micrograms (as citrate), 9	1	..	..	99.95	36.90	Actiq	OA
NP								
5403J	FENTANYL Lozenge 600 micrograms (as citrate), 9	1	..	..	99.95	36.90	Actiq	OA
NP								
5404K	FENTANYL Lozenge 800 micrograms (as citrate), 9	1	..	..	99.95	36.90	Actiq	OA
NP								

Diphenylpropylamine derivatives

METHADONE

Authority required

Initial supply, for up to 3 months, for a palliative care patient with chronic severe disabling pain not responding to non-narcotic analgesics

Caution

The risk of drug dependence is high.

Note

Telephone approvals are limited to 1 month's 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.

5399E	methadone hydrochloride 5 mg/mL oral liquid, 200 mL	1	2	..	19.25	20.40	Aspen Methadone Syrup	QA
NP								

METHADONE

Authority required

Continuing supply for a palliative care patient with chronic severe disabling pain not responding to non-narcotic analgesics

Caution

The risk of drug dependence is high.

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.

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.

5400F	methadone hydrochloride 5 mg/mL oral liquid, 200 mL	1	..	..	19.25	20.40	Aspen Methadone Syrup	QA
NP								

OTHER ANALGESICS AND ANTIPYRETICS

Anilides

PARACETAMOL

Authority required (STREAMLINED)

3649

Initial supply, for up to 4 months, for a palliative care patient for analgesia or fever where alternative therapy cannot be tolerated

5319Y	paracetamol 500 mg suppository, 24	4	3	..	*84.80	36.90	Panadol	GC
NP								
5343F	paracetamol 665 mg tablet: modified release, 96 tablets	2	3	..	*15.34	16.49	^a APO-Osteo Paracetamol 665 mg	TX
NP							^a Blooms the Chemist Osteo Pain Relief Paracetamol 665 mg	IB
							^a Chem mart Pharmacy Osteo Relief Paracetamol 665 mg	CH
							^a Osteomol 665 Paracetamol	CR
							^a Terry White Chemists	TW

PREPARATIONS WHICH MAY BE PRESCRIBED FOR PATIENTS RECEIVING PALLIATIVE CARE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
				^B 1.64	*16.98	16.49	^a Osteo Relief Paracetamol 665 mg Panadol Osteo	GC
PARACETAMOL								
<u>Authority required (STREAMLINED)</u>								
3650								
Continuing supply for a palliative care patient for analgesia or fever where alternative therapy cannot be tolerated								
<u>Note</u>								
Written or telephone authority applications for increased repeats may be approved where consultation with a palliative care specialist or service has occurred.								
5320B NP	paracetamol 500 mg suppository, 24	4	..	..	*84.80	36.90	Panadol	GC
5344G NP	paracetamol 665 mg tablet: modified release, 96 tablets	2	..	..	*15.34	16.49	^a APO-Osteo Paracetamol 665 mg	TX
							^a Blooms the Chemist Osteo Pain Relief Paracetamol 665 mg	IB
							^a Chem mart Pharmacy Osteo Relief Paracetamol 665 mg	CH
							^a Osteomol 665 Paracetamol	CR
							^a Terry White Chemists Osteo Relief Paracetamol 665 mg	TW
				^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.

5338Y NP	clonazepam 2 mg tablet, 100	1	3	..	19.08	20.23	^a Paxam 2	AF
				^B 1.93	21.01	20.23	^a Rivotril	RO
5339B NP	clonazepam 2.5 mg/mL oral liquid, 10 mL	2	3	..	*15.38	16.53	Rivotril	RO
5337X NP	clonazepam 500 microgram tablet, 100	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.

5341D NP	clonazepam 2 mg tablet, 100	1	..	..	19.08	20.23	^a Paxam 2	AF
				^B 1.93	21.01	20.23	^a Rivotril	RO
5342E NP	clonazepam 2.5 mg/mL oral liquid, 10 mL	2	..	..	*15.38	16.53	Rivotril	RO
5340C NP	clonazepam 500 microgram tablet, 100	1	..	..	13.30	14.45	^a Paxam 0.5	AF
				^B 1.71	15.01	14.45	^a Rivotril	RO

PREPARATIONS WHICH MAY BE PRESCRIBED FOR PATIENTS RECEIVING PALLIATIVE CARE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer
PSYCHOLEPTICS							
ANXIOLYTICS							
<i>Benzodiazepine derivatives</i>							
DIAZEPAM							
<u>Authority required</u>							
Initial supply, for up to 4 months, for a palliative care patient where anxiety is a problem							
<u>Note</u>							
No applications for increased repeats will be authorised.							
5355W NP	diazepam 2 mg tablet, 50	1	3	..	7.92	9.07	^a Antenex 2 AF
							^a APO-Diazepam TX
							^a Ranzepam RA
							^a Valpam 2 QA
5356X NP	diazepam 5 mg tablet, 50	1	3	..	8.04	9.19	^a Antenex 5 AF
							^a APO-Diazepam TX
							^a Diazepam-GA GN
							^a Ranzepam RA
							^a Valpam 5 QA
				^b 0.76	8.80	9.19	^a Valium RO
DIAZEPAM							
<u>Authority required</u>							
Continuing supply for a palliative care patient where anxiety is a problem							
<u>Note</u>							
Where consultation with a palliative care specialist or service has occurred, applications for increased repeats may be authorised.							
5357Y NP	diazepam 2 mg tablet, 50	1	..	..	7.92	9.07	^a Antenex 2 AF
							^a APO-Diazepam TX
							^a Ranzepam RA
							^a Valpam 2 QA
5358B NP	diazepam 5 mg tablet, 50	1	..	..	8.04	9.19	^a Antenex 5 AF
							^a APO-Diazepam TX
							^a Diazepam-GA GN
							^a Ranzepam RA
							^a Valpam 5 QA
				^b 0.76	8.80	9.19	^a Valium RO
OXAZEPAM							
<u>Authority required</u>							
Initial supply, for up to 4 months, for a palliative care patient where anxiety is a problem							
<u>Note</u>							
No applications for increased repeats will be authorised.							
5371Q NP	oxazepam 15 mg tablet, 25	2	3	..	*9.24	10.39	^a Alepam 15 AF
				^b 5.36	*14.60	10.39	^a Serepax QA
5372R NP	oxazepam 30 mg tablet, 25	2	3	..	*9.24	10.39	^a Alepam 30 AF
							^a APO-Oxazepam TX
							^a Murelax FM
				^b 5.36	*14.60	10.39	^a Serepax QA
OXAZEPAM							
<u>Authority required</u>							
Continuing supply for a palliative care patient where anxiety is a problem							
<u>Note</u>							
Where consultation with a palliative care specialist or service has occurred, applications for increased repeats may be authorised.							
5373T	oxazepam 15 mg tablet, 25	2	..	..	*9.24	10.39	^a Alepam 15 AF

PREPARATIONS WHICH MAY BE PRESCRIBED FOR PATIENTS RECEIVING PALLIATIVE CARE

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$		Brand Name and Manufacturer	
NP									
5374W	oxazepam 30 mg tablet, 25	2	..	^B 5.36	*14.60	10.39	^a	Serepax	QA
NP				..	*9.24	10.39	^a	Alepam 30	AF
							^a	APO-Oxazepam	TX
							^a	Murelax	FM
				^B 5.36	*14.60	10.39	^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.

5359C	nitrazepam 5 mg tablet, 25	2	3	..	*9.94	11.09	^a	Alodorm	AF
NP				^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.

5360D	nitrazepam 5 mg tablet, 25	2	..	..	*9.94	11.09	^a	Alodorm	AF
NP				^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.

5375X	temazepam 10 mg tablet, 25	2	3	..	*8.62	9.77	^a	APO-Temazepam	TX
NP							^a	Temaze	AF
							^a	Temtabs	FM
				^B 8.00	*16.62	9.77	^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.

5376Y	temazepam 10 mg tablet, 25	2	..	..	*8.62	9.77	^a	APO-Temazepam	TX
NP							^a	Temaze	AF
							^a	Temtabs	FM
				^B 8.00	*16.62	9.77	^a	Normison	QA

Items Available under Special Arrangements(Section 100)

Section 100 – Items Available under Special Arrangement

In addition to the drugs and medicinal preparations available under normal PBS arrangements listed in this Schedule, a number of drugs are also available as pharmaceutical benefits but are distributed under alternative arrangements where these are considered more appropriate.

These alternative arrangements are provided for under section 100 of the National Health Act 1953. Several programs exist for the provision of drugs as pharmaceutical benefits in this way and this section lists those drugs which are available under the following programs:

- **Highly Specialised Drugs Program**
- **Botulinum Toxin Program**
- **Human Growth Hormone Program**
- **IVF/GIFT Program**
- **Opiate Dependence Treatment Program**

Complete details concerning the availability of drugs as benefits under these programs may be obtained by telephoning the relevant contact number(s) shown in each section, or in certain cases, by referring to the telephone number provided for individual drugs listings.

Section 100 – Highly Specialised Drugs Program

The Australian Government provides funding for certain specialised medications under the Highly Specialised Drugs Program. Highly Specialised Drugs are medicines for the treatment of chronic conditions which, because of their clinical use or other special features, are restricted to supply through public and private hospitals having access to appropriate specialist facilities. To prescribe these drugs as pharmaceutical benefit items, medical practitioners are required to be affiliated with these specialist hospital units. A general practitioner or non-specialist hospital doctor may only prescribe Highly Specialised Drugs to provide maintenance therapy under the guidance of the treating specialist.

Benefits are available for the listed clinical indications only. There is no facility for individual patient approval for indications outside those listed.

To gain access to a Commonwealth funded drug under this program, a patient must attend a participating hospital and be a day admitted patient, a non-admitted patient or a patient on discharge, be under appropriate specialist medical care, meet the specific medical criteria and be an Australian resident in Australia (or other eligible person).

A patient will be required to pay a contribution for each supply of a highly specialised drug at a similar rate to the Pharmaceutical Benefits Scheme. Commonwealth subsidy is not available for hospital in-patients.

Reciprocal Health Care Agreement – Where a patient is entitled to be treated as an eligible person as a visitor from a country with which Australia has entered into a Reciprocal Health Care Agreement, the supply will be limited to the original prescription only. Repeat prescriptions for these patients are not permitted.

Private Hospitals – **In addition to the above requirements**, for Highly Specialised Drugs prescribed through private hospitals, claiming and approval of authority prescriptions is administered by Medicare Australia. Highly Specialised Drugs are authority required items. Medical practitioners must seek approval to prescribe these items as pharmaceutical benefits prior to their dispensing under the PBS. Approval of authority prescriptions by Medicare Australia may be obtained either by posting an Authority Prescription Form to Medicare Australia, or by using Medicare Australia's Authority Freecall service (1800 888 333). **Prescribers must quote the provider number of the hospital when applying.** Not more than two months' supply (one month's supply in the case of Clozapine), with provision for up to 5 repeats, will be authorised. Prescriptions for Highly Specialised Drugs can be dispensed by an approved private hospital's dispensary or by a community pharmacy.

The remuneration rates for Highly Specialised Drugs prescribed through private hospitals comprise the normal PBS ready- prepared dispensing fee plus a mark-up ascertained as follows:

- 10% for drugs with a price ex-manufacturer of less than \$40;
- \$4 for drugs with a price ex-manufacturer of between \$40 and \$100;
- 4% for drugs with a price ex-manufacturer of between \$100.01 and \$1000;
- \$40 for drugs with a price ex-manufacturer of greater than \$1000.

Public Hospitals – For Highly Specialised Drugs prescribed through public hospitals, claiming and access to the program is administered by the States/Territories Health Departments. Prescriptions for Highly Specialised Drugs can be dispensed by public hospital pharmacies.

If you would like further information about the Highly Specialised Drugs Program, please contact your pharmacy, Medicare Australia (Ph: 132 290) or the Australian Government adviser, the Highly Specialised Drugs Working Party Secretariat (Ph: (02) 6289 2331).

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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:

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	(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 <u>Authority required</u> 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) <u>Note</u> 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. <u>Note</u> 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. <u>Note</u> No applications for increased repeats will be authorised.						
5827Q	eltrombopag 25 mg tablet, 28	1	5	..	1558.76	Revolade	GK
5828R	eltrombopag 50 mg tablet, 28	1	5	..	3070.76	Revolade	GK

ROMIPILOSTIM

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty	Brand Name and Manufacturer	
					\$		
HOBART TAS 7001							
Further prescribing information is on the Medicare Australia website at www.medicareaustralia.gov.au .							
<u>Note</u>							
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.							
<u>Note</u>							
Special Pricing Arrangements apply.							
9697J	romiplostim 250 microgram injection, 1 x 250 microgram vial	1	..	..	1023.36	Nplate	AN
9699L	romiplostim 500 microgram injection, 1 x 500 microgram vial	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

6320P	darbepoetin alfa 10 microgram/0.4 mL injection, 4 x 0.4 mL syringes	2	5	..	*377.08	Aranesp	AN
6492Q	darbepoetin alfa 100 microgram/0.5 mL injection, 1 x 0.5 mL syringe	8	5	..	*2667.24	Aranesp SureClick	AN
6326Y	darbepoetin alfa 100 microgram/0.5 mL injection, 4 x 0.5 mL syringes	2	5	..	*2667.26	Aranesp	AN
6493R	darbepoetin alfa 150 microgram/0.3 mL injection, 1 x 0.3 mL syringe	8	5	..	*3951.24	Aranesp SureClick	AN
6365B	darbepoetin alfa 150 microgram/0.3 mL injection, 4 x 0.3 mL syringes	2	5	..	*3951.26	Aranesp	AN
6488L	darbepoetin alfa 20 microgram/0.5 mL injection, 1 x 0.5 mL syringe	8	5	..	*704.20	Aranesp SureClick	AN
6321Q	darbepoetin alfa 20 microgram/0.5 mL injection, 4 x 0.5 mL syringes	2	5	..	*704.20	Aranesp	AN
6322R	darbepoetin alfa 30 microgram/0.3 mL injection, 4 x 0.3 mL syringes	2	5	..	*960.92	Aranesp	AN
6489M	darbepoetin alfa 40 microgram/0.4 mL injection, 1 x 0.4 mL syringe	8	5	..	*1160.36	Aranesp SureClick	AN
6323T	darbepoetin alfa 40 microgram/0.4 mL injection, 4 x 0.4 mL syringes	2	5	..	*1160.36	Aranesp	AN
6324W	darbepoetin alfa 50 microgram/0.5 mL injection, 4 x 0.5 mL syringes	2	5	..	*1423.54	Aranesp	AN
6490N	darbepoetin alfa 60 microgram/0.3 mL injection, 1 x 0.3 mL syringe	8	5	..	*1663.40	Aranesp SureClick	AN
6325X	darbepoetin alfa 60 microgram/0.3 mL injection, 4 x 0.3 mL syringes	2	5	..	*1663.42	Aranesp	AN
6491P	darbepoetin alfa 80 microgram/0.4 mL injection, 1 x 0.4 mL syringe	8	5	..	*2174.76	Aranesp SureClick	AN
6438W	darbepoetin alfa 80 microgram/0.4 mL injection, 4 x 0.4 mL syringes	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

6207Q	epoetin alfa 10 000 international units/mL injection, 6 x 1 mL syringes	2	5	..	*2017.06	Eprex 10000	JC
6251B	epoetin alfa 1000 international units/0.5 mL injection, 6 x 0.5 mL syringes	2	5	..	*297.24	Eprex 1000	JC
6434P	epoetin alfa 20 000 international units/0.5 mL injection, 6 x 0.5 mL syringes	2	5	..	*3922.76	Eprex 20,000	JC

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty	Brand Name and Manufacturer	
					\$		
6204M	epoetin alfa 2000 international units/0.5 mL injection, 6 x 0.5 mL syringes	2	5	..	*544.24	Eprex 2000	JC
6205N	epoetin alfa 3000 international units/0.3 mL injection, 6 x 0.3 mL syringes	2	5	..	*700.34	Eprex 3000	JC
6339P	epoetin alfa 40 000 international units/mL injection, 1 x 1 mL syringe	2	5	..	*1300.76	Eprex 40,000	JC
6206P	epoetin alfa 4000 international units/0.4 mL injection, 6 x 0.4 mL syringes	2	5	..	*890.04	Eprex 4000	JC
6302Q	epoetin alfa 5000 international units/0.5 mL injection, 6 x 0.5 mL syringes	2	5	..	*1104.10	Eprex 5000	JC
6303R	epoetin alfa 6000 international units/0.6 mL injection, 6 x 0.6 mL syringes	2	5	..	*1301.90	Eprex 6000	JC
6305W	epoetin alfa 8000 international units/0.8 mL injection, 6 x 0.8 mL syringes	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

6485H	epoetin beta 10 000 international units/0.6 mL injection, 6 x 0.6 mL syringes	2	5	..	*2017.06	NeoRecormon	RO
6480C	epoetin beta 2000 international units/0.3 mL injection, 6 x 0.3 mL syringes	2	5	..	*544.24	NeoRecormon	RO
6481D	epoetin beta 3000 international units/0.3 mL injection, 6 x 0.3 mL syringes	2	5	..	*700.34	NeoRecormon	RO
6482E	epoetin beta 4000 international units/0.3 mL injection, 6 x 0.3 mL syringes	2	5	..	*890.04	NeoRecormon	RO
6483F	epoetin beta 5000 international units/0.3 mL injection, 6 x 0.3 mL syringes	2	5	..	*1104.12	NeoRecormon	RO
6484G	epoetin beta 6000 international units/0.3 mL injection, 6 x 0.3 mL syringes	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.

9595B	epoetin lambda 10 000 international units/mL injection, 6 x 1 mL syringes	2	5	..	*1913.36	Novicrit	NV
9685R	epoetin lambda 1000 international units/0.5 mL injection, 6 x 0.5 mL syringes	2	5	..	*281.94	Novicrit	NV
9686T	epoetin lambda 2000 international units/mL injection, 6 x 1 mL syringes	2	5	..	*515.94	Novicrit	NV
9687W	epoetin lambda 3000 international units/0.3 mL injection, 6 x 0.3 mL syringes	2	5	..	*663.84	Novicrit	NV
9688X	epoetin lambda 4000 international units/0.4 mL injection, 6 x 0.4 mL syringes	2	5	..	*843.54	Novicrit	NV
9588P	epoetin lambda 5000 international units/0.5 mL injection, 6 x 0.5 mL syringes	2	5	..	*1048.46	Novicrit	NV
9590R	epoetin lambda 6000 international units/0.6 mL injection, 6 x 0.6 mL syringes	2	5	..	*1235.84	Novicrit	NV
9593X	epoetin lambda 8000 international units/0.8 mL injection, 6 x 0.8 mL syringes	2	5	..	*1589.00	Novicrit	NV

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

9577C	methoxy polyethylene glycol-epoetin beta 100 microgram/0.3 mL injection, 1 x 0.3 mL syringe	2	5	..	*1205.58	Mircera	RO
9578D	methoxy polyethylene glycol-epoetin beta 120 microgram/0.3 mL injection, 1 x 0.3 mL syringe	2	5	..	*1388.40	Mircera	RO

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty	Brand Name and Manufacturer	
					\$		
9579E	methoxy polyethylene glycol-epoetin beta 200 microgram/0.3 mL injection, 1 x 0.3 mL syringe	2	5	..	*1971.06	Mircera	RO
9574X	methoxy polyethylene glycol-epoetin beta 30 microgram/0.3 mL injection, 1 x 0.3 mL syringe	2	5	..	*390.70	Mircera	RO
9580F	methoxy polyethylene glycol-epoetin beta 360 microgram/0.6 mL injection, 1 x 0.6 mL syringe	2	5	..	*3373.28	Mircera	RO
9575Y	methoxy polyethylene glycol-epoetin beta 50 microgram/0.3 mL injection, 1 x 0.3 mL syringe	2	5	..	*646.68	Mircera	RO
9576B	methoxy polyethylene glycol-epoetin beta 75 microgram/0.3 mL injection, 1 x 0.3 mL syringe	2	5	..	*938.62	Mircera	RO

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

CARDIOVASCULAR SYSTEM

ANTIHYPERTENSIVES

OTHER ANTIHYPERTENSIVES

Other antihypertensives

AMBRISENTAN

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	

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.

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

Note

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: 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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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. 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 Note 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)					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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.

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

GPO Box 9826

HOBART TAS 7001

Note

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: 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;

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	(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.						
	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.						
	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						
	Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.						
9649W	ambrisentan 10 mg tablet, 30	1	..	..	2923.23	Volibris	GK
9648T	ambrisentan 5 mg tablet, 30	1	..	..	2923.23	Volibris	GK

BOSENTAN

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,

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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.

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.

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

Note

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: 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:

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	(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.					
	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.					
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

Note

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: 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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	Human Services will contact prescribers prior to dispatch of the second authority prescription to confirm the tablet strength required for the patient.					
	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. 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 Note 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: 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:					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

- (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.

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.

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

Note

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer	
Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.							
6430K	bosentan 125 mg tablet, 60	1	..	..	2923.23	Tracleer	AT

BOSENTAN

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

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.

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

Note

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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

Note

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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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.

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.

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

Note

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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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 <u>Note</u> Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals. <u>Authority required</u> 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. <u>Caution</u> 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. <u>Note</u> 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					
6429J	bosentan 62.5 mg tablet, 60	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:

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	

- (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.

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

Note

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note

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.

Note

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.

Authority required

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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.

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
	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						
	Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.						
	Note 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.						
	Note 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.						
	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						
	Note 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.						
	Note 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.						
	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:						

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

- (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

Note

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note

Pharmaceutical benefits that have the form epoprostenol sodium powder for I.V. infusion 1.5 mg (base) infusion administration set and

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer	
					Qty \$			
pharmaceutical benefits that have the form epoprostenol 1.5 mg injection vial are equivalent for the purposes of substitution.								
<u>Note</u>								
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.								
5042J	EPOPROSTENOL SODIUM Powder for I.V. infusion 1.5 mg (base) infusion administration set, 1	1	..	..	77.31	^a	Flolan Kit	GK
5036C	EPOPROSTENOL SODIUM Powder for I.V. infusion 500 micrograms (base) infusion administration set, 1	1	..	..	43.37	^a	Flolan Kit	GK
10129D	epoprostenol 1.5 mg injection, 1 x 1.5 mg vial	1	..	..	77.31	^a	Veletri	AT
10111E	epoprostenol 500 microgram injection, 1 x 500 microgram vial	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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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.

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

Note

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note

Special Pricing Arrangements apply.

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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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.					
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

Note

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note

Special Pricing Arrangements apply.

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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

Note

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note

Special Pricing Arrangements apply.

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

Note

Special Pricing Arrangements apply.

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:

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

- (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

Note

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note

Special Pricing Arrangements apply.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
6456T	iloprost 20 microgram/2 mL inhalation: solution, 30 x 2 mL ampoules	1	..	..	1122.76	Ventavis	BN

MACITENTAN

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

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

Note

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: 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:

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
	(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.						

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

Note

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: Initial 3 (change or re-commencement of therapy for all patients)

Clinical criteria:

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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. 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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

HOBART TAS 7001

Note

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: 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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer	
					Qty	\$		
	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. 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. 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 Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.							
10134J	macitentan 10mg tablet, 30	1	..	..	2923.23		Opsumit	AT

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,

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

Note

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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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.

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

Note

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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

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

Note

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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer	
					Qty \$			
	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.							
	<u>Note</u>							
	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							
	<u>Note</u>							
	Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.							
9605M	sildenafil 20 mg tablet, 90	1	..	..	791.63	^a	APO-Sildenafil PHT	TX
						^a	Revatio	PF
						^a	Sildenafil Sandoz PHT	SZ
							20	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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.

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

Note

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)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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.					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

Note

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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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.

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

Note

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: 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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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					
	Note					
	Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.					
1304P	tadalafil 20 mg tablet, 56	1	..	..	878.83	Adcirca

1304P	tadalafil 20 mg tablet, 56	1	..	..	878.83	Adcirca	LY

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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 (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.

6425E	lanreotide 120 mg injection, 1 syringe	2	5	..	*4526.76	Somatuline Autogel	IS
6423C	lanreotide 60 mg injection, 1 syringe	2	5	..	*2736.76	Somatuline Autogel	IS
6424D	lanreotide 90 mg injection, 1 syringe	2	5	..	*3626.76	Somatuline Autogel	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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
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.							
6332G	lanreotide 30 mg injection: modified release [1 x 30 mg vial] (&) inert substance diluent [1 x 2 mL ampoule], 1 pack	2	11	..	*1546.76	Somatuline LA	IS
OCTREOTIDE <u>Authority required</u> 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 <u>Authority required</u> 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. <u>Authority required</u> 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.							
6426F	octreotide 10 mg injection: modified release [1 x 10 mg vial] (&) inert substance diluent [1 x 2.5 mL syringe], 1 pack	2	5	..	*2660.48	Sandostatin LAR	NV
6427G	octreotide 20 mg injection: modified release [1 x 20 mg vial] (&) inert substance diluent [1 x 2.5 mL syringe], 1 pack	2	5	..	*3526.38	Sandostatin LAR	NV
6428H	octreotide 30 mg injection: modified release [1 x 30 mg vial] (&) inert substance diluent [1 x 2.5 mL syringe], 1 pack	2	5	..	*4401.68	Sandostatin LAR	NV

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer	
					Qty \$			
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								
6228T	octreotide 100 microgram/mL injection, 5 x 1 mL ampoules	18	11	..	*1283.14	^a	Hospira Pty Limited	HH
						^a	Octreotide (SUN)	ZF
						^a	Octreotide MaxRx	GQ
						^a	Sandostatin 0.1	NV
6227R	octreotide 50 microgram/mL injection, 5 x 1 mL ampoules	18	11	..	*650.62	^a	Hospira Pty Limited	HH
						^a	Octreotide (SUN)	ZF
						^a	Octreotide MaxRx	GQ
						^a	Sandostatin 0.05	NV
6229W	octreotide 500 microgram/mL injection, 5 x 1 mL ampoules	18	11	..	*6241.24	^a	Hospira Pty Limited	HH
						^a	Octreotide (SUN)	ZF
						^a	Octreotide MaxRx	GQ
						^a	Sandostatin 0.5	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.

"Sustained" means the abnormality was detected on at least 2 blood samples collected over a period of 2 to 4 months.

Note

Special Pricing Arrangements apply.

9625N	cinacalcet 30 mg tablet, 28	2	5	..	*408.12		Sensipar	AN
9626P	cinacalcet 60 mg tablet, 28	2	5	..	*809.48		Sensipar	AN
9627Q	cinacalcet 90 mg tablet, 28	2	5	..	*1204.52		Sensipar	AN

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		

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

6221K	azithromycin 600 mg tablet, 8	2	5	..	*139.94	Zithromax	PF

CLARITHROMYCIN

Authority required

Treatment of Mycobacterium avium complex infections

6151R	clarithromycin 250 mg tablet, 100	1	2	..	28.76	Klacid	AB

6152T	clarithromycin 500 mg tablet, 100	1	2	..	50.68	Klacid	AB

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

6195C	rifabutin 150 mg capsule, 30	4	5	..	*680.00	Mycobutin	PF

ANTIVIRALS FOR SYSTEMIC USE

DIRECT ACTING ANTIVIRALS

Nucleosides and nucleotides excl. reverse transcriptase inhibitors

CIDOFOVIR

Authority required

Treatment of cytomegalovirus retinitis in patients with AIDS

6247T	cidofovir 375 mg/5 mL injection, 1 x 5 mL vial	4	3	..	*3646.76	Vistide	GI

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

6136Y	ganciclovir 500 mg injection, 5 x 500 mg vials	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

6280M	valaciclovir 500 mg tablet, 100	5	2	..	*956.26	^a APO-Valaciclovir	TX

				^a Valaciclovir RBX	RA

				^a Valtrex	AS

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer	
						^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

6357N	valganciclovir 450 mg tablet, 60	2	5	..	*4538.36	Valcyte	RO
9675F	valganciclovir 50 mg/mL oral liquid: powder for, 100 mL	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

6134W	FOSCARNET SODIUM I.V. infusion 24 mg per mL, 250 mL bottle, 6	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.

6451M	atazanavir 150 mg capsule, 60	2	5	..	*1090.58	Reyataz	BQ
6452N	atazanavir 200 mg capsule, 60	2	5	..	*1438.52	Reyataz	BQ
9614B	atazanavir 300 mg capsule, 30	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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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.					
	<u>Authority required</u>					
	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.					
	<u>Note</u>					
	No increase in the maximum quantity or number of units may be authorised.					
	<u>Note</u>					
	Treatment centres are required to have access to the following appropriate specialist facilities for the provision of clinical support services for					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	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.						
2435E	Boceprevir 200 mg capsule, 336 capsules	1	10	..	3966.76	Victrelis	MK

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

9581G	darunavir 150 mg tablet, 240	1	5	..	1095.47	Prezista	JC
5000E	darunavir 600 mg tablet, 60	2	5	..	*2144.18	Prezista	JC

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.

10000H	darunavir 800 mg tablet, 30	2	5	..	*1445.04	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.

6454Q	fosamprenavir 50 mg/mL oral liquid, 225 mL	8	5	..	*851.72	Telzir	VI
6453P	fosamprenavir 700 mg tablet, 60	2	5	..	*795.42	Telzir	VI

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
INDINAVIR							
<u>Authority required</u>							
HIV infection							
Treatment Phase: Initial							
Clinical criteria:							
Patient must be antiretroviral treatment naive,							
AND							
The treatment must be in combination with other antiretroviral agents.							
<u>Authority required</u>							
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.							
6202K	indinavir 400 mg capsule, 180	2	5	..	*953.16	Crixivan 400 mg	MK
RITONAVIR							
<u>Authority required</u>							
HIV infection							
Treatment Phase: Initial							
Clinical criteria:							
Patient must be antiretroviral treatment naive,							
AND							
The treatment must be in combination with other antiretroviral agents.							
<u>Authority required</u>							
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.							
9677H	ritonavir 100 mg tablet, 30	24	5	..	*1028.92	Norvir	VE
6494T	ritonavir 600 mg/7.5 mL oral liquid, 90 mL	10	5	..	*953.16	Norvir	VE
SAQUINAVIR							
<u>Authority required</u>							
HIV infection							
Treatment Phase: Initial							
Clinical criteria:							
Patient must be antiretroviral treatment naive,							
AND							
The treatment must be in combination with other antiretroviral agents.							
<u>Authority required</u>							
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.							
6498B	saquinavir 500 mg tablet, 120	2	5	..	*1057.88	Invirase	RO

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	<u>Note</u>						
	No increase in the maximum quantity or number of units may be authorised.						
	<u>Note</u>						
	No increase in the maximum number of repeats may be authorised.						
	<u>Note</u>						
	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.						
10197Q	simeprevir sodium 150 mg capsule, 7	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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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.					
	<u>Note</u>					
	No increase in the maximum quantity or number of units may be authorised.					
	<u>Note</u>					
	No increase in the maximum number of repeats may be authorised.					
	<u>Note</u>					
	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.					
2378E	telaprevir 375 mg tablet, 42	6	..	..	*14912.50	Incivo

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.

9610T	tipranavir 250 mg capsule, 120	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.

6265R	abacavir 20 mg/mL oral liquid, 240 mL	8	5	..	*690.20	Ziagen	VI
6264Q	abacavir 300 mg tablet, 60	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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer	
	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.						
6450L	adefovir dipivoxil 10 mg tablet, 30	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.						
6298L	didanosine 125 mg capsule: enteric, 30	2	5	..	*298.86	Videx EC	BQ
6299M	didanosine 200 mg capsule: enteric, 30	2	5	..	*346.64	Videx EC	BQ
6300N	didanosine 250 mg capsule: enteric, 30	2	5	..	*431.58	Videx EC	BQ
6301P	didanosine 400 mg capsule: enteric, 30	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.						
6137B	emtricitabine 200 mg capsule, 30	2	5	..	*593.32	Emtriva	GI
	ENTECAVIR						
	Authority required						

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer	
					Qty \$			
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.								
9603K	entecavir monohydrate 1 mg tablet, 30	2	5	..	*1296.76	Baraclude		BQ
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.								
9602J	entecavir monohydrate 500 microgram tablet, 30	2	5	..	*806.10	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.								
6194B	lamivudine 10 mg/mL oral liquid, 240 mL	8	5	..	*472.52	3TC		VI
6193Y	lamivudine 150 mg tablet, 60	2	5	..	*325.70	^a 3TC		VI
6435Q	lamivudine 300 mg tablet, 30	2	5	..	*325.70	^a Lamivudine		AF
						^a Alphapharm		
						^a Lamivudine RBX		RA
						^a 3TC		VI
						^a Lamivudine		AF
						^a Alphapharm		
						^a Lamivudine RBX		RA

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer	
					Qty \$			
LAMIVUDINE								
<u>Authority required</u>								
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								
<u>Authority required</u>								
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								
6257H	lamivudine 100 mg tablet, 28	2	5	..	*175.70	^a	Zeffix	AS
6271C	lamivudine 5 mg/mL oral liquid, 240 mL	5	5	..	*242.06	^a	Zetlam Zeffix	AF AS
STAVUDINE								
<u>Authority required</u>								
HIV infection								
Treatment Phase: Initial								
Clinical criteria:								
Patient must be antiretroviral treatment naive,								
AND								
The treatment must be in combination with other antiretroviral agents.								
<u>Authority required</u>								
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.								
6186N	stavudine 20 mg capsule, 60	2	5	..	*589.16		Zerit	BQ
6189R	stavudine 30 mg capsule, 60	2	5	..	*700.82		Zerit	BQ
6190T	stavudine 40 mg capsule, 60	2	5	..	*932.16		Zerit	BQ
TELBIVUDINE								
<u>Authority required</u>								
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								
<u>Authority required</u>								
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								
9630W	telbivudine 600 mg tablet, 28	2	5	..	*528.60		Sebivo	NV

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

Patient must have failed antihepadnaviral therapy,

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	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.						
	<u>Note</u>						
	Patients may receive treatment in combination with lamivudine but not with other PBS-subsidised antihepadnaviral therapy.						
	<u>Authority required</u>						
	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.						
	<u>Note</u>						
	Patients may receive treatment in combination with lamivudine but not with other PBS-subsidised antihepadnaviral therapy.						
6358P	tenofovir disoproxil fumarate 300 mg tablet, 30	2	5	..	*1011.60	Viread	GI
	ZIDOVUDINE						
	<u>Authority required</u>						
	HIV infection						
	Treatment Phase: Initial						
	Clinical criteria:						
	Patient must be antiretroviral treatment naive,						
	AND						
	The treatment must be in combination with other antiretroviral agents.						
	<u>Authority required</u>						
	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.						
6153W	zidovudine 100 mg capsule, 100	4	5	..	*861.48	Retrovir	VI
6154X	zidovudine 250 mg capsule, 40	6	5	..	*1279.54	Retrovir	VI
6155Y	zidovudine 50 mg/5 mL oral liquid, 200 mL	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

Patient must have previously received PBS-subsidised therapy for HIV infection,

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer	
					Qty \$		
AND							
The treatment must be in combination with other antiretroviral agents.							
1129K	nevirapine 400 mg tablet: modified release, 30 tablets	2	5	..	*481.28	Viramune XR	BY
RILPIVIRINE							
<u>Authority required</u>							
HIV infection							
Treatment Phase: Initial							
Clinical criteria:							
Patient must be antiretroviral treatment naive,							
AND							
The treatment must be in combination with other antiretroviral agents.							
<u>Authority required</u>							
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.							
1170N	rilpivirine 25 mg tablet, 30	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.

6458X	abacavir 600 mg + lamivudine 300 mg tablet, 30	2	5	..	*912.26	Kivexa	VI

ABACAVIR + LAMIVUDINE + ZIDOVUDINE

Authority required

HIV infection

Treatment Phase: Initial

Clinical criteria:

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer	
	Patient must be antiretroviral treatment naive. Population criteria: Patient must be aged 12 years or older, AND Patient must weigh 40 kg or more. <u>Authority required</u> 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.						
6327B	abacavir 300 mg + lamivudine 150 mg + zidovudine 300 mg tablet, 60	2	5	..	*1404.04	Trizivir	VI
	EMTRICITABINE + RILPIVIRINE + TENOFOVIR <u>Authority required</u> HIV infection Treatment Phase: Initial Clinical criteria: Patient must be antiretroviral treatment naive. <u>Authority required</u> HIV infection Treatment Phase: Continuing Clinical criteria: Patient must have previously received PBS-subsidised therapy for HIV infection.						
1490K	emtricitabine 200 mg + rilpivirine 25 mg + tenofovir disoproxil fumarate 300 mg tablet, 30	2	5	..	*2120.12	Eviplera	GI
	LAMIVUDINE + ZIDOVUDINE <u>Authority required</u> HIV infection Treatment Phase: Initial Clinical criteria: Patient must be antiretroviral treatment naive, AND The treatment must be in combination with other antiretroviral agents. <u>Authority required</u> 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.						
6234D	lamivudine 150 mg + zidovudine 300 mg tablet, 60	2	5	..	*825.72	^a Combivir	VI
						^a Lamivudine 150 mg + Zidovudine 300 mg Alphapharm	AF
	LOPINAVIR + RITONAVIR <u>Authority required</u> HIV infection Treatment Phase: Initial						

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer	
	Clinical criteria:						
	Patient must be antiretroviral treatment naive,						
	AND						
	The treatment must be in combination with other antiretroviral agents.						
	<u>Authority required</u>						
	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.						
9633B	lopinavir 100 mg + ritonavir 25 mg tablet, 60	2	5	..	*362.96	Kaletra	VE
6495W	lopinavir 200 mg + ritonavir 50 mg tablet, 120	2	5	..	*1416.76	Kaletra	VE
6341R	lopinavir 400 mg/5 mL + ritonavir 100 mg/5 mL oral liquid, 60 mL	10	5	..	*1336.76	Kaletra	VE
	TENOFOVIR + EMTRICITABINE						
	<u>Authority required</u>						
	HIV infection						
	Treatment Phase: Initial						
	Clinical criteria:						
	Patient must be antiretroviral treatment naive,						
	AND						
	The treatment must be in combination with other antiretroviral agents.						
	<u>Authority required</u>						
	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.						
6468K	tenofovir disoproxil fumarate 300 mg + emtricitabine 200 mg tablet, 30	2	5	..	*1576.96	Truvada	GI
	TENOFOVIR + EMTRICITABINE + EFAVIRENZ						
	<u>Authority required</u>						
	HIV infection						
	Treatment Phase: Initial						
	Clinical criteria:						
	Patient must be antiretroviral treatment naive.						
	<u>Authority required</u>						
	HIV infection						
	Treatment Phase: Continuing						
	Clinical criteria:						
	Patient must have previously received PBS-subsidised therapy for HIV infection.						
9650X	tenofovir disoproxil fumarate 300 mg + emtricitabine 200 mg + efavirenz 600 mg tablet, 30	2	5	..	*2120.12	Atripla	GI
	TENOFOVIR + EMTRICITABINE + ELVITEGRAVIR + COBICISTAT						
	<u>Authority required</u>						
	HIV infection						
	Treatment Phase: Initial						
	Clinical criteria:						
	Patient must be antiretroviral treatment naive.						

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer	
	<u>Authority required</u>						
	HIV infection						
	Treatment Phase: Continuing						
	Clinical criteria:						
	Patient must have previously received PBS-subsidised therapy for HIV infection.						
10085T	tenofovir disoproxil fumarate 300 mg + emtricitabine 200 mg + elvitegravir 150 mg + cobicistat 150 mg tablet, 30	2	5	..	*2120.12	Stribild	GI
	Other antiretrovirals						
	DOLUTEGRAVIR						
	<u>Authority required</u>						
	HIV infection						
	Treatment Phase: Initial						
	Clinical criteria:						
	Patient must be antiretroviral treatment naive,						
	AND						
	The treatment must be in combination with other antiretroviral agents.						
	<u>Authority required</u>						
	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.						
10070B	dolutegravir 50 mg tablet, 30	2	5	..	*1377.86	Tivicay	VI
	ENFUVIRTIDE						
	<u>Authority required</u>						
	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						
6455R	enfuvirtide 90 mg injection [60 x 90 mg vials] (&) inert substance diluent [60 x 1.1 mL vials], 1 pack	2	5	..	*4472.76	Fuzeon	RO
	MARAVIROC						
	<u>Authority required</u>						
	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						
9572T	maraviroc 150 mg tablet, 60	2	5	..	*1882.16	Celsentri	VI
9573W	maraviroc 300 mg tablet, 60	2	5	..	*1882.16	Celsentri	VI
	RALTEGRAVIR						
	<u>Authority required</u>						
	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,						

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer	
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.							
<u>Authority required</u>							
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.							
2754Y	raltegravir 100 mg tablet: chewable, 60	6	5	..	*2071.78	Isentress	MK
2743J	raltegravir 25 mg tablet: chewable, 60	6	5	..	*533.32	Isentress	MK
RALTEGRAVIR							
<u>Authority required</u>							
HIV infection							
Treatment Phase: Initial							
Clinical criteria:							
Patient must be antiretroviral treatment naive,							
AND							
The treatment must be in combination with other antiretroviral agents.							
<u>Authority required</u>							
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.							
9629T	raltegravir 400 mg tablet, 60	2	5	..	*1377.86	Isentress	MK

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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

Note

Special Pricing Arrangements apply.

6100C	azacitidine 100 mg injection, 1 x 100 mg vial	14	2	..	*7746.80	Vidaza	CJ

AZACITIDINE

Authority required

Continuing treatment of a patient with:

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	(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					
	<u>Note</u> 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					
	<u>Note</u> Special Pricing Arrangements apply.					
6138C	azacitidine 100 mg injection, 1 x 100 mg vial	14	5	..	*7746.80	Vidaza

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

6249X	doxorubicin hydrochloride-pegylated liposomal 20 mg/10 mL injection, 1 x 10 mL vial	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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	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))						
	<u>Authority required</u> 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						
	<u>Authority required</u> Mobilisation of peripheral blood progenitor cells, in a normal volunteer, for use in allogeneic transplantation						
	<u>Authority required</u> A patient receiving marrow-ablative chemotherapy and subsequent bone marrow transplantation						
	<u>Authority required</u> A patient with a non-myeloid malignancy receiving marrow-ablative chemotherapy and subsequent autologous peripheral blood progenitor cell transplantation						
	<u>Authority required</u> 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						
	<u>Authority required</u> 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						
	<u>Authority required</u> 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						
	<u>Authority required</u> A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in acute lymphoblastic leukaemia						
	<u>Authority required</u> 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)						
	<u>Authority required</u> A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in germ cell tumours						
	<u>Authority required</u> A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in infants and children with CNS tumours						
	<u>Authority required</u> A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in neuroblastoma						
	<u>Authority required</u> 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)						
	<u>Authority required</u> A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in relapsed Hodgkin disease						
	<u>Authority required</u> A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in sarcoma						
	<u>Authority required</u> 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)						
5830W	filgrastim 120 microgram/0.2 mL injection, 10 x 0.2 mL syringes	2	11	..	*894.18	Nivestim	HH
1082Y	filgrastim 300 microgram/0.5 mL injection, 10 x 0.5 mL syringes	2	11	..	*2179.94	TevaGrastim	AS
6291D	filgrastim 300 microgram/0.5 mL injection, 10 x 0.5 mL syringes	2	11	..	*2179.94	Neupogen	AN
9693E	filgrastim 300 microgram/0.5 mL injection, 10 x 0.5 mL syringes	2	11	..	*2179.94	Nivestim	HH

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty	Brand Name and Manufacturer	
					\$		
2747N	filgrastim 300 microgram/0.5 mL injection, 5 x 0.5 mL syringes	4	11	..	*2179.92	Zarzio	SZ
6126K	filgrastim 300 microgram/mL injection, 10 x 1 mL vials	2	11	..	*2179.94	Neupogen	AN
6292E	filgrastim 480 microgram/0.5 mL injection, 10 x 0.5 mL syringes	2	11	..	*3466.38	Neupogen	AN
9695G	filgrastim 480 microgram/0.5 mL injection, 10 x 0.5 mL syringes	2	11	..	*3466.38	Nivestim	HH
2733W	filgrastim 480 microgram/0.5 mL injection, 5 x 0.5 mL syringes	4	11	..	*3466.36	Zarzio	SZ
1113N	filgrastim 480 microgram/0.8 mL injection, 10 x 0.8 mL syringes	2	11	..	*3466.38	TevaGrastim	AS
6127L	filgrastim 480 microgram/1.6 mL injection, 10 x 1.6 mL vials	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

6337M	LENOGRASTIM Powder for injection 13,400,000 i.u. (105 micrograms) vial, 10	2	11	..	*1071.76	Granocyte 13	HH
6338N	LENOGRASTIM Powder for injection 33,600,000 i.u. (263 micrograms) vial, 10	2	11	..	*2613.96	Granocyte 34	HH

PEGFILGRASTIM

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	<u>Authority required</u> For use in a patient undergoing induction and consolidation therapy for acute myeloid leukaemia					
	<u>Authority required</u> 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					
	<u>Authority required</u> 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					
	<u>Authority required</u> 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					
	<u>Authority required</u> 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					
	<u>Authority required</u> 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					
	<u>Authority required</u> A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in acute lymphoblastic leukaemia					
	<u>Authority required</u> 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)					
	<u>Authority required</u> A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in germ cell tumours					
	<u>Authority required</u> A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in infants and children with CNS tumours					
	<u>Authority required</u> A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in neuroblastoma					
	<u>Authority required</u> 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)					
	<u>Authority required</u> A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in relapsed Hodgkin disease					
	<u>Authority required</u> A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in sarcoma					
	<u>Authority required</u> 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)					
6363X	pegfilgrastim 6 mg/0.6 mL injection, 1 x 0.6 mL syringe	1	11	..	1971.76	Neulasta AN

Interferons

INTERFERON ALFA-2A

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;

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	(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						
	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.						
6210W	interferon alfa-2a 3 million international units/0.5 mL injection, 1 x 0.5 mL syringe	30	5	..	*936.46	Roferon-A	RO
6211X	interferon alfa-2a 4.5 million international units/0.5 mL injection, 1 x 0.5 mL syringe	30	5	..	*1387.66	Roferon-A	RO
6212Y	interferon alfa-2a 6 million international units/0.5 mL injection, 1 x 0.5 mL syringe	30	5	..	*1834.06	Roferon-A	RO
6213B	interferon alfa-2a 9 million international units/0.5 mL injection, 1 x 0.5 mL syringe	30	5	..	*2728.06	Roferon-A	RO

INTERFERON ALFA-2B

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

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.

6246R	interferon alfa-2b 10 million international units/mL injection, 5 x 1 mL vials	3	5	..	*1536.25	Intron A	MK
6253D	interferon alfa-2b 18 million international units/1.2 mL injection, 1 x 1.2 mL cartridge	2	5	..	*378.54	Intron A Redipen	MK
6218G	interferon alfa-2b 18 million international units/3 mL injection, 1 x 3 mL vial	15	5	..	*2727.91	Intron A	MK
6219H	interferon alfa-2b 25 million international units/2.5 mL injection, 1 x 2.5 mL vial	15	5	..	*3770.56	Intron A	MK
6254E	interferon alfa-2b 30 million international units/1.2 mL injection, 1 x 1.2 mL cartridge	2	5	..	*626.40	Intron A Redipen	MK
6255F	interferon alfa-2b 60 million international units/1.2 mL injection, 1 x 1.2 mL cartridge	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

6148N	interferon gamma-1b 2 million international units (100 microgram/0.5 mL) injection, 6 x 0.5 mL vials	2	11	..	*2768.56	Imukin	BY

PEGINTERFERON ALFA-2A

Authority required

Treatment, as sole PBS-subsidised therapy, in a patient with chronic hepatitis B without cirrhosis who satisfies all of the following criteria:

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	(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						
	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.						
	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.						
6439X	peginterferon alfa-2a 135 microgram/0.5 mL injection, 4 x 0.5 mL syringes	2	5	..	*2378.56	Pegasys	RO
6449K	peginterferon alfa-2a 180 microgram/0.5 mL injection, 4 x 0.5 mL syringes	2	5	..	*2747.22	Pegasys	RO

PEGINTERFERON ALFA-2A (&) RIBAVIRIN

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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.					
	Note No increase in the maximum quantity or number of units may be authorised.					
	Note No increase in the maximum number of repeats may be authorised.					
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	
	(b) 24-hour access by patients to medical advice; and (c) an established liver clinic.					
	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:					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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.					
	<u>Note</u>					
	No increase in the maximum quantity or number of units may be authorised.					
	<u>Note</u>					
	No increase in the maximum number of repeats may be authorised.					
	<u>Note</u>					
	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.					
	<u>Authority required</u>					
	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.					
	<u>Note</u>					
	No increase in the maximum quantity or number of units may be authorised.					
	<u>Note</u>					
	No increase in the maximum number of repeats may be authorised.					
	<u>Note</u>					
	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.					
	<u>Authority required</u>					
	Chronic non-genotype 1 hepatitis C infection					
	Clinical criteria:					
	The treatment must be the sole PBS-subsidised treatment for hepatitis C,					
	AND					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	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. 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. Caution 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. 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.						
6392K	peginterferon alfa-2a 135 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [168 tablets], 1 pack	2	5	..	*3119.60	Pegasys RBV	RO
6394M	peginterferon alfa-2a 180 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [112 tablets], 1 pack	2	5	..	*3132.04	Pegasys RBV	RO
6395N	peginterferon alfa-2a 180 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [140 tablets], 1 pack	2	5	..	*3292.58	Pegasys RBV	RO
6396P	peginterferon alfa-2a 180 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [168 tablets], 1 pack	2	5	..	*3453.12	Pegasys RBV	RO

PEGINTERFERON ALFA-2B (&) RIBAVIRIN

Authority required

Chronic genotype 1 hepatitis C infection

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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.					
	<u>Note</u> No increase in the maximum quantity or number of units may be authorised.					
	<u>Note</u> No increase in the maximum number of repeats may be authorised.					
	<u>Note</u> 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.					
	<u>Authority required</u> 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.					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

Note

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

Note

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

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.

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.

Note

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

Note

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

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.

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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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. 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. 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;					

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
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.					
Note	No increase in the maximum quantity or number of units may be authorised.					
Note	No increase in the maximum number of repeats may be authorised.					
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.					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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.					

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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.					
	Note No increase in the maximum quantity or number of units may be authorised.					
	Note No increase in the maximum number of repeats may be authorised.					
	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.					
	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.					
	Note No increase in the maximum number of repeats may be authorised.					
	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.					
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
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.							
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.							
Caution							
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.							
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.							
6405D	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	2	5	..	*3146.38	Pegatron	MK
6400W	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	2	5	..	*2166.50	Pegatron	MK
6401X	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	2	5	..	*2469.48	Pegatron	MK

PEGINTERFERON ALFA-2B (&) RIBAVIRIN

Authority required

Chronic genotype 1 hepatitis C infection

Clinical criteria:

Patient must have compensated liver disease,

Population criteria:

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
	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.						
	<u>Note</u>						
	No increase in the maximum quantity or number of units may be authorised.						
	<u>Note</u>						
	No increase in the maximum number of repeats may be authorised.						
	<u>Note</u>						
	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.						
	<u>Authority required</u>						
	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						

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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. Note No increase in the maximum quantity or number of units may be authorised. Note No increase in the maximum number of repeats may be authorised. 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. 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.					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty		
					\$		
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.

Note

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

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.

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.

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.

Caution

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.

Note

Treatment centres are required to have access to the following appropriate specialist facilities for the provision of clinical support services for hepatitis C:

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty	Brand Name and Manufacturer	
					\$		
	(a) a nurse educator/counsellor for patients; and (b) 24-hour access by patients to medical advice; and (c) an established liver clinic.						
6407F	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	2	5	..	*3538.34	Pegatron	MK
6409H	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	2	5	..	*4126.28	Pegatron	MK
6410J	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	2	5	..	*4126.28	Pegatron	MK
9634C	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	2	5	..	*4411.24	Pegatron	MK
6402Y	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	2	5	..	*2754.42	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.

10084R	plerixafor 24 mg/1.2 mL injection: subcutaneous infusion, 1 x 1.2 mL vial	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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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.

Note

Special Pricing Arrangements apply.

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

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
	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						

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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) 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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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 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 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.					

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	(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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max. Qty \$		

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

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
9621J	abatacept 250 mg injection, 1 x 250 mg vial	1	..	..	531.37	Orencia	BQ

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 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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer	
					Qty	\$		
	(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.							
	<u>Note</u>							
	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							
	<u>Note</u>							
	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)							
	<u>Note</u>							
	Applications for treatment with eculizumab where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.							
	<u>Note</u>							
	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.							
	<u>Note</u>							
	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.							
10182X	eculizumab 300 mg/30 mL injection, 1 x 30 mL vial	1	..	..	5984.26		Soliris	XI

XI

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	
	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

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 4 repeats, according to the specified dosage in the approved Product Information (PI).

Note

Applications for treatment with eculizumab where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

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

Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

10192K	eculizumab 300 mg/30 mL injection, 1 x 30 mL vial	1	4	..	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 .

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

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).

Note

Applications for treatment with eculizumab where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

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.

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

Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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.

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).

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

Note

Applications for treatment with eculizumab where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

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.

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

Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

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 +/- 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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
	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

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).

Note

Applications for treatment with eculizumab where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

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.

Note

Kidney transplantation/dialysis is not a contraindication to recommencement of eculizumab 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.

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

Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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).

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

Note

Applications for treatment with eculizumab where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

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.

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

Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	(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 x10 ⁹ /L ; and evidence of two of the following: (i) presence of schistocytes on blood film;					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	
	(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.

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

Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

10194M	eculizumab 300 mg/30 mL injection, 1 x 30 mL vial	1	5	..	5984.26	Soliris	XI

EVEROLIMUS

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

Caution

Careful monitoring of patients is mandatory.

9582H	everolimus 1 mg tablet, 60	4	5	..	*3891.56	Certican	NV
6459Y	everolimus 250 microgram tablet, 60	2	5	..	*506.58	Certican	NV
6460B	everolimus 500 microgram tablet, 60	2	5	..	*1006.40	Certican	NV

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
6461C	everolimus 750 microgram tablet, 60	4	5	..	*2930.36	Certican	NV

MYCOPHENOLATE

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.

Caution

Careful monitoring of patients is mandatory.

Note

Management includes initiation, stabilisation and review of therapy as required.

6369F	mycophenolate 180 mg tablet: enteric, 120 tablets	2	5	..	*233.08	Myfortic	NV
6370G	mycophenolate 360 mg tablet: enteric, 120 tablets	2	5	..	*459.38	Myfortic	NV

MYCOPHENOLATE

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

Caution

Careful monitoring of patients is mandatory.

Note

For item codes 6208R and 1837Q, pharmaceutical benefits that have the form capsule 250 mg are equivalent for the purposes of substitution.

1837Q	mycophenolate Capsule 250 mg, 50	12	5	..	*572.56	^a Ceptolate	AF
6208R	mycophenolate mofetil 250 mg capsule, 100	6	5	..	*572.62	^a APO-Mycophenolate	TX
						^a CellCept	RO
						^a Mycophenolate Sandoz	SZ
						^a Pharmacor	CR
						Mycophenolate 250	

MYCOPHENOLATE

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

Caution

Careful monitoring of patients is mandatory.

6364Y	mycophenolate mofetil 1 g/5 mL oral liquid: powder for, 165 mL	2	5	..	*#517.97	CellCept	RO
6209T	mycophenolate mofetil 500 mg tablet, 50	6	5	..	*572.56	^a APO-Mycophenolate	TX

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty	Brand Name and Manufacturer	
					\$		
						a CellCept	RO
						a Ceptolate	AF
						a Mycophenolate Sandoz	SZ
						a Pharmacor	CR
						Mycophenolate 500	

NATALIZUMAB

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

Caution

Progressive multifocal leukoencephalopathy has been reported with this drug.

Note

Neurologists prescribing natalizumab under the PBS listing must be registered with the Tysabri Australian Prescribing Program.

Note

Special Pricing Arrangements apply.

9624M	natalizumab 300 mg/15 mL injection, 1 x 15 mL vial	1	5	..	1614.80	Tysabri	BD

SIROLIMUS

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

Caution

Careful monitoring of patients is mandatory.

6436R	sirolimus 1 mg tablet, 100	2	5	..	*1493.42	Rapamune	PF
6437T	sirolimus 1 mg/mL oral liquid, 60 mL	2	5	..	*980.20	Rapamune	PF
6457W	sirolimus 2 mg tablet, 100	2	5	..	*2940.10	Rapamune	PF
9748C	sirolimus 500 microgram tablet, 100	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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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.

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	
	Prior Written Approval of Complex Drugs					
	Reply Paid 9826					
	GPO Box 9826					
	HOBART TAS 7001					

Note

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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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. <u>Authority required</u> 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.					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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

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

Note

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
	Prior Written Approval of Complex Drugs						
	Reply Paid 9826						
	GPO Box 9826						
	HOBART TAS 7001						
	<u>Authority required</u>						
	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.						
	<u>Note</u>						
	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).						

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

Note

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer	
					Qty \$		
	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.						
	<u>Authority required</u>						
	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.						
	<u>Note</u>						
	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						
9678J	adalimumab 20 mg/0.4 mL injection, 2 x 0.4 mL syringes	1	..	..	1676.76	Humira	VE
9680L	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges	1	..	..	1676.76	Humira	VE
9679K	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes	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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
Use of alternative DMARDs in children is dependent on approval by the Therapeutic Goods Administration as age restrictions may apply.						

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

Note

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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).

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

Note

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

Note

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	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						
9641K	ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1	1	..	..	1676.77	Enbrel	PF
9615C	ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1	1	..	..	1676.77	Enbrel	PF

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer	
					Qty \$		
6367D	etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack	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.

10057H	infliximab 100 mg injection, 1 x 100 mg vial	1	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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					
	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					
	Note					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	Special Pricing Arrangements apply.					
	<u>Authority required</u>					
	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.					
	<u>Note</u>					
	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).					
	<u>Note</u>					
	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					

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	GPO Box 9826 HOBART TAS 7001					
	<u>Note</u> Special Pricing Arrangements apply.					
	<u>Authority required</u> 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.					
	<u>Note</u> 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					
	<u>Note</u> Special Pricing Arrangements apply.					
	<u>Authority required</u> 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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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

Note

Special Pricing Arrangements apply.

10184B	infliximab 100 mg injection, 1 x 100 mg vial	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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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;					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

(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.

Note

Special Pricing Arrangements apply.

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

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-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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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 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).

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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 infliximab therapy under the Initial 1 (new patient or patient recommencing treatment after break of more

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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

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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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.					
	<u>Authority required</u>					
	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.					
	<u>Note</u>					
	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					
6397Q	infliximab 100 mg injection, 1 x 100 mg vial	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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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 Note 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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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.

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

Note

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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 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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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

Note

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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

Authority required

Ankylosing spondylitis

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
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						
6448J	infliximab 100 mg injection, 1 x 100 mg vial	1	..	..	788.53	Remicade JC

INFLIXIMAB

Authority required

Initial 1

Initial PBS-subsidised treatment with infliximab, by a rheumatologist or clinical immunologist with expertise in the management of psoriatic arthritis, of adults who:

- (1) have severe active psoriatic arthritis; and
- (2) have received no prior PBS-subsidised biological treatment for this condition in this Treatment Cycle; and
- (3) have failed to achieve an adequate response to:
 - (a) methotrexate at a dose of at least 20 mg weekly for a minimum period of 3 months; and
 - (b) sulfasalazine at a dose of at least 2 g per day for a minimum period of 3 months; or
 - (c) leflunomide at a dose of up to 20 mg daily for a minimum period of 3 months.

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 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, 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 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

- (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 of major joints:
 - elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or
 - 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 [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]; and
- (3) a signed patient acknowledgement.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	A maximum of 22 weeks treatment will be authorised under this restriction. 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. 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). 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 to Medicare Australia 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. Patients who fail to demonstrate a response to treatment with infliximab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug, in this Treatment Cycle. Patients may re-trial infliximab 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					
	<u>Authority required</u> Initial 2 Initial PBS-subsidised treatment with infliximab, by a rheumatologist or clinical immunologist with expertise in the management of psoriatic arthritis, of adults who: (1) have a documented history of severe active psoriatic arthritis; and (2) have received prior PBS-subsidised biological treatment for this condition in this Treatment Cycle and are eligible to receive further biological therapy; and (3) have not failed treatment with infliximab during the current Treatment Cycle. Applications for patients who have received PBS-subsidised treatment with infliximab within this Treatment Cycle and who wish to re-commence 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 infliximab treatment, within the timeframes specified below. A maximum of 22 weeks treatment will be authorised under this restriction. 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. 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). Where the most recent course of PBS-subsidised infliximab 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), patients 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 infliximab treatment was approved under the continuing treatment criteria, patients 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. 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 [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]. Patients who fail to demonstrate a response to treatment with infliximab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug, in this Treatment Cycle. Patients may re-trial infliximab 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					
	<u>Authority required</u> Continuing treatment Continuing PBS-subsidised treatment with infliximab, by a rheumatologist or clinical immunologist with expertise in the management of psoriatic arthritis, of adults: (1) who have a documented history of severe active psoriatic arthritis; and (2) whose most recent course of PBS-subsidised biological agent for this condition in the current Treatment Cycle was with infliximab; and (3) who, at the time of application, demonstrate an adequate response to treatment with infliximab. An adequate response to treatment with infliximab 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: (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 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).					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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 [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)].

A maximum of 24 weeks of treatment will be approved under this restriction.

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.

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).

All applications for continuing treatment with infliximab must include a measurement of response to the prior course of therapy. 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, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Patients who fail to demonstrate a response to treatment with infliximab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug, in this Treatment Cycle. Patients may re-trial infliximab 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.

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

Note

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, 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 the following NOTES and restrictions, it only refers to adalimumab, etanercept, golimumab and infliximab.

From 1 August 2006, all patients will be 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 5-year 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 after 1 August 2010.

(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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	
	(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 all agents except for infliximab, for which a maximum of 22 weeks will be authorised. 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 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, patients will be deemed to have failed to respond to treatment with that biological agent. Grandfather patients — golimumab only. Applications for patients who commenced treatment with golimumab prior to 1 March 2010 may apply for initial PBS-subsidised treatment as continuing therapy 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 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, 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. 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; or (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.						
	Medicare Australia 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 authority 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. 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 re-qualify 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.						
6496X	infliximab 100 mg injection, 1 x 100 mg vial	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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	(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:					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

(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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	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						
	<u>Note</u>						
	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						
9612X	infliximab 100 mg injection, 1 x 100 mg vial	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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

(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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max. Qty \$		

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					
	<u>Authority required</u> 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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

Note

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty \$		
	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.						
9613Y	infliximab 100 mg injection, 1 x 100 mg vial	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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	(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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

(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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max. Qty \$		

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:

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

- (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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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

Note

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

(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.

Note

No applications for increased repeats will be authorised.

9617E	infliximab 100 mg injection, 1 x 100 mg vial	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:

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

(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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

(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

Note

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) alpha 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-alpha 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-alpha 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-alpha antagonist while they continue to show a response to therapy.

A patient who received PBS-subsidised TNF-alpha 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-alpha 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-alpha 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-alpha antagonist treatment in the most recent cycle to the date of the first application for initial treatment with a TNF-alpha antagonist under the new treatment cycle.

A patient who has failed fewer than 3 trials of TNF-alpha 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-alpha 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-alpha 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-alpha antagonist treatment in this treatment cycle and wishes to commence such therapy (Initial 1); or

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty \$		
	(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.						
9674E	infliximab 100 mg injection, 1 x 100 mg vial	1	..	..	788.53		Remicade
							JC

JC

Interleukin inhibitors

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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 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:

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

(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.

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

Note

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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 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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	
	(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

Note

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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 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,

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	

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:

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Note

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
(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.							
<u>Authority required</u>							
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.							
<u>Note</u>							
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							
10071C	tocilizumab 200 mg/10 mL injection, 1 x 10 mL vial	1	..	..	492.65	Actemra	RO
10078K	tocilizumab 400 mg/20 mL injection, 1 x 20 mL vial	1	..	..	978.54	Actemra	RO
10073E	tocilizumab 80 mg/4 mL injection, 1 x 4 mL vial	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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

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

Note

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	

(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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	
(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).

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

Note

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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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.					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
	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

Note

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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer	
					Qty \$		
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.							
<u>Note</u>							
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							
10079L	tocilizumab 200 mg/10 mL injection, 1 x 10 mL vial	1	..	..	492.65	Actemra	RO
10060L	tocilizumab 400 mg/20 mL injection, 1 x 20 mL vial	1	..	..	978.54	Actemra	RO
10068X	tocilizumab 80 mg/4 mL injection, 1 x 4 mL vial	1	..	..	201.12	Actemra	RO

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max. Qty \$		

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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

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 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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	(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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

Note

(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.

Note

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer	
					Qty \$		
	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.						
	Note						
	Special Pricing Arrangements apply.						
1423X	tocilizumab 200 mg/10 mL injection, 1 x 10 mL vial	1	..	..	492.65	Actemra	RO
1464C	tocilizumab 400 mg/20 mL injection, 1 x 20 mL vial	1	..	..	978.54	Actemra	RO
1419Q	tocilizumab 80 mg/4 mL injection, 1 x 4 mL vial	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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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.

Note

Special Pricing Arrangements apply.

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

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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. <u>Authority required</u> 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). <u>Note</u> Special Pricing Arrangements apply.					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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

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:

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer	
					Qty \$		
	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.						
	<u>Authority required</u>						
	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.						
	<u>Note</u>						
	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						
9672C	tocilizumab 200 mg/10 mL injection, 1 x 10 mL vial	1	..	..	492.65	Actemra	RO
9673D	tocilizumab 400 mg/20 mL injection, 1 x 20 mL vial	1	..	..	978.54	Actemra	RO
9671B	tocilizumab 80 mg/4 mL injection, 1 x 4 mL vial	1	..	..	201.12	Actemra	RO

Calcineurin inhibitors

CYCLOSPORIN

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

Caution

Careful monitoring of patients is mandatory.

6232B	cyclosporin 10 mg capsule, 60	2	5	..	*85.16	Neoral 10	NV

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$		Brand Name and Manufacturer	
6354K	cyclosporin 100 mg capsule, 30	4	5	..	*683.88	^a	Cyclosporin Sandoz	SZ
6125J	cyclosporin 100 mg/mL oral liquid, 50 mL	4	5	..	*1309.92	^a	Neoral 100	NV
							Neoral	NV
6352H	cyclosporin 25 mg capsule, 30	4	5	..	*166.48	^a	Cyclosporin Sandoz	SZ
6353J	cyclosporin 50 mg capsule, 30	4	5	..	*339.08	^a	Neoral 25	NV
						^a	Cyclosporin Sandoz	SZ
						^a	Neoral 50	NV

CYCLOSPORIN

Authority required

For use by organ or tissue transplant recipients

Caution

Careful monitoring of patients is mandatory.

6109M	cyclosporin 50 mg/mL injection, 10 x 1 mL ampoules	1	..	..	64.86		Sandimmun	NV

TACROLIMUS

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

Caution

Careful monitoring of patients is mandatory.

6216E	tacrolimus 1 mg capsule, 100	2	5	..	*688.66	^a	Pharmacor Tacrolimus 1	CR
						^a	Prograf	JC
						^a	Tacrolimus Sandoz	SZ
9682N	tacrolimus 1 mg capsule: modified release, 60 capsules	2	5	..	*415.90		Prograf XL	JC
6217F	tacrolimus 5 mg capsule, 50	2	5	..	*1685.14	^a	Pharmacor Tacrolimus 5	CR
						^a	Prograf	JC
						^a	Tacrolimus Sandoz	SZ
9683P	tacrolimus 5 mg capsule: modified release, 30 capsules	2	5	..	*1029.64		Prograf XL	JC
6328C	tacrolimus 500 microgram capsule, 100	2	5	..	*347.72	^a	Pharmacor Tacrolimus 0.5	CR
						^a	Prograf	JC
						^a	Tacrolimus Sandoz	SZ
9681M	tacrolimus 500 microgram capsule: modified release, 30 capsules	2	5	..	*109.12		Prograf XL	JC

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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					
	Note					
	Special Pricing Arrangements apply.					
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer	
					Qty \$		
	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 Note 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). Note Special Pricing Arrangements apply.						
2796E	lenalidomide 10 mg capsule, 21	1	3	..	5690.09	Revlimid	CJ
2798G	lenalidomide 5 mg capsule, 21	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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

(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

Note

Special Pricing Arrangements apply.

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:

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer	
					Qty \$		
	(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.						
	<u>Note</u>						
	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).						
	<u>Note</u>						
	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						
	<u>Note</u>						
	Special Pricing Arrangements apply.						
9643M	lenalidomide 10 mg capsule, 21	1	..	..	5690.09	Revlimid	CJ
9644N	lenalidomide 15 mg capsule, 21	1	..	..	6628.37	Revlimid	CJ
9645P	lenalidomide 25 mg capsule, 21	1	..	..	6980.96	Revlimid	CJ
9642L	lenalidomide 5 mg capsule, 21	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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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.

Note

Special Pricing Arrangements apply.

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

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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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 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:

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

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

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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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 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. 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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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

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-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.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	
9611W	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.					

THALIDOMIDE

Authority required

Multiple myeloma

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
<u>Caution</u>							
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.							
<u>Note</u>							
Patients receiving thalidomide under the PBS listing must be registered in the i-access risk management program.							
9684Q	thalidomide 100 mg capsule, 28	2	..	..	*1726.76	Thalomid	CJ
6469L	thalidomide 50 mg capsule, 28	4	..	..	*1726.76	Thalomid	CJ

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		

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

6284R	baclofen 10 mg/5 mL injection: intrathecal, 1 x 5 mL ampoule	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

9619G	ibandronic acid 6 mg/6 mL injection, 1 x 6 mL vial	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.

6286W	pamidronate disodium 15 mg/5 mL injection, 1 x 5 mL vial	4	2	..	*91.40	Pamisol	HH
6288Y	pamidronate disodium 60 mg/10 mL injection, 1 x 10 mL vial	1	2	..	91.40	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.

6279L	pamidronate disodium 30 mg injection [2 x 30 mg vials] (& inert substance diluent [2 x 10 mL ampoules], 1 pack	1	2	..	91.41	^a Aredia 30 mg	NV
6287X	pamidronate disodium 30 mg/10 mL injection, 1 x 10 mL vial	2	2	..	*91.42	^a Pamisol	HH

PAMIDRONATE DISODIUM

Authority required

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer	
					Qty	\$		
	Hypercalcaemia of malignancy							
	Clinical criteria:							
	Patient must have a malignancy refractory to anti-neoplastic therapy.							
	<u>Authority required</u>							
	Multiple myeloma							
	<u>Authority required</u>							
	Bone metastases							
	Clinical criteria:							
	The condition must be due to breast cancer.							
	<u>Note</u>							
	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.							
6223M	pamidronate disodium 90 mg injection [1 x 90 mg vial] (&) inert substance diluent [1 x 10 mL ampoule], 1 pack	1	11	..	132.57	^a	Aredia 90 mg	NV
6289B	pamidronate disodium 90 mg/10 mL injection, 1 x 10 mL vial	1	11	..	132.57	^a	Pamisol	HH
	ZOLEDRONIC ACID							
	<u>Authority required</u>							
	Multiple myeloma							
	<u>Authority required</u>							
	Bone metastases from breast cancer							
	<u>Authority required</u>							
	Bone metastases from castration-resistant prostate cancer							
	<u>Authority required</u>							
	Treatment of hypercalcaemia of malignancy refractory to anti-neoplastic therapy							
	<u>Note</u>							
	Special Pricing Arrangements apply.							
6371H	zoledronic acid 4 mg/5 mL injection, 1 x 5 mL vial	1	11	..	474.76		Zometa	NV

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		

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.

9744W	levodopa 20 mg/mL + carbidopa monohydrate 5 mg/mL gel: intestinal, 7 x 100 mL bags	8	5	..	*11582.76	Duodopa	VE

Dopamine agonists

APOMORPHINE

Authority required

Parkinson's disease in patients severely disabled by motor fluctuations which do not respond to other therapy

9607P	apomorphine hydrochloride 20 mg/2 mL injection, 5 x 2 mL ampoules	72	5	..	*7243.48	Apomine	HH
9647R	apomorphine hydrochloride 50 mg/10 mL injection: subcutaneous infusion, 5 x 10 mL syringes	36	5	..	*7054.12	Apomine PFS	HH
9640J	apomorphine hydrochloride 50 mg/5 mL injection, 5 x 5 mL ampoules	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 (CPMSplus) or Clopineconnect.

6102E	clozapine 100 mg tablet, 100	2	..	..	*258.84	^a Clopine 100	HH
						^a Clozaril 100	NV
6418T	clozapine 200 mg tablet, 100	2	..	..	*510.92	Clopine 200	HH
6101D	clozapine 25 mg tablet, 100	2	..	..	*75.40	^a Clopine 25	HH
						^a Clozaril 25	NV
6417R	clozapine 50 mg tablet, 100	2	..	..	*141.22	Clopine 50	HH
9632Y	clozapine 50 mg/mL oral liquid, 100 mL	1	..	..	147.16	Clopine Suspension	HH

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

RESPIRATORY SYSTEM

DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES

OTHER SYSTEMIC DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES

Other systemic drugs for obstructive airway diseases

OMALIZUMAB

Authority required

Initial treatment of uncontrolled severe allergic asthma

Initial PBS-subsidised treatment with omalizumab by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma, of a patient aged 12 years or older with uncontrolled severe allergic asthma who has been under the care of this physician for at least 12 months, and satisfies the following criteria:

(a) has 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 standard clinical features, including:

(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

(b) duration of asthma of at least 1 year; and

(c) FEV1 less than or equal to 80% predicted, documented on 3 or more occasions in the previous 12 months; and

(d) past or current evidence of atopy, documented by skin prick testing or RAST; and

(e) total serum human immunoglobulin E (IgE) greater than or equal to 76 IU/mL; and

(f) 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; and

(g) has failed to achieve adequate control with optimised asthma therapy, despite formal assessment of and adherence to correct inhaler technique, which has been documented (see NOTE). 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) oral corticosteroids (at least 10 mg per day prednisolone (or equivalent)) for at least 6 weeks, 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. 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 can be found on the Medicare Australia website [www.medicareaustralia.gov.au].

The initial IgE assessment must be no more than 12 months old at the time of application. A re-assessment of free IgE can only be made at least 12 months after the last dose of omalizumab. For patients re-commencing omalizumab within 12 months of the last dose the previous pre-omalizumab IgE level should be used.

The IgE pathology report must be provided with the authority 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 on oral corticosteroids and 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 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 (may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)) 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 while on oral corticosteroids (date and treatment); and

(iii) the signed patient acknowledgement; and

(c) a completed Asthma Control Questionnaire (ACQ-5) calculation sheet including the date of assessment of the patient's symptoms. (For copies of the ACQ please contact Novartis Medical Information on 1800 671 203 or medinfo.phauno@novartis.com)

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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

to the TGA-approved Product Information) to be administered every 2 or 4 weeks.

Where fewer than the required number of repeats to complete 28 weeks of treatment are requested at the time of the application, authority approvals for sufficient repeats to complete 28 weeks of omalizumab therapy 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.

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 24 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 to Medicare Australia 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 to Medicare Australia within this timeframe, the patient will be deemed to have failed to respond to treatment with omalizumab. It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 24 to 26 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised omalizumab treatment.

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.

Authority required

Continuing treatment

Continuing PBS-subsidised treatment with omalizumab, by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma, of a patient who:

- (a) has a documented history of severe allergic asthma; and
- (b) has demonstrated or sustained an adequate response to treatment with omalizumab.

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.

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 (may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)) 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. (For copies of the ACQ please contact Novartis Medical Information on 1800 671 203 or medinfo.phauno@novartis.com)

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 20 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. If the same physician cannot assess the patient please call Medicare Australia on 1800 700 270.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia 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 to Medicare Australia within this timeframe, the patient will be deemed to have failed to respond to treatment with omalizumab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 20 to 22 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised omalizumab treatment.

Patients are eligible to receive continuing courses of omalizumab treatment of up to 24 weeks providing they continue to demonstrate an adequate response to treatment.

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.

Where fewer than the required number of repeats to complete 24 weeks of treatment are requested at the time of the application, authority approvals for sufficient repeats to complete 24 weeks of omalizumab therapy 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 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.

Authority required

Initial PBS-subsidised treatment of severe allergic asthma in a patient who has previously received non-PBS-subsidised therapy with omalizumab (grandfather patients)

Initial PBS-subsidised supply for continuing treatment with omalizumab by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma, of a patient aged 12 years or older with severe allergic asthma who satisfies the following criteria:

- (a) has a diagnosis of asthma confirmed and documented by a respiratory physician, clinical immunologist, allergist or general physician

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	
	experienced in the management of patients with severe asthma, defined by standard clinical features, including:					
	(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					
	(b) duration of asthma of at least 1 year; and					
	(c) past or current evidence of atopy, documented by skin prick testing or RAST; 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 criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment for grandfathered patients; and					
	(e) prior to omalizumab therapy had failed to achieve adequate control with optimised asthma therapy. 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, and					
	(ii) may have included maintenance dose oral corticosteroids; and					
	(f) has demonstrated an adequate response to treatment with omalizumab.					
	A review of the patient's records should be conducted to extract pre- and post-omalizumab data on symptoms, quality of life, medication doses, exacerbations and hospitalisations. Examples of parameters to establish response include:					
	(i) a reduction in Asthma Control Questionnaire (ACQ-5) score of at least 0.5;					
	(ii) an improvement of at least 0.5 in the Asthma Quality of Life Questionnaire (AQLQ or mini-AQLQ);					
	(iii) maintenance oral corticosteroid dose reduced by at least 25% from baseline; and/or					
	(iv) a reduction in the number of hospitalisations or severe exacerbations requiring use of systemic corticosteroids, compared to the 12 months prior to commencement of omalizumab.					
	Where baseline assessments are not available, please call Medicare Australia on 1800 700 270 to discuss.					
	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. Details of the accepted contraindications and toxicities, including severity, which will be accepted for the purposes of exempting a patient from the requirement of treatment with optimised asthma therapy can be found on the Medicare Australia website [www.medicareaustralia.gov.au].					
	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 (may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)) which includes the following:					
	(i) details of prior optimised asthma drug therapy (dosage, date of commencement and duration of therapy); and					
	(ii) details of pre- and post-omalizumab data on symptoms, quality of life, medication doses, exacerbations and hospitalisations; and					
	(iii) the signed patient acknowledgement.					
	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.					
	Where fewer than the required number of repeats to complete 24 weeks of treatment are requested at the time of the application, authority approvals for sufficient repeats to complete 24 weeks of omalizumab therapy 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 24 weeks.					
	An assessment of the patient's continued response to this course of PBS-subsidised treatment must be made at around 20 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 same parameters used to establish response to non-PBS-subsidised therapy with omalizumab should be used for the assessment.					
	This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia 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 to Medicare Australia within this timeframe, the patient will be deemed to have failed to respond to treatment with omalizumab.					
	It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 20 to 22 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised omalizumab treatment.					
	Patients are eligible to receive continuing courses of omalizumab treatment of up to 24 weeks providing they continue to demonstrate an adequate response to treatment.					
	Patients may qualify for PBS-subsidised treatment under this restriction once only. 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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

Note

Any queries concerning the arrangements to prescribe omalizumab 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 omalizumab should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Note

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.

Initial treatment authorisations will be limited to provide for a maximum of 28 weeks of therapy with omalizumab.

A patient must be assessed for response to a course of Initial PBS-subsidised treatment following a minimum of 24 weeks of therapy with omalizumab, and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date of assessment.

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 omalizumab.

For second and subsequent courses of PBS-subsidised omalizumab 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.

(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.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted omalizumab supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to Medicare Australia 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 submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with omalizumab.

(2) Baseline measurements to determine response.

Medicare Australia 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 Medicare Australia 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) Patients 'grandfathered' onto PBS-subsidised treatment with omalizumab.

A patient who commenced treatment with omalizumab for uncontrolled severe allergic asthma prior to 1 November 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 omalizumab will be authorised under this criterion.

Following completion of the Initial PBS-subsidised course, further applications for treatment with omalizumab will be assessed under the continuing treatment restriction.

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
'Grandfather' arrangements will only apply for the first treatment cycle (initial treatment course with or without continuing treatment course/s). For the second and subsequent cycles, a 'Grandfathered' patient must re-qualify for Initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 6 month break in PBS-subsidised therapy' above for further details. (5) 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. <u>Note</u> 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.medicareaustralia.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). <u>Note</u> Special Pricing Arrangements apply.							
10122R	omalizumab 150 mg/mL injection, 1 x 1 mL syringe	1	..	..	433.16	Xolair	NV
10110D	omalizumab 75 mg/0.5 mL injection, 1 x 0.5 mL syringe	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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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.					
	<u>Authority required</u> 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.					
	<u>Authority required</u> 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.					
	<u>Note</u> Dornase alfa is not PBS-subsidised for use in combination with PBS-subsidised mannitol.					
	<u>Note</u> It is highly desirable that all patients be included in the national cystic fibrosis patient database.					
6120D	dornase alfa 2.5 mg/2.5 mL inhalation: solution, 30 x 2.5 mL ampoules	2	5	..	*2406.76	Pulmozyme RO
	MANNITOL <u>Authority required</u> 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.					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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.) <u>Authority required</u> 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. <u>Note</u> Mannitol is not PBS-subsidised for use in combination with PBS-subsidised dornase alfa. <u>Note</u> It is highly desirable that all patients be included in the national cystic fibrosis patient database.					
2008Q	MANNITOL Pack containing 280 capsules containing powder for inhalation 40 mg and 2 inhalers, 1	4	5	..	*1782.76	bronchitol XA

OTHER RESPIRATORY SYSTEM PRODUCTS

OTHER RESPIRATORY SYSTEM PRODUCTS

Other respiratory system products

IVACAFTOR

Authority required

Cystic fibrosis

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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, ciprofloxacin, 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 hospitalisation (including hospital-in-the home) in the previous 12 months.					
	<u>Authority required</u>					
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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, ciprofloxacin, 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 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

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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, ciprofloxacin, 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 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 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.					
	Note No increase in the maximum number of repeats may be authorised.					
	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					
10175M	ivacaftor 150 mg tablet, 56	1	5	..	22546.76	Kalydeco
						VR

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer	
					Qty \$		

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.

6499C	deferasirox 125 mg tablet: dispersible, 28	6	5	..	*1448.26	Exjade	NV
6500D	deferasirox 250 mg tablet: dispersible, 28	6	5	..	*2849.68	Exjade	NV
9600G	deferasirox 500 mg tablet: dispersible, 28	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

9638G	deferiprone 100 mg/mL oral liquid, 250 mL	5	5	..	*1173.16	Ferriprox	TX
6416Q	deferiprone 500 mg tablet, 100	6	5	..	*2750.14	Ferriprox	TX

DEFERRIOXAMINE

Authority required

Disorders of erythropoiesis associated with treatment-related chronic iron overload

6270B	desferrioxamine mesylate 2 g injection, 1 x 2 g vial	60	5	..	*1771.36	^a Hospira Pty Limited	HH
6113R	desferrioxamine mesylate 500 mg injection, 10 x 500 mg vials	40	5	^B 17.40	*1788.76	^a Desferal 2 g	NV
				..	*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

Management of hyperphosphataemia in a patient with chronic kidney disease on dialysis whose serum phosphate is not controlled on calcium and where serum phosphate is greater than 1.6 mmol per L at the commencement of therapy.

Management includes initiation, stabilisation and review of therapy as required

Authority required

Management of hyperphosphataemia in a patient with chronic kidney disease on dialysis whose serum phosphate is not controlled on calcium and where the serum calcium times phosphate product is greater than 4.0 at the commencement of therapy.

Management includes initiation, stabilisation and review of therapy as required

Note

Not to be used in combination with sevelamer.

9637F	LANTHANUM Tablet, chewable, 1000 mg (as carbonate hydrate), 90	2	5	..	*932.38	Fosrenol	ZI
9635D	LANTHANUM Tablet, chewable, 500 mg (as carbonate hydrate), 90	2	5	..	*551.24	Fosrenol	ZI
9636E	LANTHANUM Tablet, chewable, 750 mg (as carbonate hydrate), 90	2	5	..	*828.94	Fosrenol	ZI

SEVELAMER

Authority required

Management of hyperphosphataemia in a patient with chronic kidney disease on dialysis whose serum phosphate is not controlled on calcium and

HIGHLY SPECIALISED DRUGS PROGRAM (Private Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	
	where serum phosphate is greater than 1.6 mmol per L at the commencement of therapy. Management includes initiation, stabilisation and review of therapy as required <u>Authority required</u> Management of hyperphosphataemia in a patient with chronic kidney disease on dialysis whose serum phosphate is not controlled on calcium and where the serum calcium times phosphate product is greater than 4.0 at the commencement of therapy. Management includes initiation, stabilisation and review of therapy as required <u>Note</u> Not to be used in combination with lanthanum.					
9620H	sevelamer hydrochloride 800 mg tablet, 180	2	5	..	*651.56	Renagel
						GZ

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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:

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	(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 <u>Authority required</u> 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) <u>Note</u> 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. <u>Note</u> 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. <u>Note</u> No applications for increased repeats will be authorised.						
5825N	eltrombopag 25 mg tablet, 28	1	5	..	1512.00	Revolade	GK
5826P	eltrombopag 50 mg tablet, 28	1	5	..	3024.00	Revolade	GK

ROMIPILOSTIM

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty	Brand Name and Manufacturer	
					\$		
HOBART TAS 7001							
Further prescribing information is on the Medicare Australia website at www.medicareaustralia.gov.au .							
<u>Note</u>							
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.							
<u>Note</u>							
Special Pricing Arrangements apply.							
9696H	romiplostim 250 microgram injection, 1 x 250 microgram vial	1	..	..	977.50	Nplate	AN
9698K	romiplostim 500 microgram injection, 1 x 500 microgram vial	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

5637Q	darbepoetin alfa 10 microgram/0.4 mL injection, 4 x 0.4 mL syringes	2	5	..	*356.08	Aranesp	AN
5649H	darbepoetin alfa 100 microgram/0.5 mL injection, 1 x 0.5 mL syringe	8	5	..	*2620.48	Aranesp SureClick	AN
5651K	darbepoetin alfa 100 microgram/0.5 mL injection, 4 x 0.5 mL syringes	2	5	..	*2620.50	Aranesp	AN
5650J	darbepoetin alfa 150 microgram/0.3 mL injection, 1 x 0.3 mL syringe	8	5	..	*3904.48	Aranesp SureClick	AN
5643B	darbepoetin alfa 150 microgram/0.3 mL injection, 4 x 0.3 mL syringes	2	5	..	*3904.50	Aranesp	AN
5645D	darbepoetin alfa 20 microgram/0.5 mL injection, 1 x 0.5 mL syringe	8	5	..	*670.64	Aranesp SureClick	AN
5638R	darbepoetin alfa 20 microgram/0.5 mL injection, 4 x 0.5 mL syringes	2	5	..	*670.62	Aranesp	AN
5639T	darbepoetin alfa 30 microgram/0.3 mL injection, 4 x 0.3 mL syringes	2	5	..	*917.46	Aranesp	AN
5646E	darbepoetin alfa 40 microgram/0.4 mL injection, 1 x 0.4 mL syringe	8	5	..	*1113.60	Aranesp SureClick	AN
5640W	darbepoetin alfa 40 microgram/0.4 mL injection, 4 x 0.4 mL syringes	2	5	..	*1113.60	Aranesp	AN
5641X	darbepoetin alfa 50 microgram/0.5 mL injection, 4 x 0.5 mL syringes	2	5	..	*1376.78	Aranesp	AN
5647F	darbepoetin alfa 60 microgram/0.3 mL injection, 1 x 0.3 mL syringe	8	5	..	*1616.64	Aranesp SureClick	AN
5642Y	darbepoetin alfa 60 microgram/0.3 mL injection, 4 x 0.3 mL syringes	2	5	..	*1616.66	Aranesp	AN
5648G	darbepoetin alfa 80 microgram/0.4 mL injection, 1 x 0.4 mL syringe	8	5	..	*2128.00	Aranesp SureClick	AN
5644C	darbepoetin alfa 80 microgram/0.4 mL injection, 4 x 0.4 mL syringes	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

5722E	epoetin alfa 10 000 international units/mL injection, 6 x 1 mL syringes	2	5	..	*1970.30	Eprex 10000	JC
5714R	epoetin alfa 1000 international units/0.5 mL injection, 6 x 0.5 mL syringes	2	5	..	*279.30	Eprex 1000	JC

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty	Brand Name and Manufacturer	
					\$		
5713Q	epoetin alfa 20 000 international units/0.5 mL injection, 6 x 0.5 mL syringes	2	5	..	*3876.00	Eprex 20,000	JC
5719B	epoetin alfa 2000 international units/0.5 mL injection, 6 x 0.5 mL syringes	2	5	..	*516.80	Eprex 2000	JC
5720C	epoetin alfa 3000 international units/0.3 mL injection, 6 x 0.3 mL syringes	2	5	..	*666.90	Eprex 3000	JC
5718Y	epoetin alfa 40 000 international units/mL injection, 1 x 1 mL syringe	2	5	..	*1254.00	Eprex 40,000	JC
5721D	epoetin alfa 4000 international units/0.4 mL injection, 6 x 0.4 mL syringes	2	5	..	*849.30	Eprex 4000	JC
5715T	epoetin alfa 5000 international units/0.5 mL injection, 6 x 0.5 mL syringes	2	5	..	*1057.34	Eprex 5000	JC
5716W	epoetin alfa 6000 international units/0.6 mL injection, 6 x 0.6 mL syringes	2	5	..	*1255.14	Eprex 6000	JC
5717X	epoetin alfa 8000 international units/0.8 mL injection, 6 x 0.8 mL syringes	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

5729M	epoetin beta 10 000 international units/0.6 mL injection, 6 x 0.6 mL syringes	2	5	..	*1970.30	NeoRecormon	RO
5724G	epoetin beta 2000 international units/0.3 mL injection, 6 x 0.3 mL syringes	2	5	..	*516.80	NeoRecormon	RO
5725H	epoetin beta 3000 international units/0.3 mL injection, 6 x 0.3 mL syringes	2	5	..	*666.90	NeoRecormon	RO
5726J	epoetin beta 4000 international units/0.3 mL injection, 6 x 0.3 mL syringes	2	5	..	*849.30	NeoRecormon	RO
5727K	epoetin beta 5000 international units/0.3 mL injection, 6 x 0.3 mL syringes	2	5	..	*1057.36	NeoRecormon	RO
5728L	epoetin beta 6000 international units/0.3 mL injection, 6 x 0.3 mL syringes	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.

9596C	epoetin lambda 10 000 international units/mL injection, 6 x 1 mL syringes	2	5	..	*1866.60	Novicrit	NV
9668W	epoetin lambda 1000 international units/0.5 mL injection, 6 x 0.5 mL syringes	2	5	..	*264.60	Novicrit	NV
9669X	epoetin lambda 2000 international units/mL injection, 6 x 1 mL syringes	2	5	..	*489.60	Novicrit	NV
9670Y	epoetin lambda 3000 international units/0.3 mL injection, 6 x 0.3 mL syringes	2	5	..	*631.80	Novicrit	NV
9587N	epoetin lambda 4000 international units/0.4 mL injection, 6 x 0.4 mL syringes	2	5	..	*804.60	Novicrit	NV
9589Q	epoetin lambda 5000 international units/0.5 mL injection, 6 x 0.5 mL syringes	2	5	..	*1001.70	Novicrit	NV
9591T	epoetin lambda 6000 international units/0.6 mL injection, 6 x 0.6 mL syringes	2	5	..	*1189.08	Novicrit	NV
9594Y	epoetin lambda 8000 international units/0.8 mL injection, 6 x 0.8 mL syringes	2	5	..	*1542.24	Novicrit	NV

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty	Brand Name and Manufacturer	
					\$		
5797D	methoxy polyethylene glycol-epoetin beta 100 microgram/0.3 mL injection, 1 x 0.3 mL syringe	2	5	..	*1158.82	Mircera	RO
5798E	methoxy polyethylene glycol-epoetin beta 120 microgram/0.3 mL injection, 1 x 0.3 mL syringe	2	5	..	*1341.64	Mircera	RO
5799F	methoxy polyethylene glycol-epoetin beta 200 microgram/0.3 mL injection, 1 x 0.3 mL syringe	2	5	..	*1924.30	Mircera	RO
5794Y	methoxy polyethylene glycol-epoetin beta 30 microgram/0.3 mL injection, 1 x 0.3 mL syringe	2	5	..	*369.18	Mircera	RO
5800G	methoxy polyethylene glycol-epoetin beta 360 microgram/0.6 mL injection, 1 x 0.6 mL syringe	2	5	..	*3326.52	Mircera	RO
5795B	methoxy polyethylene glycol-epoetin beta 50 microgram/0.3 mL injection, 1 x 0.3 mL syringe	2	5	..	*615.30	Mircera	RO
5796C	methoxy polyethylene glycol-epoetin beta 75 microgram/0.3 mL injection, 1 x 0.3 mL syringe	2	5	..	*896.02	Mircera	RO

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

CARDIOVASCULAR SYSTEM

ANTIHYPERTENSIVES

OTHER ANTIHYPERTENSIVES

Other antihypertensives

AMBRISENTAN

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	

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.

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

Note

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: 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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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. 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 Note 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)					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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.

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

GPO Box 9826

HOBART TAS 7001

Note

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: 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;

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
(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.							
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.							
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							
Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.							
5608E	ambrisentan 10 mg tablet, 30	1	..	..	2876.47	Volibris	GK
5607D	ambrisentan 5 mg tablet, 30	1	..	..	2876.47	Volibris	GK

BOSENTAN

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,

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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.

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.

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

Note

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: 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:

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

- (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.

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.

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

Note

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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
	Human Services will contact prescribers prior to dispatch of the second authority prescription to confirm the tablet strength required for the patient.						

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.

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

Note

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: 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:

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

- (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.

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.

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

Note

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer	
Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.							
5619R	bosentan 125 mg tablet, 60	1	..	..	2876.47	Tracleer	AT

BOSENTAN

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

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.

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

Note

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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

Note

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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

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.

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

Note

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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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					
	<u>Note</u> Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.					
	<u>Authority required</u> 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.					
	<u>Caution</u> 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.					
	<u>Note</u> 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					
5618Q	bosentan 62.5 mg tablet, 60	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:

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

- (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.

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

Note

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note

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.

Note

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.

Authority required

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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.

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
	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						
	Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.						
	Note 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.						
	Note 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.						
	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						
	Note 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.						
	Note 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.						
	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:						

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

- (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

Note

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note

Pharmaceutical benefits that have the form epoprostenol sodium powder for I.V. infusion 1.5 mg (base) infusion administration set and

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer	
					Price for Max.	Qty		
	pharmaceutical benefits that have the form epoprostenol 1.5 mg injection vial are equivalent for the purposes of substitution.							
Note								
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.								
5035B	EPOPROSTENOL SODIUM Powder for I.V. infusion 1.5 mg (base) infusion administration set, 1	1	..	..	66.55	^a	Flolan Kit	GK
5030R	EPOPROSTENOL SODIUM Powder for I.V. infusion 500 micrograms (base) infusion administration set, 1	1	..	..	33.28	^a	Flolan Kit	GK
10117L	epoprostenol 1.5 mg injection, 1 x 1.5 mg vial	1	..	..	66.55	^a	Veletri	AT
10130E	epoprostenol 500 microgram injection, 1 x 500 microgram vial	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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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.

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

Note

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note

Special Pricing Arrangements apply.

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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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.					
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

Note

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note

Special Pricing Arrangements apply.

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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	<u>Note</u> 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 <u>Note</u> Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals. <u>Note</u> Special Pricing Arrangements apply. <u>Authority required</u> 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. <u>Note</u> 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 <u>Note</u> Special Pricing Arrangements apply. <u>Authority required</u> 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:					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

- (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

Note

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

Note

Special Pricing Arrangements apply.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
5751Q	iloprost 20 microgram/2 mL inhalation: solution, 30 x 2 mL ampoules	1	..	..	1076.00	Ventavis	BN

MACITENTAN

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

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

Note

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: 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:

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	(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. 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 Note 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: Initial 3 (change or re-commencement of therapy for all patients) Clinical criteria:					

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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. 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					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

HOBART TAS 7001

Note

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: 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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	
	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. 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. 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 Note Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.						
10136L	macitentan 10mg tablet, 30	1	..	..	2876.47		Opsumit
							AT

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,

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

Note

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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

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

Note

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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

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

Note

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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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

Note

Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.

9547L	sildenafil 20 mg tablet, 90	1	..	..	754.68	^a	APO-Sildenafil PHT	TX
						^a	Revatio	PF
						^a	Sildenafil Sandoz PHT 20	SZ

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

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

Note

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)

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
	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.						

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

Note

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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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.

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

Note

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: 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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					
	Note					
	Refer to the Department of Human Services website at www.humanservices.gov.au for a list of designated hospitals.					
1308W	tadalafil 20 mg tablet, 56	1	..	..	838.53	Adcirca

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Dispensed Price for Max.						
Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Qty \$	Brand Name and Manufacturer

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS

PITUITARY AND HYPOTHALAMIC HORMONES AND ANALOGUES

HYPOTHALAMIC HORMONES

Somatostatin and analogues

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.

5779E	lanreotide 120 mg injection, 1 syringe	2	5	..	*4480.00	Somatuline Autogel	IS
5777C	lanreotide 60 mg injection, 1 syringe	2	5	..	*2690.00	Somatuline Autogel	IS
5778D	lanreotide 90 mg injection, 1 syringe	2	5	..	*3580.00	Somatuline Autogel	IS

LANREOTIDE

Authority required (STREAMLINED)

4567

Acromegaly

Clinical criteria:

The condition must be active,

AND

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
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.							
5776B	lanreotide 30 mg injection: modified release [1 x 30 mg vial] (&) inert substance diluent [1 x 2 mL ampoule], 1 pack	2	11	..	*1500.00	Somatuline LA	IS
OCTREOTIDE							
<u>Authority required (STREAMLINED)</u>							
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							
<u>Authority required (STREAMLINED)</u>							
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.							
<u>Authority required (STREAMLINED)</u>							
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.							
9511N	octreotide 10 mg injection: modified release [1 x 10 mg vial] (&) inert substance diluent [1 x 2.5 mL syringe], 1 pack	2	5	..	*2613.72	Sandostatin LAR	NV
9512P	octreotide 20 mg injection: modified release [1 x 20 mg vial] (&) inert substance diluent [1 x 2.5 mL syringe], 1 pack	2	5	..	*3479.62	Sandostatin LAR	NV
9513Q	octreotide 30 mg injection: modified release [1 x 30 mg vial] (&) inert substance diluent [1 x 2.5 mL syringe], 1 pack	2	5	..	*4354.92	Sandostatin LAR	NV

OCTREOTIDE

Authority required (STREAMLINED)

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer	
					Qty \$			
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								
<u>Authority required (STREAMLINED)</u>								
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								
9509L	octreotide 100 microgram/mL injection, 5 x 1 mL ampoules	18	11	..	*1236.42	^a	Hospira Pty Limited	HH
						^a	Octreotide (SUN)	ZF
						^a	Octreotide MaxRx	GQ
						^a	Sandostatin 0.1	NV
9508K	octreotide 50 microgram/mL injection, 5 x 1 mL ampoules	18	11	..	*619.02	^a	Hospira Pty Limited	HH
						^a	Octreotide (SUN)	ZF
						^a	Octreotide MaxRx	GQ
						^a	Sandostatin 0.05	NV
9510M	octreotide 500 microgram/mL injection, 5 x 1 mL ampoules	18	11	..	*6194.52	^a	Hospira Pty Limited	HH
						^a	Octreotide (SUN)	ZF
						^a	Octreotide MaxRx	GQ
						^a	Sandostatin 0.5	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.

Note

Special Pricing Arrangements apply.

5621W	cinacalcet 30 mg tablet, 28	2	5	..	*385.92		Sensipar	AN
5622X	cinacalcet 60 mg tablet, 28	2	5	..	*771.84		Sensipar	AN
5623Y	cinacalcet 90 mg tablet, 28	2	5	..	*1157.76		Sensipar	AN

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		

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

5616N	azithromycin 600 mg tablet, 8	2	5	..	*128.06	Zithromax	PF

CLARITHROMYCIN

Authority required (STREAMLINED)

3325

Treatment of Mycobacterium avium complex infections

5625C	clarithromycin 250 mg tablet, 100	1	2	..	20.00	Klacid	AB

5624B	clarithromycin 500 mg tablet, 100	1	2	..	39.93	Klacid	AB

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

9541E	rifabutin 150 mg capsule, 30	4	5	..	*647.36	Mycobutin	PF

ANTIVIRALS FOR SYSTEMIC USE

DIRECT ACTING ANTIVIRALS

Nucleosides and nucleotides excl. reverse transcriptase inhibitors

CIDOFOVIR

Authority required (STREAMLINED)

3322

Treatment of cytomegalovirus retinitis in patients with AIDS

5620T	cidofovir 375 mg/5 mL injection, 1 x 5 mL vial	4	3	..	*3600.00	Vistide	GI

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

5749N	ganciclovir 500 mg injection, 5 x 500 mg vials	2	1	..	*560.00	Cymeveene	RO

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer	
					Qty \$			
VALACICLOVIR								
<u>Authority required (STREAMLINED)</u>								
3419								
Prophylaxis of cytomegalovirus (CMV) infection and disease following renal transplantation in patients at risk of CMV disease								
9568N	valaciclovir 500 mg tablet, 100	5	2	..	*913.00	^a	APO-Valaciclovir	TX
						^a	Valaciclovir RBX	RA
						^a	Valtrex	AS
						^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

9569P	valganciclovir 450 mg tablet, 60	2	5	..	*4491.60		Valcyte	RO
9655E	valganciclovir 50 mg/mL oral liquid: powder for, 100 mL	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

5747L	FOSCARNET SODIUM I.V. infusion 24 mg per mL, 250 mL bottle, 6	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.

5613K	atazanavir 150 mg capsule, 60	2	5	..	*1043.82		Reyataz	BQ
5614L	atazanavir 200 mg capsule, 60	2	5	..	*1391.76		Reyataz	BQ
5612J	atazanavir 300 mg capsule, 30	2	5	..	*1043.82		Reyataz	BQ

BOCEPREVIR

Authority required (STREAMLINED)

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	
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.						
	<u>Authority required (STREAMLINED)</u>						
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						

2433C	Boceprevir 200 mg capsule, 336 capsules	1	10	..	3920.00	Victrelis	MK

3392M	darunavir 600 mg tablet, 60	2	5	..	*2097.42	Prezista	JC

2980W	darunavir 800 mg tablet, 30	2	5	..	*1398.28	Prezista	JC

HIV infection

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer	
					Qty \$		
	Treatment Phase: Initial						
	Clinical criteria:						
	Patient must be antiretroviral treatment naive,						
	AND						
	The treatment must be in combination with other antiretroviral agents.						
	<u>Authority required (STREAMLINED)</u>						
	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.						
5745J	fosamprenavir 50 mg/mL oral liquid, 225 mL	8	5	..	*812.48	Telzir	VI
5746K	fosamprenavir 700 mg tablet, 60	2	5	..	*758.32	Telzir	VI
	INDINAVIR						
	<u>Authority required (STREAMLINED)</u>						
	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.						
	<u>Authority required (STREAMLINED)</u>						
	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.						
5752R	indinavir 400 mg capsule, 180	2	5	..	*910.00	Crixivan 400 mg	MK
	RITONAVIR						
	<u>Authority required (STREAMLINED)</u>						
	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.						
	<u>Authority required (STREAMLINED)</u>						
	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.						
9660K	ritonavir 100 mg tablet, 30	24	5	..	*982.80	Norvir	VE

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
9542F	ritonavir 600 mg/7.5 mL oral liquid, 90 mL	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.

9545J	saquinavir 500 mg tablet, 120	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:

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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. Note No increase in the maximum number of repeats may be authorised. 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.					
10200W	simeprevir sodium 150 mg capsule, 7	6	..	..	*14865.72	Olysio

JC

TELAPREVIR

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
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. <u>Authority required (STREAMLINED)</u> 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. <u>Note</u> No increase in the maximum quantity or number of units may be authorised. <u>Note</u> No increase in the maximum number of repeats may be authorised. <u>Note</u> 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.							
2437G	telaprevir 375 mg tablet, 42	6	..	..	*14865.72	Incivo	JC
TIPRANAVIR <u>Authority required (STREAMLINED)</u> 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 <u>Note</u> Special Pricing Arrangements apply.							
9567M	tipranavir 250 mg capsule, 120	2	5	..	*2142.00	Aptivus	BY

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max. Qty \$		

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.

5602W	abacavir 20 mg/mL oral liquid, 240 mL	8	5	..	*657.12	Ziagen	VI
5601T	abacavir 300 mg tablet, 60	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.

5606C	adefovir dipivoxil 10 mg tablet, 30	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,

				Premium	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer	
Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	\$			
	AND						
	The treatment must be in combination with other antiretroviral agents.						
5663C	didanosine 125 mg capsule: enteric, 30	2	5	..	*280.86	Videx EC	BQ
5664D	didanosine 200 mg capsule: enteric, 30	2	5	..	*326.80	Videx EC	BQ
5665E	didanosine 250 mg capsule: enteric, 30	2	5	..	*408.48	Videx EC	BQ
5666F	didanosine 400 mg capsule: enteric, 30	2	5	..	*653.58	Videx EC	BQ
	EMTRICITABINE						
	<u>Authority required (STREAMLINED)</u>						
	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.						
	<u>Authority required (STREAMLINED)</u>						
	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.						
5709L	emtricitabine 200 mg capsule, 30	2	5	..	*564.00	Emtriva	GI
	ENTECAVIR						
	<u>Authority required (STREAMLINED)</u>						
	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						
	<u>Authority required (STREAMLINED)</u>						
	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.						
5712P	entecavir monohydrate 1 mg tablet, 30	2	5	..	*1250.00	Baraclude	BQ
	ENTECAVIR						
	<u>Authority required (STREAMLINED)</u>						
	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						
	<u>Authority required (STREAMLINED)</u>						

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer	
					Qty	\$		
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.								
5711N	entecavir monohydrate 500 microgram tablet, 30	2	5	..	*768.60		Baraclude	BQ
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.								
5773W	lamivudine 10 mg/mL oral liquid, 240 mL	8	5	..	*447.84		3TC	VI
5772T	lamivudine 150 mg tablet, 60	2	5	..	*306.68	^a	3TC	VI
5774X	lamivudine 300 mg tablet, 30	2	5	..	*306.68	^a	Lamivudine	AF
						^a	Alphapharm	
						^a	Lamivudine RBX	RA
						^a	3TC	VI
						^a	Lamivudine	AF
						^a	Alphapharm	
						^a	Lamivudine RBX	RA
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								
5770Q	lamivudine 100 mg tablet, 28	2	5	..	*162.44	^a	Zeffix	AS
5771R	lamivudine 5 mg/mL oral liquid, 240 mL	5	5	..	*226.25	^a	Zetlam	AF
							Zeffix	AS

STAVUDINE

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	AND					
	The treatment must be in combination with other antiretroviral agents.					
	<u>Authority required (STREAMLINED)</u>					
	4489					
	Chronic hepatitis B					
	Clinical criteria:					
	Patient must not have cirrhosis,					
	AND					
	Patient must be nucleoside analogue naïve,					
	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.					
	<u>Note</u>					
	Patients may receive treatment in combination with lamivudine but not with other PBS-subsidised antihepadnaviral therapy.					
	<u>Authority required (STREAMLINED)</u>					
	4476					
	Chronic hepatitis B					
	Clinical criteria:					
	Patient must have cirrhosis,					
	AND					
	Patient must be nucleoside analogue naïve,					
	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.					
	<u>Note</u>					
	Patients may receive treatment in combination with lamivudine but not with other PBS-subsidised antihepadnaviral therapy.					
	<u>Authority required (STREAMLINED)</u>					
	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.					
	<u>Note</u>					
	Patients may receive treatment in combination with lamivudine but not with other PBS-subsidised antihepadnaviral therapy.					
	<u>Authority required (STREAMLINED)</u>					
	4510					
	Chronic hepatitis B					
	Clinical criteria:					
	Patient must have cirrhosis,					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty	Brand Name and Manufacturer	
					\$		
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.							
<u>Note</u>							
Patients may receive treatment in combination with lamivudine but not with other PBS-subsidised antihepadnaviral therapy.							
9563H	tenofovir disoproxil fumarate 300 mg tablet, 30	2	5	..	*966.20	Viread	GI
ZIDOVUDINE							
<u>Authority required (STREAMLINED)</u>							
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.							
<u>Authority required (STREAMLINED)</u>							
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.							
9651Y	zidovudine 100 mg capsule, 100	4	5	..	*821.84	Retrovir	VI
9652B	zidovudine 250 mg capsule, 40	6	5	..	*1232.76	Retrovir	VI
9570Q	zidovudine 50 mg/5 mL oral liquid, 200 mL	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.

5708K	efavirenz 200 mg tablet, 90	2	5	..	*543.16	Stocrin	MK
5707J	efavirenz 30 mg/mL oral liquid, 180 mL	7	5	..	*570.29	Stocrin	MK

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty	Brand Name and Manufacturer	
					\$		
5706H	efavirenz 600 mg tablet, 30	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

5084N	etravirine 200 mg tablet, 60	2	5	..	*1233.00	Intelence	JC

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.

9507J	nevirapine 10 mg/mL oral liquid, 240 mL	10	5	..	*1350.00	Viramune	BY
9506H	nevirapine 200 mg tablet, 60	2	5	..	*456.26	^a Nevipin	GN
						^a Nevirapine Alphapharm	AF
						^a Nevirapine RBX	RA
						^a Viramune	BY

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.

1132N	nevirapine 400 mg tablet: modified release, 30 tablets	2	5	..	*456.26	Viramune XR	BY

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
RILPIVIRINE						
<u>Authority required (STREAMLINED)</u>						
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.						
<u>Authority required (STREAMLINED)</u>						
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.						
1173R	rilpivirine 25 mg tablet, 30	2	5	..	*543.16	Edurant
						JC

Antivirals for treatment of HIV infections, combinations

ABACAVIR + LAMIVUDINE <u>Authority required (STREAMLINED)</u> 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.							
<u>Authority required (STREAMLINED)</u> 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.							
5603X	abacavir 600 mg + lamivudine 300 mg tablet, 30	2	5	..	*870.68	Kivexa	VI

ABACAVIR + LAMIVUDINE + ZIDOVUDINE

Authority required (STREAMLINED)

4495

HIV infection

Treatment Phase: Initial

Clinical criteria:

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	Patient must be antiretroviral treatment naive.						
	Population criteria:						
	Patient must be aged 12 years or older,						
	AND						
	Patient must weigh 40 kg or more.						
	<u>Authority required (STREAMLINED)</u>						
	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.						
5604Y	abacavir 300 mg + lamivudine 150 mg + zidovudine 300 mg tablet, 60	2	5	..	*1357.28	Trizivir	VI
	EMTRICITABINE + RILPIVIRINE + TENOFOVIR						
	<u>Authority required (STREAMLINED)</u>						
	4522						
	HIV infection						
	Treatment Phase: Initial						
	Clinical criteria:						
	Patient must be antiretroviral treatment naive.						
	<u>Authority required (STREAMLINED)</u>						
	4470						
	HIV infection						
	Treatment Phase: Continuing						
	Clinical criteria:						
	Patient must have previously received PBS-subsidised therapy for HIV infection.						
1491L	emtricitabine 200 mg + rilpivirine 25 mg + tenofovir disoproxil fumarate 300 mg tablet, 30	2	5	..	*2073.36	Eviplera	GI
	LAMIVUDINE + ZIDOVUDINE						
	<u>Authority required (STREAMLINED)</u>						
	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.						
	<u>Authority required (STREAMLINED)</u>						
	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.						
5775Y	lamivudine 150 mg + zidovudine 300 mg tablet, 60	2	5	..	*787.46	^a Combivir	VI
						^a Lamivudine 150 mg + Zidovudine 300 mg Alphapharm	AF

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
LOPINAVIR + RITONAVIR						
<u>Authority required (STREAMLINED)</u>						
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.						
<u>Authority required (STREAMLINED)</u>						
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.						
5790R	lopinavir 100 mg + ritonavir 25 mg tablet, 60	2	5	..	*342.50	Kaletra VE
5791T	lopinavir 200 mg + ritonavir 50 mg tablet, 120	2	5	..	*1370.00	Kaletra VE
5789Q	lopinavir 400 mg/5 mL + ritonavir 100 mg/5 mL oral liquid, 60 mL	10	5	..	*1290.00	Kaletra VE
TENOFOVIR + EMTRICITABINE						
<u>Authority required (STREAMLINED)</u>						
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.						
<u>Authority required (STREAMLINED)</u>						
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.						
9564J	tenofovir disoproxil fumarate 300 mg + emtricitabine 200 mg tablet, 30	2	5	..	*1530.20	Truvada GI
TENOFOVIR + EMTRICITABINE + EFVIRENZ						
<u>Authority required (STREAMLINED)</u>						
4522						
HIV infection						
Treatment Phase: Initial						
Clinical criteria:						
Patient must be antiretroviral treatment naive.						
<u>Authority required (STREAMLINED)</u>						
4470						
HIV infection						
Treatment Phase: Continuing						
Clinical criteria:						

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
Patient must have previously received PBS-subsidised therapy for HIV infection.							
9565K	tenofovir disoproxil fumarate 300 mg + emtricitabine 200 mg + efavirenz 600 mg tablet. 30	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.

10088Y	tenofovir disoproxil fumarate 300 mg + emtricitabine 200 mg + elvitegravir 150 mg + cobicistat 150 mg tablet, 30	2	5	..	*2073.36	Stribild	GI

Other antirvirals

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.

10065R	dolutegravir 50 mg tablet, 30	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

5710M	enfuvirtide 90 mg injection [60 x 90 mg vials] (&) inert substance diluent [60 x 1.1 mL vials], 1 pack	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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty	Brand Name and Manufacturer	
					\$		
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							
5792W	maraviroc 150 mg tablet, 60	2	5	..	*1835.40	Celsentri	VI
5793X	maraviroc 300 mg tablet, 60	2	5	..	*1835.40	Celsentri	VI

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.

2760G	raltegravir 100 mg tablet: chewable, 60	6	5	..	*2025.00	Isentress	MK
2736B	raltegravir 25 mg tablet: chewable, 60	6	5	..	*506.28	Isentress	MK

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.

9523F	raltegravir 400 mg tablet, 60	2	5	..	*1331.10	Isentress	MK

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

Note

Special Pricing Arrangements apply.

9597D	azacitidine 100 mg injection, 1 x 100 mg vial	14	2	..	*7700.00	Vidaza	CJ

AZACITIDINE

Authority required

Continuing treatment of a patient with:

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	(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					
	<u>Note</u> 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					
	<u>Note</u> Special Pricing Arrangements apply.					
9598E	azacitidine 100 mg injection, 1 x 100 mg vial	14	5	..	*7700.00	Vidaza

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

5705G	doxorubicin hydrochloride-pegylated liposomal 20 mg/10 mL injection, 1 x 10 mL vial	4	5	..	*2093.24	^a	Caelyx JC
						^a	Liposomal Doxorubicin ZF SUN

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
<u>Authority required (STREAMLINED)</u>						
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))						
<u>Authority required (STREAMLINED)</u>						
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						
<u>Authority required (STREAMLINED)</u>						
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						
<u>Authority required (STREAMLINED)</u>						
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						
<u>Authority required (STREAMLINED)</u>						
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						
<u>Authority required (STREAMLINED)</u>						
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						
<u>Authority required (STREAMLINED)</u>						
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)						
<u>Authority required (STREAMLINED)</u>						
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))						
<u>Authority required (STREAMLINED)</u>						
3370						
A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in acute lymphoblastic leukaemia						
<u>Authority required (STREAMLINED)</u>						
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)						
<u>Authority required (STREAMLINED)</u>						
3372						
A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in germ cell tumours						
<u>Authority required (STREAMLINED)</u>						
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						
<u>Authority required (STREAMLINED)</u>						
3374						
A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in neuroblastoma						
<u>Authority required (STREAMLINED)</u>						

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
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)							
<u>Authority required (STREAMLINED)</u>							
3376							
A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in relapsed Hodgkin disease							
<u>Authority required (STREAMLINED)</u>							
3377							
A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in sarcoma							
<u>Authority required (STREAMLINED)</u>							
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)							
5829T	filgrastim 120 microgram/0.2 mL injection, 10 x 0.2 mL syringes	2	11	..	*853.28	Nivestim	HH
1123D	filgrastim 300 microgram/0.5 mL injection, 10 x 0.5 mL syringes	2	11	..	*2133.18	TevaGrastim	AS
5742F	filgrastim 300 microgram/0.5 mL injection, 10 x 0.5 mL syringes	2	11	..	*2133.18	Neupogen	AN
9692D	filgrastim 300 microgram/0.5 mL injection, 10 x 0.5 mL syringes	2	11	..	*2133.18	Nivestim	HH
2758E	filgrastim 300 microgram/0.5 mL injection, 5 x 0.5 mL syringes	4	11	..	*2133.16	Zarzio	SZ
5741E	filgrastim 300 microgram/mL injection, 10 x 1 mL vials	2	11	..	*2133.18	Neupogen	AN
5744H	filgrastim 480 microgram/0.5 mL injection, 10 x 0.5 mL syringes	2	11	..	*3419.62	Neupogen	AN
9694F	filgrastim 480 microgram/0.5 mL injection, 10 x 0.5 mL syringes	2	11	..	*3419.62	Nivestim	HH
2783L	filgrastim 480 microgram/0.5 mL injection, 5 x 0.5 mL syringes	4	11	..	*3419.60	Zarzio	SZ
1126G	filgrastim 480 microgram/0.8 mL injection, 10 x 0.8 mL syringes	2	11	..	*3419.62	TevaGrastim	AS
5743G	filgrastim 480 microgram/1.6 mL injection, 10 x 1.6 mL vials	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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer	
	leukaemia						
	<u>Authority required (STREAMLINED)</u>						
	3398						
	Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in Ewing's sarcoma						
	<u>Authority required (STREAMLINED)</u>						
	3399						
	Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in germ cell tumours						
	<u>Authority required (STREAMLINED)</u>						
	3400						
	Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in infants and children with CNS tumours						
	<u>Authority required (STREAMLINED)</u>						
	3401						
	Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in neuroblastoma						
	<u>Authority required (STREAMLINED)</u>						
	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)						
	<u>Authority required (STREAMLINED)</u>						
	3403						
	Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in osteosarcoma						
	<u>Authority required (STREAMLINED)</u>						
	3404						
	Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in relapsed Hodgkin's disease						
	<u>Authority required (STREAMLINED)</u>						
	3405						
	Patients being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in rhabdomyosarcoma						
5787N	LENOGRASTIM Powder for injection 13,400,000 i.u. (105 micrograms) vial, 10	2	11	..	*1025.00	Granocyte 13	HH
5788P	LENOGRASTIM Powder for injection 33,600,000 i.u. (263 micrograms) vial, 10	2	11	..	*2567.20	Granocyte 34	HH
	PEGFILGRASTIM						
	<u>Authority required (STREAMLINED)</u>						
	3357						
	For use in a patient undergoing induction and consolidation therapy for acute myeloid leukaemia						
	<u>Authority required (STREAMLINED)</u>						
	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						
	<u>Authority required (STREAMLINED)</u>						
	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						
	<u>Authority required (STREAMLINED)</u>						
	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						
	<u>Authority required (STREAMLINED)</u>						
	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						
	<u>Authority required (STREAMLINED)</u>						
	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						

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	
	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						
	<u>Authority required (STREAMLINED)</u>						
	3370						
	A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in acute lymphoblastic leukaemia						
	<u>Authority required (STREAMLINED)</u>						
	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)						
	<u>Authority required (STREAMLINED)</u>						
	3372						
	A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in germ cell tumours						
	<u>Authority required (STREAMLINED)</u>						
	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						
	<u>Authority required (STREAMLINED)</u>						
	3374						
	A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in neuroblastoma						
	<u>Authority required (STREAMLINED)</u>						
	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)						
	<u>Authority required (STREAMLINED)</u>						
	3376						
	A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in relapsed Hodgkin disease						
	<u>Authority required (STREAMLINED)</u>						
	3377						
	A patient being treated with aggressive chemotherapy with the intention of achieving a cure or substantial remission in sarcoma						
	<u>Authority required (STREAMLINED)</u>						
	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)						
9514R	pegfilgrastim 6 mg/0.6 mL injection, 1 x 0.6 mL syringe	1	11	..	1925.00		Neulasta AN

Interferons

INTERFERON ALFA-2A

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

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.

5759D	interferon alfa-2a 3 million international units/0.5 mL injection, 1 x 0.5 mL syringe	30	5	..	*894.00		Roferon-A RO

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty	Brand Name and Manufacturer	
					\$		
5760E	interferon alfa-2a 4.5 million international units/0.5 mL injection, 1 x 0.5 mL syringe	30	5	..	*1341.00	Roferon-A	RO
5761F	interferon alfa-2a 6 million international units/0.5 mL injection, 1 x 0.5 mL syringe	30	5	..	*1787.40	Roferon-A	RO
5762G	interferon alfa-2a 9 million international units/0.5 mL injection, 1 x 0.5 mL syringe	30	5	..	*2681.40	Roferon-A	RO

INTERFERON ALFA-2B

Authority required (STREAMLINED)

3384

Adjuvantive 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

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.

5768N	interferon alfa-2b 10 million international units/mL injection, 5 x 1 mL vials	3	5	..	*1489.50	Intron A	MK
5763H	interferon alfa-2b 18 million international units/1.2 mL injection, 1 x 1.2 mL cartridge	2	5	..	*357.48	Intron A Redipen	MK
5766L	interferon alfa-2b 18 million international units/3 mL injection, 1 x 3 mL vial	15	5	..	*2681.10	Intron A	MK
5767M	interferon alfa-2b 25 million international units/2.5 mL injection, 1 x 2.5 mL vial	15	5	..	*3723.75	Intron A	MK
5764J	interferon alfa-2b 30 million international units/1.2 mL injection, 1 x 1.2 mL cartridge	2	5	..	*595.80	Intron A Redipen	MK
5765K	interferon alfa-2b 60 million international units/1.2 mL injection, 1 x 1.2 mL cartridge	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

5769P	interferon gamma-1b 2 million international units (100 microgram/0.5 mL) injection, 6 x 0.5 mL vials	2	11	..	*2721.80	Imukin	BY

PEGINTERFERON ALFA-2A

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)

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
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 <u>Authority required (STREAMLINED)</u>						
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 <u>Caution</u> 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. <u>Note</u> 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.						
9515T	peginterferon alfa-2a 135 microgram/0.5 mL injection, 4 x 0.5 mL syringes	2	5	..	*2331.80	Pegasys	RO
9516W	peginterferon alfa-2a 180 microgram/0.5 mL injection, 4 x 0.5 mL syringes	2	5	..	*2700.46	Pegasys	RO

PEGINTERFERON ALFA-2A (&) RIBAVIRIN

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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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.					
	Note					
	No increase in the maximum quantity or number of units may be authorised.					
	Note					
	No increase in the maximum number of repeats may be authorised.					
	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.					
	Authority required (STREAMLINED)					
	4197					
	Chronic genotype 1 hepatitis C infection					

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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.					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	<u>Note</u> No increase in the maximum quantity or number of units may be authorised.					
	<u>Note</u> No increase in the maximum number of repeats may be authorised.					
	<u>Note</u> 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.					
	<u>Authority required (STREAMLINED)</u>					
	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.					
	<u>Note</u> No increase in the maximum quantity or number of units may be authorised.					
	<u>Note</u> No increase in the maximum number of repeats may be authorised.					
	<u>Note</u> 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.					
	<u>Authority required (STREAMLINED)</u>					
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	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.						
	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.						
	Caution						
	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.						
	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.						
9524G	peginterferon alfa-2a 135 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [168 tablets], 1 pack	2	5	..	*3072.84	Pegasys RBV	RO
9525H	peginterferon alfa-2a 180 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [112 tablets], 1 pack	2	5	..	*3085.28	Pegasys RBV	RO
9526J	peginterferon alfa-2a 180 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [140 tablets], 1 pack	2	5	..	*3245.82	Pegasys RBV	RO
9527K	peginterferon alfa-2a 180 microgram/0.5 mL injection [4 x 0.5 mL syringes] (&) ribavirin 200 mg tablet [168 tablets], 1 pack	2	5	..	*3406.36	Pegasys RBV	RO

PEGINTERFERON ALFA-2B (&) RIBAVIRIN

Authority required (STREAMLINED)

4189

Chronic genotype 1 hepatitis C infection

Clinical criteria:

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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.					
	Note					
	No increase in the maximum quantity or number of units may be authorised.					
	Note					
	No increase in the maximum number of repeats may be authorised.					
	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.					
	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.					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

Note

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

Note

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

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.

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.

Note

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

Note

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

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.

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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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.					
	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.					
	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					

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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.					
	Note No increase in the maximum quantity or number of units may be authorised.					
	Note No increase in the maximum number of repeats may be authorised.					
	Note Treatment centres are required to have access to the following appropriate specialist facilities for the provision of clinical support services for hepatitis C:					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	(a) a nurse educator/counsellor for patients; and (b) 24-hour access by patients to medical advice; and (c) an established liver clinic.					
	<u>Authority required (STREAMLINED)</u> 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					

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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.					
	Note					
	No increase in the maximum quantity or number of units may be authorised.					
	Note					
	No increase in the maximum number of repeats may be authorised.					
	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.					
	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.					
	Note					
	No increase in the maximum number of repeats may be authorised.					
	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.					
	Authority required (STREAMLINED)					
	4187					
	Chronic non-genotype 1 hepatitis C infection					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer	
					Qty \$		
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.							
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.							
Caution							
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.							
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.							
9534T	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	2	5	..	*3099.62	Pegatron	MK
9529M	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	2	5	..	*2119.74	Pegatron	MK
9530N	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	2	5	..	*2422.72	Pegatron	MK

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
PEGINTERFERON ALFA-2B (&) RIBAVIRIN						
<u>Authority required (STREAMLINED)</u>						
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.						

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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.					
	Note					
	No increase in the maximum quantity or number of units may be authorised.					
	Note					
	No increase in the maximum number of repeats may be authorised.					
	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.					
	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.					

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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. <u>Note</u> No increase in the maximum quantity or number of units may be authorised. <u>Note</u> No increase in the maximum number of repeats may be authorised. <u>Note</u> 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. <u>Authority required (STREAMLINED)</u> 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					

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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.					
	Note					
	No increase in the maximum number of repeats may be authorised.					
	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.					
	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.					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		

For patients who are eligible for 48 weeks of treatment, a maximum of 5 repeats may be prescribed.

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.

Caution

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.

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.

9536X	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	2	5	..	*3491.58	Pegatron	MK
9538B	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	2	5	..	*4079.52	Pegatron	MK
9539C	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	2	5	..	*4079.52	Pegatron	MK
9540D	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	2	5	..	*4364.48	Pegatron	MK
9531P	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	2	5	..	*2707.66	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.

10083Q	plerixafor 24 mg/1.2 mL injection: subcutaneous infusion, 1 x 1.2 mL vial	1	1	..	6991.00	Mozobil	GZ

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
				\$	\$		

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

(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.

Note

Special Pricing Arrangements apply.

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

Note

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
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).						
<u>Note</u>						
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						
<u>Note</u>						
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,						

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

- 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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max. Qty \$		

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

(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:

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	
	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						
5605B	abatacept 250 mg injection, 1 x 250 mg vial	1	..	..	504.43		Orencia
							BQ

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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).

Note

Applications for treatment with eculizumab where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

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.

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

Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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 ecilizumab 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 ecilizumab 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 ecilizumab 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 ecilizumab 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 ecilizumab is severe extra-renal complications that have significantly improved; and
- (8) If the indication for continuing ecilizumab 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).

Note

Applications for treatment with ecilizumab where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

Note

WARNING: Ecilizumab 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 ecilizumab; revaccinate according to current

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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.

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

Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

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 +/- 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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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

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).

Note

Applications for treatment with eculizumab where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

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.

Note

Kidney transplantation/dialysis is not a contraindication to recommencement of eculizumab 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.

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

Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

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,

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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).

Note

Applications for treatment with eculizumab where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

Note

WARNING: Eculizumab increases the risk of meningococcal infections (septicaemia and/or meningitis)

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	> 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.

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

Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

- (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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty \$		
	(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.						
	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						
	Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.						
10183Y	eculizumab 300 mg/30 mL injection, 1 x 30 mL vial	1	5	..	5937.50		Soliris
							XI

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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

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).

Note

Applications for treatment with eculizumab where the dose and dosing frequency exceeds that specified in the approved PI will not be approved.

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

Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.

10190H	eculizumab 300 mg/30 mL injection, 1 x 30 mL vial	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 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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	(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 Note 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) Note Applications for treatment with eculizumab where the dose and dosing frequency exceeds that specified in the approved PI will not be approved. 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. 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 Written applications for authority to prescribe must be submitted to Department of Human Services. Human Services will then contact the prescriber by telephone.						
10191J	eculizumab 300 mg/30 mL injection, 1 x 30 mL vial	1	..	..	5937.50	Soliris	XI

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
EVEROLIMUS							
<u>Authority required (STREAMLINED)</u>							
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							
<u>Authority required (STREAMLINED)</u>							
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							
<u>Caution</u>							
Careful monitoring of patients is mandatory.							
5737Y	everolimus 1 mg tablet, 60	4	5	..	*3844.80	Certican	NV
5738B	everolimus 250 microgram tablet, 60	2	5	..	*480.60	Certican	NV
5739C	everolimus 500 microgram tablet, 60	2	5	..	*961.20	Certican	NV
5740D	everolimus 750 microgram tablet, 60	4	5	..	*2883.60	Certican	NV
MYCOPHENOLATE							
<u>Authority required (STREAMLINED)</u>							
4084							
Prophylaxis of renal allograft rejection							
Treatment Phase: Management							
Clinical criteria:							
The treatment must be under the supervision and direction of a transplant unit.							
<u>Authority required (STREAMLINED)</u>							
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.							
<u>Caution</u>							
Careful monitoring of patients is mandatory.							
<u>Note</u>							
Management includes initiation, stabilisation and review of therapy as required.							
9503E	mycophenolate 180 mg tablet: enteric, 120 tablets	2	5	..	*217.62	Myfortic	NV
9504F	mycophenolate 360 mg tablet: enteric, 120 tablets	2	5	..	*435.22	Myfortic	NV
MYCOPHENOLATE							
<u>Authority required (STREAMLINED)</u>							
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							
<u>Authority required (STREAMLINED)</u>							
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							
<u>Caution</u>							
Careful monitoring of patients is mandatory.							
<u>Note</u>							
For item codes 9501C and 1839T, pharmaceutical benefits that have the form capsule 250 mg are equivalent for the purposes of substitution.							
1839T	mycophenolate Capsule 250 mg, 50	12	5	..	*544.08 ^a	Ceptolate	AF

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$		Brand Name and Manufacturer	
9501C	mycophenolate mofetil 250 mg capsule, 100	6	5	..	*544.08	^a	APO-Mycophenolate	TX
						^a	CellCept	RO
						^a	Mycophenolate Sandoz	SZ
						^a	Pharmacor	CR
							Mycophenolate 250	

MYCOPHENOLATE

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

Caution

Careful monitoring of patients is mandatory.

9500B	mycophenolate mofetil 1 g/5 mL oral liquid: powder for, 165 mL	2	5	..	*489.02		CellCept	RO
9502D	mycophenolate mofetil 500 mg tablet, 50	6	5	..	*544.02	^a	APO-Mycophenolate	TX
						^a	CellCept	RO
						^a	Ceptolate	AF
						^a	Mycophenolate Sandoz	SZ
						^a	Pharmacor	CR
							Mycophenolate 500	

NATALIZUMAB

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

Caution

Progressive multifocal leukoencephalopathy has been reported with this drug.

Note

Neurologists prescribing natalizumab under the PBS listing must be registered with the Tysabri Australian Prescribing Program.

Note

Special Pricing Arrangements apply.

9505G	natalizumab 300 mg/15 mL injection, 1 x 15 mL vial	1	5	..	1568.04		Tysabri	BD

SIROLIMUS

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

Caution

Careful monitoring of patients is mandatory.

9549N	sirolimus 1 mg tablet, 100	2	5	..	*1446.66		Rapamune	PF
9550P	sirolimus 1 mg/mL oral liquid, 60 mL	2	5	..	*936.00		Rapamune	PF
9548M	sirolimus 2 mg tablet, 100	2	5	..	*2893.34		Rapamune	PF
9747B	sirolimus 500 microgram tablet, 100	2	5	..	*723.34		Rapamune	PF

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
				\$	\$	\$	

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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.

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

Note

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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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: 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.					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
						\$	
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).

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

Note

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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

ceased.

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).

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	
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

Note

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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:

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	Department of Human Services Prior Written Approval of Complex Drugs Reply Paid 9826 GPO Box 9826 HOBART TAS 7001						
9661L	adalimumab 20 mg/0.4 mL injection, 2 x 0.4 mL syringes	1	..	..	1630.00	Humira	VE
9663N	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL cartridges	1	..	..	1630.00	Humira	VE
9662M	adalimumab 40 mg/0.8 mL injection, 2 x 0.8 mL syringes	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:

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	(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.

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

Note

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

(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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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).

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

Note

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,

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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. <u>Authority required</u> 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. <u>Note</u> 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 <u>Authority required</u> 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:					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	(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

Note

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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:

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
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							
5735W	ETANERCEPT Injection 50 mg in 1 mL single use auto-injector, 4, 1	1	..	..	1630.01	Enbrel	PF
5733R	ETANERCEPT Injections 50 mg in 1 mL single use pre-filled syringes, 4, 1	1	..	..	1630.01	Enbrel	PF
5734T	etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack	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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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.

10067W	infliximab 100 mg injection, 1 x 100 mg vial	5	1	..	*3758.50	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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max. Qty \$		

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

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

Note

Special Pricing Arrangements apply.

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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. <u>Note</u> 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). <u>Note</u> 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 <u>Note</u> Special Pricing Arrangements apply. <u>Authority required</u> 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. <u>Note</u> 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					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

HOBART TAS 7001

Note

Special Pricing Arrangements apply.

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

Note

Special Pricing Arrangements apply.

10196P	infliximab 100 mg injection, 1 x 100 mg vial	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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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					
	Note					
	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,					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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.

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

Note

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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
(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 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:					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
	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						

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	Reply Paid 9826					
	GPO Box 9826					
	HOBART TAS 7001					

Note

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty \$		
	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. <u>Authority required</u> 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. <u>Note</u> 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						
5753T	infliximab 100 mg injection, 1 x 100 mg vial	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)].

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					
	<u>Authority required</u> 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 infliximb 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					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max. Qty \$		

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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,

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

(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)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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 (CAI) Score to no greater than 150; or					
	(b) improvement of intestinal inflammation as demonstrated by:					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

(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

Note

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	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.						
5754W	infliximab 100 mg injection, 1 x 100 mg vial	1	..	..	751.70	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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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					
5755X	infliximab 100 mg injection, 1 x 100 mg vial	1	..	..	751.70	Remicade
						JC

INFLIXIMAB

Authority required

Initial 1

Initial PBS-subsidised treatment with infliximab, by a rheumatologist or clinical immunologist with expertise in the management of psoriatic arthritis, of adults who:

- (1) have severe active psoriatic arthritis; and
- (2) have received no prior PBS-subsidised biological treatment for this condition in this Treatment Cycle; and
- (3) have failed to achieve an adequate response to:
 - (a) methotrexate at a dose of at least 20 mg weekly for a minimum period of 3 months; and
 - (b) sulfasalazine at a dose of at least 2 g per day for a minimum period of 3 months; or
 - (c) leflunomide at a dose of up to 20 mg daily for a minimum period of 3 months.

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 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, 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 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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

either

(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 of major joints:

— elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or

— 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 [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)]; and

(3) a signed patient acknowledgement.

A maximum of 22 weeks treatment will be authorised under this restriction.

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.

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).

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 to Medicare Australia 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.

Patients who fail to demonstrate a response to treatment with infliximab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug, in this Treatment Cycle. Patients may re-trial infliximab 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

Authority required

Initial 2

Initial PBS-subsidised treatment with infliximab, by a rheumatologist or clinical immunologist with expertise in the management of psoriatic arthritis, of adults who:

(1) have a documented history of severe active psoriatic arthritis; and

(2) have received prior PBS-subsidised biological treatment for this condition in this Treatment Cycle and are eligible to receive further biological therapy; and

(3) have not failed treatment with infliximab during the current Treatment Cycle.

Applications for patients who have received PBS-subsidised treatment with infliximab within this Treatment Cycle and who wish to re-commence 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 infliximab treatment, within the timeframes specified below.

A maximum of 22 weeks treatment will be authorised under this restriction.

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.

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).

Where the most recent course of PBS-subsidised infliximab 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), patients 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 infliximab treatment was approved under the continuing treatment criteria, patients 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.

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 [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)].

Patients who fail to demonstrate a response to treatment with infliximab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug, in this Treatment Cycle. Patients may re-trial infliximab 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

Authority required

Continuing treatment

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

Continuing PBS-subsidised treatment with infliximab, by a rheumatologist or clinical immunologist with expertise in the management of psoriatic arthritis, of adults:

- (1) who have a documented history of severe active psoriatic arthritis; and
- (2) whose most recent course of PBS-subsidised biological agent for this condition in the current Treatment Cycle was with infliximab; and
- (3) who, at the time of application, demonstrate an adequate response to treatment with infliximab.

An adequate response to treatment with infliximab 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:

- (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 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 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 [may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)].

A maximum of 24 weeks of treatment will be approved under this restriction.

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.

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).

All applications for continuing treatment with infliximab must include a measurement of response to the prior course of therapy. 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, it must be accompanied by an assessment of response to a minimum of 12 weeks of treatment with the initial treatment course.

Patients who fail to demonstrate a response to treatment with infliximab under this restriction will not be eligible to receive further PBS-subsidised treatment with this drug, in this Treatment Cycle. Patients may re-trial infliximab 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

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

Note

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, 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 the following NOTES and restrictions, it only refers to adalimumab, etanercept, golimumab and infliximab.

From 1 August 2006, all patients will be 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 5-year 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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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 after 1 August 2010.

(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 all agents except for infliximab, for which a maximum of 22 weeks will be authorised. 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 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, patients will be deemed to have failed to respond to treatment with that biological agent.

Grandfather patients — golimumab only.

Applications for patients who commenced treatment with golimumab prior to 1 March 2010 may apply for initial PBS-subsidised treatment as continuing therapy 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 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, 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.

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; or
- (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.

Medicare Australia 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 authority 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. 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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty	Brand Name and Manufacturer	
					\$		
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 re-qualify 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.							
5756Y	infliximab 100 mg injection, 1 x 100 mg vial	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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

(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.

Note

Special Pricing Arrangements apply.

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	HOBART TAS 7001					

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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 22 weeks of treatment under this restriction,

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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).

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

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
	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.						

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

(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 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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	HOBART TAS 7001					
	<u>Authority required</u> 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. <u>Note</u> 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:					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

Department of Human Services

Prior Written Approval of Complex Drugs

Reply Paid 9826

HOBART TAS 7001

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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 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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer	
					Qty \$		
Treatment criteria:							
Must be treated by a rheumatologist; OR							
Must be treated by a clinical immunologist with expertise in the management of rheumatoid arthritis.							
<u>Note</u>							
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							
5757B	infliximab 100 mg injection, 1 x 100 mg vial	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)];
 - (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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

(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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

(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

Note

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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.					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	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.						
	<u>Note</u>						
	No applications for increased repeats will be authorised.						
5758C	infliximab 100 mg injection, 1 x 100 mg vial	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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max. Qty \$		

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	

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

Note

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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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.					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	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.						
9654D	infliximab 100 mg injection, 1 x 100 mg vial	1	..	..	751.70	Remicade	JC

Interleukin inhibitors

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	
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.

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

Note

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

(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 qualify 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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

(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

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

Note

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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: 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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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

Note

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty	Brand Name and Manufacturer	
					\$		
	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.						
	<u>Authority required</u>						
	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.						
	<u>Note</u>						
	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						
10056G	tocilizumab 200 mg/10 mL injection, 1 x 10 mL vial	1	..	..	467.20	Actemra	RO
10064Q	tocilizumab 400 mg/20 mL injection, 1 x 20 mL vial	1	..	..	934.40	Actemra	RO
10077J	tocilizumab 80 mg/4 mL injection, 1 x 4 mL vial	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:

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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.

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

Note

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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).

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).

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					
	Note					
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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 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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

GPO Box 9826

HOBART TAS 7001

Note

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	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. <u>Authority required</u> 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. <u>Note</u> 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						
10058J	tocilizumab 200 mg/10 mL injection, 1 x 10 mL vial	1	..	..	467.20	Actemra	RO
10072D	tocilizumab 400 mg/20 mL injection, 1 x 20 mL vial	1	..	..	934.40	Actemra	RO
10081N	tocilizumab 80 mg/4 mL injection, 1 x 4 mL vial	1	..	..	186.88	Actemra	RO

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	
	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					
	<u>Authority required</u>					
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

(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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

(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

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 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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max. Qty \$		

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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.

Note

(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.

Note

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	(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.						
	Note Special Pricing Arrangements apply.						
1481Y	tocilizumab 200 mg/10 mL injection, 1 x 10 mL vial	1	..	..	467.20	Actemra	RO
1482B	tocilizumab 400 mg/20 mL injection, 1 x 20 mL vial	1	..	..	934.40	Actemra	RO

Note

Special Pricing Arrangements apply.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
1476Q	tocilizumab 80 mg/4 mL injection, 1 x 4 mL vial	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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

Note

Special Pricing Arrangements apply.

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

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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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.

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

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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.					

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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. <u>Authority required</u> 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. <u>Note</u> 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 <u>Authority required</u> 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.					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

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

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,

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

- 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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	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. <u>Authority required</u> 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. <u>Note</u> 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						
9658H	tocilizumab 200 mg/10 mL injection, 1 x 10 mL vial	1	..	..	467.20	Actemra	RO
9659J	tocilizumab 400 mg/20 mL injection, 1 x 20 mL vial	1	..	..	934.40	Actemra	RO

RO

RO

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer	
					Qty	\$		
9657G	tocilizumab 80 mg/4 mL injection, 1 x 4 mL vial	1	..	..	186.88		Actemra	RO

Calcineurin inhibitors

CYCLOSPORIN

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

Caution

Careful monitoring of patients is mandatory.

5632K	cyclosporin 10 mg capsule, 60	2	5	..	*74.40		Neoral 10	NV
5636P	cyclosporin 100 mg capsule, 30	4	5	..	*651.08	^a	Cyclosporin Sandoz	SZ
						^a	Neoral 100	NV
5633L	cyclosporin 100 mg/mL oral liquid, 50 mL	4	5	..	*1263.16		Neoral	NV
5634M	cyclosporin 25 mg capsule, 30	4	5	..	*153.56	^a	Cyclosporin Sandoz	SZ
						^a	Neoral 25	NV
5635N	cyclosporin 50 mg capsule, 30	4	5	..	*319.52	^a	Cyclosporin Sandoz	SZ
						^a	Neoral 50	NV

CYCLOSPORIN

Authority required (STREAMLINED)

3333

For use by organ or tissue transplant recipients

Caution

Careful monitoring of patients is mandatory.

5631J	cyclosporin 50 mg/mL injection, 10 x 1 mL ampoules	1	..	..	54.10		Sandimmun	NV

TACROLIMUS

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

Caution

Careful monitoring of patients is mandatory.

9560E	tacrolimus 1 mg capsule, 100	2	5	..	*655.68	^a	Pharmacor Tacrolimus 1	CR
						^a	Prograf	JC
						^a	Tacrolimus Sandoz	SZ
9665Q	tacrolimus 1 mg capsule: modified release, 60 capsules	2	5	..	*393.40		Prograf XL	JC

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$		Brand Name and Manufacturer	
9561F	tacrolimus 5 mg capsule, 50	2	5	..	*1638.38	^a	Pharmacor Tacrolimus 5	CR
						^a	Prograf	JC
						^a	Tacrolimus Sandoz	SZ
9666R	tacrolimus 5 mg capsule: modified release, 30 capsules	2	5	..	*983.54		Prograf XL	JC
9558C	tacrolimus 500 microgram capsule, 100	2	5	..	*327.84	^a	Pharmacor Tacrolimus 0.5	CR
						^a	Prograf	JC
						^a	Tacrolimus Sandoz	SZ
9664P	tacrolimus 500 microgram capsule: modified release, 30 capsules	2	5	..	*98.36		Prograf XL	JC

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer	
	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						
	<u>Note</u> Special Pricing Arrangements apply.						
	<u>Authority required</u> 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.						
	<u>Note</u> 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						
	<u>Note</u> 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).						
	<u>Note</u> Special Pricing Arrangements apply.						
2802L	lenalidomide 10 mg capsule, 21	1	3	..	5643.33	Revlimid	CJ
2799H	lenalidomide 5 mg capsule, 21	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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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.					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
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							
Note Special Pricing Arrangements apply.							
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).							
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							
Note Special Pricing Arrangements apply.							
5784K	lenalidomide 10 mg capsule, 21	1	..	..	5643.33	Revlimid	CJ
5785L	lenalidomide 15 mg capsule, 21	1	..	..	6581.61	Revlimid	CJ
5786M	lenalidomide 25 mg capsule, 21	1	..	..	6934.20	Revlimid	CJ
5783J	lenalidomide 5 mg capsule, 21	1	..	..	5392.38	Revlimid	CJ

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	RITUXIMAB <u>Authority required</u> 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.					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.		Brand Name and Manufacturer
					Qty	\$	

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.

Note

Special Pricing Arrangements apply.

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

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	

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.

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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.					
	<u>Authority required</u>					
	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					

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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). Note Special Pricing Arrangements apply. 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 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,					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

- 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

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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. <u>Authority required</u> 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:					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

(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.

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

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.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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.					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer	
					Qty \$		
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.							
9544H	rituximab 500 mg/50 mL injection, 1 x 50 mL vial	1	..	..	2032.91	Mabthera	RO

THALIDOMIDE

Authority required (STREAMLINED)

3342

Multiple myeloma

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.

Note

Patients receiving thalidomide under the PBS listing must be registered in the i-access risk management program.

9667T	thalidomide 100 mg capsule, 28	2	..	..	*1680.00	Thalomid	CJ
9566L	thalidomide 50 mg capsule, 28	4	..	..	*1680.00	Thalomid	CJ

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		

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

5617P	baclofen 10 mg/5 mL injection: intrathecal, 1 x 5 mL ampoule	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

5750P	ibandronic acid 6 mg/6 mL injection, 1 x 6 mL vial	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.

5667G	pamidronate disodium 15 mg/5 mL injection, 1 x 5 mL vial	4	2	..	*80.64	Pamisol	HH

5669J	pamidronate disodium 60 mg/10 mL injection, 1 x 10 mL vial	1	2	..	80.64	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.

5702D	pamidronate disodium 30 mg injection [2 x 30 mg	1	2	..	80.65 ^a	Aredia 30 mg	NV

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer	
					Price for Max.	Qty		
					\$	\$		
5668H	vials] (&) inert substance diluent [2 x 10 mL ampoules], 1 pack pamidronate disodium 30 mg/10 mL injection, 1 x 10 mL vial	2	2	..	*80.66	^a	Pamisol	HH
PAMIDRONATE DISODIUM								
<u>Authority required (STREAMLINED)</u>								
4421								
Hypercalcaemia of malignancy								
Clinical criteria:								
Patient must have a malignancy refractory to anti-neoplastic therapy.								
<u>Authority required (STREAMLINED)</u>								
4432								
Multiple myeloma								
<u>Authority required (STREAMLINED)</u>								
4426								
Bone metastases								
Clinical criteria:								
The condition must be due to breast cancer.								
<u>Note</u>								
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.								
5703E	pamidronate disodium 90 mg injection [1 x 90 mg vial] (&) inert substance diluent [1 x 10 mL ampoule], 1 pack	1	11	..	120.97	^a	Aredia 90 mg	NV
5670K	pamidronate disodium 90 mg/10 mL injection, 1 x 10 mL vial	1	11	..	120.97	^a	Pamisol	HH
ZOLEDRONIC ACID								
<u>Authority required (STREAMLINED)</u>								
3342								
Multiple myeloma								
<u>Authority required (STREAMLINED)</u>								
3343								
Bone metastases from breast cancer								
<u>Authority required (STREAMLINED)</u>								
4052								
Bone metastases from castration-resistant prostate cancer								
<u>Authority required (STREAMLINED)</u>								
3341								
Treatment of hypercalcaemia of malignancy refractory to anti-neoplastic therapy								
<u>Note</u>								
Special Pricing Arrangements apply.								
9653C	zoledronic acid 4 mg/5 mL injection, 1 x 5 mL vial	1	11	..	450.00		Zometa	NV

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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.

9743T	levodopa 20 mg/mL + carbidopa monohydrate 5 mg/mL gel: intestinal, 7 x 100 mL bags	8	5	..	*11536.00	Duodopa	VE

Dopamine agonists

APOMORPHINE

Authority required (STREAMLINED)

3314

Parkinson's disease in patients severely disabled by motor fluctuations which do not respond to other therapy

5609F	apomorphine hydrochloride 20 mg/2 mL injection, 5 x 2 mL ampoules	72	5	..	*7196.40	Apomine	HH
5611H	apomorphine hydrochloride 50 mg/10 mL injection: subcutaneous infusion, 5 x 10 mL syringes	36	5	..	*7007.40	Apomine PFS	HH
5610G	apomorphine hydrochloride 50 mg/5 mL injection, 5 x 5 mL ampoules	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 (CPMSplus) or Clopineconnect.

5629G	clozapine 100 mg tablet, 100	2	..	..	*242.38	^a Clopine 100	HH
						^a Clozaril 100	NV
5627E	clozapine 200 mg tablet, 100	2	..	..	*484.76	Clopine 200	HH
5628F	clozapine 25 mg tablet, 100	2	..	..	*64.64	^a Clopine 25	HH
						^a Clozaril 25	NV
5626D	clozapine 50 mg tablet, 100	2	..	..	*129.28	Clopine 50	HH
5630H	clozapine 50 mg/mL oral liquid, 100 mL	1	..	..	135.00	Clopine Suspension	HH

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

RESPIRATORY SYSTEM

DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES

OTHER SYSTEMIC DRUGS FOR OBSTRUCTIVE AIRWAY DISEASES

Other systemic drugs for obstructive airway diseases

OMALIZUMAB

Authority required

Initial treatment of uncontrolled severe allergic asthma

Initial PBS-subsidised treatment with omalizumab by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma, of a patient aged 12 years or older with uncontrolled severe allergic asthma who has been under the care of this physician for at least 12 months, and satisfies the following criteria:

(a) has 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 standard clinical features, including:

(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

(b) duration of asthma of at least 1 year; and

(c) FEV1 less than or equal to 80% predicted, documented on 3 or more occasions in the previous 12 months; and

(d) past or current evidence of atopy, documented by skin prick testing or RAST; and

(e) total serum human immunoglobulin E (IgE) greater than or equal to 76 IU/mL; and

(f) 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; and

(g) has failed to achieve adequate control with optimised asthma therapy, despite formal assessment of and adherence to correct inhaler technique, which has been documented (see NOTE). 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) oral corticosteroids (at least 10 mg per day prednisolone (or equivalent)) for at least 6 weeks, 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. 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 can be found on the Medicare Australia website [www.medicareaustralia.gov.au].

The initial IgE assessment must be no more than 12 months old at the time of application. A re-assessment of free IgE can only be made at least 12 months after the last dose of omalizumab. For patients re-commencing omalizumab within 12 months of the last dose the previous pre-omalizumab IgE level should be used.

The IgE pathology report must be provided with the authority 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 on oral corticosteroids and 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 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 (may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)) 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 while on oral corticosteroids (date and treatment); and

(iii) the signed patient acknowledgement; and

(c) a completed Asthma Control Questionnaire (ACQ-5) calculation sheet including the date of assessment of the patient's symptoms. (For copies of the ACQ please contact Novartis Medical Information on 1800 671 203 or medinfo.phauno@novartis.com)

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed		Brand Name and Manufacturer
					Price for Max.	Qty	
					\$	\$	

to the TGA-approved Product Information) to be administered every 2 or 4 weeks.

Where fewer than the required number of repeats to complete 28 weeks of treatment are requested at the time of the application, authority approvals for sufficient repeats to complete 28 weeks of omalizumab therapy 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.

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 24 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 to Medicare Australia 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 to Medicare Australia within this timeframe, the patient will be deemed to have failed to respond to treatment with omalizumab. It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 24 to 26 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised omalizumab treatment.

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.

Authority required

Continuing treatment

Continuing PBS-subsidised treatment with omalizumab, by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma, of a patient who:

- (a) has a documented history of severe allergic asthma; and
- (b) has demonstrated or sustained an adequate response to treatment with omalizumab.

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.

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 (may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)) 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. (For copies of the ACQ please contact Novartis Medical Information on 1800 671 203 or medinfo.phauno@novartis.com)

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 20 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. If the same physician cannot assess the patient please call Medicare Australia on 1800 700 270.

This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia 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 to Medicare Australia within this timeframe, the patient will be deemed to have failed to respond to treatment with omalizumab.

It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 20 to 22 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised omalizumab treatment.

Patients are eligible to receive continuing courses of omalizumab treatment of up to 24 weeks providing they continue to demonstrate an adequate response to treatment.

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.

Where fewer than the required number of repeats to complete 24 weeks of treatment are requested at the time of the application, authority approvals for sufficient repeats to complete 24 weeks of omalizumab therapy 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 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.

Authority required

Initial PBS-subsidised treatment of severe allergic asthma in a patient who has previously received non-PBS-subsidised therapy with omalizumab (grandfather patients)

Initial PBS-subsidised supply for continuing treatment with omalizumab by a respiratory physician, clinical immunologist, allergist or general physician experienced in the management of patients with severe asthma, of a patient aged 12 years or older with severe allergic asthma who satisfies the following criteria:

- (a) has a diagnosis of asthma confirmed and documented by a respiratory physician, clinical immunologist, allergist or general physician

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
	experienced in the management of patients with severe asthma, defined by standard clinical features, including:					
	(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					
	(b) duration of asthma of at least 1 year; and					
	(c) past or current evidence of atopy, documented by skin prick testing or RAST; 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 criteria for ongoing PBS-subsidised treatment, as outlined in the restriction for continuing treatment for grandfathered patients; and					
	(e) prior to omalizumab therapy had failed to achieve adequate control with optimised asthma therapy. 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, and					
	(ii) may have included maintenance dose oral corticosteroids; and					
	(f) has demonstrated an adequate response to treatment with omalizumab.					
	A review of the patient's records should be conducted to extract pre- and post-omalizumab data on symptoms, quality of life, medication doses, exacerbations and hospitalisations. Examples of parameters to establish response include:					
	(i) a reduction in Asthma Control Questionnaire (ACQ-5) score of at least 0.5;					
	(ii) an improvement of at least 0.5 in the Asthma Quality of Life Questionnaire (AQLQ or mini-AQLQ);					
	(iii) maintenance oral corticosteroid dose reduced by at least 25% from baseline; and/or					
	(iv) a reduction in the number of hospitalisations or severe exacerbations requiring use of systemic corticosteroids, compared to the 12 months prior to commencement of omalizumab.					
	Where baseline assessments are not available, please call Medicare Australia on 1800 700 270 to discuss.					
	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. Details of the accepted contraindications and toxicities, including severity, which will be accepted for the purposes of exempting a patient from the requirement of treatment with optimised asthma therapy can be found on the Medicare Australia website [www.medicareaustralia.gov.au].					
	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 (may be downloaded from the Medicare Australia website (www.medicareaustralia.gov.au)) which includes the following:					
	(i) details of prior optimised asthma drug therapy (dosage, date of commencement and duration of therapy); and					
	(ii) details of pre- and post-omalizumab data on symptoms, quality of life, medication doses, exacerbations and hospitalisations; and					
	(iii) the signed patient acknowledgement.					
	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.					
	Where fewer than the required number of repeats to complete 24 weeks of treatment are requested at the time of the application, authority approvals for sufficient repeats to complete 24 weeks of omalizumab therapy 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 24 weeks.					
	An assessment of the patient's continued response to this course of PBS-subsidised treatment must be made at around 20 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 same parameters used to establish response to non-PBS-subsidised therapy with omalizumab should be used for the assessment.					
	This assessment, which will be used to determine eligibility for continuing treatment, must be submitted to Medicare Australia 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 to Medicare Australia within this timeframe, the patient will be deemed to have failed to respond to treatment with omalizumab.					
	It is recommended that an application for continuing treatment is posted to Medicare Australia at the time of the 20 to 22 week assessment, to ensure continuity of treatment for those patients who meet the continuation criterion for PBS-subsidised omalizumab treatment.					
	Patients are eligible to receive continuing courses of omalizumab treatment of up to 24 weeks providing they continue to demonstrate an adequate response to treatment.					
	Patients may qualify for PBS-subsidised treatment under this restriction once only. 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					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

Note

Any queries concerning the arrangements to prescribe omalizumab 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 omalizumab should be forwarded to:

Medicare Australia

Prior Written Approval of Specialised Drugs

Reply Paid 9826

GPO Box 9826

HOBART TAS 7001

Note

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.

Initial treatment authorisations will be limited to provide for a maximum of 28 weeks of therapy with omalizumab.

A patient must be assessed for response to a course of Initial PBS-subsidised treatment following a minimum of 24 weeks of therapy with omalizumab, and this assessment must be submitted to Medicare Australia no later than 4 weeks from the date of assessment.

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 omalizumab.

For second and subsequent courses of PBS-subsidised omalizumab 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.

(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.

It is recommended that a patient be reviewed in the month prior to completing their current course of treatment to ensure uninterrupted omalizumab supply.

Assessments of response to a course of PBS-subsidised therapy must be submitted to Medicare Australia 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 submitted to Medicare Australia within these timeframes, the patient will be deemed to have failed to respond to treatment with omalizumab.

(2) Baseline measurements to determine response.

Medicare Australia 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 Medicare Australia 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) Patients 'grandfathered' onto PBS-subsidised treatment with omalizumab.

A patient who commenced treatment with omalizumab for uncontrolled severe allergic asthma prior to 1 November 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 omalizumab will be authorised under this criterion.

Following completion of the Initial PBS-subsidised course, further applications for treatment with omalizumab will be assessed under the continuing treatment restriction.

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
'Grandfather' arrangements will only apply for the first treatment cycle (initial treatment course with or without continuing treatment course/s). For the second and subsequent cycles, a 'Grandfathered' patient must re-qualify for Initial treatment under the criteria that apply to a new patient. See 'Re-commencement of treatment after a 6 month break in PBS-subsidised therapy' above for further details. (5) 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. <u>Note</u> 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.medicareaustralia.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). <u>Note</u> Special Pricing Arrangements apply.							
10109C	omalizumab 150 mg/mL injection, 1 x 1 mL syringe	1	..	..	410.00	Xolair	NV
10118M	omalizumab 75 mg/0.5 mL injection, 1 x 0.5 mL syringe	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.)

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
<u>Authority required (STREAMLINED)</u>						
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.						
<u>Authority required (STREAMLINED)</u>						
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.						
<u>Authority required (STREAMLINED)</u>						
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.						
<u>Note</u>						
Dornase alfa is not PBS-subsidised for use in combination with PBS-subsidised mannitol.						
<u>Note</u>						
It is highly desirable that all patients be included in the national cystic fibrosis patient database.						
5704F	dornase alfa 2.5 mg/2.5 mL inhalation: solution, 30 x 2.5 mL ampoules	2	5	..	*2360.00	Pulmozyme RO

MANNITOL

Authority required (STREAMLINED)

4299

Cystic fibrosis

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	
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.)						
<u>Authority required (STREAMLINED)</u>						
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.						
<u>Note</u>						
Mannitol is not PBS-subsidised for use in combination with PBS-subsidised dornase alfa.						
<u>Note</u>						
It is highly desirable that all patients be included in the national cystic fibrosis patient database.						
2015C	MANNITOL Pack containing 280 capsules containing powder for inhalation 40 mg and 2 inhalers. 1	4	5	..	*1736.00	bronchitol XA

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer
					Price for Max. Qty \$	

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, ciprofloxacin, 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 hospitalisation (including hospital-in-the home) in the previous 12 months.

Authority required

Cystic fibrosis

Treatment Phase: Continuing treatment

Clinical criteria:

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Brand Name and Manufacturer
	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: aprennavir, aprepitant, atazanavir, ciprofloxacin, 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 hospitalisation (including hospital in the home) in the previous 6 months.					
	<u>Authority required</u>					
	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.					

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max.	Brand Name and Manufacturer
					Qty \$	

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, ciprofloxacin, 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 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 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.

Note

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

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

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		
	HOBART TAS 7001						
10170G	ivacaftor 150 mg tablet, 56	1	5	..	22500.00	Kalydeco	VR

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Brand Name and Manufacturer	
					Price for Max. Qty \$		

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.

5654N	deferasirox 125 mg tablet: dispersible, 28	6	5	..	*1401.48	Exjade	NV
5655P	deferasirox 250 mg tablet: dispersible, 28	6	5	..	*2802.90	Exjade	NV
5656Q	deferasirox 500 mg tablet: dispersible, 28	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

5658T	deferiprone 100 mg/mL oral liquid, 250 mL	5	5	..	*1126.40	Ferriprox	TX
5657R	deferiprone 500 mg tablet, 100	6	5	..	*2703.36	Ferriprox	TX

DEFERRIOXAMINE

Authority required (STREAMLINED)

3340

Disorders of erythropoiesis associated with treatment-related chronic iron overload

5661Y	desferrioxamine mesylate 2 g injection, 1 x 2 g vial	60	5	..	*1724.40	^a Hospira Pty Limited	HH
5662B	desferrioxamine mesylate 500 mg injection, 10 x 500 mg vials	40	5	^B 17.40	*1741.80	^a Desferal 2 g	NV
				..	*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)

3390

Management of hyperphosphataemia in a patient with chronic kidney disease on dialysis whose serum phosphate is not controlled on calcium and where serum phosphate is greater than 1.6 mmol per L at the commencement of therapy.

Management includes initiation, stabilisation and review of therapy as required

Authority required (STREAMLINED)

3391

Management of hyperphosphataemia in a patient with chronic kidney disease on dialysis whose serum phosphate is not controlled on calcium and where the serum calcium times phosphate product is greater than 4.0 at the commencement of therapy.

Management includes initiation, stabilisation and review of therapy as required

Note

Not to be used in combination with sevelamer.

5782H	LANTHANUM Tablet, chewable, 1000 mg (as carbonate hydrate), 90	2	5	..	*890.02	Fosrenol	ZI
5780F	LANTHANUM Tablet, chewable, 500 mg (as carbonate hydrate), 90	2	5	..	*523.54	Fosrenol	ZI

HIGHLY SPECIALISED DRUGS PROGRAM (Public Hospital)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty	Brand Name and Manufacturer	
					\$		
5781G	LANTHANUM Tablet, chewable, 750 mg (as carbonate hydrate), 90	2	5	..	*790.56	Fosrenol	ZI

SEVELAMER

Authority required (STREAMLINED)

3390

Management of hyperphosphataemia in a patient with chronic kidney disease on dialysis whose serum phosphate is not controlled on calcium and where serum phosphate is greater than 1.6 mmol per L at the commencement of therapy.

Management includes initiation, stabilisation and review of therapy as required

Authority required (STREAMLINED)

3391

Management of hyperphosphataemia in a patient with chronic kidney disease on dialysis whose serum phosphate is not controlled on calcium and where the serum calcium times phosphate product is greater than 4.0 at the commencement of therapy.

Management includes initiation, stabilisation and review of therapy as required

Note

Not to be used in combination with lanthanum.

9546K	sevelamer hydrochloride 800 mg tablet, 180	2	5	..	*620.00	Renagel	GZ

SECTION 100 (BOTULINUM TOXIN PROGRAM)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	Price ex manufacturer \$	Brand Name and Manufacturer
BOTULINUM TOXIN TYPE A				
<u>Criteria for availability</u>				
Blepharospasm or hemifacial spasm				
Population criteria:				
Patient must be aged 12 years or older.				
<u>Note</u>				
Arrangements to prescribe this item should be made by medical practitioners with the Department of Human Services, contact telephone number 1800 700 270.				
<u>Note</u>				
The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.				
<u>Criteria for availability</u>				
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.				
<u>Note</u>				
Arrangements to prescribe this item should be made by medical practitioners with the Department of Human Services, contact telephone number 1800 700 270.				
<u>Note</u>				
The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.				
<u>Criteria for availability</u>				
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.				
<u>Note</u>				
Arrangements to prescribe this item should be made by medical practitioners with the Department of Human Services, contact telephone number 1800 700 270.				
<u>Note</u>				
The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.				
<u>Criteria for availability</u>				
Spasmodic torticollis				
Clinical criteria:				
The treatment must be as monotherapy; OR				
The treatment must be as adjunctive therapy to current standard care.				
<u>Note</u>				
Arrangements to prescribe this item should be made by medical practitioners with the Department of Human Services, contact telephone number 1800 700 270.				
<u>Note</u>				
The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.				
<u>Criteria for availability</u>				
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.				
<u>Note</u>				

SECTION 100 (BOTULINUM TOXIN PROGRAM)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	Price ex manufacturer \$	Brand Name and Manufacturer
	Arrangements to prescribe this item should be made by medical practitioners with the Department of Human Services, contact telephone number 1800 700 270.			
	<u>Note</u> The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent. <u>Criteria for availability</u> 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. <u>Note</u> Arrangements to prescribe this item should be made by medical practitioners with the Department of Human Services, contact telephone number 1800 700 270. <u>Note</u> 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. <u>Note</u> The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent. <u>Criteria for availability</u> 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 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. <u>Note</u> Arrangements to prescribe this item should be made by medical practitioners with the Department of Human Services, contact telephone number 1800 700 270. <u>Note</u> The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent. <u>Criteria for availability</u> 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. <u>Note</u> Arrangements to prescribe this item should be made by medical practitioners with the Department of Human Services, contact telephone number 1800 700 270. <u>Note</u> The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent. <u>Note</u> Special Pricing Arrangements apply. <u>Criteria for availability</u> Urinary incontinence Clinical criteria: The condition must be due to neurogenic detrusor overactivity, as demonstrated by urodynamic study,			

SECTION 100 (BOTULINUM TOXIN PROGRAM)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	Price ex manufacturer \$	Brand Name and Manufacturer
	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. Note Arrangements to prescribe this item should be made by medical practitioners with the Department of Human Services, contact telephone number 1800 700 270. Note The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent. Note Special Pricing Arrangements apply. Criteria for availability 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. Note Arrangements to prescribe this item should be made by medical practitioners with the Department of Human Services, contact telephone number 1800 700 270. Note The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent. Note Special Pricing Arrangements apply. Criteria for availability 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:			

SECTION 100 (BOTULINUM TOXIN PROGRAM)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	Price ex	Brand Name and Manufacturer	
			manufacturer \$		
	Patient must be aged 18 years or older.				
	<u>Note</u>				
	Arrangements to prescribe this item should be made by medical practitioners with the Department of Human Services, contact telephone number 1800 700 270.				
	<u>Note</u>				
	The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.				
	<u>Note</u>				
	Special Pricing Arrangements apply.				
6103F	botulinum toxin type A 100 units injection, 1 x 100 units vial	1	415.50	Botox	AG

CLOSTRIDIUM BOTULINUM TYPE A TOXIN-HAEMAGGLUTININ COMPLEX

Criteria for availability

Treatment of dynamic equinus foot deformity due to spasticity in an ambulant paediatric cerebral palsy patient aged from 2 to 17 years inclusive

Criteria for availability

Continuing PBS-subsidised treatment of dynamic equinus foot deformity due to spasticity in an ambulant cerebral palsy patient 18 years of age or older who was commenced on PBS-subsidised treatment with clostridium botulinum type A toxin-haemagglutinin complex as a paediatric patient

Criteria for availability

Treatment of spasmodic torticollis, either as monotherapy or as adjunctive therapy to current standard care

Criteria for availability

Treatment of blepharospasm or hemifacial spasm in an adult

Criteria for availability

Treatment of moderate to severe spasticity [defined as MAS greater than or equal to 3 using modified Ashworth scale] of the upper limb in adults following a stroke, as second line therapy when standard management has failed (e.g. physiotherapy and/or oral spasticity agents) or as an adjunct to physical therapy.

Maximum number of treatments to be authorised is 4 (total 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

Note

Arrangements to prescribe this item should be made by medical practitioners with Medicare Australia, contact telephone number 1800 700 270.

Note

The units used to express the potency of botulinum toxin preparations currently available for PBS subsidy are not equivalent.

1152P	clostridium botulinum type A toxin-haemagglutinin complex 300 units injection, 1 x 300 units vial	1	361.52	Dysport	IS
6293F	clostridium botulinum type A toxin-haemagglutinin complex 500 units injection, 1 x 500 units vial	1	644.81	Dysport	IS

SECTION 100 (HUMAN GROWTH HORMONE)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	Price ex manufacturer \$	Brand Name and Manufacturer	
SOMATROPIN					
<u>Criteria for availability</u>					
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					
<u>Note</u>					
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					
6329D	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	1	396.00	Saizen 8 mg click.easy	SG
9586M	SOMATROPIN (Recombinant human growth hormone) Powder for injection 12 mg (36 i.u.) with diluent in pre-filled pen (with preservative), 1	1	594.00	Genotropin GoQuick	PF
9585L	SOMATROPIN (Recombinant human growth hormone) Powder for injection 5 mg (15 i.u.) with diluent in pre-filled pen (with preservative), 1	1	247.50	Genotropin GoQuick	PF
9628R	somatropin 1.8 international units (600 microgram) injection [7 x 600 microgram syringes] (& inert substance diluent [7 x 0.25 mL syringes], 1 pack	1	207.90	Genotropin MiniQuick	PF
6266T	somatropin 12 international units (4 mg) injection [1 x 4 mg vial] (& inert substance diluent [1 vial], 1 pack	1	198.00	Zomacton	FP
6295H	somatropin 15 international units (5 mg/1.5 mL) injection, 1 x 1.5 mL cartridge	1	247.50	Norditropin SimpleXx	NO
6476W	somatropin 15 international units (5 mg/1.5 mL) injection, 1 x 1.5 mL cartridge	1	247.50	Omnitrope	SZ
6169Q	somatropin 18 international units (6 mg) injection [1 x 6 mg cartridge] (& inert substance diluent [1 x 3.15 mL syringe], 1 pack	1	297.00	Humatrope	LY
5822K	somatropin 18 international units (6 mg/1.03 mL) injection, 1 x 1.03 mL cartridge	1	297.00	Saizen	SG
6313G	somatropin 2.4 international units (800 microgram) injection [7 x 800 microgram syringes] (& inert substance diluent [7 x 0.25 mL syringes], 1 pack	1	277.20	Genotropin MiniQuick	PF
6314H	somatropin 3 international units (1 mg) injection [7 x 1 mg syringes] (& inert substance diluent [7 x 0.25 mL syringes], 1 pack	1	346.50	Genotropin MiniQuick	PF
6315J	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	1	415.80	Genotropin MiniQuick	PF
6310D	somatropin 30 international units (10 mg) injection [1 x 10 mg vial] (& inert substance diluent [1 x 1 mL syringe], 1 pack	1	495.00	Zomacton	FP
6296J	somatropin 30 international units (10 mg/1.5 mL) injection, 1 x 1.5 mL cartridge	1	495.00	Norditropin SimpleXx	NO
6311E	somatropin 30 international units (10 mg/1.5 mL) injection, 1 x 1.5 mL cartridge	1	495.00	Omnitrope	SZ

SECTION 100 (HUMAN GROWTH HORMONE)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	Price ex manufacturer \$	Brand Name and Manufacturer	
9604L	somatropin 30 international units (10 mg/2 mL) injection, 1 x 2 mL cartridge	1	495.00	NutropinAq	IS
6312F	somatropin 36 international units (12 mg) injection [1 x 12 mg cartridge] (&) inert substance diluent [1 x 1 mL cartridge], 1 pack	1	594.00	Genotropin	PF
6170R	somatropin 36 international units (12 mg) injection [1 x 12 mg cartridge] (&) inert substance diluent [1 x 3.15 mL syringe], 1 pack	1	594.00	Humatrope	LY
5824M	somatropin 36 international units (12 mg/1.5 mL) injection, 1 x 1.5 mL cartridge	1	594.00	Saizen	SG
6316K	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	1	485.10	Genotropin MiniQuick	PF
6317L	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	1	554.40	Genotropin MiniQuick	PF
6297K	somatropin 45 international units (15 mg/1.5 mL) injection, 1 x 1.5 mL cartridge	1	742.50	Norditropin SimpleXx	NO
6318M	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	1	623.70	Genotropin MiniQuick	PF
6319N	somatropin 6 international units (2 mg) injection [7 x 2 mg syringes] (&) inert substance diluent [7 x 0.25 mL syringes], 1 pack	1	693.00	Genotropin MiniQuick	PF
3388H	somatropin 60 international units (20 mg/2.5 mL) injection, 1 x 2.5 mL cartridge	1	990.00	Saizen	SG
6345Y	somatropin 72 international units (24 mg) injection [1 x 24 mg cartridge] (&) inert substance diluent [1 x 3.15 mL syringe], 1 pack	1	1188.00	Humatrope	LY

SOMATROPIN

Criteria for availability

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

Note

Special Pricing Arrangements apply.

5818F	somatropin 15 international units (5 mg/1.5 mL) injection, 1 x 1.5 mL cartridge	1	315.50	Norditropin FlexPro	NO
5819G	somatropin 30 international units (10 mg/1.5 mL) injection, 1 x 1.5 mL cartridge	1	631.00	Norditropin FlexPro	NO
5820H	somatropin 45 international units (15 mg/1.5 mL) injection, 1 x 1.5 mL cartridge	1	946.50	Norditropin FlexPro	NO

SECTION 100 (IVF/GIFT TREATMENT)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	Price ex manufacturer \$	Brand Name and Manufacturer	
CETRORELIX					
<u>Criteria for availability</u>					
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					
<u>Note</u>					
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.					
9599F	cetrorelix 250 microgram injection [1 x 250 microgram vial] (&) inert substance diluent [1 x 1 mL syringe], 1 pack	1	46.08	Cetrotide	SG
CHORIOGONADOTROPIN ALFA					
<u>Criteria for availability</u>					
Patients who are receiving medical treatment as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule					
<u>Note</u>					
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.					
<u>Note</u>					
Special Pricing Arrangements apply.					
6182J	choriogonadotropin alfa 250 microgram/0.5 mL injection, 1 x 0.5 mL cartridge	1	54.80	Ovidrel	SG
9631X	choriogonadotropin alfa 250 microgram/0.5 mL injection, 1 x 0.5 mL syringe	1	54.80	Ovidrel	SG
CORIFOLLITROPIN ALFA					
<u>Criteria for availability</u>					
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.					
<u>Note</u>					
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.					
5816D	corifollitropin alfa 100 microgram/0.5 mL injection, 1 x 0.5 mL syringe	1	410.14	Elonva	MK
5817E	corifollitropin alfa 150 microgram/0.5 mL injection, 1 x 0.5 mL syringe	1	673.51	Elonva	MK
FOLLITROPIN ALFA					
<u>Criteria for availability</u>					
Patients who are receiving medical treatment as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule					
<u>Note</u>					
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.					
6431L	follitropin alfa 300 international units / 0.5 mL (21.84 microgram/0.5 mL) injection, 1 x 0.5 mL cartridge	1	145.20	Gonal-f Pen	SG
6432M	follitropin alfa 450 international units / 0.75 mL (32.76 microgram/0.75 mL) injection, 1 x 0.75 mL cartridge	1	217.80	Gonal-f Pen	SG
6433N	follitropin alfa 900 international units / 1.5 mL (65.52 microgram/1.5 mL) injection, 1 x 1.5 mL cartridge	1	435.60	Gonal-f Pen	SG
FOLLITROPIN BETA					
<u>Criteria for availability</u>					
Patients who are receiving medical treatment as described in items 13200, 13201, 13202 or 13203 of the Medicare Benefits Schedule					
<u>Note</u>					
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.					
6335K	follitropin beta 300 international units/0.36 mL injection, 1 x 0.36 mL	1	150.00	Puregon 300 IU/0.36	MK

SECTION 100 (IVF/GIFT TREATMENT)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	Price ex manufacturer \$	Brand Name and Manufacturer	
6336L	cartridge follitropin beta 600 international units/0.72 mL injection, 1 x 0.72 mL	1	292.72	Puregon 600 IU/0.72 mL	MK
6464F	cartridge follitropin beta 900 international units/1.08 mL injection, 1 x 1.08 mL	1	435.15	Puregon 900 IU/1.08 mL	MK

GANIRELIX

Criteria for availability

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.

9583J	ganirelix 250 microgram/0.5 mL injection, 1 x 0.5 mL syringe	1	46.08	Orgalutran	MK
9584K	ganirelix 250 microgram/0.5 mL injection, 5 x 0.5 mL syringes	1	230.40	Orgalutran	MK

GONADOTROPHIN CHORIONIC HUMAN

Criteria for availability

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.

6178E	gonadotrophin chorionic human 1500 international units injection [3 x 1500 international units ampoules] (&) inert substance diluent [3 x 1 mL ampoules], 1 pack	1	39.57	Pregnyl	MK
6181H	gonadotrophin chorionic human 5000 international units injection [1 x 5000 international units ampoule] (&) inert substance diluent [1 x 1 mL ampoule], 1 pack	1	11.49	Pregnyl	MK

GONADOTROPHIN-MENOPAUSAL HUMAN

Criteria for availability

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.

2038G	gonadotrophin-menopausal human 1200 international units injection [1 x 1200 international units vial] (&) inert substance diluent [2 x 1 mL syringes], 1 pack	1	531.18	Menopur 1200	FP
2036E	gonadotrophin-menopausal human 600 international units injection [1 x 600 international units vial] (&) inert substance diluent [1 x 1 mL syringe], 1 pack	1	265.59	Menopur 600	FP

NAFARELIN

Criteria for availability

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.

5815C	nafarelin 200 microgram/actuation nasal spray, 60 actuations	1	106.00	Synarel	PF

PROGESTERONE

Criteria for availability

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

SECTION 100 (IVF/GIFT TREATMENT)

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	Price ex manufacturer \$	Brand Name and Manufacturer	
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.					
9608Q	progesterone 100 mg pessary, 15	1	50.40	Oipro	ON
10116K	progesterone 100 mg pessary, 21	1	49.39	Endometrin	FP
9609R	progesterone 200 mg pessary, 15	1	55.60	Oipro	ON

PROGESTERONE

Criteria for availability

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.

Note

Special Pricing Arrangements apply.

6366C	progesterone 8% vaginal gel, 15 applications	1	148.50	Crinone 8%	SG

OPIATE DEPENDENCE TREATMENT PROGRAM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	Price ex manufacturer \$	Brand Name and Manufacturer	
BUPRENORPHINE					
<u>Criteria for availability</u>					
Treatment of opiate dependence, including maintenance and detoxification (withdrawal), within a framework of medical, social and psychological treatment					
<u>Note</u>					
Treatment must be in accordance with the law of the relevant State or Territory.					
<u>Note</u>					
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.					
6308B NP	buprenorphine 2 mg tablet, 7	1	10.50	Subutex	RC
6307Y NP	buprenorphine 400 microgram tablet, 7	1	6.16	Subutex	RC
6309C NP	buprenorphine 8 mg tablet, 7	1	30.10	Subutex	RC
BUPRENORPHINE + NALOXONE					
<u>Criteria for availability</u>					
Treatment of opiate dependence within a framework of medical, social and psychological treatment					
<u>Caution</u>					
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.					
<u>Note</u>					
Treatment must be in accordance with the law of the relevant State or Territory.					
<u>Note</u>					
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.					
9749D NP	buprenorphine 2 mg + naloxone 500 microgram film: sublingual, 28 films	1	46.20	Suboxone Film 2/0.5	RC
9750E NP	buprenorphine 8 mg + naloxone 2 mg film: sublingual, 28 films	1	132.44	Suboxone Film 8/2	RC
METHADONE					
<u>Criteria for availability</u>					
Treatment of opiate dependence in accordance with the law of the relevant State or Territory					
<u>Caution</u>					
The risk of drug dependence is high.					
<u>Note</u>					
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.					
6172W NP	methadone hydrochloride 5 mg/mL oral liquid, 1000 mL	1	33.20	^a Aspen Methadone Syrup	QA
				^a Biodone Forte	MW
6171T NP	methadone hydrochloride 5 mg/mL oral liquid, 200 mL	1	7.91	^a Aspen Methadone Syrup	QA
				^a Biodone Forte	MW

Section 3 – Container Prices, Fees, Standard Packs and Prices for Ready Prepared Pharmaceutical Benefits

CONTAINER PRICES FOR QUANTITIES OF READY PREPARED BENEFITS LESS THAN THE STANDARD PACK:

Injectables	150 mL vial	\$0.81
Other Items	25 mL vial	\$0.32

(The 25 mL is the most commonly used size)

FEES:

Dispensing Fee for Ready Prepared Benefits	\$6.76
Dangerous Drug Fee	\$2.71
Additional Fee for Agreed Price Ready Prepared Benefits	\$1.15

NOTE -

Standard packs and prices (including mark-up, but without dispensing fee and dangerous drug fee) are for items against the price of which an asterisk () is shown in Section 2 of the Schedule.*

(APPLY WASTAGE FACTOR IN CALCULATING BROKEN QUANTITY PRICES)

Code	Name, Form/Strength	Pack and Price	Manufacturer
8048N	abciximab 10 mg/5 mL injection, 1 x 5 mL vial	1@ 482.23	LY
1003T	aciclovir 200 mg tablet, 25	25@ 12.83	AF, GN, SZ
1003T	aciclovir 200 mg tablet, 25	25@ 13.86	GK
2014B	alginate sodium 500 mg/10 mL + calcium carbonate 160 mg/10 mL + sodium bicarbonate 267 mg/10 mL oral liquid, 500 mL	1@ 4.13	RC
1557Y	allopurinol 100 mg tablet, 100	100@ 2.28	AF
2159P	aluminium hydroxide 250 mg/5 mL + magnesium hydroxide 120 mg/5 mL + magnesium trisilicate 120 mg/5 mL oral liquid, 500 mL	1@ 5.64	FM
2157M	ALUMINIUM HYDROXIDE with MAGNESIUM HYDROXIDE Oral suspension 200 mg-200 mg per 5 mL, 500 mL, 1	1@ 5.64	JT
3417W	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	1@ 625.39	SB
9330C	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	1@ 625.39	SB
8678R	amino acid formula without phenylalanine 1 g tablet, 75	1@ 59.19	SB
8554F	amino acid formula without phenylalanine 500 mg capsule, 200	1@ 79.37	SB
2347M	amino acid formula without phenylalanine oral liquid: powder for, 30 x 20 g sachets	1@ 208.07	SB
10161T	amino acid formula without valine, leucine and isoleucine containing 5 g of protein equivalent oral liquid: powder for, 30 x 6 g sachets	1@ 257.66	VF
8479G	amino acid formula with vitamins, minerals and long chain polyunsaturated fatty acids without phenylalanine oral liquid: powder for, 400 g	1@ 87.15	SB
9438R	amino acid formula with vitamins and minerals without lysine and low in tryptophan oral liquid: powder for, 30 x 24 g sachets	1@ 526.99	VF
5484P	amino acid formula with vitamins and minerals without lysine and low in tryptophan oral liquid: powder for, 30 x 25 g sachets	1@ 787.00	VF
2650L	amino acid formula with vitamins and minerals without lysine and low in tryptophan oral liquid: powder for, 400 g	1@ 95.36	SB
2646G	amino acid formula with vitamins and minerals without lysine and low in tryptophan oral liquid: powder for, 500 g	1@ 222.29	SB
3444G	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	1@ 526.99	VF
3443F	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	1@ 772.99	VF
8058D	amino acid formula with vitamins and minerals without methionine, threonine and valine and low in isoleucine oral liquid: powder for, 400 g	1@ 95.36	SB
8059E	amino acid formula with vitamins and minerals without methionine, threonine and valine and low in isoleucine oral liquid: powder for, 500 g	1@ 222.29	SB
8061G		1@ 337.29	SB
1923F	AMINO ACID FORMULA with VITAMINS and MINERALS without METHIONINE, THREONINE and VALINE and low in ISOLEUCINE Oral liquid 130 mL, 30, 1	1@ 772.99	VF
9133Q	amino acid formula with vitamins and minerals without methionine oral liquid, 30 x 130 mL cans	1@ 772.99	VF
2640Y	amino acid formula with vitamins and minerals without methionine oral liquid, 30 x 174 mL pouches	1@ 1018.99	VF
2639X	amino acid formula with vitamins and minerals without methionine oral liquid, 30 x 87 mL pouches	1@ 526.99	VF
8677Q	amino acid formula with vitamins and minerals without methionine oral liquid: powder for, 30 x 24 g sachets	1@ 526.99	VF
8744F	amino acid formula with vitamins and minerals without methionine oral liquid: powder for, 30 x 25 g sachets	1@ 772.99	VF
8417B	amino acid formula with vitamins and minerals without methionine oral liquid: powder for, 400 g	1@ 95.36	SB
8328H	amino acid formula with vitamins and minerals without methionine oral liquid: powder for, 500 g	1@ 222.29	SB
8416Y		1@ 337.29	SB
1548L	AMINO ACID FORMULA with VITAMINS and MINERALS without METHIONINE Oral liquid 125 mL, 30, 1	1@ 1030.64	SB
9132P	amino acid formula with vitamins and minerals without phenylalanine	1@ 772.99	VF

(APPLY WASTAGE FACTOR IN CALCULATING BROKEN QUANTITY PRICES)

Code	Name, Form/Strength	Pack and Price	Manufacturer
2701E	and tyrosine oral liquid, 30 x 130 mL cans	1@ 1018.99	VF
2674R	amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid, 30 x 174 mL pouches	1@ 526.99	VF
8631G	amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid, 30 x 87 mL pouches	1@ 526.99	VF
8667E	amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid: powder for, 30 x 24 g sachets	1@ 772.99	VF
9395L	amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid: powder for, 30 x 25 g sachets	1@ 448.51	SB
8445L	amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid: powder for, 30 x 29 g sachets	1@ 95.36	SB
3078B	amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid: powder for, 400 g	1@ 337.29	SB
8446M	amino acid formula with vitamins and minerals without phenylalanine and tyrosine oral liquid: powder for, 500 g	1@ 222.29	SB
1547K	AMINO ACID FORMULA with VITAMINS and MINERALS without PHENYLALANINE and TYROSINE Oral liquid 125 mL, 30, 1	1@ 1030.64	SB
8746H	amino acid formula with vitamins and minerals without phenylalanine oral liquid, 18 x 250 mL cans	18@ 261.37	SB
9021T	amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 125 mL cans	1@ 514.34	SB
8846N	amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 130 mL cans	1@ 385.48	VF
2474F	amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 174 mL cans	1@ 511.90	VF
5483N	amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 85 g sachets	1@ 263.05	VF
2382J	amino acid formula with vitamins and minerals without phenylalanine oral liquid, 30 x 87 mL cans	1@ 257.09	VF
9396M	amino acid formula with vitamins and minerals without phenylalanine oral liquid, 36 x 125 mL cans	1@ 315.86	SB
9397N	amino acid formula with vitamins and minerals without phenylalanine oral liquid, 60 x 62.5 mL cans	1@ 526.47	SB
8555G	amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 30 x 24 g sachets	1@ 263.05	VF
8591E	amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 30 x 25 g sachets	1@ 385.68	VF
8804J	amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 30 x 27.8 g sachets	1@ 514.34	SB
8613H	amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 30 x 29 g sachets	1@ 221.42	SB
8727H	amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 30 x 50 g sachets	1@ 501.88	SB
2738D	amino acid formula with vitamins and minerals without phenylalanine oral liquid: powder for, 500 g	1@ 109.70	SB
2739E	amino acid formula with vitamins and minerals without phenylalanine oral semi-solid, 36 x 109 g jars	1@ 168.25	SB
2806Q	AMINO ACID FORMULA with VITAMINS and MINERALS without PHENYLALANINE Sachets 18.2 g, 60, 1	1@ 615.44	SB
1411G	AMINO ACID FORMULA with VITAMINS and MINERALS without PHENYLALANINE Sachets 34 g, 30, 1	1@ 544.55	SB
1909L	amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid, 30 x 130 mL cans	1@ 511.90	VF
2375B	amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid, 30 x 174 mL pouches	1@ 772.99	VF
2654Q	amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid, 30 x 87 mL pouches	1@ 1018.99	VF
2651M	amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 30 x 24 g sachets	1@ 526.99	VF
8592F	amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 30 x 25 g sachets	1@ 526.99	VF
8632H	amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 30 x 29 g sachets	1@ 772.99	VF
8745G	amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 500 g	1@ 448.51	SB

(APPLY WASTAGE FACTOR IN CALCULATING BROKEN QUANTITY PRICES)

Code	Name, Form/Strength	Pack and Price	Manufacturer
2380G	amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 400 g	1@ 95.36	SB
8057C	amino acid formula with vitamins and minerals without valine, leucine and isoleucine oral liquid: powder for, 500 g	1@ 337.29	SB
8260R		1@ 222.29	SB
8310J		1@ 666.39	SB
1546J	AMINO ACID FORMULA with VITAMINS and MINERALS without VALINE, LEUCINE and ISOLEUCINE Oral liquid 125 mL, 30, 1	1@ 1030.64	SB
1914R	AMINO ACID FORMULA with VITAMINS and MINERALS without VALINE, LEUCINE and ISOLEUCINE Sachets 34 g, 30, 1	1@ 1021.93	VF
9499Y	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	1@ 625.39	SB
1180D	amino acid synthetic formula oral liquid: powder for, 400 g	1@ 44.34	SB
1192R		1@ 44.34	SB
1521C		1@ 43.77	SB
2250K		1@ 43.77	AB
8574G		1@ 44.34	AB
8575H		1@ 44.34	AB
8754R		1@ 44.34	SB
8755T		1@ 44.34	SB
1545H	amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids and medium chain triglycerides oral liquid: powder for, 400 g	1@ 44.65	SB
2900P		1@ 45.18	NT
2928D		1@ 45.18	NT
5466Q		1@ 45.18	SB
5467R		1@ 45.18	SB
2246F	amino acid synthetic formula supplemented with long chain polyunsaturated fatty acids oral liquid: powder for, 400 g	1@ 45.18	SB
2560R		1@ 45.18	SB
9339M		1@ 45.18	AB
9340N		1@ 45.18	AB
8736T	amisulpride 100 mg/mL oral liquid, 60 mL	1@ 71.16	SW
9386B	amylopectin modified long chain oral liquid: powder for, 30 x 60 g sachets	1@ 186.47	VF
10036F	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	1@ 91.10	VF
5482M	arginine with carbohydrate containing 2 g arginine oral liquid: powder for, 30 x 4 g sachets	1@ 191.10	VF
9437Q	arginine with carbohydrate containing 500 mg arginine oral liquid: powder for, 30 x 4 g sachets	1@ 127.40	VF
10093F	arginine with carbohydrate containing 5 g arginine oral liquid: powder for, 30 x 7.6 g sachets	1@ 254.17	VF
9092M	atomoxetine 10 mg capsule, 28	28@ 107.38	LY
9093N	atomoxetine 18 mg capsule, 28	28@ 107.38	LY
9094P	atomoxetine 25 mg capsule, 28	28@ 107.38	LY
9095Q	atomoxetine 40 mg capsule, 28	28@ 107.38	LY
9096R	atomoxetine 60 mg capsule, 28	28@ 107.38	LY
1140B	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	1@ 151.15	SW
2647H	benzylpenicillin 3 g injection, 1 x 3 g vial	1@ 8.31	CS
3399X		1@ 8.31	CS
1775K	benzylpenicillin 600 mg injection, 1 x 600 mg vial	1@ 4.83	CS
3398W		1@ 4.83	CS
2812B	betamethasone (as valerate) 0.02% (200 microgram/g) cream, 100 g	1@ 12.34	QA
2812B	betamethasone (as valerate) 0.02% (200 microgram/g) cream, 100 g	1@ 10.13	MK
2812B	betamethasone (as valerate) 0.02% (200 microgram/g) cream, 100 g	1@ 8.90	FM, FR
2544X	biperiden hydrochloride 2 mg tablet, 100	100@ 7.23	LM
1260H	bisacodyl 10 mg suppository, 10	1@ 4.84	PP
1260H	bisacodyl 10 mg suppository, 10	1@ 5.34	BY
5303D		1@ 5.34	BY
5303D		1@ 4.84	PP

(APPLY WASTAGE FACTOR IN CALCULATING BROKEN QUANTITY PRICES)

Code	Name, Form/Strength	Pack and Price	Manufacturer
5307H		1@ 5.34	BY
5307H		1@ 4.84	PP
1258F	bisacodyl 10 mg suppository, 12	1@ 3.97	PP
5304E		1@ 3.97	PP
5308J		1@ 3.97	PP
1443Y	bromocriptine 2.5 mg tablet, 30	30@ 12.50	NV
10015D	budesonide 100 microgram/actuation + eformoterol fumarate dihydrate 3 microgram/actuation inhalation: pressurised, 120 actuations	1@ 26.17	AP
10018G	budesonide 200 microgram/actuation + eformoterol fumarate dihydrate 6 microgram/actuation inhalation: pressurised, 120 actuations	1@ 41.32	AP
10024N	budesonide 50 microgram/actuation + eformoterol fumarate dihydrate 3 microgram/actuation inhalation: pressurised, 120 actuations	1@ 24.02	AP
3116B	CALCIUM Tablet (chewable) 500 mg (as carbonate), 60	60@ 5.62	IA, PP
2422L	CARBAMAZEPINE Tablet 100 mg, 100	100@ 6.04	SZ
2422L	CARBAMAZEPINE Tablet 100 mg, 100	100@ 7.52	NV
5039F		100@ 7.52	NV
5039F		100@ 6.04	SZ
1706T	CARBAMAZEPINE Tablet 200 mg, 100	100@ 11.29	SZ
1706T	CARBAMAZEPINE Tablet 200 mg, 100	100@ 12.77	NV
1724R		100@ 12.77	NV
1724R		100@ 11.29	SZ
1153Q	carbimazole 5 mg tablet, 100	100@ 12.31	LM, PQ
8369L	carbohydrate, fat, vitamins, minerals and trace elements oral liquid: powder for, 400 g	1@ 38.97	SB
10050Y	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	1@ 60.46	VF
10039J	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	1@ 116.43	VF
2058H	carbomer 0.2% + triglyceride lipids 1% eye gel, 30 x 600 mg unit doses	1@ 9.89	BU
2090B		1@ 9.89	BU
5502N	carbomer-974 0.3% eye gel, 30 x 500 mg unit doses	1@ 9.88	AQ
8514D		1@ 9.88	AQ
5504Q	carbomer-980 0.2% (2 mg/g) eye drops, 30 x 0.6 mL unit doses	1@ 9.89	AQ
8578L		1@ 9.89	AQ
5509Y	carmellose sodium 0.25% (1.5 mg/0.6 mL) eye drops, 24 x 0.6 mL unit doses	1@ 8.50	CX
8823J		1@ 8.50	CX
2338C	carmellose sodium 0.5% (2 mg/0.4 mL) eye drops, 30 x 0.4 mL unit doses	1@ 8.29	PP
2338C	carmellose sodium 0.5% (2 mg/0.4 mL) eye drops, 30 x 0.4 mL unit doses	1@ 9.88	AG
5506T		1@ 9.88	AG
5506T		1@ 8.29	PP
5561Q	carmellose sodium 0.5% + glycerol 0.9% eye drops, 30 x 0.4 mL unit doses	1@ 9.88	AG
9307W		1@ 9.88	AG
2324H	carmellose sodium 1% (4 mg/0.4 mL) eye drops, 30 x 0.4 mL unit doses	1@ 9.88	AG
2324H	carmellose sodium 1% (4 mg/0.4 mL) eye drops, 30 x 0.4 mL unit doses	1@ 8.29	PP
5505R		1@ 8.29	PP
5505R		1@ 9.88	AG
5510B	carmellose sodium 1% (6 mg/0.6 mL) eye gel, 28 x 0.6 mL unit doses	1@ 9.22	CX
8824K		1@ 9.22	CX
8315P	CEFEPIME Powder for injection 1 g (as hydrochloride), 1	1@ 5.39	AE, AF, HH, OE, SZ
8316Q	CEFEPIME Powder for injection 2 g (as hydrochloride), 1	1@ 10.26	AE, AF, HH, OE, SZ
1085D	cefotaxime 1 g injection, 1 x 1 g vial	1@ 1.47	SZ
5048Q		1@ 1.47	SZ
1086E	cefotaxime 2 g injection, 1 x 2 g vial	1@ 2.73	SZ
5049R		1@ 2.73	SZ
1784X	ceftriaxone 1 g injection, 1 x 1 g vial	1@ 1.68	AE, HH, PP, SZ
1785Y	ceftriaxone 2 g injection, 1 x 2 g vial	1@ 3.12	AE, AF, HH, SZ
1783W	ceftriaxone 500 mg injection, 1 x 500 mg vial	1@ 1.08	AE, PP

(APPLY WASTAGE FACTOR IN CALCULATING BROKEN QUANTITY PRICES)

Code	Name, Form/Strength	Pack and Price	Manufacturer
2655R	cephalexin 250 mg capsule, 20	20@ 1.13	AF, CH, CR, EA, GN, GQ, GX, LN, RA, SZ, TW, TX
2655R	cephalexin 250 mg capsule, 20	20@ 5.45	AS
1797N	cephazolin 1 g injection, 5 x 1 g vials	5@ 4.26	AE, HH
1799Q		5@ 4.26	AE, HH
5479J	cephazolin 2 g injection, 1 x 2 g vial	1@ 1.96	AF, SZ
9326W		1@ 1.96	AF, SZ
1256D	cephazolin 500 mg injection, 5 x 500 mg vials	5@ 3.20	AE
5477G		5@ 3.20	AE
1163F	chlorambucil 2 mg tablet, 25	25@ 36.84	AS
1585K	chlorthalidone 25 mg tablet, 50	50@ 5.58	LM
2967E	cholestyramine 4 g oral liquid: powder for, 50 x 4.7 g sachets	1@ 32.76	QA
9249T		1@ 32.76	QA
1217C	ciprofloxacin 0.3% eye drops, 5 mL	1@ 11.03	IQ
1217C	ciprofloxacin 0.3% eye drops, 5 mL	1@ 12.06	AQ
5564W		1@ 12.06	AQ
5564W		1@ 11.03	IQ
5481L	citrulline with carbohydrate containing 1 g citrulline oral liquid: powder for, 30 x 4 g sachets	1@ 127.40	VF
1808E	clonazepam 2.5 mg/mL oral liquid, 10 mL	1@ 4.31	RO
5339B		1@ 4.31	RO
5342E		1@ 4.31	RO
1806C	clonazepam 2 mg tablet, 100	100@ 12.32	AF
1806C	clonazepam 2 mg tablet, 100	100@ 14.25	RO
1805B	clonazepam 500 microgram tablet, 100	100@ 6.54	AF
1805B	clonazepam 500 microgram tablet, 100	100@ 8.25	RO
8785J	CODEINE PHOSPHATE with PARACETAMOL Tablet 30 mg-500 mg, 20	20@ 3.32	SW
8785J	CODEINE PHOSPHATE with PARACETAMOL Tablet 30 mg-500 mg, 20	20@ 0.92	AL, AV, FM, GQ, SZ, TX
8661W	cyclosporin 100 mg/mL oral liquid, 50 mL	1@ 353.12	NV
8660T	cyclosporin 100 mg capsule, 30	30@ 184.01	NV, SZ
8657P	cyclosporin 10 mg capsule, 60	60@ 44.00	NV
8658Q	cyclosporin 25 mg capsule, 30	30@ 45.41	NV, SZ
8659R	cyclosporin 50 mg capsule, 30	30@ 94.48	NV, SZ
1270W	cyproterone acetate 50 mg tablet, 50	50@ 59.79	AF, EA, ER, GN, GX, HX, QA, SY
1270W	cyproterone acetate 50 mg tablet, 50	50@ 60.91	BN
9164H	cystine with carbohydrate containing 500 mg cystine oral liquid: powder for, 30 x 4 g sachets	1@ 127.40	VF
9319L	dabigatran etexilate 110 mg capsule, 10	10@ 15.59	BY
9323Q		10@ 15.59	BY
9318K	dabigatran etexilate 75 mg capsule, 10	10@ 19.56	BY
9322P		10@ 19.56	BY
8959M	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	10@ 136.11	PF
8960N	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	10@ 162.39	PF
1229Q	dalteparin sodium 10 000 anti-Xa international units/mL injection, 10 x 1 mL syringes	10@ 84.57	PF
8957K		10@ 82.88	PF
1296F	dalteparin sodium 12 500 anti-Xa international units/0.5 mL injection, 10 x 0.5 mL syringes	10@ 117.43	PF
8958L		10@ 114.43	PF
8603T	dalteparin sodium 2500 anti-Xa international units/0.2 mL injection, 10 x 0.2 mL syringes	10@ 49.16	PF
8641T		10@ 49.16	PF
2816F	dalteparin sodium 5000 anti-Xa international units/0.2 mL injection, 10 x 0.2 mL syringes	10@ 51.23	PF
8642W		10@ 51.23	PF
8643X	dalteparin sodium 7500 anti-Xa international units/0.75 mL injection, 10 x 0.75 mL syringes	10@ 61.96	PF
8956J		10@ 61.96	PF

(APPLY WASTAGE FACTOR IN CALCULATING BROKEN QUANTITY PRICES)

Code	Name, Form/Strength	Pack and Price	Manufacturer
2129C	desmopressin acetate 100 microgram/mL nasal drops, 2.5 mL	1@ 30.95	FP
8711L	desmopressin acetate 10 microgram/actuation nasal spray, 60 actuations	1@ 77.31	FP
8662X	desmopressin acetate 200 microgram tablet, 30	30@ 57.83	FP
5521N	dextran-70 0.1% + hypromellose 0.3% eye drops, 28 x 0.4 mL unit doses	1@ 9.55	AQ
8299T		1@ 9.55	AQ
1302M	diclofenac sodium 100 mg suppository, 20	20@ 9.25	NV
5079H		20@ 9.25	NV
5363G		20@ 9.25	NV
5366K		20@ 9.25	NV
1299J	diclofenac sodium 25 mg tablet: enteric, 50 tablets	50@ 2.17	AF, CH, EA, GN, QA, SZ, TW, TX
1299J	diclofenac sodium 25 mg tablet: enteric, 50 tablets	50@ 2.98	NV
5076E		50@ 2.17	AF, CH, EA, GN, QA, SZ, TW, TX
5076E		50@ 2.98	NV
5361E		50@ 2.17	AF, CH, EA, GN, QA, SZ, TW, TX
5361E		50@ 2.98	NV
5364H		50@ 2.17	AF, CH, EA, GN, QA, SZ, TW, TX
5364H		50@ 2.98	NV
3164M	digoxin 50 microgram/mL oral liquid, 60 mL	1@ 17.35	QA
10040K	docosahexaenoic acid with carbohydrate containing 200 mg docosahexaenoic acid oral liquid: powder for, 30 x 4g sachets	1@ 91.10	VF
2703G	doxycycline 100 mg capsule: modified release, 7 capsules	7@ 2.27	YT
2703G	doxycycline 100 mg capsule: modified release, 7 capsules	7@ 3.62	YN
2702F	doxycycline 100 mg tablet, 7	7@ 1.28	AF, GN, QA
2714W		7@ 1.28	AF, EA, GN, QA
9107H		7@ 1.28	CH, GX, HX, TW
9108J		7@ 1.28	CH, HX, TW
5435C	enoxaparin sodium 100 mg/mL injection, 10 x 1 mL syringes	10@ 102.33	SW
8558K	enoxaparin sodium 20 mg/0.2 mL injection, 10 x 0.2 mL syringes	10@ 49.16	SW
8716R		10@ 49.16	SW
9195Y	enoxaparin sodium 40 mg/0.4 mL injection, 10 x 0.4 mL ampoules	10@ 51.23	SW
9196B		10@ 51.23	SW
8510X	enoxaparin sodium 40 mg/0.4 mL injection, 10 x 0.4 mL syringes	10@ 51.23	SW
8639Q		10@ 51.23	SW
8640R	enoxaparin sodium 60 mg/0.6 mL injection, 10 x 0.6 mL syringes	10@ 73.26	SW
5434B	enoxaparin sodium 80 mg/0.8 mL injection, 10 x 0.8 mL syringes	10@ 84.28	SW
8367J	entacapone 200 mg tablet, 100	100@ 137.70	NV
8397Y	eprosartan 400 mg tablet, 28	28@ 8.86	AB
8951D		28@ 8.86	AB
8683B	eptifibatide 20 mg/10 mL injection, 1 x 10 mL vial	1@ 128.06	MK
8684C	eptifibatide 75 mg/100 mL injection, 1 x 100 mL vial	1@ 337.98	MK
1397M	erythromycin (as lactobionate) 1 g injection, 1 x 1 g vial	1@ 38.01	LM
5088T		1@ 38.01	LM
9329B	essential amino acids formula oral liquid: powder for, 2 x 200 g cans	1@ 199.02	SB
2027Q	essential amino acids formula with minerals and vitamin C oral liquid: powder for, 400 g	1@ 125.55	SB
9385Y	essential amino acids formula with vitamins and minerals oral liquid: powder for, 50 x 12.5 g sachets	1@ 377.52	VF
1954W	etanercept 25 mg injection [4 x 25 mg vials] (&) inert substance diluent [4 x 1 mL syringes], 1 pack	1@ 883.97	PF
3445H		1@ 883.97	PF
3448L		1@ 883.97	PF
8637N		1@ 883.97	PF
8638P		1@ 883.97	PF
8778B		1@ 883.97	PF
8779C		1@ 883.97	PF
9035M		1@ 883.97	PF
9036N		1@ 883.97	PF
9037P		1@ 883.97	PF
9429G		1@ 883.97	PF
8748K	ethacrynic acid 25 mg tablet, 100	100@ 95.44	FK

(APPLY WASTAGE FACTOR IN CALCULATING BROKEN QUANTITY PRICES)

Code	Name, Form/Strength	Pack and Price	Manufacturer
9352F	everolimus 1 mg tablet, 60	60@ 1031.17	NV
8842J	everolimus 750 microgram tablet, 60	60@ 786.10	NV
5411T	FENTANYL Lozenge 1200 micrograms (as citrate), 30	30@ 285.15	OA
5412W	FENTANYL Lozenge 1600 micrograms (as citrate), 30	30@ 285.15	OA
5407N	FENTANYL Lozenge 200 micrograms (as citrate), 30	30@ 285.15	OA
5408P	FENTANYL Lozenge 400 micrograms (as citrate), 30	30@ 285.15	OA
5409Q	FENTANYL Lozenge 600 micrograms (as citrate), 30	30@ 285.15	OA
5410R	FENTANYL Lozenge 800 micrograms (as citrate), 30	30@ 285.15	OA
1473M	fluconazole 100 mg/50 mL injection, 1 x 50 mL vial	1@ 2.25	AE, HX, SZ
1474N	fluconazole 200 mg/100 mL injection, 1 x 100 mL vial	1@ 4.24	AE, AF, HX, SZ
1433K	fludrocortisone acetate 100 microgram tablet, 100	100@ 20.04	QA
2958Q	folic acid 500 microgram tablet, 100	100@ 2.46	AF, PP
1437P	folic acid 5 mg tablet, 100	100@ 3.80	AF
8812T	folinic acid 100 mg/10 mL injection, 1 x 10 mL vial	1@ 5.63	SZ
9041W	folinic acid 300 mg/30 mL injection, 1 x 30 mL vial	1@ 16.48	HH, SZ
8740B	folinic acid 50 mg/5 mL injection, 1 x 5 mL vial	1@ 6.11	HH
1575X	folinic acid 50 mg/5 mL injection, 5 x 5 mL ampoules	5@ 30.51	SZ
8713N	follitropin alfa 300 international units / 0.5 mL (21.84 microgram/0.5 mL) injection, 1 x 0.5 mL cartridge	1@ 162.36	SG
8714P	follitropin alfa 450 international units / 0.75 mL (32.76 microgram/0.75 mL) injection, 1 x 0.75 mL cartridge	1@ 243.55	SG
8715Q	follitropin alfa 900 international units / 1.5 mL (65.52 microgram/1.5 mL) injection, 1 x 1.5 mL cartridge	1@ 487.09	SG
8565T	follitropin beta 300 international units/0.36 mL injection, 1 x 0.36 mL cartridge	1@ 167.73	MK
8566W	follitropin beta 600 international units/0.72 mL injection, 1 x 0.72 mL cartridge	1@ 327.32	MK
8871X	follitropin beta 900 international units/1.08 mL injection, 1 x 1.08 mL cartridge	1@ 486.58	MK
8775W	FONDAPARINUX SODIUM Injection 2.5 mg in 0.5 mL single dose pre-filled syringe, 2	2@ 37.05	AS
1810G	frusemide 20 mg tablet, 50	50@ 0.87	FM
1810G	frusemide 20 mg tablet, 50	50@ 1.84	SW
8444K	gelatin-succinylated 20 g/500 mL injection, 1 x 500 mL bag	1@ 13.11	BR
2245E	glucose 5% (50 g/1000 mL) injection, 1 x 1000 mL bag	1@ 2.07	BX
5106R		1@ 2.07	BX
3106L	glucose and ketone indicator urine strip: diagnostic, 50 diagnostic strips	1@ 5.44	RD
3107M		1@ 5.50	BN
9254C		1@ 5.44	RD
9255D		1@ 5.50	BN
10139P	glucose indicator blood strip: diagnostic, 50	1@ 23.38	WI
10147C		1@ 23.38	WI
2263D		1@ 23.38	MS
2673Q		1@ 23.38	JJ
2697Y		1@ 23.38	JJ
2860M		1@ 23.38	NA
2890D		1@ 23.38	NA
2914J		1@ 19.74	NA
3406G		1@ 23.38	LB
3407H		1@ 23.38	LB
3441D		1@ 23.38	JJ
3442E		1@ 23.38	JJ
5043K		1@ 23.38	RD
5053Y		1@ 23.38	RD
8739Y		1@ 23.38	RD
8749L		1@ 23.38	OZ
8759B		1@ 23.38	LB
8795X		1@ 23.38	PX
9263M		1@ 23.38	OZ
9267R		1@ 23.38	MS
9274D		1@ 23.38	RD
9276F		1@ 23.38	NA
9277G		1@ 23.38	NA
9278H		1@ 23.38	LB
9279J		1@ 19.74	NA

(APPLY WASTAGE FACTOR IN CALCULATING BROKEN QUANTITY PRICES)

Code	Name, Form/Strength	Pack and Price	Manufacturer
9281L		1@ 23.38	PX
9297H		1@ 23.38	QB
9298J		1@ 23.38	QB
9471L		1@ 23.38	EH
9472M		1@ 23.38	EH
9485F		1@ 23.38	OI
9486G		1@ 23.38	OI
8806L	glucose indicator blood strip: diagnostic, 51 diagnostic strips	1@ 23.38	RD
9275E		1@ 23.38	RD
3104J	glucose indicator urine strip: diagnostic, 50 diagnostic strips	1@ 6.70	BN
9253B		1@ 6.70	BN
2556M	glycerol 1.4 g suppository, 12	1@ 4.49	PP
5312N		1@ 4.49	PP
5315R		1@ 4.49	PP
2557N	glycerol 2.8 g suppository, 12	1@ 4.66	PP
5313P		1@ 4.66	PP
5316T		1@ 4.66	PP
2555L	glycerol 700 mg suppository, 12	1@ 4.35	PP
5311M		1@ 4.35	PP
5314Q		1@ 4.35	PP
10195N	glycine with carbohydrate containing 500 mg of glycine oral liquid: powder for, 30 x 4 g sachets	1@ 127.40	VF
2712R	glycomacropeptide and essential amino acids oral liquid, 12 x 500 mL bottles	1@ 105.31	QH
2696X	glycomacropeptide and essential amino acids with vitamins and minerals bar, 7 x 54 g	1@ 61.43	QH
2644E	glycomacropeptide and essential amino acids with vitamins and minerals bar, 7 x 81 g	1@ 92.15	QH
2685H	glycomacropeptide and essential amino acids with vitamins and minerals oral liquid: powder for, 28 x 49 g sachets	1@ 368.34	QH
8728J	granisetron 2 mg tablet, 1	1@ 11.49	RO
1076P	heparin sodium 35 000 international units/35 mL injection, 1 x 35 mL vial	1@ 31.15	HH
2652N	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	1@ 42.96	SB
10185C	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	1@ 196.11	SB
9446E	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	1@ 42.96	SB
1640H	hydralazine hydrochloride 25 mg tablet, 100	100@ 5.44	AF
1639G	hydralazine hydrochloride 50 mg tablet, 100	100@ 6.30	AF
1486F	hydrochlorothiazide 50 mg + amiloride hydrochloride 5 mg tablet, 50	50@ 3.54	AS
1501B	hydrocortisone (as sodium succinate) 100 mg injection [1 x 100 mg vial] (&) inert substance diluent [1 x 2 mL vial], 1 pack	1@ 5.64	PF
1510L		1@ 5.64	PF
5118J		1@ 5.64	PF
1511M	hydrocortisone (as sodium succinate) 250 mg injection [1 x 250 mg vial] (&) inert substance diluent [1 x 2 mL vial], 1 pack	1@ 9.64	PF
5119K		1@ 9.64	PF
1502C	hydrocortisone acetate 10% (100 mg/g) enema, 21.1 g	1@ 17.01	HM
9487H	HYDROXYETHYL STARCH 130/0.4 I.V. infusion 30 g per 500 mL, 500 mL, 1	1@ 13.11	PK
5317W	hyoscine butylbromide 20 mg/mL injection, 5 x 1 mL ampoules	5@ 17.02	BY
5318X		5@ 17.02	BY
3190X	ibuprofen 400 mg tablet, 30	30@ 2.77	AB
5123P		30@ 2.77	AB
5368M		30@ 2.77	AB
5370P		30@ 2.77	AB
2448W	idarubicin hydrochloride 10 mg capsule, 1	1@ 162.69	PF
2446R	idarubicin hydrochloride 5 mg capsule, 1	1@ 87.06	PF
2757D	indomethacin 100 mg suppository, 20	20@ 8.04	AS
5128X		20@ 8.04	AS

(APPLY WASTAGE FACTOR IN CALCULATING BROKEN QUANTITY PRICES)

Code	Name, Form/Strength	Pack and Price	Manufacturer
5378C		20@ 8.04	AS
5380E		20@ 8.04	AS
2454E	indomethacin 25 mg capsule, 50	50@ 3.22	AF
2454E	indomethacin 25 mg capsule, 50	50@ 5.54	AS
5126T		50@ 3.22	AF
5126T		50@ 5.54	AS
5377B		50@ 3.22	AF
5377B		50@ 5.54	AS
5379D		50@ 5.54	AS
5379D		50@ 3.22	AF
8571D	insulin aspart 100 international units/mL injection, 1 x 10 mL vial	1@ 30.57	NO
8435Y	insulin aspart 100 international units/mL injection, 5 x 3 mL cartridges	1@ 51.56	NF, NO
8609D	insulin aspart 30 international units/mL + insulin aspart protamine 70 international units/mL injection, 5 x 3 mL syringes	1@ 51.56	NF, NO
9040T	insulin detemir 100 international units/mL injection, 5 x 3 mL cartridges	1@ 85.26	NF, NO
9039R	insulin glargine 100 international units/mL injection, 5 x 3 mL cartridges	1@ 85.26	AV, SW
9224L	insulin glulisine 100 international units/mL injection, 1 x 10 mL vial	1@ 30.57	SW
1921D	insulin glulisine 100 international units/mL injection, 5 x 3 mL cartridges	1@ 51.56	AV, SW
1711C	insulin isophane bovine 100 international units/mL injection, 1 x 10 mL vial	1@ 78.86	AS
1533Q	insulin isophane human 100 international units/mL injection, 1 x 10 mL vial	1@ 25.48	LY, NO
1761Q	insulin isophane human 100 international units/mL injection, 5 x 3 mL cartridges	1@ 43.58	LY, NI, NO
1763T	insulin isophane human 70 international units/mL + insulin neutral human 30 international units/mL injection, 5 x 3 mL cartridges	1@ 43.58	LY, NI, NO
8084L	insulin lispro 100 international units/mL injection, 1 x 10 mL vial	1@ 30.57	LY
8212F	insulin lispro 100 international units/mL injection, 5 x 3 mL cartridges	1@ 51.56	KP, LY
8390N	insulin lispro 25 international units/mL + insulin lispro protamine 75 international units/mL injection, 5 x 3 mL cartridges	1@ 51.56	KP, LY
8874C	insulin lispro 50 international units/mL + insulin lispro protamine 50 international units/mL injection, 5 x 3 mL cartridges	1@ 51.56	KP, LY
1713E	insulin neutral bovine 100 international units/mL injection, 1 x 10 mL vial	1@ 78.86	AS
1531N	insulin neutral human 100 international units/mL injection, 1 x 10 mL vial	1@ 25.48	LY, NO
1762R	insulin neutral human 100 international units/mL injection, 5 x 3 mL cartridges	1@ 43.58	LY, NO
1426C	insulin neutral human 30 international units/mL + insulin isophane human 70 international units/mL injection, 1 x 10 mL vial	1@ 25.48	LY
2062M	insulin neutral human 50 international units/mL + insulin isophane human 50 international units/mL injection, 5 x 3 mL cartridges	1@ 43.58	NO
8180M	interferon alfa-2a 3 million international units/0.5 mL injection, 1 x 0.5 mL syringe	1@ 33.32	RO
8181N		1@ 33.32	RO
8182P	interferon alfa-2a 4.5 million international units/0.5 mL injection, 1 x 0.5 mL syringe	1@ 51.66	RO
8551C		1@ 51.66	RO
8183Q	interferon alfa-2a 6 million international units/0.5 mL injection, 1 x 0.5 mL syringe	1@ 67.66	RO
8552D		1@ 67.66	RO
8184R	interferon alfa-2a 9 million international units/0.5 mL injection, 1 x 0.5 mL syringe	1@ 99.94	RO
8553E		1@ 99.94	RO
8348J	interferon alfa-2b 18 million international units/1.2 mL injection, 1 x 1.2 mL cartridge	1@ 199.87	MK
8572E		1@ 199.87	MK
8476D	interferon alfa-2b 30 million international units/1.2 mL injection, 1 x 1.2 mL cartridge	1@ 333.11	MK
8671J	ipratropium bromide 20 microgram/actuation inhalation: pressurised, 200 actuations	1@ 13.71	BY
1542E	ipratropium bromide 250 microgram/mL inhalation: solution, 30 x 1 mL ampoules	1@ 10.76	AF, QA, TX
1542E	ipratropium bromide 250 microgram/mL inhalation: solution, 30 x 1 mL ampoules	1@ 11.02	BY

(APPLY WASTAGE FACTOR IN CALCULATING BROKEN QUANTITY PRICES)

Code	Name, Form/Strength	Pack and Price	Manufacturer
8238N	ipratropium bromide 500 microgram/mL inhalation: solution, 30 x 1 mL ampoules	1@ 12.72	AF, QA, TX
8238N	ipratropium bromide 500 microgram/mL inhalation: solution, 30 x 1 mL ampoules	1@ 12.96	BY
10104T	iron (as ferric carboxymaltose) 500 mg/10 mL injection, 1 x 10 mL vial	1@ 155.23	VL
9436P	isoleucine with carbohydrate containing 1 g isoleucine oral liquid: powder for, 30 x 4 g sachets	1@ 140.14	VF
9134R	isoleucine with carbohydrate containing 50 mg isoleucine oral liquid: powder for, 30 x 4 g sachets	1@ 127.40	VF
2588F	isosorbide dinitrate 5 mg tablet: sublingual, 100	100@ 4.07	QA
2868Y	ivermectin 3 mg tablet, 4	4@ 23.89	MK
1588N	ketoprofen 100 mg suppository, 20	20@ 9.44	SW
5139L		20@ 9.44	SW
2286H	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	1@ 1.58	BX
5387M	LACTULOSE Mixture 3.34 g per 5 mL, 500 mL, 1	1@ 3.94	QA
5387M	LACTULOSE Mixture 3.34 g per 5 mL, 500 mL, 1	1@ 4.83	AF
5388N		1@ 3.94	QA
5388N		1@ 4.83	AF
9148L	lapatinib 250 mg tablet, 70	70@ 1690.52	GK
8798C	levodopa 100 mg + carbidopa anhydrous 25 mg + entacapone 200 mg tablet, 100	100@ 167.75	NV
9345W	levodopa 125 mg + carbidopa anhydrous 31.25 mg + entacapone 200 mg tablet, 100	100@ 173.77	NV
8799D	levodopa 150 mg + carbidopa anhydrous 37.5 mg + entacapone 200 mg tablet, 100	100@ 182.77	NV
9292C	levodopa 200 mg + carbidopa anhydrous 50 mg + entacapone 200 mg tablet, 100	100@ 196.60	NV
8970D	levodopa 20 mg/mL + carbidopa monohydrate 5 mg/mL gel: intestinal, 7 x 100 mL bags	7@ 1459.49	VE
8797B	levodopa 50 mg + carbidopa anhydrous 12.5 mg + entacapone 200 mg tablet, 100	100@ 152.73	NV
9344T	levodopa 75 mg + carbidopa anhydrous 18.75 mg + entacapone 200 mg tablet, 100	100@ 159.35	NV
8290H	lithium carbonate 450 mg tablet: modified release, 100 tablets	100@ 13.94	AS
8203R	losartan potassium 50 mg tablet, 30	30@ 8.99	AF
10112F	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	1@ 9.42	NE
10126Y		1@ 9.42	NE
10127B		1@ 9.42	NE
5389P	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	1@ 14.13	AE, GN, HM, NE, QA, TX
5390Q		1@ 14.13	AE, GN, HM, NE, QA, TX
2351R	macrogol-3350 1 g/g oral liquid: powder for, 30 x 17 g sachets	1@ 14.13	ON
2353W		1@ 14.13	ON
5426N	macrogol-3350 1 g/g oral liquid: powder for, 510 g	1@ 14.13	KY
5427P		1@ 14.13	KY
1598D	mercaptopurine 50 mg tablet, 25	25@ 65.09	AS
8753Q	mesalazine 1 g/100 mL enema, 7 x 100 mL	1@ 82.45	FP
8768L	mesalazine 1 g/application enema, 14 applications	1@ 82.45	OA
3413P	mesalazine 1 g tablet: modified release, 60 tablets	60@ 162.13	FP
8616L	mesalazine 2 g/60 mL enema, 7 x 60 mL	1@ 82.45	OA
8617M	mesalazine 4 g/60 mL enema, 7 x 60 mL	1@ 109.87	OA
8598M	mesalazine 500 mg granules, 100 x 500 mg sachets	100@ 145.51	OA
8731M	mesalazine 500 mg tablet: enteric, 100 tablets	100@ 145.51	OA
2214M	mesalazine 500 mg tablet: modified release, 100 tablets	100@ 145.51	FP
1818Q	METHOTREXATE Injection 50 mg in 2 mL, 1	1@ 3.00	GN
5423K	methylxanthine bromide 12 mg/0.6 mL injection, 1 x 0.6 mL vial	1@ 41.39	LM
2277W	metronidazole 500 mg/100 mL (0.5%) injection, 5 x 100 mL bags	5@ 6.24	AE
2298Y		5@ 6.24	AE
8282X	milk powder lactose free formula oral liquid: powder for, 900 g	1@ 21.29	AS

(APPLY WASTAGE FACTOR IN CALCULATING BROKEN QUANTITY PRICES)

Code	Name, Form/Strength	Pack and Price	Manufacturer
8283Y		1@ 21.29	AS
2975N	milk powder lactose free formula predigested oral liquid: powder for, 900 g	1@ 17.80	NU
2989H		1@ 17.80	NU
2357C	milk powder lactose modified predigested oral liquid: powder for, 900 g	1@ 22.13	SJ
2358D		1@ 22.13	SJ
3092R	milk powder synthetic low calcium oral liquid: powder for, 400 g	1@ 46.87	SB
8630F	milk protein and fat formula with vitamins and minerals carbohydrate free oral liquid: powder for, 225 g	1@ 26.75	SB
8816B	modafinil 100 mg tablet, 60	60@ 170.28	CS
1836P	mycophenolate Capsule 250 mg, 50	50@ 51.75	AF
8649F	mycophenolate mofetil 250 mg capsule, 100	100@ 103.50	CR, RO, SZ, TX
8650G	mycophenolate mofetil 500 mg tablet, 50	50@ 103.49	AF, CR, RO, SZ, TX
2192J	naloxone hydrochloride 400 microgram/mL injection, 1 x 1 mL syringe	1@ 19.68	UC
2196N		1@ 19.68	UC
1674D	naproxen 250 mg tablet, 50	50@ 3.46	AF
1674D	naproxen 250 mg tablet, 50	50@ 4.58	RO
5176K		50@ 3.46	AF
5176K		50@ 4.58	RO
5345H		50@ 4.58	RO
5345H		50@ 3.46	AF
5349M		50@ 4.58	RO
5349M		50@ 3.46	AF
8298R	naratriptan 2.5 mg tablet, 2	2@ 11.13	AS
9734H		2@ 11.13	AS
9316H	nebivolol 1.25 mg tablet, 28	28@ 22.10	FK
2732T	nitrazepam 5 mg tablet, 25	25@ 2.83	IA
2732T	nitrazepam 5 mg tablet, 25	25@ 1.59	AF
5359C		25@ 2.83	IA
5359C		25@ 1.59	AF
5360D		25@ 1.59	AF
5360D		25@ 2.83	IA
1698J	nystatin 100 000 international units/g cream, 15 g	1@ 6.07	FM
5567B	ofloxacin 0.3% (3 mg/mL) eye drops, 5 mL	1@ 14.44	AG
8383F		1@ 14.44	AG
9294E	olanzapine 210 mg injection: modified release [1 x 210 mg vial] (&) inert substance diluent [1 x 3 mL vial], 1 pack	1@ 246.68	LY
9295F	olanzapine 300 mg injection: modified release [1 x 300 mg vial] (&) inert substance diluent [1 x 3 mL vial], 1 pack	1@ 401.42	LY
3134Y	oxazepam 15 mg tablet, 25	25@ 3.92	QA
3134Y	oxazepam 15 mg tablet, 25	25@ 1.24	AF
5371Q		25@ 1.24	AF
5371Q		25@ 3.92	QA
5373T		25@ 3.92	QA
5373T		25@ 1.24	AF
3135B	oxazepam 30 mg tablet, 25	25@ 1.24	AF, FM, TX
3135B	oxazepam 30 mg tablet, 25	25@ 3.92	QA
5372R		25@ 1.24	AF, FM, TX
5372R		25@ 3.92	QA
5374W		25@ 3.92	QA
5374W		25@ 1.24	AF, FM, TX
8588B	oxcarbazepine 60 mg/mL oral liquid, 250 mL	1@ 65.85	NV
8461H	pamidronate disodium 15 mg/5 mL injection, 1 x 5 mL vial	1@ 23.85	HH
8462J	pamidronate disodium 30 mg/10 mL injection, 1 x 10 mL vial	1@ 47.70	HH
8020D	pancreatic extract 10 000 international units capsule: modified release, 100 capsules	100@ 35.45	AB
9226N		100@ 35.45	AB
8021E	pancreatic extract 25 000 international units capsule: modified release, 100 capsules	100@ 70.66	AB
9227P		100@ 70.66	AB
9412J	pancreatic extract 40 000 international units capsule: modified release, 100 capsules	100@ 111.77	AB
9413K		100@ 111.77	AB
5453B	pancreatic extract 5000 international units/100 mg granules: enteric-coated, 20 g	1@ 45.12	AB

(APPLY WASTAGE FACTOR IN CALCULATING BROKEN QUANTITY PRICES)

Code	Name, Form/Strength	Pack and Price	Manufacturer
5454C		1@ 45.12	AB
8366H	pancrelipase 25 000 units capsule, 100	100@ 65.74	TM
9229R		100@ 65.74	TM
5319Y	paracetamol 500 mg suppository, 24	1@ 19.51	GC
5320B		1@ 19.51	GC
5224Y	paracetamol 500 mg tablet, 100	100@ 1.90	AF, FM, GN, GQ, SW, SZ, TX
8784H		100@ 1.90	AF, FM, GN, GQ, SW, SZ, TX
5343F	paracetamol 665 mg tablet: modified release, 96 tablets	96@ 4.29	CH, CR, IB, TW, TX
5343F	paracetamol 665 mg tablet: modified release, 96 tablets	96@ 5.11	GC
5344G		96@ 4.29	CH, CR, IB, TW, TX
5344G		96@ 5.11	GC
8814X		96@ 4.29	CH, CR, IB, TW, TX
8814X		96@ 5.11	GC
2167C	paraffin + retinyl palmitate 138 microgram/g (equivalent to 250 units/g vitamin A) eye ointment, 5 g	1@ 7.41	AE
2202X		1@ 7.41	AE
2222Y		1@ 7.41	AE
1754H	paraffin 1 g/g eye ointment, 3.5 g	1@ 8.68	AQ
1754H	paraffin 1 g/g eye ointment, 3.5 g	1@ 7.41	IQ
5523Q		1@ 8.68	AQ
5523Q		1@ 7.41	IQ
9217D		1@ 7.41	IQ
9217D		1@ 8.68	AQ
10157N	perampanel 2 mg tablet, 7	7@ 22.94	EI
1166J	phenoxybenzamine hydrochloride 10 mg capsule, 30	1@ 66.16	GH
5024K	phenoxymethylpenicillin 125 mg/5 mL oral liquid: powder for, 100 mL	1@ 3.88	AE
8976K		1@ 3.88	AE
5012T	phenoxymethylpenicillin 150 mg/5 mL oral liquid, 100 mL	1@ 8.54	QA
5012T	phenoxymethylpenicillin 150 mg/5 mL oral liquid, 100 mL	1@ 7.59	FM
9143F		1@ 8.54	QA
9143F		1@ 7.59	FM
5029Q	phenoxymethylpenicillin 250 mg/5 mL oral liquid: powder for, 100 mL	1@ 5.16	AE
8977L		1@ 5.16	AE
1703P	phenoxymethylpenicillin 250 mg tablet, 25	25@ 2.45	QA
1787C		25@ 2.45	QA
3360W		25@ 2.45	QA
3028J	phenoxymethylpenicillin 500 mg tablet, 25	25@ 3.62	QA
3361X		25@ 3.62	QA
9384X	phenylalanine with carbohydrate containing 50 mg phenylalanine oral liquid: powder for, 30 x 4 g sachets	1@ 127.40	VF
5532E	polyethylene glycol-400 0.4% + propylene glycol 0.3% eye drops, 28 x 0.8 mL unit doses	1@ 13.83	AQ
9170P		1@ 13.83	AQ
9475Q	polylactic acid 150 mg injection, 1 x 150 mg vial	1@ 220.02	SW
9476R		1@ 220.02	SW
2642C	potassium chloride 600 mg (8 mmol potassium) tablet: modified release, 100 tablets	100@ 3.23	NM
2642C	potassium chloride 600 mg (8 mmol potassium) tablet: modified release, 100 tablets	100@ 4.70	NV
1920C	prednisolone (as sodium phosphate) 20 mg/100 mL enema, 7 x 100 mL	7@ 51.23	QA
2554K	prednisolone (as sodium phosphate) 5 mg suppository, 10	1@ 11.76	QA
1948M	promethazine hydrochloride 50 mg/2 mL injection, 5 x 2 mL ampoules	5@ 11.91	HH
3374N		5@ 11.91	HH
1953T	propantheline bromide 15 mg tablet, 100	100@ 10.02	QA
1955X	propylthiouracil 50 mg tablet, 100	100@ 21.61	PL
2676W	protein hydrolysate formula with medium chain triglycerides oral liquid: powder for, 400 g	1@ 20.69	NT
8259Q	protein hydrolysate formula with medium chain triglycerides oral liquid: powder for, 450 g	1@ 12.93	NU
2608G	pyridostigmine bromide 180 mg tablet: modified release, 50 tablets	50@ 71.40	IA
2724J	PYRIDOSTIGMINE BROMIDE Tablet 10 mg, 50	50@ 8.29	IA
8162N	ranitidine 150 mg/10 mL oral liquid, 300 mL	1@ 9.05	AS
1937Y	ranitidine 150 mg tablet: effervescent, 30	30@ 3.25	AS

(APPLY WASTAGE FACTOR IN CALCULATING BROKEN QUANTITY PRICES)

Code	Name, Form/Strength	Pack and Price		Manufacturer
8790P	risperidone 1 mg tablet: orally disintegrating, 28	28@	8.59	JC
8792R		28@	8.59	JC
8780D	risperidone 25 mg injection: modified release [1 x 25 mg vial] (&) inert substance diluent [1 x 2 mL syringe], 1 pack	1@	135.34	JC
8794W	risperidone 2 mg tablet: orally disintegrating, 28	28@	17.27	JC
9080X		28@	17.27	JC
8781E	risperidone 37.5 mg injection: modified release [1 x 37.5 mg vial] (&) inert substance diluent [1 x 2 mL syringe], 1 pack	1@	173.51	JC
9075P	risperidone 3 mg tablet: orally disintegrating, 28	28@	24.57	JC
9076Q	risperidone 4 mg tablet: orally disintegrating, 28	28@	32.70	JC
1842Y	risperidone 500 microgram tablet, 20	20@	2.56	JC, TX
1846E		20@	2.56	JC, TX
8788M	risperidone 500 microgram tablet: orally disintegrating, 28	28@	4.30	JC
8870W		28@	4.30	JC
8782F	risperidone 50 mg injection: modified release [1 x 50 mg vial] (&) inert substance diluent [1 x 2 mL syringe], 1 pack	1@	211.28	JC
9313E	rizatriptan 10 mg wafer, 2	2@	9.35	MK
8288F	salbutamol 100 microgram/actuation inhalation: pressurised, 200	1@	4.86	GK
8288F	salbutamol 100 microgram/actuation inhalation: pressurised, 200	1@	3.69	AL, TX
2000G	salbutamol 2.5 mg/2.5 mL inhalation: solution, 30 x 2.5 mL ampoules	1@	4.60	AF, CR, GN, GX, QA, SZ, TX, UA
2000G	salbutamol 2.5 mg/2.5 mL inhalation: solution, 30 x 2.5 mL ampoules	1@	5.20	GK
10143W	salbutamol 200 microgram inhalation: powder for, 128 capsules	128@	6.18	GK
1103C	salbutamol 2 mg/5 mL oral liquid, 150 mL	1@	7.89	GK
2001H	salbutamol 5 mg/2.5 mL inhalation: solution, 30 x 2.5 mL ampoules	1@	4.84	AF, CR, GN, GX, QA, SZ, TX, UA
2001H	salbutamol 5 mg/2.5 mL inhalation: solution, 30 x 2.5 mL ampoules	1@	5.42	GK
8354Q	salbutamol Oral pressurised inhalation in breath actuated device 100 micrograms (base) per dose (200 doses), CFC-free formulation, 1	1@	16.09	IA
2997R	salcatonin 100 international units/mL injection, 5 x 1 mL ampoules	5@	51.57	NV
2995P	salcatonin 50 international units/mL injection, 5 x 1 mL ampoules	5@	33.54	NV
10086W	sapropterin dihydrochloride 100 mg tablet: soluble, 30 tablets	30@	883.33	SG
10087X		30@	883.33	SG
2281C	sodium chloride 0.18% (1.8 g/1000 mL) + glucose 4% (40 g/1000 mL) injection, 1 x 1000 mL bag	1@	3.42	BX
5214K		1@	3.42	BX
2279Y	sodium chloride 0.225% (1.125 g/500 mL) + glucose 3.75% (18.75 g/500 mL) injection, 1 x 500 mL bag	1@	4.47	BX
5215L		1@	4.47	BX
2278X	sodium chloride 0.45% (2.25 g/500 mL) + glucose 2.5% (12.5 g/500 mL) injection, 1 x 500 mL bag	1@	4.47	BX
5216M		1@	4.47	BX
2264E	sodium chloride 0.9% (9 g/1000 mL) injection, 1 x 1000 mL bag	1@	1.69	BX
5212H		1@	1.69	BX
2260Y	sodium chloride 3% (30 g/1000 mL) injection, 1 x 1000 mL bag	1@	2.56	BX
5213J		1@	2.56	BX
2266G	sodium chloride 8.6 g/1000 mL + potassium chloride 300 mg/1000 mL + calcium chloride dihydrate 330 mg/1000 mL injection, 1 x 1000 mL bag	1@	5.90	BX
3199J	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	1@	7.77	BX
9380Q	sorafenib 200 mg tablet, 60	60@	3225.33	BN
2091C	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	1@	12.93	AE, JT
5331N		1@	12.93	AE, JT
5332P		1@	12.93	AE, JT
5545W	soy lecithin 1% (10 mg/mL) + tocopherols 0.002% (20 microgram/mL) + vitamin A palmitate 0.025% (250 microgram/mL) eye spray, 100 actuations	1@	14.82	RB
9448G		1@	14.82	RB
8577K	soy protein and fat formula with vitamins and minerals carbohydrate free oral liquid, 1 x 384 mL can	1@	5.53	AB
2093E	sulfasalazine 500 mg tablet, 100	100@	21.93	PF
9208P		100@	21.93	PF

(APPLY WASTAGE FACTOR IN CALCULATING BROKEN QUANTITY PRICES)

Code	Name, Form/Strength	Pack and Price	Manufacturer
2096H	SULFASALAZINE Tablet 500 mg (enteric coated), 100	100@ 25.16	PF
2096H	SULFASALAZINE Tablet 500 mg (enteric coated), 100	100@ 23.92	FZ
9209Q		100@ 25.16	PF
9209Q		100@ 23.92	FZ
8885P	SUMATRIPTAN Tablet (fast disintegrating) 50 mg (as succinate), 2	2@ 6.01	AS
8144P	SUMATRIPTAN Tablet 50 mg (as succinate), 2	2@ 4.77	AF, AS, CH, QA, SZ, TW, TX
8144P	SUMATRIPTAN Tablet 50 mg (as succinate), 2	2@ 6.01	LN
1880Y	tamoxifen 20 mg tablet, 30	30@ 16.23	AP
2088X	temazepam 10 mg tablet, 25	25@ 0.93	AF, FM, TX
2088X	temazepam 10 mg tablet, 25	25@ 4.93	QA
5375X		25@ 0.93	AF, FM, TX
5375X		25@ 4.93	QA
5376Y		25@ 0.93	AF, FM, TX
5376Y		25@ 4.93	QA
8821G	temozolomide 100 mg capsule, 5	5@ 419.09	AF, EA, GN, MK, ON, QA
9361Q	temozolomide 140 mg capsule, 5	5@ 568.77	AF, EA, GN, MK, ON, QA
10062N	temozolomide 180 mg capsule, 5	5@ 680.65	GN, MK, ON
8820F	temozolomide 20 mg capsule, 5	5@ 101.28	AF, EA, GN, MK, ON, QA
8819E	temozolomide 5 mg capsule, 5	5@ 35.66	AF, EA, GN, MK, ON, QA
9160D	terbinafine hydrochloride 1% cream, 15 g	1@ 15.47	NC
2817G	terbutaline sulfate 500 microgram/actuation inhalation: powder for, 100 actuations	1@ 5.72	AP
2832C	tetracosactrin 1 mg/mL injection: modified release, 1 x 1 mL ampoule	1@ 12.97	NV
8222R	tiagabine 10 mg tablet, 50	50@ 66.21	OA
8223T	tiagabine 15 mg tablet, 50	50@ 95.24	OA
8221Q	tiagabine 5 mg tablet, 50	50@ 33.10	OA
10113G	ticarcillin 3 g + clavulanic acid 100 mg injection, 1 x 3.1 g vial	1@ 15.70	AS
10125X		1@ 15.70	AS
1356J	tobramycin 80 mg/2 mL injection, 5 x 2 mL vials	5@ 29.30	HH
8872Y	tobramycin Injection 80 mg (base) in 2 mL (without preservative), 5	5@ 29.30	PF
2117K	triamcinolone acetonide 0.02% (200 microgram/g) cream, 100 g	1@ 3.99	FM
2117K	triamcinolone acetonide 0.02% (200 microgram/g) cream, 100 g	1@ 5.88	QA
2118L	triamcinolone acetonide 0.02% (200 microgram/g) ointment, 100 g	1@ 3.99	FM
2118L	triamcinolone acetonide 0.02% (200 microgram/g) ointment, 100 g	1@ 5.88	QA
10037G	triglycerides long chain oral liquid, 18 x 250 mL cartons	1@ 146.70	VF
9308X	triglycerides long chain with glucose polymer oral liquid, 18 x 250 mL cans	1@ 55.56	VF
10189G	triglycerides long chain with glucose polymer oral liquid, 27 x 200 mL cartons	1@ 92.71	SB
9309Y	triglycerides long chain with glucose polymer oral liquid, 6 x 1000 mL bottles	1@ 74.40	VF
3136C	triglycerides medium chain and long chain with glucose polymer oral liquid: powder for, 400 g	1@ 36.14	SB
9383W	triglycerides medium chain formula oral liquid: powder for, 30 x 16 g sachets	1@ 61.80	VF
10152H	triglycerides medium chain formula oral liquid: powder for, 400 g	1@ 51.86	SB
10154K		1@ 50.63	NT
10155L		1@ 54.55	VF
1938B		1@ 54.55	VF
8478F		1@ 51.86	SB
3128P	triglycerides medium chain oil: oral, 500 mL	1@ 22.98	SB
10049X	triglycerides medium chain oral liquid, 18 x 250 mL cartons	1@ 188.55	VF
9327X	triglycerides medium chain oral liquid, 1 x 250 mL bottle	1@ 26.00	SB
2666H	trimethoprim 300 mg tablet, 7	7@ 3.85	QA
2666H	trimethoprim 300 mg tablet, 7	7@ 1.96	AF
9165J	tyrosine with carbohydrate containing 1 g tyrosine oral liquid: powder for, 30 x 4 g sachets	1@ 127.40	VF
8448P	ursodeoxycholic acid 250 mg capsule, 100	100@ 183.09	OA
8133C	valaciclovir 500 mg tablet, 10	10@ 21.88	AF, AS, CH, EA, GN, QA, SZ, TW, TX, UA,

(APPLY WASTAGE FACTOR IN CALCULATING BROKEN QUANTITY PRICES)

Code	Name, Form/Strength	Pack and Price		Manufacturer
9434M	valine with carbohydrate containing 1 g valine oral liquid: powder for, 30 x 4 g sachets	1@	140.14	VN VF
9135T	valine with carbohydrate containing 50 mg valine oral liquid: powder for, 30 x 4 g sachets	1@	127.40	VF
2294R	valproate sodium 100 mg tablet, 100	100@	12.79	SW
2293Q	valproate sodium 200 mg/5 mL oral liquid, 300 mL	1@	16.08	SW
2295T		1@	16.08	SW
2289L	valproate sodium 200 mg tablet: enteric, 100	100@	9.35	AF, QA, SZ, WA
2289L	valproate sodium 200 mg tablet: enteric, 100	100@	10.35	SW
2290M	valproate sodium 500 mg tablet: enteric, 100	100@	18.33	AF, QA, SZ, WA
2290M	valproate sodium 500 mg tablet: enteric, 100	100@	19.33	SW
3113W	vancomycin 125 mg capsule, 20	20@	112.92	AS
2270L	vancomycin 1 g injection, 1 x 1 g vial	1@	4.00	AF, GN, HH, SZ
3114X	vancomycin 250 mg capsule, 20	20@	216.81	AS
3130R	vancomycin 500 mg injection, 1 x 500 mg vial	1@	1.99	AF, AS, HH, SZ
3131T		1@	1.99	AF, AS, HH, SZ
3323X		1@	1.99	AF, AS, HH, SZ
9129L	varenicline 1 mg tablet, 56	56@	112.64	PF
9009E	vinorelbine 20 mg capsule, 1	1@	78.64	FB
9010F	vinorelbine 30 mg capsule, 1	1@	117.55	FB
9328Y	vitamins, minerals and trace elements with carbohydrate oral liquid: powder for, 200 g	1@	64.00	SB
9382T	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	1@	164.35	VF
2870C	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	1@	394.46	VF
8587Y	whey protein formula supplemented with amino acids, vitamins and minerals, and low in protein, phosphate, potassium and lactose oral liquid: powder for, 400 g	1@	66.22	SB
8266C	zolmitriptan 2.5 mg tablet, 2	2@	11.09	AP
8266C	zolmitriptan 2.5 mg tablet, 2	2@	9.71	QA, TX
9390F	zonisamide 100 mg capsule, 56	56@	43.52	SA

Section 4

Drug Tariff

Container Prices

Standard Formulae Preparations

**Table of Codes, Maximum Quantities, and Number of
Repeats for Extemporaneously Prepared
Pharmaceutical Benefits**

Drug Tariff

Drug	Standard	Recovery Prices			
		0.1 g/mL	1 g/mL	10 g/mL	100 g/mL
		\$	\$	\$	\$
Acacia Mucilage (by weight)	APF 15	0.01	0.09	0.70	6.21
Acacia, powdered	BP	0.02	0.16	1.25	11.07
Acetic Acid (6 per cent)	BP	0.01	0.02	0.14	1.23
Acetic Acid (33 per cent)	BP	0.01	0.06	0.46	4.08
Acetone (use as additive only)	BP	0.02	0.15	1.23	10.95
Alum	BP	0.01	0.07	0.57	5.07
Aluminium Acetate Solution	BP	0.02	0.16	1.29	11.48
Anise Water Concentrated 1 in 40 (use as additive only)	BP	0.01	0.07	0.55	4.91
Aqueous Cream (for use only as a base combined with active ingredients)	APF	0.01	0.02	0.19	1.66
Ascorbic Acid (for use only as an ingredient of ferrous sulfate mixtures)	BP	0.24	1.89	15.08	134.04
Aspirin	BP	0.07	0.58	4.66	41.40
Belladonna Tincture	BP	0.09	0.72	5.72	50.83
Benzocaine	BP	0.07	0.57	4.57	40.60
Benzoic Acid	BP	0.06	0.44	3.49	30.98
Benzoic Acid Compound Ointment	APF	0.02	0.12	0.99	8.81
Benzoic Acid Solution	BP	0.02	0.12	0.94	8.33
Benzoin Compound Tincture	BP	0.03	0.25	1.96	17.40
Boric Acid (use as additive only)	BP	0.01	0.11	0.91	8.05
Boric Acid, Olive Oil and Zinc Oxide Ointment	QHF	0.01	0.10	0.77	6.89
Calcium Hydroxide	BP	0.10	0.78	6.22	55.25
Calcium Hydroxide Solution	BP	0.01	0.02	0.15	1.37
Castor Oil (use as additive only)	BP	0.02	0.17	1.34	11.88
Cetomacrogol Aqueous Cream (for use only as a base combined with active ingredients)	APF	0.01	0.04	0.28	2.51
Cetrimide Aqueous Cream (for use only as a base combined with active ingredients)	APF	0.02	0.13	1.04	9.22
Chlorhexidine Acetate (use as additive only)	BP	0.63	5.02	40.16	356.94
Chlorhexidine Aqueous Cream (for use only as a base combined with active ingredients)	APF	0.03	0.21	1.68	14.96
Chloroform (use as additive only)	BP	0.09	0.68	5.42	48.18

Drug	Standard	Recovery Prices			
		0.1 g/mL	1 g/mL	10 g/mL	100 g/mL
		\$	\$	\$	\$
Chloroform Spirit	BP	0.01	0.08	0.64	5.65
Chloroform Water Concentrated 1 in 40	APF 15	0.01	0.10	0.79	7.02
Citric Acid Monohydrate	BP	0.03	0.26	2.08	18.45
Coal Tar	BP	0.23	1.80	14.36	127.60
Coal Tar Solution	BP	0.02	0.13	1.05	9.34
Cocaine Hydrochloride	BP	6.09	48.74	389.90	3465.77
Coconut Oil	BP	0.01	0.10	0.80	7.16
Codeine Linctus	APF	0.01	0.06	0.48	4.26
Codeine Phosphate (may only be prescribed in linctuses, mixtures or mixtures for children)	BP	2.72	21.75	174.00	1546.67
Collodion Flexible	BP	0.18	1.43	11.42	101.50
Dithranol	BP	4.77	38.15	305.20	2712.84
Emulsifying Ointment (for use only as a base combined with active ingredients)	BP	0.01	0.06	0.48	4.27
Ephedrine Hydrochloride (may only be prescribed in nasal instillations)	BP	1.56	12.49	99.90	888.00
Ethanol (90 per cent) (use as additive only)	BP	0.01	0.03	0.27	2.37
Ethanol (96 per cent) (use as additive only)	BP	0.01	0.04	0.29	2.54
Ether Solvent (use as additive only)	BP	0.17	1.34	10.72	95.31
Eucalyptus Oil (use as additive only)	BP	0.02	0.14	1.09	9.65
Ferrous Sulfate	BP	0.16	1.28	10.27	91.25
Formaldehyde Solution	BP	0.12	0.92	7.37	65.55
Gentian Alkaline Mixture	APF	0.01	0.07	0.52	4.63
Glycerol	BP	0.01	0.07	0.59	5.23
Honey Purified (use as additive only)	BP 1993	0.01	0.02	0.17	1.53
Hydroxybenzoate Compound Solution	APF	0.07	0.59	4.72	41.96
Iodine	BP	0.27	2.18	17.40	154.67
Iodine Alcoholic Solution	BP	0.03	0.21	1.69	15.03
Iodine Aqueous Oral Solution	BP	0.04	0.29	2.35	20.88
Kaolin Mixture	BPC 1968	0.01	0.10	0.83	7.37
Kaolin and Opium Mixture	APF 14	0.01	0.09	0.69	6.10
Lactic Acid	BP	0.08	0.64	5.09	45.21
Lavender Spike Oil	BPC 1968	0.11	0.87	6.95	61.75
Liquorice Liquid Extract	BP	0.03	0.25	1.99	17.70
Magnesium Carbonate Light	BP	0.04	0.34	2.74	24.38
Magnesium Sulfate (may only be prescribed for other than oral use)	BP	0.01	0.01	0.11	0.98

Drug	Standard	Recovery Prices			
		0.1 g/mL	1 g/mL	10 g/mL	100 g/mL
		\$	\$	\$	\$
Magnesium Trisilicate	BP	0.04	0.34	2.69	23.95
Menthol, Racemic or Levomenthol	BP	0.26	2.11	16.87	149.94
Methyl Hydroxybenzoate	BP	0.36	2.87	22.94	203.91
Methyl Hydroxybenzoate Solution	APF	0.04	0.30	2.41	21.43
Methylated Industrial Spirit (use as additive only)	BP	0.01	0.04	0.30	2.67
Olive Oil (use as additive only)	BP	0.01	0.10	0.78	6.93
Paraffin Hard	BP	0.04	0.28	2.22	19.76
Paraffin Liquid (may only be prescribed for other than oral use)	BP	0.01	0.03	0.26	2.35
Paraffin Light Liquid	BP	0.02	0.17	1.39	12.38
Paraffin Soft White	BP	0.01	0.04	0.35	3.12
Paraffin Soft Yellow	BP	0.01	0.04	0.35	3.12
Peppermint Oil (use as additive only)	BP	0.14	1.14	9.14	81.21
Peppermint Water Concentrated 1 in 40 (use as additive only)	APF 16	0.04	0.31	2.51	22.35
Phenobarbitone Sodium (may only be prescribed for the treatment of epilepsy)	BP	10.67	85.38	683.00	6071.11
Phenol Liquefied (not available for ear drops)	BP	0.20	1.58	12.67	112.59
Podophyllum Resin	BP	3.50	27.99	223.88	1990.04
Potassium Citrate	BP	0.02	0.18	1.40	12.41
Potassium Iodide	BP	0.11	0.84	6.73	59.80
Potassium Permanganate	BP	0.04	0.32	2.58	22.96
Propyl Hydroxybenzoate	BP	0.28	2.25	17.98	159.82
Propylene Glycol	BP	0.01	0.10	0.80	7.09
Red Syrup	APF 15	0.02	0.13	1.07	9.50
Resorcinol	BP	0.37	2.97	23.76	211.20
Salicylic Acid	BP	0.04	0.29	2.28	20.24
Salicylic Acid Ointment	APF	0.02	0.13	1.01	9.00
Salicylic Acid Ointment	BP	0.02	0.13	1.01	9.00
Simple Ointment (white) (for use only as a base combined with active ingredients)	BP	0.02	0.15	1.16	10.33
Simple Ointment (yellow) (for use only as a base combined with active ingredients)	BP	0.02	0.15	1.16	10.33
Sodium Bicarbonate	BP	0.01	0.09	0.75	6.67
Sodium Chloride	BP	0.02	0.15	1.20	10.64
Sodium Chloride Solution	BP	0.01	0.01	0.08	0.73
Sodium Citrate	BP	0.03	0.25	1.97	17.48

Drug	Standard	Recovery Prices			
		0.1 g/mL	1 g/mL	10 g/mL	100 g/mL
		\$	\$	\$	\$
Sodium Thiosulfate (use as additive only)	BP	0.03	0.24	1.95	17.35
Starch	BP	0.02	0.16	1.27	11.27
Sulfur Ointment (for use only as a base combined with active ingredients)	BP 1980	0.02	0.15	1.20	10.66
Sulfur Precipitated	BP 1980	0.02	0.17	1.35	12.04
Syrup	BP	0.01	0.03	0.23	2.07
Talc Purified, sterilised	BP	0.03	0.27	2.12	18.84
Thymol	BP	0.25	2.03	16.24	144.36
Thymol Compound Mouth Wash	APF 15	0.01	0.10	0.81	7.22
Tragacanth Compound Powder	BP 1980	0.08	0.60	4.76	42.31
Tragacanth Mucilage	APF 13	0.01	0.06	0.44	3.90
Tragacanth Mucilage	BPC 1973	0.01	0.05	0.37	3.32
Tragacanth, powdered	BP	0.25	1.96	15.64	139.05
Trichloroacetic Acid	BP 1980	0.35	2.83	22.63	201.12
Triethanolamine	BP	0.06	0.51	4.08	36.25
Water For Injections, sterilised (b) (extemporaneously prepared eye drops and eye lotions)	BP	—	—	11.37	11.37
Water Purified	BP	0.01	0.01	0.07	0.59
Wool Alcohols Ointment (white) (for use only as a base combined with active ingredients)	BP	0.02	0.15	1.16	10.34
Wool Alcohols Ointment (yellow) (for use only as a base combined with active ingredients)	BP	0.02	0.15	1.16	10.34
Wool Fat	BP	0.02	0.14	1.08	9.58
Wool Fat Hydrous	BP	0.02	0.13	1.05	9.36
Zinc Compound Paste	BP	0.04	0.35	2.81	24.99
Zinc Cream (for use only as a base combined with active ingredients)	BP	0.01	0.08	0.62	5.49
Zinc Oxide	BP	0.02	0.15	1.22	10.81
Zinc and Salicylic Acid Paste	BP	0.02	0.16	1.31	11.62
Zinc Sulfate	BP	0.03	0.25	1.97	17.54

Container Prices

Container Prices	\$
DISPENSING BOTTLES –	
25mL	0.63
50mL	0.58
100mL	0.76
200mL	0.98
500mL	1.34
POISON BOTTLES –	
25mL	0.66
50mL	0.74
100mL	0.77
200mL	1.14
500mL	1.34
SCREW CAP JARS –	
25g	0.97
50g	1.09
100g	1.25
200g	0.89
500g	1.29
DROPPER CONTAINERS –	
15mL polythene	0.89
15mL glass	0.86
Dispensing Fee for Extemporaneously Prepared Benefits	8.80
Additional Fee for Agreed PriceExtemporaneously Prepared Benefits	1.50

Standard Formula Preparations

The following list is not intended to indicate in any way which particular formula an approved pharmacist should use in filling a prescription.

The prices shown in the column 'Dispensed Price for Max. Qty' are for the ingredients, the container and the dispensing fee. The prices shown in the column 'Maximum Recordable Value for Safety Net' are for the ingredients, the container and the dispensing fee and, where applicable, the additional fee for agreed price benefits.

KEY TO REFERENCES:

APF	Australian Pharmaceutical Formulary
BP	British Pharmacopoeia
BPC	British Pharmaceutical Codex
QHF	Queensland Hospital Formulary

Code	Item	Reference	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$
	CREAMS (Maximum Quantity 100 g and 1 Repeat)			
7502W	Salicylic Acid and Sulfur Aqueous	APF	12.55	14.05
	DUSTING POWDERS (Maximum Quantity 100 g and 1 Repeat)			
7458M	Zinc, Starch and Talc	APF 15 & BPC 1973	26.50	28.00
	EAR DROPS (Maximum Quantity 15 mL and 2 Repeats)			
7642F	Aluminium Acetate	APF	10.91	12.41
7643G	Aluminium Acetate	BP	11.63	13.13
7314Y	Sodium Bicarbonate	APF & BP	10.16	11.66
7313X	Spirit	APF	9.94	11.44
	INHALATIONS (Maximum Quantity 50 mL and 1 Repeat)			
7484X	Benzoin and Menthol	APF	21.44	22.94
7308P	Menthol	APF	12.99	14.49
7310R	Menthol and Eucalyptus	BP 1980	13.83	15.33
	LINCTUSES CONTAINING CODEINE PHOSPHATE (Maximum Quantity 100 mL and 0 Repeats)			
7530H	Codeine	APF	13.82	15.32
	LOTIONS (Maximum Quantity 200 mL and 2 Repeats)			
7709R	Aluminium Acetate Aqueous	APF	12.35	13.85
	MIXTURES, OTHER (Maximum Quantity 200 mL and 4 Repeats)			
7604F	Gentian Alkaline	APF	19.05	20.55
7348R	Kaolin	BPC 1968	24.52	26.02
7301G	Kaolin and Opium	APF 14	21.97	23.47
7342K	Magnesium Trisilicate	BPC 1968	18.68	20.18
7343L	Magnesium Trisilicate and Belladonna	BPC 1968	24.26	25.76

Code	Item	Reference	Dispensed Price for Max. Qty	Maximum Recordable Value for Safety Net
			\$	\$
	MOUTH WASHES (Maximum Quantity 200 mL and 1 Repeat)			
7457L	Thymol Compound	APF 15	24.39	25.89
	OINTMENTS (Maximum Quantity 100 g and 1 Repeat)			
7914M	Benzoic Acid Compound	APF & BP	18.86	20.36
7902X	Boric Acid, Olive Oil and Zinc Oxide	QHF	16.94	18.44
7926E	Salicylic Acid	APF	19.05	20.55
7928G	Salicylic Acid (extemporaneous formula)	BP	19.05	20.55
	PAINTS (Maximum Quantity 25 mL and 1 Repeat)			
7567G	Podophyllin Compound	APF 16 & BP	119.29	36.90
7568H	Salicylic Acid	APF	38.72	36.90
	PASTES, OTHER (Maximum Quantity 100 g and 1 Repeat)			
7558T	Zinc	APF & BP	35.04	36.54
	POWDER FOR INTERNAL USE (Maximum Quantity 100 g and 2 Repeats)			
7545D	Magnesium Trisilicate	BP	33.64	35.14

—CONTAINER RATES ARE INCLUDED—

**Table of Codes, Maximum Quantities, and Number of Repeats
for Extemporaneously Prepared Benefits**

Code	Preparation	Maximum Quantity	Number of Repeats
13Q	Creams	100 g	1
48M	Dusting Powders	100 g	1
15T	Ear Drops	15 mL	2
19B	Eye Drops containing Cocaine Hydrochloride	15 mL	..
22E	Eye Drops, Other	15 mL	5
23F	Eye Lotions	200 mL	2
29M	Inhalations	50 mL	1
64J	Linctuses containing Codeine Phosphate	100 mL	..
34T	Linctuses, Other	100 mL	2
39C	Lotions	200 mL	2
65K	Mixtures containing Codeine Phosphate	200 mL	..
40D	Mixtures, Other	200 mL	4
66L	Mixtures for Children containing Codeine Phosphate	100 mL	..
41E	Mixtures for Children, Other	100 mL	4
30N	Mouth Washes	200 mL	1
42F	Nasal Instillations	15 mL	2
43G	Ointments, Waxes	100 g	1
44H	Paints	25 mL	1
63H	Pastes containing Cocaine Hydrochloride	25 g	..
45J	Pastes, Other	100 g	1
49N	Powders for Internal Use	100 g	2
52R	Solutions	200 mL	2

Special Note: Purified Water BP is the minimum requirement for water in all PBS extemporaneous preparations.



Australian Government

Department of Health

REPATRIATION SCHEDULE OF PHARMACEUTICAL BENEFITS

1 December 2014

The benefits listed in this Schedule may only be prescribed to Department of Veterans' Affairs beneficiaries holding a:

- Repatriation Health Card For All Conditions (gold); or
- Repatriation Health Card For Specific Conditions (white); or
- Repatriation Pharmaceutical Benefits Card (orange);

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.	 The image shows a sample Gold Repatriation Health Card. It is a gold-colored card with the Australian Government coat of arms and the text 'Australian Government Department of Veterans' Affairs' at the top. The main title is 'Repatriation Health Card For All Conditions Within Australia'. A large red 'SAMPLE' watermark is diagonally across the center. Below the watermark, it says 'File No.' and 'Card expires or on recall'.
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.	 The image shows a sample White Repatriation Health Card. It is a white card with the Australian Government coat of arms and the text 'Australian Government Department of Veterans' Affairs' at the top. The main title is 'Repatriation Health Card - For Specific Conditions'. A large red 'SAMPLE' watermark is diagonally across the center. Below the watermark, it says 'File No.' and 'Card expires or on recall'.
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.	 The image shows a sample Orange Repatriation Pharmaceutical Benefits Card. It is an orange card with the Australian Government coat of arms and the text 'Australian Government Department of Veterans' Affairs' at the top. The main title is 'Repatriation Pharmaceutical Benefits Card'. A large red 'SAMPLE' watermark is diagonally across the center. Below the watermark, it says 'File No.' and 'Card expires or on recall'. At the bottom left, it says 'PHARMACEUTICALS ONLY'.

For more information go to the Department of Veterans' Affairs website:
http://www.dva.gov.au/service_providers/treatment_cards/Pages/index.aspx

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. The Department of Human Services 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:
 - a Gold Repatriation Health Card – For All Conditions; or
 - a White Repatriation Health Card – For Specific Conditions; or
 - an Orange Repatriation Pharmaceutical Benefits Card.
- Where possible the LDO shall prescribe in accordance with the provisions governing dental prescribing under the Pharmaceutical Benefits Scheme (PBS).
- 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 patients 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. The Department of Human Services 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 the Department of Human Services. 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".

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.

SUMMARY OF CHANGES

Repatriation Pharmaceutical Benefits

Additions

Addition – Item

- 10169F **CLOPIDOGREL**, clopidogrel 75 mg tablet, 28 (*Clopidogrel GH*)
 10177P **DOCUSATE + SENNOSIDE B**, docusate sodium 50 mg + sennoside B 8 mg tablet, 90 (*Pharmacy Action Laxative with Senna*)
 10186D **PARACETAMOL + CODEINE**, paracetamol 500 mg + codeine phosphate hemihydrate 15 mg tablet, 20 (*Pharmacy Action Paracetamol Plus Codeine*)

Addition – Brand

- 2224C *Alendronate plus D3-DRLA, RZ* – **ALENDRONATE + COLECALCIFEROL**, alendronate 70 mg + colecalciferol 140 microgram tablet, 4
 4077N *Pharmacy Action Low Dose Aspirin, GQ* – **ASPIRIN**, aspirin 100 mg tablet: enteric, 84
 4094L *Cal-500, PP* – **CALCIUM**, CALCIUM Tablet (chewable) 500 mg (as carbonate), 60
 4333C *Cal-500, PP* – **CALCIUM**, CALCIUM Tablet (chewable) 500 mg (as carbonate), 60
 4175R *Pharmacy Action Cetrelief, GQ* – **CETIRIZINE**, cetirizine hydrochloride 10 mg tablet, 30
 4004R *Pharmacy Action Anti-Fungal Cream, GQ* – **CLOTRIMAZOLE**, clotrimazole 1% (10 mg/g) cream, 20 g
 4016J *Pharmacy Action FemCream, GQ* – **CLOTRIMAZOLE**, clotrimazole 1% (10 mg/g) cream, 35 g
 4233T *Finasteride GH 5, GQ* – **FINASTERIDE**, finasteride 5 mg tablet, 30
 4233T *Finnacar, QA* – **FINASTERIDE**, finasteride 5 mg tablet, 30
 4313B *Pharmacy Action Lorastyne, GQ* – **LORATADINE**, loratadine 10 mg tablet, 30
 4029C *Pharmacy Action Sinus & Nasal Decongestant Relief, GQ* – **PSEUDOEPHEDRINE**, pseudoephedrine hydrochloride 60 mg tablet, 12
 4584G *Vasafil 25, QA* – **SILDENAFIL**, sildenafil 25 mg tablet, 4
 4585H *Vasafil 50, QA* – **SILDENAFIL**, sildenafil 50 mg tablet, 4
 4586J *Silaran, RA* – **SILDENAFIL**, sildenafil 100 mg tablet, 4
 4586J *Sildenafil GH, GQ* – **SILDENAFIL**, sildenafil 100 mg tablet, 4
 4586J *Vasafil 100, QA* – **SILDENAFIL**, sildenafil 100 mg tablet, 4
 4011D *Terbinafine GH, GQ* – **TERBINAFINE**, terbinafine 250 mg tablet, 42

Addition – Equivalence Indicator

- 2224C *Fosamax Plus 70 mg/140 mcg, MK* – **ALENDRONATE + COLECALCIFEROL**, alendronate 70 mg + colecalciferol 140 microgram tablet, 4
 4077N *Cartia, AS* – **ASPIRIN**, aspirin 100 mg tablet: enteric, 84
 4004R *Clonea, AF* – **CLOTRIMAZOLE**, clotrimazole 1% (10 mg/g) cream, 20 g
 4016J *APO-Clotrimazole 6 Day Cream, TX* – **CLOTRIMAZOLE**, clotrimazole 1% (10 mg/g) cream, 35 g
 4029C *Logicin Sinus, QA* – **PSEUDOEPHEDRINE**, pseudoephedrine hydrochloride 60 mg tablet, 12

Addition – Note

- 4179Y **CLOPIDOGREL**, clopidogrel 75 mg tablet, 28 (*APO-Clopidogrel, Chem mart Clopidogrel, Iscover, Piax, Plavix, Terry White Chemists Clopidogrel*)

Alterations

Alteration – Restriction

- 4179Y **CLOPIDOGREL**, clopidogrel 75 mg tablet, 28 (*APO-Clopidogrel, Chem mart Clopidogrel, Iscover, Piax, Plavix, Terry White Chemists Clopidogrel*)

Alteration – Manufacturer Code

		From	To
4568K	<i>Aquae</i> – CARMELLOSE SODIUM , carmellose sodium 10 mg/mL oral spray, 25 mL	VT	IA
4569L	<i>Aquae</i> – CARMELLOSE SODIUM , carmellose sodium 10 mg/mL oral spray, 100 mL	VT	IA

Deletions

Deletion – Brand

- 4011D *Terbinafine-DP, GN* – **Terbinafine**, terbinafine 250 mg tablet, 42

Therapeutic Index for RPBS

ALIMENTARY TRACT AND METABOLISM	1197
STOMATOLOGICAL PREPARATIONS	1197
STOMATOLOGICAL PREPARATIONS	1197
DRUGS FOR ACID RELATED DISORDERS	1197
ANTACIDS	1197
DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS	1197
DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS	1197
BELLADONNA AND DERIVATIVES, PLAIN	1197
DRUGS FOR CONSTIPATION	1197
DRUGS FOR CONSTIPATION	1197
ANTIOBESITY PREPARATIONS, EXCL. DIET PRODUCTS	1198
ANTIOBESITY PREPARATIONS, EXCL. DIET PRODUCTS	1198
VITAMINS	1199
VITAMIN B1, PLAIN AND IN COMBINATION WITH VITAMIN B6 AND B12	1199
VITAMIN B-COMPLEX, INCL. COMBINATIONS	1199
MINERAL SUPPLEMENTS	1199
CALCIUM	1199
OTHER MINERAL SUPPLEMENTS	1200
BLOOD AND BLOOD FORMING ORGANS	1201
ANTITHROMBOTIC AGENTS	1201
ANTITHROMBOTIC AGENTS	1201
BLOOD SUBSTITUTES AND PERFUSION SOLUTIONS	1201
IRRIGATING SOLUTIONS	1201
CARDIOVASCULAR SYSTEM	1202
VASOPROTECTIVES	1202
AGENTS FOR TREATMENT OF HEMORRHOIDS AND ANAL FISSURES FOR TOPICAL USE	1202
DERMATOLOGICALS	1203
ANTIFUNGALS FOR DERMATOLOGICAL USE	1203
ANTIFUNGALS FOR TOPICAL USE	1203
ANTIFUNGALS FOR SYSTEMIC USE	1203
EMOLLIENTS AND PROTECTIVES	1204
EMOLLIENTS AND PROTECTIVES	1204
PROTECTIVES AGAINST UV-RADIATION	1204
ANTIPRURITICS, INCL. ANTIHISTAMINES, ANESTHETICS, ETC.	1205
ANTIPRURITICS, INCL. ANTIHISTAMINES, ANESTHETICS, ETC.	1205
ANTIPSORIATICS	1205
ANTIPSORIATICS FOR TOPICAL USE	1205
ANTIBIOTICS AND CHEMOTHERAPEUTICS FOR DERMATOLOGICAL USE	1205
ANTIBIOTICS FOR TOPICAL USE	1205
CHEMOTHERAPEUTICS FOR TOPICAL USE	1205
CORTICOSTEROIDS, DERMATOLOGICAL PREPARATIONS	1206
CORTICOSTEROIDS, PLAIN	1206
ANTISEPTICS AND DISINFECTANTS	1206
ANTISEPTICS AND DISINFECTANTS	1206
OTHER DERMATOLOGICAL PREPARATIONS	1206
OTHER DERMATOLOGICAL PREPARATIONS	1206
GENITO URINARY SYSTEM AND SEX HORMONES	1209
GYNECOLOGICAL ANTIINFECTIVES AND ANTISEPTICS	1209
ANTIINFECTIVES AND ANTISEPTICS, EXCL. COMBINATIONS WITH CORTICOSTEROIDS	1209
OTHER GYNECOLOGICALS	1209
OTHER GYNECOLOGICALS	1209
UROLOGICALS	1209
UROLOGICALS	1209
DRUGS USED IN BENIGN PROSTATIC HYPERTROPHY	1210
ANTIINFECTIVES FOR SYSTEMIC USE	1212
ANTIBACTERIALS FOR SYSTEMIC USE	1212

MACROLIDES, LINCOSAMIDES AND STREPTOGRAMINS	1212
ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	1213
ANTINEOPLASTIC AGENTS	1213
ANTIMETABOLITES.....	1213
IMMUNOSUPPRESSANTS.....	1213
IMMUNOSUPPRESSANTS.....	1213
MUSCULO-SKELETAL SYSTEM.....	1214
ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS	1214
ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS, NON-STERIODS.....	1214
TOPICAL PRODUCTS FOR JOINT AND MUSCULAR PAIN.....	1214
TOPICAL PRODUCTS FOR JOINT AND MUSCULAR PAIN	1214
DRUGS FOR TREATMENT OF BONE DISEASES.....	1214
DRUGS AFFECTING BONE STRUCTURE AND MINERALIZATION	1214
NERVOUS SYSTEM.....	1216
ANALGESICS.....	1216
OPIOIDS	1216
OTHER ANALGESICS AND ANTIPYRETICS	1216
PSYCHOLEPTICS	1217
ANXIOLYTICS.....	1217
HYPNOTICS AND SEDATIVES	1217
OTHER NERVOUS SYSTEM DRUGS	1218
DRUGS USED IN ADDICTIVE DISORDERS	1218
ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS.....	1219
ANTHELMINTICS	1219
ANTINEMATODAL AGENTS	1219
RESPIRATORY SYSTEM.....	1220
NASAL PREPARATIONS.....	1220
DECONGESTANTS AND OTHER NASAL PREPARATIONS FOR TOPICAL USE	1220
NASAL DECONGESTANTS FOR SYSTEMIC USE.....	1220
COUGH AND COLD PREPARATIONS	1220
EXPECTORANTS, EXCL. COMBINATIONS WITH COUGH SUPPRESSANTS.....	1220
COUGH SUPPRESSANTS, EXCL. COMBINATIONS WITH EXPECTORANTS.....	1220
ANTIHISTAMINES FOR SYSTEMIC USE	1221
ANTIHISTAMINES FOR SYSTEMIC USE.....	1221
SENSORY ORGANS.....	1222
OPHTHALMOLOGICALS.....	1222
DECONGESTANTS AND ANTIALLERGICS.....	1222
OTOLOGICALS	1222
OTHER OTOLOGICALS	1222
VARIOUS.....	1223
ALL OTHER THERAPEUTIC PRODUCTS.....	1223
ALL OTHER THERAPEUTIC PRODUCTS.....	1223
ALL OTHER NON-THERAPEUTIC PRODUCTS.....	1226
ALL OTHER NON-THERAPEUTIC PRODUCTS.....	1226

Section 1

Drugs, Medicines and Dressings

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

ALIMENTARY TRACT AND METABOLISM

STOMATOLOGICAL PREPARATIONS

STOMATOLOGICAL PREPARATIONS

Antiinfectives and antiseptics for local oral treatment

CHLORHEXIDINE

4161B	chlorhexidine gluconate 0.2% (2 mg/mL) mouthwash, 250 mL	‡1	..	..	12.23	6.00	Plaqacide	OB
4204G	chlorhexidine gluconate 0.2% (2 mg/mL) mouthwash, 300 mL	‡1	..	..	15.62	6.00	Savacol Mouth and Throat Rinse	OM

Other agents for local oral treatment

CARMELLOSE SODIUM

4569L	carmellose sodium 10 mg/mL oral spray, 100 mL	‡1	..	..	13.49	6.00	Aquae	IA
4568K	carmellose sodium 10 mg/mL oral spray, 25 mL	‡1	1	..	11.64	6.00	Aquae	IA

DRUGS FOR ACID RELATED DISORDERS

ANTACIDS

Calcium compounds

CALCIUM CARBONATE + GLYCINE

Note

For patients with chronic renal failure.

4055K	calcium carbonate 420 mg + glycine 180 mg tablet: chewable, 100	2	5	..	*23.52	6.00	Titralac	MM

Combinations and complexes of aluminium, calcium and magnesium compounds

ALUMINIUM HYDROXIDE WITH MAGNESIUM HYDROXIDE AND SIMETHICONE

4118R	ALUMINIUM HYDROXIDE with MAGNESIUM HYDROXIDE and SIMETHICONE Oral suspension 400 mg-400 mg-30 mg per 5 mL, 500 mL, 1	2	5	..	*22.98	6.00	Mylanta Double Strength	JT
4453J	ALUMINIUM HYDROXIDE with MAGNESIUM HYDROXIDE and SIMETHICONE Tablet 400 mg-400 mg-40 mg, 100	2	5	..	*46.46	6.00	Mylanta Double Strength	JT

DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS

DRUGS FOR FUNCTIONAL GASTROINTESTINAL DISORDERS

Synthetic anticholinergics, esters with tertiary amino group

MEBEVERINE

4328T	mebeverine hydrochloride 135 mg tablet, 90	1	..	..	27.25	6.00	^a Colese	AF
				..	32.43	6.00	^a Colofac	AB

BELLADONNA AND DERIVATIVES, PLAIN

Belladonna alkaloids, semisynthetic, quaternary ammonium compounds

HYOSCINE BUTYLBROMIDE

4279F	hyoscine butylbromide 20 mg/mL injection, 5 x 1 mL ampoules	1	..	..	24.55	6.00	Buscopan	BY

DRUGS FOR CONSTIPATION

DRUGS FOR CONSTIPATION

Softeners, emollients

DOCUSATE

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
4200C	docusate sodium 50 mg tablet, 100	1	2	..	14.65	6.00	Coloxyl 50	FM
Contact laxatives								
DOCUSATE + SENNOSIDE B								
4028B	docusate sodium 50 mg + sennoside B 8 mg tablet, 100	1	2	..	14.75	6.00	Soflax	GN
10177P	docusate sodium 50 mg + sennoside B 8 mg tablet, 90	1	2	..	13.48	6.00	Pharmacy Action Laxative with Senna	GQ
DOCUSATE + SENNOSIDES								
4198Y	docusate sodium 50 mg + sennosides 11.27 mg tablet, 90	1	2	..	13.52	6.00	^a Co-Senna	PP
				..	17.03	6.00	^a Coloxyl with Senna	FM
SENNOSIDE B								
4455L	sennoside B 7.5 mg tablet, 100	1	1	..	12.94	6.00	^a Senna-Gen	PP
				..	14.20	6.00	^a Senokot	RC
Bulk-forming laxatives								
ISPAGHULA HUSK DRY								
4285M	ispaghula husk dry 3.5 g oral liquid: powder for, 30 x 3.5 g sachets	1	1	..	17.98	6.00	Fybogel	RC
PSYLLIUM HUSK POWDER								
4422R	PSYLLIUM HYDROPHILIC MUCILLOID Oral powder (non-flavoured) 336 g, 1	1	1	..	18.36	6.00	Fibre Health Natural Granular	PP
				..	22.01	6.00	Metamucil Natural Granular	PY
4419N	PSYLLIUM HYDROPHILIC MUCILLOID Oral powder (orange-flavoured, sugar-free) 283 g, 1	1	1	..	22.01	6.00	Metamucil Orange Smooth	PY
RHAMNUS FRANGULA + STERCULIA								
4558X	rhamnus frangula 80 mg/g + sterculia 620 mg/g granules, 500 g	1	1	..	26.71	6.00	Normacol Plus	NE
Enemas								
SORBITOL + CITRATE + LAURYL SULFOACETATE SODIUM								
4462W	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	1	..	..	12.44	6.00	Micolette	AE
							Microlax	JT
Other drugs for constipation								
GLYCEROL								
<u>Restricted benefit</u>								
Short-term use when oral laxative therapy has failed or is inappropriate								
4246L	glycerol 2.8 g suppository, 12	3	..	..	*20.74	6.00	Petrus Pharmaceuticals Pty Ltd	PP

ANTIOBESITY PREPARATIONS, EXCL. DIET PRODUCTS

ANTIOBESITY 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).

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
4570M	orlistat 120 mg capsule, 84	1	2	..	140.50	6.00	Xenical	RO

VITAMINS

VITAMIN B1, PLAIN AND IN COMBINATION WITH VITAMIN B6 AND B12

Vitamin B1, plain

THIAMINE

4043T	thiamine hydrochloride 100 mg tablet, 100	1	2	..	10.45	6.00	Betavit	PP

VITAMIN B-COMPLEX, INCL. COMBINATIONS

Vitamin B-complex, plain

CYANOCOBALAMIN + FERRIC PYROPHOSPHATE + LYSINE + PYRIDOXINE + THIAMINE

4493L	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	\$1	2	..	13.68	6.00	Accomin Adult Tonic	PF

MINERAL SUPPLEMENTS

CALCIUM

Calcium

CALCIUM

Restricted benefit

Hyperphosphataemia in chronic renal failure

4094L	CALCIUM Tablet (chewable) 500 mg (as carbonate), 60	4	1	..	*29.24	6.00	^a Cal-500	PP
4142B	CALCIUM Tablet 600 mg (as carbonate), 120	2	1	..	*22.54	6.00	^a Cal-Sup CAL-600	IA PP

CALCIUM

Restricted benefit

Hypocalcaemia

Restricted benefit

Osteoporosis

Restricted benefit

Proven calcium malabsorption

4333C	CALCIUM Tablet (chewable) 500 mg (as	2	1	..	*18.00	6.00	^a Cal-500	PP

ALIMENTARY TRACT AND METABOLISM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer	
					Price for Max. Qty \$	Recordable Value for Safety Net \$		
	carbonate), 60							
4082W	CALCIUM Tablet 600 mg (as carbonate), 120	1	1	..	14.65	6.00	^a Cal-Sup CAL-600	IA PP

OTHER MINERAL SUPPLEMENTS
Magnesium

MAGNESIUM ASPARTATE DIHYDRATE
Restricted benefit

Patients with documented hypomagnesaemia

4321K	magnesium aspartate dihydrate 500 mg (equivalent to 37.4 mg of magnesium) tablet, 50	1	..	..	14.04	6.00	Mag-Sup	PP
				..	14.73	6.00	Magmin	BB

BLOOD AND BLOOD FORMING ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

BLOOD AND BLOOD FORMING ORGANS

ANTITHROMBOTIC AGENTS

ANTITHROMBOTIC AGENTS

Platelet aggregation inhibitors excl. heparin

ASPIRIN

Note

The enteric coated preparations are for patients with a significant risk of gastrointestinal bleeding.

4078P	aspirin 100 mg capsule: enteric, 84	1	1	..	14.96	6.00	Astrix	YN
4077N	aspirin 100 mg tablet: enteric, 84	1	1	..	14.05	6.00	^a Cartia	AS
							^a Pharmacy Action Low Dose Aspirin	GQ
4076M	aspirin 100 mg tablet, 90	1	1	..	16.01	6.00	Cardiprin 100	RC

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.

10169F	clopidogrel 75 mg tablet, 28	1	3	..	19.33	6.00	^a Clopidogrel GH	GQ
4179Y	clopidogrel 75 mg tablet, 28	1	3	..	19.33	6.00	^a APO-Clopidogrel	TX
							^a Chem mart Clopidogrel	CH
							^a Iscover	AV
							^a Piax	AF
							^a Plavix	SW
							^a Terry White Chemists Clopidogrel	TW

BLOOD SUBSTITUTES AND PERFUSION SOLUTIONS

IRRIGATING SOLUTIONS

Salt solutions

SODIUM CHLORIDE

4460R	sodium chloride 0.9% (4.5 g/500 mL) solution, 1 x 500 mL bottle	£1	2	..	10.67	6.00	Baxter Healthcare Pty Ltd	BX
4461T	sodium chloride 0.9% (9 g/1000 mL) solution, 1 x 1000 mL bottle	£1	2	..	10.99	6.00	Baxter Healthcare Pty Ltd	BX

CARDIOVASCULAR SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

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							
4039N	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	\$1	1	..	14.78	6.00	Anusol JT
4040P	zinc oxide 300 mg + peru balsam 50 mg + benzyl benzoate 33 mg suppository, 12	\$1	1	..	13.69	6.00	Anusol JT

DERMATOLOGICALS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

DERMATOLOGICALS

ANTIFUNGALS FOR DERMATOLOGICAL USE

ANTIFUNGALS FOR TOPICAL USE

Antibiotics

NYSTATIN

4001N	nystatin 100 000 international units/g cream, 15 g	‡1	1	..	12.83	6.00	Mycostatin	FM

Imidazole and triazole derivatives

CLOTRIMAZOLE

4004R	clotrimazole 1% (10 mg/g) cream, 20 g	‡1	1	..	8.78	6.00	^a Pharmacy Action Anti-Fungal Cream	GQ
				..	9.18	6.00	^a Clonea	AF

KETOCONAZOLE

Restricted benefit

Severe seborrhoeic dermatitis

4007X	ketoconazole 2% (20 mg/g) shampoo, 100 mL	‡1	..	..	19.71	6.00	Sebizole	GN
4008Y	ketoconazole 2% (20 mg/g) shampoo, 60 mL	‡1	..	..	18.65	6.00	Nizoral 2%	JT

MICONAZOLE

4341L	miconazole 2% solution, 30 mL	‡1	1	..	19.81	6.00	Daktarin Tincture	JT
4454K	miconazole nitrate 2% (20 mg/g) cream, 30 g	‡1	1	..	15.13	6.00	Daktarin	JT
3400Y	miconazole nitrate 2% (20 mg/g) cream, 40 g	‡1	1	..	14.02	6.00	Resolve Thrush	EO

Other antifungals for topical use

AMOROLFINE

Restricted benefit

Onychomycosis

4010C	amorolfine 5% application, 5 mL	‡1	1	..	86.85	6.00	Aporyl	TX
				..	96.48	6.00	Loceryl	GA

CICLOPIROX

Restricted benefit

Severe seborrhoeic dermatitis

4106D	ciclopirox olamine 1.5% (15 mg/g) shampoo, 60 mL	‡1	..	..	19.08	6.00	Stieprox Liquid	GK

TERBINAFINE

Restricted benefit

Tinea pedis

4463X	terbinafine 1% gel, 15 g	‡1	..	..	23.69	6.00	Lamisil DermGel	NC
4473K	terbinafine hydrochloride 1% cream, 15 g	‡1	1	..	22.23	6.00	Lamisil	NC

TOLNAFTATE

4481W	tolnaftate 0.07% (700 microgram/g) spray, 100 g	‡1	..	..	15.43	6.00	Tinaderm	MK

ANTIFUNGALS FOR SYSTEMIC USE

Antifungals for systemic use

TERBINAFINE

DERMATOLOGICALS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
<u>Authority required</u>								
Onychomycosis due to dermatophyte infection proven by microscopy or culture and confirmed by an approved pathology provider								
4011D	terbinafine 250 mg tablet, 42	1	1	..	45.58	6.00	^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

4551M	dimethicone-350 15% (150 mg/g) + glycerol 2% (20 mg/g) cream, 500 g	¥1	..	..	26.75	6.00	Silic 15	EO
4556T	dimethicone-350 15% (150 mg/g) + glycerol 2% (20 mg/g) cream, 75 g	¥1	..	..	12.87	6.00	Silic 15	EO

Soft paraffin and fat products

WOOL ALCOHOLS

4041Q	wool alcohols 6% (60 mg/g) ointment, 100 g	¥1	1	..	14.52	6.00	Eucerin	BE

Carbamide products

UREA

4042R	urea 10% (100 mg/g) cream, 100 g	¥1	2	..	12.53	6.00	Aquacare H.P.	AG
				..	12.79	6.00	Urederm	VT
				..	13.11	6.00	Calmurid	OL

Other emollients and protectives

CARMELLOSE SODIUM + GELATIN + PECTIN

4518T	carmellose sodium 16.7% + gelatin 16.7% + pectin 16.7% paste: oromucosal, 5 g	¥1	..	..	12.19	6.00	Orabase	QA

SKIN EMOLLIENT

4122Y	SKIN EMOLLIENT Bath oil 500 mL, 1	¥1	2	..	17.69	6.00	Alpha Keri Bath Oil	MT
				..	20.10	6.00	QV Bath Oil	EO
				..	20.19	6.00	Hamilton Skin Therapy Oil	KY
4107E	SKIN EMOLLIENT Lotion 500 mL, 1	¥1	2	..	17.69	6.00	Alpha Keri Lotion	MT

PROTECTIVES AGAINST UV-RADIATION

Protectives against UV-radiation for topical use

SUNSCREENS

4307Q	SUNSCREENS Cream 75 g, 1	¥1	2	..	18.39	6.00	Sunsense Sensitive SPF 30+	EO
4546G	SUNSCREENS Lotion (non-alcoholic) 125 mL, 1	¥1	2	..	16.32	6.00	Aquasun Lotion SPF 18	PF
				..	16.41	6.00	Hamilton Sunscreen	KY

DERMATOLOGICALS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
				..	18.39	6.00	Family Sunscreen Milk SPF 15 SunSense Ultra SPF 30+	EO

ANTIPRURITICS, INCL. ANTIHISTAMINES, ANESTHETICS, ETC.

ANTIPRURITICS, INCL. ANTIHISTAMINES, ANESTHETICS, ETC.

Anesthetics for topical use

LIGNOCAINE

4308R	lignocaine hydrochloride anhydrous 2% (20 mg/mL) oral liquid, 200 mL	\$1	..	..	95.37	6.00	Xylocaine Viscous	AP

Other antipruritics

PINE TAR WITH TRIETHANOLAMINE LAURYL SULFATE

Note

For patients who have failed to respond to simple moisturising agents.

4408B	PINE TAR with TRIETHANOLAMINE LAURYL SULFATE Solution 23 mg-60 mg per mL (2.3%-6%), 500 mL, 1	\$1	2	..	23.26	6.00	Pinetarsol	EO

ANTIPSORIATICS

ANTIPSORIATICS FOR TOPICAL USE

Tars

COAL TAR SOLUTION + PHENOL + SULFUR-PRECIPITATED

4505D	coal tar solution 5% + phenol 0.5% + sulfur-precipitated 0.5% gel, 30 g	\$1	2	..	16.36	6.00	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

4348W	mupirocin 2% (20 mg/g) cream, 15 g	\$1	..	..	17.59	6.00	Bactroban	GK
4350Y	mupirocin 2% (20 mg/g) ointment, 15 g	\$1	..	..	17.59	6.00	Bactroban	GK

CHEMOTHERAPEUTICS FOR TOPICAL USE

Antivirals

PODOPHYLLOTOXIN

Authority required

For the treatment of ano-genital warts

4390C	podophyllotoxin 0.15% (1.5 mg/g) cream, 5 g	\$1	..	..	53.00	6.00	Wartec Cream	GK
4566H	podophyllotoxin 0.5% solution, 3.5 mL	\$1	..	..	40.09	6.00	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.

2464Q	ingenol mebutate 0.015% gel, 3 x 470 mg tubes	1	..	..	139.60	6.00	Picato	LO

INGENOL MEBUTATE

DERMATOLOGICALS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	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.							
2468X	ingenol mebutate 0.05% gel, 2 x 470 mg tubes	1	..	..	139.60	6.00	Picato	LO

CORTICOSTEROIDS, DERMATOLOGICAL PREPARATIONS

CORTICOSTEROIDS, PLAIN

*Corticosteroids, potent (group III)***BETAMETHASONE VALERATE**

4131K	betamethasone (as valerate) 0.1% (1 mg/g) cream, 30 g	1	2	..	22.77	6.00	Betnovate	QA
4132L	betamethasone (as valerate) 0.1% (1 mg/g) ointment, 30 g	1	2	..	22.77	6.00	Betnovate	QA

MOMETASONE**Note**

Application to large areas of skin for longer than four weeks is not recommended.

4342M	mometasone furoate 0.1% (1 mg/g) cream, 50 g	1	..	..	33.82	6.00	Elocon	MK
4343N	mometasone furoate 0.1% (1 mg/g) ointment, 50 g	1	..	..	33.82	6.00	Elocon	MK

ANTISEPTICS AND DISINFECTANTS

ANTISEPTICS AND DISINFECTANTS

*Iodine products***POVIDONE-IODINE**

4411E	povidone-iodine 10% solution, 100 mL	1	..	..	22.45	6.00	Betadine Antiseptic Liquid	SW

OTHER DERMATOLOGICAL PREPARATIONS

OTHER DERMATOLOGICAL PREPARATIONS

*Medicated shampoos***COAL TAR SOLUTION + TAR + SALICYLIC ACID**

4447C	coal tar solution 1% (10 mg/g) + tar 1% (10 mg/g) + salicylic acid 2% (20 mg/g) solution, 250 mL	1	2	..	19.18	6.00	Sebitar	EO

SALICYLIC ACID + BENZALKONIUM CHLORIDE + ALCOHOL + COAL TAR SOLUTION + POLYOXYETHYLENE ETHERS

4560B	SALICYLIC ACID with COAL TAR SOLUTION Scalp cleanser 20 mg-50 mg per mL (2%-5%), 200 mL, 1	1	2	..	20.72	6.00	Ionil-T	GA

SELENIUM SULFIDE

4452H	selenium sulfide 2.5% (25 mg/mL) shampoo, 125 mL	1	..	..	14.48	6.00	Selsun	DQ

TAR + CADE OIL + COAL TAR + ARACHIS OIL EXTRACT OF COAL TAR

4405W	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	1	2	..	24.48	6.00	Polytar	GK

*Wart and anti-corn preparations***LACTIC ACID + SALICYLIC ACID**

4386W	lactic acid 16.7% (167 mg/mL) + salicylic acid 16.7% (167 mg/mL) application,	1	..	..	18.49	6.00	Duofilm Solution	GK

DERMATOLOGICALS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
15 mL								
Other dermatologicals								
DICLOFENAC								
<u>Authority required</u>								
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								
<u>Note</u>								
Maximum quantity of four tubes (original + 3 repeats) in 12 months.								
4046Y	diclofenac sodium 3% gel, 25 g	#1	3	..	58.53	6.00	Solaraze 3% Gel	CS
ICHTHAMMOL								
<u>Note</u>								
For patients who have failed to respond to simple moisturising agents.								
4281H	ichthammol Cream 5 mg-10 mg-10 mg per g (0.5%-1%-1%), 50 g, 1	#1	2	..	18.44	6.00	Egoderm Cream	EO
ICHTHAMMOL + ZINC OXIDE								
<u>Note</u>								
For patients who have failed to respond to simple moisturising agents.								
4280G	ichthammol 1% (10 mg/g) + zinc oxide 15% (150 mg/g) ointment, 50 g	#1	2	..	18.44	6.00	Egoderm Ointment	EO
IMIQUIMOD								
<u>Authority required</u>								
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.								
<u>Note</u>								
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.								
4134N	imiquimod 5% cream, 12 x 250 mg sachets	1	1	..	135.72	6.00	^a Aldara	IA
10106X	imiquimod 5% cream, 2 x 2 g pump packs	1	1	..	135.72	6.00	^a Aldiq	QA
							^a APO-Imiquimod	TX
							^a Aldara Pump	IA
IMIQUIMOD								
<u>Authority required</u>								
Primary treatment of histopathologically confirmed superficial basal cell carcinoma where other standard treatments are inappropriate and topical drug therapy is required								
4559Y	imiquimod 5% cream, 12 x 250 mg sachets	1	1	..	135.72	6.00	^a Aldara	IA
							^a Aldiq	QA
							^a APO-Imiquimod	TX
PANTHENOL								
<u>Note</u>								
To be used in conjunction with the scalp cleanser salicylic acid with coal tar solution and pine tar (code 4447C).								
4510J	panthenol conditioner, 200 g	#1	2	..	14.59	6.00	SebiRinse	EO
PARAFFIN LIGHT LIQUID + COCOAMPHODIACETATE DISODIUM								
4549K	paraffin light liquid 3.5% (35 mg/mL) + cocoamphodiacetate disodium 3% (30 mg/mL) lotion, 500 mL	#1	2	..	21.08	6.00	Hamilton Skin Therapy Wash	KY
ZINC OXIDE + MAIZE STARCH + CHLORPHENESIN + TALC-PURIFIED								
4497Q	zinc oxide 25% (250 mg/g) + maize starch 55.85% (558.5 mg/g) +	#1	1	..	12.59	6.00	Z.S.C.	QA

DERMATOLOGICALS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	
	chlorphenesin 1% (10 mg/g) + talc- purified 18.07% (180.7 mg/g) powder: dusting, 100 g						

GENITO URINARY SYSTEM AND SEX HORMONES

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

GENITO URINARY SYSTEM AND SEX HORMONES

GYNECOLOGICAL ANTIINFECTIVES AND ANTISEPTICS

ANTIINFECTIVES AND ANTISEPTICS, EXCL. COMBINATIONS WITH CORTICOSTEROIDS

Antibiotics

4013F	NYSTATIN nystatin 20 000 international units/g vaginal cream, 75 g	£1	1	..	14.13	6.00	Nilstat	QA

Imidazole derivatives

4016J	CLOTRIMAZOLE clotrimazole 1% (10 mg/g) cream, 35 g	£1	..	..	14.03	6.00	^a Pharmacy Action FemCream	GQ
				..	15.42	6.00	^a APO-Clotrimazole 6 Day Cream	TX
4017K	clotrimazole 2% (20 mg/g) cream, 20 g	£1	..	..	15.42	6.00	APO-Clotrimazole 3 Day Cream	TX

OTHER GYNECOLOGICALS

OTHER GYNECOLOGICALS

4434J	ACETIC ACID + HYDROXYQUINOLINE + RICINOLEIC ACID acetic acid 0.94% + hydroxyquinoline sulfate 0.025% + ricinoleic acid 0.75% vaginal gel, 100 g	£1	..	..	33.24	6.00	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.

10031Y	alprostadil 10 microgram injection [1 x 10 microgram vial] (&) inert substance diluent [1 syringe], 1 pack	6	3	..	*105.82	6.00	Caverject	PF
10030X	alprostadil 20 microgram injection [1 x 20 microgram vial] (&) inert substance diluent [1 syringe], 1 pack	6	3	..	*133.18	6.00	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

4586J	sildenafil 100 mg tablet, 4	1	5	..	73.33	6.00	^a APO-Sildenafil	TX
							^a Chem mart Sildenafil	CH
							^a Sildenafil GH	GQ
							^a Terry White Chemists Sildenafil	TW
				..	86.02	6.00	^a Vasafil 100	QA
							^a Silaran	RA
							^a Viagra	PF
4584G	sildenafil 25 mg tablet, 4	1	5	..	55.21	6.00	^a Vasafil 25	QA
				..	55.22	6.00	^a APO-Sildenafil	TX

GENITO URINARY SYSTEM AND SEX HORMONES

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
4585H	sildenafil 50 mg tablet, 4	1	5	..	64.32	6.00	^a Viagra	PF
				..	68.31	6.00	^a APO-Sildenafil	TX
				..	80.03	6.00	^a Vasafil 50 ^a Viagra	QA PF

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

4596X	tadalafil 10 mg tablet, 4	1	5	..	98.96	6.00	Cialis	LY
4597Y	tadalafil 20 mg tablet, 4	1	5	..	98.96	6.00	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

4290T	vardeafil 10 mg tablet, 4	1	5	..	73.13	6.00	Levitra	BN
4302K	vardeafil 20 mg tablet, 4	1	5	..	83.86	6.00	Levitra	BN

Other urologicals

BICARBONATE + CITRATE + TARTARIC ACID

Restricted benefit

For relief of urinary symptoms when antibiotic or other therapy alone is inappropriate

4049D	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	1	4	..	13.89	6.00	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

4277D	alfuzosin hydrochloride 10 mg tablet: modified release, 30 tablets	1	5	..	63.70	6.00	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.

10102Q	dutasteride 500 microgram + tamsulosin hydrochloride 400 microgram capsule: modified release, 30	1	5	..	35.63	6.00	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

4070F	tamsulosin hydrochloride 400 microgram tablet: modified release, 30	1	5	..	63.70	6.00	Flomaxtra	CS
							Tamsulosin Sandoz SR	SZ

TERAZOSIN

GENITO URINARY SYSTEM AND SEX HORMONES

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
<u>Authority required</u>								
Treatment of benign prostatic hyperplasia where surgery is inappropriate, or where other drug treatment has failed or is contraindicated								
4396J	terazosin 1 mg tablet [7 tablets] (&) terazosin 2 mg tablet [7 tablets], 14	1	..	..	20.39	6.00	Hytrin	AB
4399M	terazosin 10 mg tablet, 28	1	5	..	86.40	6.00	Hytrin	AB
4397K	terazosin 2 mg tablet, 28	1	5	..	42.03	6.00	Hytrin	AB
4398L	terazosin 5 mg tablet, 28	1	5	..	58.53	6.00	Hytrin	AB

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.

10095H	dutasteride 500 microgram capsule, 30	1	5	..	30.77	6.00	Avodart	GK

FINASTERIDE

Authority required

Treatment of benign prostatic hyperplasia where surgery is inappropriate, or where other drug treatment has failed or is contraindicated

4303L	finasteride 5 mg tablet, 28	1	5	..	91.60	6.00	^a Finpro	RZ
							^a Pharmacy Choice Finasteride	RI
4233T	finasteride 5 mg tablet, 30	1	5	..	78.03	6.00	^a Finasteride GH 5	GQ
				..	97.66	6.00	^a Finasteride RBX	RA
				..	102.45	6.00	^a Finnacar	QA
							^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

Macrolides

[illegible]

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS

ANTINEOPLASTIC AGENTS

ANTIMETABOLITES

Pyrimidine analogues

FLUOROURACIL

4222F	fluorouracil 5% (50 mg/g) cream, 20 g	#1	..	..	60.96	6.00	Efudix	VT

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

4284L	infliximab 100 mg injection, 1 x 100 mg vial	1	2	..	847.32	6.00	Remicade	JC

MUSCULO-SKELETAL SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

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

4190M	diclofenac sodium 50 mg + misoprostol 200 microgram tablet, 60	1	2	..	38.12	6.00	Arthrotec 50	PF

TOPICAL PRODUCTS FOR JOINT AND MUSCULAR PAIN

TOPICAL PRODUCTS FOR JOINT AND MUSCULAR PAIN

Preparations with salicylic acid derivatives

METHYL SALICYLATE

4026X	methyl salicylate 25% (0.25 mL/mL) liniment, 100 mL	1	1	..	10.28	6.00	Gold Cross	BI
4023R	methyl salicylate 50% (500 mg/g) ointment, 100 g	1	1	..	12.51	6.00	Gold Cross	BI

METHYL SALICYLATE + MENTHOL + EUCALYPTUS OIL

4022Q	methyl salicylate 25% (250 mg/g) + menthol 4% (40 mg/g) + eucalyptus oil 10% (100 mg/g) cream, 100 g	1	1	..	14.36	6.00	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)

2191H	RISEDRONATE SODIUM Tablet 35 mg (enteric coated), 4	1	5	..	42.11	6.00	Actonel EC	SW
4444X	risedronate sodium 35 mg tablet, 4	1	5	..	42.11	6.00	^a Acris Once-a-Week	AF
							^a APO-Risedronate	TX
							^a Risedronate-GA	GN
							^a Risedronate Sandoz	SZ
							^a Risedro once a week	QA
4443W	risedronate sodium 5 mg tablet, 28	1	5	..	42.11	6.00	Actonel	SW

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)

2224C	alendronate 70 mg + colecalciferol 140 microgram tablet, 4	1	5	..	45.51	6.00	^a Alendronate plus D3-DRLA	RZ
				..	48.00	6.00	^a Fosamax Plus 70 mg/140 mcg	MK
2194L	alendronate 70 mg + colecalciferol 70 microgram tablet, 4	1	5	..	45.51	6.00	Fosamax Plus	MK

ALENDRONATE + COLECALCIFEROL (&) CALCIUM CARBONATE

MUSCULO-SKELETAL SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
<u>Authority required</u>								
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)								
2273P	alendronate 70 mg + colecalciferol 140 microgram tablet [4] (&) calcium (as carbonate) 500 mg tablet [48], 1 pack	‡1	5	..	45.51	6.00	Fosamax Plus D-Cal	MK
RISEDRONATE (&) CALCIUM CARBONATE								
<u>Authority required</u>								
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)								
2220W	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	‡1	5	..	45.73	6.00	Actonel EC Combi	SW
4059P	risedronate sodium 35 mg tablet [4] (&) calcium (as carbonate) 500 mg tablet [24], 28	‡1	5	..	45.73	6.00	Acris Combi	AF
RISEDRONATE (&) CALCIUM CARBONATE + COLECALCIFEROL								
<u>Authority required</u>								
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)								
2254P	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	‡1	5	..	45.73	6.00	Actonel EC Combi D	SW

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

NERVOUS SYSTEM

ANALGESICS

OPIOIDS

Natural opium alkaloids

MORPHINE

Restricted benefit

Chronic severe disabling pain not responding to non-narcotic analgesics

Caution

The risk of drug dependence is high.

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.

4349X	morphine sulfate 200 mg tablet: modified release, 28 tablets	1	..	..	122.20	6.00	MS Contin	MF

OTHER ANALGESICS AND ANTIPYRETICS

Salicylic acid and derivatives

ASPIRIN + CODEINE

4286N	aspirin 300 mg + codeine phosphate 8 mg tablet: dispersible, 40	1	2	..	14.52	6.00	Aspalgin 40	QA

Anilides

PARACETAMOL + CODEINE

4170L	paracetamol 500 mg + codeine phosphate 15 mg tablet, 20	1	2	..	10.07	6.00	Prodeine 15	SW
4275B	paracetamol 500 mg + codeine phosphate 8 mg tablet, 40	1	2	..	11.03	6.00	Panamax Co. 40	SW
4171M	paracetamol 500 mg + codeine phosphate 8 mg tablet, 50	1	2	..	13.20	6.00	Codalgin	FM
10186D	paracetamol 500 mg + codeine phosphate hemihydrate 15 mg tablet, 20	1	2	..	10.07	6.00	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

4591P	gabapentin 100 mg capsule, 100	1	5	..	14.01	6.00	^a APO-Gabapentin	TX
							^a Gabapentin Aspen 100	FM
							^a Gabatine 100	QA
							^a Neurontin	PF
							^a Nupentin 100	AF
4592Q	gabapentin 300 mg capsule, 100	1	5	..	30.97	6.00	^a DBL Gabapentin	HH
							^a Gabapentin 300	CR
							^a Gabapentin Aspen 300	FM
							^a Gabatine 300	QA
							^a Gantin	GN
							^a GenRx Gabapentin	GX
							^a Neurontin	PF
							^a Nupentin 300	AF
4593R	gabapentin 400 mg capsule, 100	1	5	..	39.79	6.00	^a DBL Gabapentin	HH
							^a Gabapentin 400	CR
							^a Gabapentin Aspen 400	FM
							^a Gabatine 400	QA

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
							^a Gantin	GN
							^a GenRx Gabapentin	GX
							^a Neurontin	PF
							^a Nupentin 400	AF
4594T	gabapentin 600 mg tablet, 100	1	5	..	56.90	6.00	^a Gabapentin Aspen 600	FM
							^a Gabatine 600	QA
							^a GenRx Gabapentin	GX
							^a Neurontin	PF
							^a Nupentin Tabs	AF
4595W	gabapentin 800 mg tablet, 100	1	5	..	73.60	6.00	^a Gabapentin Aspen 800	FM
							^a Gabatine 800	QA
							^a Gantin	GN
							^a GenRx Gabapentin	GX
							^a Neurontin	PF
							^a Nupentin Tabs	AF

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.

4150K	bromazepam 3 mg tablet, 30	2	..	..	*29.82	6.00	Lexotan	RO
4151L	bromazepam 6 mg tablet, 30	2	..	..	*36.44	6.00	Lexotan	RO

Azaspirodecanedione derivatives

BUSPIRONE

Authority required

For the short-term treatment of anxiety

4145E	buspirone hydrochloride 10 mg tablet, 50	1	..	..	55.18	6.00	Buspar	QA
4144D	buspirone hydrochloride 5 mg tablet, 50	1	..	..	38.33	6.00	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.

4216X	flunitrazepam 1 mg tablet, 30	1	..	..	15.22	6.00	Hypnodorm	AF

Benzodiazepine related drugs

ZOPICLONE

NERVOUS SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
<u>Restricted benefit</u>								
For the short-term treatment of insomnia								
4522B	zopiclone 7.5 mg tablet, 30	1	..	..	22.10	6.00	^a Imrest	AF
				..	25.25	6.00	^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.

4577X	nicotine 10 mg/16 hours patch, 7	2	..	..	*55.12	6.00	Nicorette Patch	JT
4572P	nicotine 14 mg/24 hours patch, 7	2	..	..	*54.90	6.00	QuitX	AF
4578Y	nicotine 15 mg/16 hours patch, 7	2	2	..	*69.08 *60.30	6.00 6.00	Nicabate CQ 14 Nicorette Patch	GC JT
4573Q	nicotine 21 mg/24 hours patch, 7	2	2	..	*58.02	6.00	QuitX	AF
4576W	nicotine 5 mg/16 hours patch, 7	2	..	..	*69.08 *51.14	6.00 6.00	Nicabate CQ 21 Nicorette Patch	GC JT
4571N	nicotine 7 mg/24 hours patch, 7	2	..	..	*51.74	6.00	QuitX	AF

ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS

ANTHELMINTICS

ANTINEMATODAL AGENTS

Benzimidazole derivatives

MEBENDAZOLE

4325P	mebendazole 100 mg tablet, 6	1	..	..	15.26	6.00	Vermox	IA

RESPIRATORY SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

RESPIRATORY SYSTEM

NASAL PREPARATIONS

DECONGESTANTS AND OTHER NASAL PREPARATIONS FOR TOPICAL USE

Sympathomimetics, plain

OXYMETAZOLINE

4378K	oxymetazoline hydrochloride 0.05% (500 microgram/mL) nasal spray, 15 mL	‡1	..	..	17.49	6.00	Drixine	MK
4379L	oxymetazoline hydrochloride 0.05% (500 microgram/mL) nasal spray, 18 mL	‡1	..	..	17.10	6.00	Logicin Rapid Relief	QA

Antiallergic agents, excl. corticosteroids

CROMOGLYCATE

4468E	cromoglycate sodium 2% (20 mg/mL) nasal spray, 26 mL	‡1	5	..	23.25	6.00	Rynacrom	SW

LEVOCABASTINE

4311X	levocabastine 0.05% (500 microgram/mL) nasal spray, 100 actuations	‡1	2	..	18.58	6.00	Livostin	JT

Corticosteroids

BUDESONIDE

Restricted benefit

Severe intractable rhinitis

4092J	budesonide 64 microgram/actuation nasal spray, 120 actuations	‡1	..	..	37.51	6.00	Budamax Aqueous	PM

Other nasal preparations

IPRATROPIUM

Restricted benefit

Severe intractable rhinorrhoea, associated with perennial rhinitis, unresponsive to insufflated nasal steroids

4089F	ipratropium bromide anhydrous 21 microgram/actuation nasal spray, 180 actuations	‡1	5	..	23.93	6.00	Atrovent Nasal Aqueous	BY
4090G	ipratropium bromide anhydrous 42 microgram/actuation nasal spray, 180 actuations	‡1	5	..	30.81	6.00	Atrovent Nasal Forte	BY

NASAL DECONGESTANTS FOR SYSTEMIC USE

Sympathomimetics

PSEUDOEPHEDRINE

4029C	pseudoephedrine hydrochloride 60 mg tablet, 12	1	..	..	10.61	6.00	^a Pharmacy Action Sinus & Nasal Decongestant Relief	GQ
				..	11.36	6.00	^a Logicin Sinus	QA

COUGH AND COLD PREPARATIONS

EXPECTORANTS, EXCL. COMBINATIONS WITH COUGH SUPPRESSANTS

Expectorants

AMMONIUM + SENEGA ROOT

4074K	ammonium bicarbonate 25 mg/mL + senega root 25 mg/mL oral liquid, 200 mL	‡1	4	..	9.52	6.00	Gold Cross	BI

COUGH SUPPRESSANTS, EXCL. COMBINATIONS WITH EXPECTORANTS

Opium alkaloids and derivatives

PHOLCODINE

RESPIRATORY SYSTEM

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
4071G	pholcodine 1 mg/mL oral liquid, 100 mL	1	2	..	9.36	6.00	Gold Cross	BI
				..	14.95	6.00	Duro-Tuss	IA

ANTI-HISTAMINES FOR SYSTEMIC USE

ANTI-HISTAMINES FOR SYSTEMIC USE

Piperazine derivatives

CETIRIZINE

4175R	cetirizine hydrochloride 10 mg tablet, 30	1	..	..	26.28	6.00	^a Pharmacy Action Cetrelief	GQ
				..	29.99	6.00	^a Alzene	AF
				..	33.21	6.00	Zilarex	SZ
				..	39.79	6.00	^a Zyrtec	JT

Other antihistamines for systemic use

FEXOFENADINE

4238C	fexofenadine hydrochloride 120 mg tablet, 30	1	..	..	29.76	6.00	^a Xergic	AF
				..	35.05	6.00	^a Fexal	SZ
				..	47.47	6.00	^a Telfast 120	SW
4237B	fexofenadine hydrochloride 60 mg tablet, 20	3	..	..	*55.33	6.00	Telfast	SW

LORATADINE

4313B	loratadine 10 mg tablet, 30	1	..	..	29.07	6.00	^a Pharmacy Action Lorastyne	GQ
				..	33.33	6.00	^a Allereze	AF
				..	43.99	6.00	^a Lorano	SZ
				..	46.26	6.00	^a Claratyne	MK

SENSORY ORGANS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	

SENSORY ORGANS

OPHTHALMOLOGICALS

DECONGESTANTS AND ANTIALLERGICS

Sympathomimetics used as decongestants

4035J	NAPHAZOLINE naphazoline hydrochloride 0.1% eye drops, 15 mL	‡1	1	..	15.43	6.00	Albalon Liquifilm	AG
4032F	NAPHAZOLINE + ANTAZOLINE naphazoline hydrochloride 0.05% + antazoline phosphate 0.5% eye drops, 15 mL	‡1	1	..	15.14	6.00	Albalon-A	AG
4310W	LEVOCABASTINE levocabastine 0.05% eye drops, 4 mL	‡1	1	..	18.58	6.00	Livostin	JT

Other antiallergics

OTOLOGICALS

OTHER OTOLOGICALS

Indifferent preparations

4176T	CARBAMIDE PEROXIDE carbamide peroxide 6.5% ear drops, 12 mL	‡1	..	..	15.59	6.00	Ear Clear for Ear Wax Removal	KY
4180B	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	‡1	..	..	14.42	6.00	Cerumol	UN
4199B	DOCUSATE docusate sodium 0.5% (5 mg/mL) ear drops, 10 mL	‡1	..	..	14.81	6.00	Waxsol	HM

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed	Maximum	Brand Name and Manufacturer
					Price for Max. Qty \$	Recordable Value for Safety Net \$	

VARIOUS

ALL OTHER THERAPEUTIC PRODUCTS

ALL OTHER THERAPEUTIC PRODUCTS
Drugs for treatment of hyperkalemia and hyperphosphatemia

POLYSTYRENE SULFONATE SODIUM							
4470G	polystyrene sulfonate sodium 999.3 mg/g powder, 454 g	±1	2	..	71.46	6.00	Resonium-A SW

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

REPATRIATION PHARMACEUTICAL BENEFITS SCHEME (RPBS) 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	- Film; - Film Island	- Gauze—Paraffin; - Non-adherent
(B) Absorbing	- Foam (Light Exudate); - Hydroactive (Superficial Wound—Light Exudate)	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	- Foam (Light Exudate); - Hydroactive (Superficial Wound—Light Exudate); - Hydrocolloid (Superficial Wound—Light Exudate)	Hydrocolloid (Cavity Wound)
(B) Moisture donating	- Hydrogel—Amorphous; - Hydrogel—Sheet	Hydrogel—Amorphous
HIGH EXUDATE:	Superficial	Cavity
(A) Absorbing	- Alginate (Superficial Wound); - Foam—Heavy Exudate; - Hydroactive (Superficial Wound—Moderate Exudate); - Hydrocolloid (Superficial Wound—Moderate/High Exudate)	- Alginate (Cavity Wound); - Foam—Moderate Exudate (see “cavity conforming” product); - Hydroactive (Cavity Wound); - Hydrocolloid (Cavity Wound)
(B) Moisture donating	NOT APPROPRIATE	

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

YELLOW SLOUGHY WOUND

Aims: (1) to remove slough; (2) to encourage granulation; (3) to absorb excess exudate.

LIGHT EXUDATE:	Superficial					Cavity	
(A) Absorbing	• Cadexomer Iodine; • Foam—Light Exudate; • Foam with Charcoal; • Hydroactive (Superficial Wound—Moderate Exudate); • Hydrocolloid (Superficial Wound—Moderate Exudate)					• Cadexomer Iodine; • Hydrocolloid (Cavity Wound)	
(B) Moisture Donating	• Hydrogel—Amorphous; • Hydrogel—Sheet					• Hydrogel—Amorphous	
HIGH EXUDATE:	Superficial					Cavity	
(A) Absorbing	• Alginate (Superficial Wound); • Cadexomer Iodine; • Foam—Heavy Exudate; • Hydroactive (Superficial Wound—Moderate/High Exudate); • Hydrocolloid (Superficial Wound—Moderate/High Exudate)					• 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	• Hydroactive (Superficial Wound—Light Exudate); • Hydrocolloid (Superficial Wound—Light/Moderate Exudate)					• Hydrocolloid (Cavity Wound)	
(B) Moisture donating	• Hydrogel—Amorphous; • Hydrogel—Sheet					• 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.

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer

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 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 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.

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.

ALL OTHER NON-THERAPEUTIC PRODUCTS

ALL OTHER NON-THERAPEUTIC PRODUCTS

LUBRICATING AGENT

4306P	lubricating agent jelly, 100 g	1	..	..	10.47	6.00	Lubri-Gel	PP

Other non-therapeutic auxiliary products

BANDAGE ABSORBENT WOOL

4653X	bandage absorbent wool 10 cm x 3 m bandage, 1	1	..	..	20.66	6.00	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.

4717G	bandage calico large bandage: triangular, 1 bandage	#1	..	..	13.38	6.00	Handy 36361414	BV

BANDAGE COMPRESSION

Note

Treatment of varices and oedema associated with venous disease and lymphoedema; contraindicated in arterial disease.

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.

4654Y	BANDAGE-COMPRESSION Bandage, short stretch, 8 cm x 2.6 m, 1	5	..	..	*76.11	6.00	Comprilan 01027-00	BV
4748X	bandage compression 10 cm x 3 m bandage: high stretch, 1 bandage	5	..	..	*73.26	6.00	Surepress 650947	CC
				..	*152.96	6.00	Tensopress 71723-00	BV

BANDAGE COMPRESSION

Note

Treatment of varices and oedema associated with venous disease and lymphoedema; contraindicated in arterial disease.

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.

4657D	bandage compression 10 cm x 3.5 m bandage: high stretch, 1 bandage	5	..	..	*78.91	6.00	Setopress 3505	MH

BANDAGE COMPRESSION

Note

Treatment of varices and oedema associated with venous disease and lymphoedema; contraindicated in arterial disease.

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
4859R	bandage tubular 10 cm x 1 m bandage, 1	#1	..	..	15.32	6.00	Tubigrip F 1548	MH
4855M	bandage tubular 6.25 cm x 1 m bandage, 1	#1	..	..	15.32	6.00	Tubigrip B 1520	MH
4856N	bandage tubular 6.75 cm x 1 m bandage, 1	#1	..	..	15.32	6.00	Tubigrip C 1545	MH
4857P	bandage tubular 7.5 cm x 1 m bandage, 1	#1	..	..	15.32	6.00	Tubigrip D 1546	MH
4858Q	bandage tubular 8.75 cm x 1 m bandage, 1	#1	..	..	15.32	6.00	Tubigrip E 1547	MH
BANDAGE TUBULAR								
4663K	bandage tubular size C (15 cm to 25 cm) bandage: straight, 1 bandage	#1	..	..	15.73	6.00	Elastoplast 2225	BE
4664L	bandage tubular size D (25 cm to 43 cm) bandage: straight, 1 bandage	#1	..	..	15.73	6.00	Elastoplast 2226	BE
4665M	bandage tubular size E (35 cm to 45 cm) bandage: straight, 1 bandage	#1	..	..	15.73	6.00	Elastoplast 2227	BE
BANDAGE TUBULAR FINGER								
4798M	BANDAGE-TUBULAR (FINGER) Complete pack including applicator, 1	#1	..	..	18.11	6.00	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.								
4673Y	bandage tubular light weight 10 m bandage: large limb size, 1 bandage	#1	..	..	28.47	6.00	Tubifast 2438	MH
4672X	bandage tubular light weight 10 m bandage: medium limb size, 1 bandage	#1	..	..	27.06	6.00	Tubifast 2436	MH
4671W	bandage tubular light weight 10 m bandage: small limb size, 1 bandage	#1	..	..	23.10	6.00	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.								
4675C	bandage tubular long stocking bandage: XX/large size, 1 bandage	2	..	..	*37.48	6.00	Tubigrip 1486	MH
4799N	bandage tubular long stocking bandage: large size, 1 bandage	2	..	..	*37.46	6.00	Tubigrip 1484	MH
4797L	bandage tubular long stocking bandage: medium size, 1 bandage	2	..	..	*37.46	6.00	Tubigrip 1483	MH
4674B	bandage tubular long stocking bandage: small size, 1 bandage	2	..	..	*37.46	6.00	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.								
4816L	bandage tubular short stocking bandage: large D/E size, 1 bandage	2	..	..	*25.72	6.00	Tubigrip 1481	MH
4815K	bandage tubular short stocking bandage: medium C/D size, 1 bandage	2	..	..	*25.72	6.00	Tubigrip 1480	MH

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
4661H	bandage tubular short stocking bandage: small B/C size, 1 bandage	2	..	..	*25.72	6.00	Tubigrip 1479	MH
BANDAGE ZINC PASTE								
Note Used as an adjunct in the management of leg ulceration and associated eczema and skin conditions.								
4670T	bandage zinc paste 10 cm x 9.1 m bandage, 1	2	3	..	*29.12	6.00	Flexidress 650941	CC
BANDAGE ZINC PASTE								
Note Used as an adjunct in the management of leg ulceration and associated eczema and skin conditions.								
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.								
4669R	bandage zinc paste 7.5 cm x 6 m bandage, 1	2	3	..	*30.00	6.00	Steripaste 3610	MH
BANDAGE ZINC PASTE								
Note Used as an adjunct in the management of leg ulceration and associated eczema and skin conditions.								
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.								
4750B	bandage zinc paste 7.5 cm x 6 m bandage, 1	2	3	..	*79.12	6.00	Viscopaste 4948	SN
4760M	bandage zinc paste 80 cm (stockings) bandage, 4	1	3	..	91.26	6.00	ZipZoc 66000747	SN
BETAINE + POLYAMINOPROPYL BIGUANIDE								
2525X	betaine 0.1% (40 microgram/40 mL) + polyaminopropyl biguanide 0.1% (40 microgram/40 mL), 6 x 40 mL ampoules	1	..	..	27.01	6.00	Prontosan Wound Irrigation Solution	BR
CADEXOMER-IODINE								
Note Suitable for yellow sloughy infected and malodorous wounds.								
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.								
4937W	DRESSING with CADEXOMER IODINE Sheets 17 g (10 cm x 8 cm), 2, 1	1	..	..	163.92	6.00	Iodosorb 66051360	SN
4935R	DRESSING with CADEXOMER IODINE Sheets 5 g (6 cm x 4 cm), 5, 1	1	2	..	107.59	6.00	Iodosorb 66051330	SN
4931M	cadexomer-iodine 3 g powder: dusting sterile, 7 x 3 g sachets	1	2	..	70.65	6.00	Iodosorb Powder 66051070	SN
4933P	cadexomer-iodine 50% (500 mg/g) ointment, 2 x 20 g tubes	1	2	..	112.77	6.00	Iodosorb Ointment 66051230	SN
4932N	cadexomer-iodine 50% (500 mg/g) ointment, 4 x 10 g tubes	1	2	..	113.83	6.00	Iodosorb Ointment 66051240	SN
4936T	cadexomer-iodine 8 cm x 6 cm dressing, 3 x 10 g sheets	1	2	..	155.54	6.00	Iodosorb 66051340	SN
DRESSING ACTIVATED CHARCOAL MALODOROUS WOUND								
4742N	dressing activated charcoal malodorous wound 10 cm x 10 cm dressing, 10	1	..	..	79.32	6.00	CarboFLEX 403202	CC
4681J	dressing activated charcoal malodorous wound 10.5 cm x 10.5 cm dressing, 1	10	..	..	*101.26	6.00	Actisorb Plus MAP105	JJ

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
4743P	dressing activated charcoal malodorous wound 15 cm x 20 cm dressing, 5	1	..	..	90.21	6.00	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.								
4832H	DRESSING-ALGINATE (CAVITY WOUND) Rope 2 g, 1	10	..	..	*109.46	6.00	Sorbsan 1411	UM
1905G	DRESSING-ALGINATE (CAVITY WOUND) Rope 2 g, 5	2	..	..	*115.60	6.00	Kaltostat 168117	CC
DRESSING ALGINATE CAVITY WOUND								
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.								
4682K	dressing alginate cavity wound 2 g (40 cm) rope, 6 x 2 g	2	..	..	*138.06	6.00	Comfeel SeaSorb Filler 3740	CT
DRESSING ALGINATE SUPERFICIAL WOUND								
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.								
4831G	dressing alginate superficial wound 10 cm x 10 cm dressing, 1	10	1	..	*84.76	6.00	Sorbsan 1410	UM
				..	*90.46	6.00	Comfeel SeaSorb Dressing 3710	CT
4684M	dressing alginate superficial wound 5 cm x 5 cm dressing, 1	10	1	..	*47.26	6.00	Comfeel SeaSorb Dressing 3705	CT
DRESSING ALGINATE SUPERFICIAL 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.								
4700J	dressing alginate superficial wound 10 cm x 10 cm dressing, 10	1	1	..	105.49	6.00	Algisite M 66000520	SN
4691X	dressing alginate superficial wound 15 cm x 20 cm dressing, 10	1	1	..	251.87	6.00	Algisite M 66000521	SN
4699H	dressing alginate superficial wound 5 cm x 5 cm dressing, 10	1	1	..	49.74	6.00	Kaltostat 168210	CC
				..	54.57	6.00	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.								
4683L	dressing alginate superficial wound 7.5 cm x 12 cm dressing, 10	1	1	..	91.42	6.00	Kaltostat 168212	CC
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.								
4893M	dressing film 10 cm x 12 cm dressing, 10	1	..	..	34.08	6.00	Op-Site Flexigrid 4629	SN

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
DRESSING FILM								
4687Q	dressing film 10 cm x 12 cm dressing, 4	1	..	..	19.99	6.00	Nexcare Tegaderm Transparent H1626	MM
4688R	dressing film 15 cm x 20 cm dressing, 1	6	..	..	*31.00	6.00	Tegaderm Transparent 1628	MM
4686P	dressing film 6 cm x 7 cm dressing, 8	1	..	..	15.98	6.00	Nexcare Tegaderm Transparent H1624	MM
DRESSING FILM ISLAND								
4689T	dressing film island 5 cm x 7 cm dressing, 1	10	..	..	*16.56	6.00	Tegaderm Transparent Island 3582	MM
4690W	dressing film island 9 cm x 10 cm dressing, 1	10	..	..	*28.06	6.00	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.								
4898T	dressing film island 5 cm x 7.2 cm dressing, 5	2	..	..	*29.32	6.00	Cutifilm Plus 36361370	SN
4899W	dressing film island 8 cm x 10 cm dressing, 5	2	..	..	*45.92	6.00	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.								
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.								
4795J	dressing foam heavy exudate 10 cm x 10 cm dressing, 10	1	1	..	132.80	6.00	Allevyn 66007637	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.								
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.								
4590N	dressing foam moderate exudate 12.5 cm x 12.5 cm dressing, 10	1	..	..	132.11	6.00	Allevyn Adhesive 66000044	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.								
4694C	dressing foam moderate exudate cavity conforming foam, 1 x 20 g sachet	1	1	..	95.09	6.00	Cavicare 4563	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.								
10017F	dressing foam with silicone 10.3 cm x 10.3 cm dressing, 10	1	..	..	55.40	6.00	Allevyn Life 66801067	SN
10029W	dressing foam with silicone 12.9 cm x 12.9 cm dressing, 10	1	..	..	79.61	6.00	Allevyn Life 66801068	SN

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
10023M	dressings foam with silicone 15.4 cm x 15.4 cm dressing, 10	1	..	..	110.59	6.00	Allevyn Life 66801069	SN
10021K	dressings foam with silicone 21 cm x 21 cm dressing, 10	1	..	..	220.75	6.00	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.

2439J	dressings foam with silicone and silver 10 cm x 10 cm dressing, 5	1	..	..	109.64	6.00	Mepilex Ag	MH
2470B	dressings foam with silicone and silver 10 cm x 10 cm dressing, 5	1	..	..	117.40	6.00	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.

4196W	dressings foam with silicone heavy exudate 10 cm x 10 cm dressing, 10	1	..	..	73.50	6.00	Allevyn Gentle 66800248	SN
4230P	dressings foam with silicone heavy exudate 10 cm x 10 cm dressing, 10	1	..	..	73.50	6.00	Allevyn Gentle Border 66800270	SN
4207K	dressings foam with silicone heavy exudate 7.5 cm x 7.5 cm dressing, 10	1	..	..	51.71	6.00	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.

4643J	dressings foam with silicone heavy exudate 10 cm x 10 cm dressing, 5	1	..	..	43.02	6.00	Mepilex Border 295300	MH
4642H	dressings foam with silicone heavy exudate 7.5 cm x 7.5 cm dressing, 5	1	..	..	31.11	6.00	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.

4645L	dressings foam with silicone light exudate 10 cm x 10 cm dressing, 5	1	..	..	38.55	6.00	Mepilex Lite 284100	MH
4644K	dressings foam with silicone light exudate 6 cm x 8.5 cm dressing, 5	1	..	..	28.40	6.00	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.

4626L	dressings foam with silicone moderate exudate 10 cm x 10 cm dressing, 5	1	..	..	43.02	6.00	Mepilex 294100	MH

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
DRESSING FOAM WITH SILVER								
<u>Authority required</u>								
For wounds where there is evidence of critical colonisation and for well-assessed chronic wounds that have not responded to conventional dressings								
<u>Note</u>								
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.								
4255Y	dressing foam with silver 10 cm x 10 cm dressing, 10	¥1	..	..	201.94	6.00	Allevyn Ag Adhesive 66800075	SN
4259E	dressing foam with silver 10 cm x 10 cm dressing, 10	¥1	..	..	205.72	6.00	Allevyn Ag Non-Adhesive 66800086	SN
4266M	dressing foam with silver 10 cm x 10 cm dressing, 10	¥1	..	..	201.94	6.00	Allevyn Ag Gentle Border 66800461	SN
4258D	dressing foam with silver 12.5 cm x 12.5 cm dressing, 10	¥1	..	..	246.56	6.00	Allevyn Ag Adhesive 66800078	SN
4270R	dressing foam with silver 12.5 cm x 12.5 cm dressing, 10	¥1	..	..	246.56	6.00	Allevyn Ag Gentle Border 66800462	SN
4252T	dressing foam with silver 7.5 cm x 7.5 cm dressing, 10	¥1	..	..	135.91	6.00	Allevyn Ag Adhesive 66800073	SN
4263J	dressing foam with silver 7.5 cm x 7.5 cm dressing, 10	¥1	..	..	135.91	6.00	Allevyn Ag Gentle Border 66800460	SN
DRESSING GAUZE ABSORBENT								
<u>Note</u>								
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.								
4708T	dressing gauze absorbent 10 cm x 10 cm pad, 100	¥1	..	..	30.25	6.00	Handy 71117-06	BV
4707R	dressing gauze absorbent 5 cm x 5 cm pad, 100	¥1	..	..	15.13	6.00	Handy 71117-05	BV
DRESSING GAUZE EYE								
4768Y	dressing gauze eye pad, 12	¥1	..	..	13.17	6.00	Curity 4112	KE
DRESSING GAUZE PARAFFIN								
<u>Note</u>								
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.								
4759L	dressing gauze paraffin 10 cm x 10 cm dressing, 10	¥1	..	..	21.26	6.00	Jelonet 7404	SN
DRESSING GAUZE PARAFFIN WITH CHLORHEXIDINE ACETATE								
<u>Note</u>								
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.								
4845B	dressing gauze paraffin with chlorhexidine acetate 10 cm x 10 cm dressing, 10	¥1	2	..	24.65	6.00	Bactigras 7457	SN
DRESSING HYDROACTIVE CAVITY WOUND								
<u>Note</u>								
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.								
4919X	dressing hydroactive cavity wound 10 cm x 10 cm dressing, 5	2	1	..	*200.48	6.00	Allevyn Plus Cavity 66047573	SN
4918W	dressing hydroactive cavity wound 5 cm x 6 cm dressing, 10	¥1	1	..	94.84	6.00	Allevyn Plus Cavity 66047571	SN

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
4949L	DRESSING-HYDROACTIVE (DEBRIDEMENT) Dressings 4 cm, 10, 1	#1	..	..	85.22	6.00	TenderWet 24 Active 609210	HR
4948K	DRESSING-HYDROACTIVE (DEBRIDEMENT) Dressings 5.5 cm, 10, 1	#1	..	..	87.27	6.00	TenderWet Active Cavity 609272	HR
4950M	DRESSING-HYDROACTIVE (DEBRIDEMENT) Dressings 7.5 cm x 7.5 cm, 10, 1	#1	..	..	115.58	6.00	TenderWet 24 Active 609213	HR
DRESSING HYDROACTIVE SUPERFICIAL WOUND HIGH EXUDATE SEMI-PERMEABLE ABSORBENT FOAM								
4692Y	dressing hydroactive superficial wound high exudate semi-permeable absorbent foam 10 cm x 10 cm (foam alternative) dressing, 10	#1	..	..	55.24	6.00	CombiDERM 651031	CC
4695D	dressing hydroactive superficial wound high exudate semi-permeable absorbent foam 11 cm x 11 cm dressing: island, 10 dressings	#1	..	..	111.58	6.00	Tielle MTL101E	JJ
4693B	dressing hydroactive superficial wound high exudate semi-permeable absorbent foam 15 cm x 18 cm (foam alternative) dressing, 5	#1	..	..	72.06	6.00	CombiDERM 651027	CC
4696E	dressing hydroactive superficial wound high exudate semi-permeable absorbent foam 18 cm x 18 cm dressing: island, 5 dressings	#1	..	..	136.18	6.00	Tielle MT2442	JJ
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.								
4927H	dressing hydroactive superficial wound high exudate semi-permeable absorbent foam 10 cm x 10 cm pad: waterproof, 10 pads	#1	1	..	88.27	6.00	Biatain Non-adhesive 3410	CT
4929K	dressing hydroactive superficial wound high exudate semi-permeable absorbent foam 12 cm x 12 cm pad: waterproof, 10 pads	#1	1	..	97.29	6.00	Biatain Adhesive 3420	CT
4928J	dressing hydroactive superficial wound high exudate semi-permeable absorbent foam 15 cm x 15 cm pad: waterproof, 5 pads	#1	2	..	86.79	6.00	Biatain Non-adhesive 3413	CT
4930L	dressing hydroactive superficial wound high exudate semi-permeable absorbent foam 18 cm x 18 cm pad: waterproof, 5 pads	#1	2	..	94.16	6.00	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.								
4906F	dressing hydroactive superficial wound light exudate 10 cm x 10 cm dressing, 5	2	1	..	*113.60	6.00	Allevyn Thin 66047578	SN
4905E	dressing hydroactive superficial wound light exudate 5 cm x 6 cm dressing, 10	#1	1	..	62.07	6.00	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

[illegible]

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
4923D	DRESSING-HYDROCOLLOID (SUPERFICIAL WOUND-MODERATE EXUDATE) Dressings with alginate 10 cm x 10 cm, 10, 1	#1	1	..	82.34	6.00	Comfeel Plus Ulcer Dressing 3110	CT
4679G	dressing hydrocolloid superficial wound moderate exudate 10 cm (round) dressing, 1	5	..	..	*59.96	6.00	Comfeel Plus Pressure Relieving 3353	CT
4678F	dressing hydrocolloid superficial wound moderate exudate 7 cm (butterfly shape) dressing, 1	5	..	..	*55.51	6.00	Comfeel Plus Pressure Relieving 3350	CT
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.								
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.								
4921B	dressing hydrocolloid superficial wound moderate exudate 10 cm x 10 cm dressing, 10	#1	1	..	86.04	6.00	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.								
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.								
4945G	dressing hydrocolloid superficial wound moderate exudate 10 cm x 10 cm dressing, 10	#1	1	..	48.49	6.00	Hydrocoll 900744	HR
4946H	dressing hydrocolloid superficial wound moderate exudate 15 cm x 15 cm dressing, 10	#1	1	..	90.25	6.00	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.								
4897R	dressing hydrocolloid superficial wound moderate exudate 10 cm x 10 cm dressing, 5	2	1	..	*81.74	6.00	DuoDERM CGF H7660	CC
4920Y	dressing hydrocolloid superficial wound moderate exudate 20 cm x 20 cm dressing, 5	2	1	..	*222.66	6.00	DuoDERM CGF H7662	CC
DRESSING HYDROFIBRE ALTERNATE TO ALGINATES								
2797F	dressing hydrofibre alternate to alginates 10 cm x 10 cm dressing, 10	#1	1	..	101.32	6.00	Aquacel Extra 420672	CC
2803M	dressing hydrofibre alternate to alginates 15 cm x 15 cm dressing, 5	2	1	..	*209.04	6.00	Aquacel Extra 420673	CC
4698G	dressing hydrofibre alternate to alginates 2 g (30 cm) rope, 5 x 2 g	#1	1	..	84.05	6.00	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.								
2486W	dressing hydrofibre gelling fibre 10 cm x 10 cm dressing, 10	#1	1	..	95.82	6.00	Durafiber 66800560	SN
2445Q	dressing hydrofibre gelling fibre 15 cm x 15 cm dressing, 5	#2	1	..	*199.16	6.00	Durafiber 66800561	SN
2462N	dressing hydrofibre gelling fibre 2 cm x	#1	1	..	80.04	6.00	Durafiber 66800563	SN

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
	45 cm rope, 5							
	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.							
10097K	dressing hydrofibre with silver 10 cm x 10 cm dressing, 10	\$1	1	..	262.40	6.00	Aquacel Ag 403708	CC
10098L	dressing hydrofibre with silver 15 cm x 15 cm dressing, 5	\$1	1	..	279.45	6.00	Aquacel Ag 403710	CC
10105W	dressing hydrofibre with silver 2 cm x 45 cm rope, 5	\$1	1	..	224.78	6.00	Aquacel Ag 403771	CC
	DRESSING HYDROGEL							
2471C	dressing hydrogel 10 cm x 10 cm dressing, 20	1	..	..	114.38	6.00	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.							
	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.							
4912M	dressing hydrogel amorphous gel, 10 x 15 g tubes	\$1	1	..	64.82	6.00	DuoDERM Gel H7990	CC
				..	72.43	6.00	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.							
	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.							
4894N	dressing hydrogel amorphous gel, 25 g	4	3	..	*66.56	6.00	Intrasite Gel 7313	SN
4599C	dressing hydrogel amorphous gel, 50 g	3	3	..	*31.57	6.00	SoloSite Gel 36361338	SN
	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.							
4913N	dressing hydrogel amorphous gel, 3 x 30 g tubes	3	1	..	*97.45	6.00	DuoDERM Gel H7987	CC
4914P	dressing hydrogel amorphous gel, 50 g	3	3	..	*33.46	6.00	Solugel 10336	JJ
	DRESSING HYDROGEL FOAM							
2533H	dressing hydrogel foam 10 cm x 10 cm dressing, 10	1	..	..	79.79	6.00	Sorbact Foam Dressing S98310	QL
	DRESSING HYDROGEL RIBBON							
2512F	dressing hydrogel ribbon 1 cm x 50 cm dressing, 20	1	..	..	118.23	6.00	Sorbact Ribbon Gauze S98118	QL
2529D	dressing hydrogel ribbon 5 cm x 200 cm dressing, 10	1	..	..	114.38	6.00	Sorbact Ribbon Gauze S98120	QL

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
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.								
4806Y	dressing hydrogel sheet 10 cm x 10 cm dressing, 5	2	..	..	*53.62	6.00	Aquaclear 900796	HR
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.								
4911L	dressing hydrogel sheet 9.5 cm x 10.2 cm dressing, 5	2	..	..	*83.54	6.00	Nu-Gel 2497	JJ
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.								
4243H	DRESSING SELF ADHESIVE NON-ADHERENT DRY ABSORBENT Dressings, non-woven, with silicone 5 cm x 7.5 cm, 10, 1	#1	..	..	63.96	6.00	Mepitel 290510	MH
4244J	DRESSING SELF ADHESIVE NON-ADHERENT DRY ABSORBENT Dressings, non-woven, with silicone 7.5 cm x 10 cm, 10, 1	#1	..	..	107.96	6.00	Mepitel 290710	MH
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.								
4861W	dressing non adherent 10 cm x 10 cm dressing, 10	#1	..	..	36.03	6.00	Melolin 66974933	SN
4862X	dressing non adherent 10 cm x 10 cm dressing, 5	2	..	..	*25.44	6.00	Cutilin Non-Stick Wound Pad 36361375	SN
4819P	dressing non adherent 5 cm x 5 cm dressing, 5	2	..	..	*15.96	6.00	Cutilin Non-Stick Wound Pad 36361374	SN
4860T	dressing non adherent 5 cm x 5 cm dressing, 5	2	..	..	*17.24	6.00	Melolin 36361357	SN
DRESSING NON ADHERENT								
4755G	dressing non adherent 5 cm x 7.5 cm dressing, 10	#1	..	..	11.36	6.00	Telfa 1970C	KE
4758K	dressing non adherent 7.5 cm x 10 cm self adhesive dressing, 6	#1	..	..	11.57	6.00	Telfa 2140C	KE
4844Y	dressing non adherent 7.5 cm x 10 cm self adhesive dressing, 6	#1	2	..	12.36	6.00	Telfa 7650C	KE
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.								
4944F	dressing non adherent 7.5 cm x 10 cm dressing, 10	#1	..	..	15.58	6.00	Atrauman 499513	HR
DRESSING TULLE NON GAUZE PARAFFIN								

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
4909J	dressing tulle non gauze paraffin 7.6 cm x 7.6 cm dressing, 1	10	1	..	*16.06	6.00	Adaptic 2012	JJ

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.

4646M	dressing with silver 10 cm x 10 cm dressing: hydroactive, 5 dressings	\$1	..	..	176.22	6.00	Biatain Ag 9622	CT
4647N	dressing with silver 12.5 cm x 12.5 cm dressing: hydroactive, 5 dressings	\$1	..	..	191.63	6.00	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.

4648P	dressing with silver 10 cm x 10 cm dressing: tulle, 3 dressings	\$1	..	..	44.12	6.00	Atrauman Ag 499572	HR

GAUZE AND COTTON TISSUE COMBINE ROLL

4761N	gauze and cotton tissue combine roll 10 cm x 10 m roll: wrapped pack, 1 pack	\$1	..	..	17.55	6.00	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.

4767X	gauze and cotton tissue combine roll 9 cm x 10 m roll: wrapped pack, 1 pack	\$1	..	..	11.92	6.00	BSN 2902165	BV

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.

4917T	tape non woven retention polyacrylate 2.5 cm x 10 m tape, 1 roll	\$1	..	..	11.38	6.00	Mefix 310250	MH

TAPE NON WOVEN RETENTION POLYACRYLATE

4915Q	tape non woven retention polyacrylate 2.5 cm x 9.1 m tape, 1 roll	\$1	..	..	13.21	6.00	Medipore 2961	MM

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.

4780N	tape plaster adhesive elastic 2.5 cm x 2.5 m tape, 1 roll	\$1	..	..	13.95	6.00	Leukoplast 01071-00	BV
4781P	tape plaster adhesive elastic 5 cm x 2.5 m tape, 1 roll	\$1	..	..	20.50	6.00	Leukoplast 01072-00	BV
4782Q	tape plaster adhesive elastic 7.5 cm x 2.5 m tape, 1 roll	\$1	..	..	24.55	6.00	Leukoplast 01073-00	BV

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

VARIOUS

Code	Name, Restriction, Manner of Administration and Form	Max. Qty (Packs)	No. of Rpts	Premium \$	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Brand Name and Manufacturer	
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.								
4783R	tape plaster adhesive hypoallergenic 1.25 cm x 5 m tape, 1 roll	#1	..	..	11.10	6.00	Leukopor 2471	BV
4785W	tape plaster adhesive hypoallergenic 1.25 cm x 5 m tape, 1 roll	#1	..	..	11.42	6.00	Leukosilk 1021	BV
4787Y	tape plaster adhesive hypoallergenic 2.5 cm x 5 m tape, 1 roll	#1	..	..	14.34	6.00	Leukosilk 1022	BV
4794H	tape plaster adhesive hypoallergenic 2.5 cm x 5 m tape, 1 roll	#1	..	..	13.76	6.00	Leukopor 2472	BV
4788B	tape plaster adhesive hypoallergenic 5 cm x 5 m stretch tape, 1 roll	#1	..	..	17.55	6.00	Leukoflex 1124	BV
4789C	tape plaster adhesive hypoallergenic 5 cm x 5 m stretch tape, 1 roll	#1	..	..	18.55	6.00	Leukosilk 1024	BV
4790D	tape plaster adhesive hypoallergenic 5 cm x 5 m stretch tape, 1 roll	#1	..	..	17.63	6.00	Leukopor 2474	BV
TAPE PLASTER ADHESIVE HYPOALLERGENIC								
4848E	tape plaster adhesive hypoallergenic 1.9 cm x 5.4 m dispenser tape, 1 roll	#1	..	..	11.39	6.00	Nexcare Durable Cloth First Aid Tape 799	MM
4849F	tape plaster adhesive hypoallergenic 1.9 cm x 7.3 m dispenser tape, 1 roll	#1	..	..	11.39	6.00	Nexcare Gentle Paper First Aid Tape 789	MM
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.								
4239D	tape plaster adhesive with silicone 2 cm x 3 m tape, 1 roll	#1	..	..	21.71	6.00	Mepitac 298300	MH
4240E	tape plaster adhesive with silicone 4 cm x 1.5 m tape, 1 roll	#1	..	..	21.71	6.00	Mepitac 298400	MH

Section 2

Standard Packs and Prices

NOTE—

Standard packs and prices (including mark-up, but without dispensing fee and dangerous drug fee) are for items against the price of which an asterisk () is shown in Section 1 of the Schedule.*

(APPLY WASTAGE FACTOR IN CALCULATING BROKEN QUANTITY PRICES)

Code	Name, Form/Strength	Pack and Price	Manufacturer
10031Y	alprostadil 10 microgram injection [1 x 10 microgram vial] (&) inert substance diluent [1 syringe], 1 pack	1@ 16.51	PF
10030X	alprostadil 20 microgram injection [1 x 20 microgram vial] (&) inert substance diluent [1 syringe], 1 pack	1@ 21.07	PF
4118R	ALUMINIUM HYDROXIDE with MAGNESIUM HYDROXIDE and SIMETHICONE Oral suspension 400 mg-400 mg-30 mg per 5 mL, 500 mL, 1	1@ 8.11	JT
4453J	ALUMINIUM HYDROXIDE with MAGNESIUM HYDROXIDE and SIMETHICONE Tablet 400 mg-400 mg-40 mg, 100	100@ 19.85	JT
4657D	bandage compression 10 cm x 3.5 m bandage: high stretch, 1 bandage	1@ 14.43	MH
4748X	bandage compression 10 cm x 3 m bandage: high stretch, 1 bandage	1@ 13.30	CC
4748X	bandage compression 10 cm x 3 m bandage: high stretch, 1 bandage	1@ 29.24	BV
4654Y	BANDAGE-COMPRESSION Bandage, short stretch, 8 cm x 2.6 m, 1	1@ 13.87	BV
4598B	bandage compression bandage: four layer, 1 bandage	1@ 30.65	SN
4658E		1@ 45.52	SN
4813H	bandage retention cohesive heavy 10 cm x 1.3 m bandage, 1	1@ 7.33	MM
4660G	bandage retention cohesive heavy 10 cm x 2 m bandage, 1	1@ 6.47	MM
4814J	bandage retention cohesive heavy 15 cm x 1.3 m bandage, 1	1@ 10.88	MM
4811F	bandage retention cohesive heavy 5 cm x 1.3 m bandage, 1	1@ 3.80	MM
4812G	bandage retention cohesive heavy 7.5 cm x 1.3 m bandage, 1	1@ 5.44	MM
4662J	bandage retention cohesive light 10 cm x 2 m bandage, 1	1@ 12.33	BV
4719J	bandage retention cohesive light 6 cm x 2 m bandage, 1	1@ 4.69	BV
4729X	bandage retention cotton crepe 10 cm x 2.3 m bandage, 1	1@ 12.08	BV
4729X	bandage retention cotton crepe 10 cm x 2.3 m bandage, 1	1@ 9.48	KE
4727T	bandage retention cotton crepe 5 cm x 2.3 m bandage, 1	1@ 6.73	BV
4727T	bandage retention cotton crepe 5 cm x 2.3 m bandage, 1	1@ 5.50	KE
4728W	bandage retention cotton crepe 7.5 cm x 2.3 m bandage, 1	1@ 7.90	KE
4728W	bandage retention cotton crepe 7.5 cm x 2.3 m bandage, 1	1@ 9.23	BV
4799N	bandage tubular long stocking bandage: large size, 1 bandage	1@ 15.35	MH
4797L	bandage tubular long stocking bandage: medium size, 1 bandage	1@ 15.35	MH
4674B	bandage tubular long stocking bandage: small size, 1 bandage	1@ 15.35	MH
4675C	bandage tubular long stocking bandage: XX/large size, 1 bandage	1@ 15.36	MH
4816L	bandage tubular short stocking bandage: large D/E size, 1 bandage	1@ 9.48	MH
4815K	bandage tubular short stocking bandage: medium C/D size, 1 bandage	1@ 9.48	MH
4661H	bandage tubular short stocking bandage: small B/C size, 1 bandage	1@ 9.48	MH
4670T	bandage zinc paste 10 cm x 9.1 m bandage, 1	1@ 11.18	CC
4669R	bandage zinc paste 7.5 cm x 6 m bandage, 1	1@ 11.62	MH
4750B		1@ 36.18	SN
4150K	bromazepam 3 mg tablet, 30	30@ 11.53	RO
4151L	bromazepam 6 mg tablet, 30	30@ 14.84	RO
4055K	calcium carbonate 420 mg + glycine 180 mg tablet: chewable, 100	100@ 8.38	MM
4094L	CALCIUM Tablet (chewable) 500 mg (as carbonate), 60	60@ 5.62	IA, PP
4333C		60@ 5.62	IA, PP
4142B	CALCIUM Tablet 600 mg (as carbonate), 120	120@ 7.89	PP
4681J	dressing activated charcoal malodorous wound 10.5 cm x 10.5 cm dressing, 1	1@ 9.45	JJ
4832H	DRESSING-ALGINATE (CAVITY WOUND) Rope 2 g, 1	1@ 10.27	UM
1905G	DRESSING-ALGINATE (CAVITY WOUND) Rope 2 g, 5	5@ 54.42	CC
4682K	dressing alginate cavity wound 2 g (40 cm) rope, 6 x 2 g	1@ 65.65	CT
4831G	dressing alginate superficial wound 10 cm x 10 cm dressing, 1	1@ 7.80	UM
4831G	dressing alginate superficial wound 10 cm x 10 cm dressing, 1	1@ 8.37	CT
4684M	dressing alginate superficial wound 5 cm x 5 cm dressing, 1	1@ 4.05	CT
4688R	dressing film 15 cm x 20 cm dressing, 1	1@ 4.04	MM
4898T	dressing film island 5 cm x 7.2 cm dressing, 5	1@ 11.28	SN
4689T	dressing film island 5 cm x 7 cm dressing, 1	1@ 0.98	MM
4899W	dressing film island 8 cm x 10 cm dressing, 5	1@ 19.58	SN
4690W	dressing film island 9 cm x 10 cm dressing, 1	1@ 2.13	MM
4919X	dressing hydroactive cavity wound 10 cm x 10 cm dressing, 5	1@ 96.86	SN
4906F	dressing hydroactive superficial wound light exudate 10 cm x 10 cm dressing, 5	1@ 53.42	SN
4886E	dressing hydroactive superficial wound moderate exudate 10 cm x 10 cm dressing, 5	1@ 39.17	SN
4896Q	dressing hydrocolloid cavity wound paste, 30 g	1@ 13.87	CC
4895P	dressing hydrocolloid cavity wound paste, 50 g	1@ 18.40	CT
4679G	dressing hydrocolloid superficial wound moderate exudate 10 cm	1@ 10.64	CT

(APPLY WASTAGE FACTOR IN CALCULATING BROKEN QUANTITY PRICES)

Code	Name, Form/Strength	Pack and Price	Manufacturer
4897R	(round) dressing, 1 dressing hydrocolloid superficial wound moderate exudate 10 cm x 10 cm dressing, 5	1@ 37.49	CC
4920Y	dressing hydrocolloid superficial wound moderate exudate 20 cm x 20 cm dressing, 5	1@ 107.95	CC
4678F	dressing hydrocolloid superficial wound moderate exudate 7 cm (butterfly shape) dressing, 1	1@ 9.75	CT
2803M	dressing hydrofibre alternate to alginates 15 cm x 15 cm dressing, 5	1@ 101.14	CC
2445Q	dressing hydrofibre gelling fibre 15 cm x 15 cm dressing, 5	1@ 96.20	SN
4894N	dressing hydrogel amorphous gel, 25 g	1@ 14.95	SN
4913N	dressing hydrogel amorphous gel, 3 x 30 g tubes	1@ 30.23	CC
4599C	dressing hydrogel amorphous gel, 50 g	1@ 8.27	SN
4914P		1@ 8.90	JJ
4806Y	dressing hydrogel sheet 10 cm x 10 cm dressing, 5	1@ 23.43	HR
4911L	dressing hydrogel sheet 9.5 cm x 10.2 cm dressing, 5	1@ 38.39	JJ
4862X	dressing non adherent 10 cm x 10 cm dressing, 5	1@ 9.34	SN
4819P	dressing non adherent 5 cm x 5 cm dressing, 5	1@ 4.60	SN
4860T		1@ 5.24	SN
4909J	dressing tulle non gauze paraffin 7.6 cm x 7.6 cm dressing, 1	1@ 0.93	JJ
4237B	fexofenadine hydrochloride 60 mg tablet, 20	20@ 16.19	SW
4246L	glycerol 2.8 g suppository, 12	1@ 4.66	PP
4577X	nicotine 10 mg/16 hours patch, 7	1@ 24.18	JT
4572P	nicotine 14 mg/24 hours patch, 7	1@ 24.07	AF
4572P	nicotine 14 mg/24 hours patch, 7	1@ 31.16	GC
4578Y	nicotine 15 mg/16 hours patch, 7	1@ 26.77	JT
4573Q	nicotine 21 mg/24 hours patch, 7	1@ 31.16	GC
4573Q	nicotine 21 mg/24 hours patch, 7	1@ 25.63	AF
4576W	nicotine 5 mg/16 hours patch, 7	1@ 22.19	JT
4571N	nicotine 7 mg/24 hours patch, 7	1@ 22.49	AF

GENERIC/PROPRIETARY INDEX

GENERIC/PROPRIETARY INDEX

3

3TC (VI)	
.Section 100	717, 967

A

ABACAVIR	
.Section 100	715, 965
ABACAVIR + LAMIVUDINE	
.Section 100	722, 972
ABACAVIR + LAMIVUDINE + ZIDOVUDINE	
.Section 100	722, 972
ABATACEPT	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	294, 301
.Section 100	749, 1002
Abbacillin-V (QA)	
.ANTIINFECTIVES FOR SYSTEMIC USE	222
Abbacillin-VK Filmtab (QA)	
.ANTIINFECTIVES FOR SYSTEMIC USE	222, 223
ABCIXIMAB	
.BLOOD AND BLOOD FORMING ORGANS	109
Abilify (BQ)	
.NERVOUS SYSTEM	526
ABIRATERONE	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	291
Abisart (AF)	
.CARDIOVASCULAR SYSTEM	150
Abisart HCT 150/12.5 (AF)	
.CARDIOVASCULAR SYSTEM	154
Abisart HCT 300/12.5 (AF)	
.CARDIOVASCULAR SYSTEM	154
Abisart HCT 300/25 (AF)	
.CARDIOVASCULAR SYSTEM	154
ACAMPROSATE	
.NERVOUS SYSTEM	558
ACARBOSE	
.ALIMENTARY TRACT AND METABOLISM	95
Accomin Adult Tonic (PF)	
.Repatriation Schedule	1199
Accu-Chek Active (RD)	
.VARIOUS	599, 600
Accu-Chek Advantage/Sensor Comfort (RD)	
.VARIOUS	599, 600
Accu-Chek Aviva (RD)	
.VARIOUS	600, 601
Accu-Chek Go (RD)	
.VARIOUS	600, 601
Accu-Chek Integra (RD)	
.VARIOUS	600, 601
Accu-Chek Mobile (RD)	

.VARIOUS	601
Accu-Chek Performa (RD)	
.VARIOUS	599, 600
Accupril (PF)	
.CARDIOVASCULAR SYSTEM	143
Accuretic 10/12.5mg (PF)	
.CARDIOVASCULAR SYSTEM	147
Accuretic 20/12.5mg (PF)	
.CARDIOVASCULAR SYSTEM	147
ACETAZOLAMIDE	
.SENSORY ORGANS	579
Acetec (AL)	
.CARDIOVASCULAR SYSTEM	140
ACETIC ACID + HYDROXYQUINOLINE + RICINOLEIC ACID	
.Repatriation Schedule	1209
ACICLOVIR	
.ANTIINFECTIVES FOR SYSTEMIC USE	245, 246
.SENSORY ORGANS	576
Aciclovir 200 (CR)	
.ANTIINFECTIVES FOR SYSTEMIC USE	245
Aciclovir 800 (CR)	
.ANTIINFECTIVES FOR SYSTEMIC USE	246
Aciclovir GH (GQ)	
.ANTIINFECTIVES FOR SYSTEMIC USE	245
Acihexal (SZ)	
.ANTIINFECTIVES FOR SYSTEMIC USE	245, 246
Aci-Jel (CU)	
.Repatriation Schedule	1209
Acimax Tablets (AL)	
.ALIMENTARY TRACT AND METABOLISM	70
ACITRETIN	
.DERMATOLOGICALS	192
Acitretin Actavis (GN)	
.DERMATOLOGICALS	192
Aclasta (NV)	
.MUSCULO-SKELETAL SYSTEM	473
ACLIDINIUM	
.RESPIRATORY SYSTEM	571
Aclor 125 (QA)	
.ANTIINFECTIVES FOR SYSTEMIC USE	229
Aclor 250 (QA)	
.ANTIINFECTIVES FOR SYSTEMIC USE	229
Acpio 15 (QA)	
.ALIMENTARY TRACT AND METABOLISM	97
Acpio 30 (QA)	
.ALIMENTARY TRACT AND METABOLISM	97
Acpio 45 (QA)	
.ALIMENTARY TRACT AND METABOLISM	98
Acquin Aspen 10 (AS)	
.CARDIOVASCULAR SYSTEM	143
Acquin Aspen 20 (AS)	
.CARDIOVASCULAR SYSTEM	143
Acquin Aspen 5 (AS)	
.CARDIOVASCULAR SYSTEM	143

GENERIC/PROPRIETARY INDEX

<i>Acris Combi (AF)</i>		.ANTINEOPLASTIC AND IMMUNOMODULATING	
.MUSCULO-SKELETAL SYSTEM	477	AGENTS	308, 314, 317, 320, 323, 330, 333, 336, 339, 342, 345, 351, 357, 361
.Repatriation Schedule	1215	.Section 100	772, 1025
<i>Acris Once-a-Month (AF)</i>		ADAPALENE + BENZOYL PEROXIDE	
.MUSCULO-SKELETAL SYSTEM	472	.DERMATOLOGICALS	195
<i>Acris Once-a-Week (AF)</i>		<i>Adaptic 2012 (JJ)</i>	
.MUSCULO-SKELETAL SYSTEM	472	.Repatriation Schedule	1239
.Repatriation Schedule	1214	<i>Adcirca (LY)</i>	
<i>Actemra (RO)</i>		.Section 100	703, 951
.Section 100	843, 852, 858, 868, 1095, 1104, 1110, 1111, 1120, 1121	<i>add-ins (SB)</i>	
<i>Actilax (AF)</i>		.VARIOUS	622
.ALIMENTARY TRACT AND METABOLISM	79	<i>Addos XR 30 (QA)</i>	
.Palliative Care	634	.CARDIOVASCULAR SYSTEM	138
<i>Actiq (OA)</i>		<i>Addos XR 60 (QA)</i>	
.Palliative Care	643, 644	.CARDIOVASCULAR SYSTEM	138
<i>Actisorb Plus MAP105 (JJ)</i>		<i>Adefin 10 (AF)</i>	
.Repatriation Schedule	1229	.CARDIOVASCULAR SYSTEM	138
<i>Actonel (SW)</i>		<i>Adefin 20 (AF)</i>	
.MUSCULO-SKELETAL SYSTEM	472	.CARDIOVASCULAR SYSTEM	138
.Repatriation Schedule	1214	<i>Adefin XL 30 (AF)</i>	
<i>Actonel EC (SW)</i>		.CARDIOVASCULAR SYSTEM	138
.MUSCULO-SKELETAL SYSTEM	472	<i>Adefin XL 60 (AF)</i>	
.Repatriation Schedule	1214	.CARDIOVASCULAR SYSTEM	139
<i>Actonel EC Combi (SW)</i>		ADEFOVIR DIPIVOXIL	
.MUSCULO-SKELETAL SYSTEM	477	.Section 100	715, 965
.Repatriation Schedule	1215	<i>Adesan (AF)</i>	
<i>Actonel EC Combi D (SW)</i>		.CARDIOVASCULAR SYSTEM	149
.MUSCULO-SKELETAL SYSTEM	478	<i>Adesan HCT 16/12.5 (AF)</i>	
.Repatriation Schedule	1215	.CARDIOVASCULAR SYSTEM	152
<i>Actonel Once-a-Month (SW)</i>		<i>Adesan HCT 32/12.5 (AF)</i>	
.MUSCULO-SKELETAL SYSTEM	472	.CARDIOVASCULAR SYSTEM	152
<i>Actos (TK)</i>		<i>Adesan HCT 32/25 (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM	97, 98	.CARDIOVASCULAR SYSTEM	153
<i>Actrapid (NO)</i>		ADRENALINE	
.ALIMENTARY TRACT AND METABOLISM	87	.CARDIOVASCULAR SYSTEM	127, 128
<i>Actrapid Penfill 3 mL (NO)</i>		.RESPIRATORY SYSTEM	572
.ALIMENTARY TRACT AND METABOLISM	87	<i>ADT Booster (CS)</i>	
<i>Acyclo-V 200 (AF)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE	250
.ANTIINFECTIVES FOR SYSTEMIC USE	245	.Prescriber Bag	62
<i>Acyclo-V 800 (AF)</i>		<i>Advantan (BN)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	246	.DERMATOLOGICALS	194
<i>Adalat 10 (BN)</i>		<i>Aeron 250 (QA)</i>	
.CARDIOVASCULAR SYSTEM	138	.RESPIRATORY SYSTEM	571
<i>Adalat 20 (BN)</i>		<i>Aeron 500 (QA)</i>	
.CARDIOVASCULAR SYSTEM	138	.RESPIRATORY SYSTEM	572
<i>Adalat Oros 20mg (BN)</i>		<i>Afinitor (NV)</i>	
.CARDIOVASCULAR SYSTEM	138	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>Adalat Oros 30 (BN)</i>		AGENTS	262, 263, 264
.CARDIOVASCULAR SYSTEM	138	AFLIBERCEPT	
<i>Adalat Oros 60 (BN)</i>		.SENSORY ORGANS	584
.CARDIOVASCULAR SYSTEM	139	<i>Aggrastat (AS)</i>	
ADALIMUMAB		.BLOOD AND BLOOD FORMING ORGANS	114
		<i>Airomir Autohaler (IA)</i>	
		.RESPIRATORY SYSTEM	565

GENERIC/PROPRIETARY INDEX

<i>Akamin 50 (AF)</i>		<i>Alepam 30 (AF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	219	.NERVOUS SYSTEM.....	532
<i>Akineton (LM)</i>		.Palliative Care.....	646, 647
.NERVOUS SYSTEM.....	510	<i>Alfamino (NT)</i>	
<i>Albalon Liquifilm (AG)</i>		.VARIOUS.....	611, 612
.Repatriation Schedule.....	1222	<i>Alfaré (NT)</i>	
<i>Albalon-A (AG)</i>		.VARIOUS.....	615
.Repatriation Schedule.....	1222	ALFUZOSIN	
ALBENDAZOLE		.Repatriation Schedule.....	1210
.ANTIPARASITIC PRODUCTS, INSECTICIDES AND		ALGINATE SODIUM + CALCIUM CARBONATE +	
REPELLENTS.....	562	BICARBONATE	
<i>Albey Bee Venom (HL)</i>		.ALIMENTARY TRACT AND METABOLISM.....	73
.VARIOUS.....	596	<i>Algisite M 66000519 (SN)</i>	
<i>Albey Paper Wasp Venom (HL)</i>		.Repatriation Schedule.....	1230
.VARIOUS.....	596	<i>Algisite M 66000520 (SN)</i>	
<i>Albey Yellow Jacket Venom (HL)</i>		.Repatriation Schedule.....	1230
.VARIOUS.....	596	<i>Algisite M 66000521 (SN)</i>	
<i>Aldactone (PF)</i>		.Repatriation Schedule.....	1230
.CARDIOVASCULAR SYSTEM.....	132	<i>Alkeran (AS)</i>	
<i>Aldara (IA)</i>		.ANTINEOPLASTIC AND IMMUNOMODULATING	
.DERMATOLOGICALS.....	197	AGENTS.....	251
.Repatriation Schedule.....	1207	<i>Allegron (AS)</i>	
<i>Aldara Pump (IA)</i>		.NERVOUS SYSTEM.....	535
.DERMATOLOGICALS.....	197	<i>Allereze (AF)</i>	
.Repatriation Schedule.....	1207	.Repatriation Schedule.....	1221
<i>Aldiq (QA)</i>		<i>Allewyn 66007637 (SN)</i>	
.DERMATOLOGICALS.....	197	.Repatriation Schedule.....	1231
.Repatriation Schedule.....	1207	<i>Allewyn Adhesive 66000044 (SN)</i>	
<i>Aldomet (AS)</i>		.Repatriation Schedule.....	1231
.CARDIOVASCULAR SYSTEM.....	130	<i>Allewyn Ag Adhesive 66800073 (SN)</i>	
<i>Alendro Once Weekly (QA)</i>		.Repatriation Schedule.....	1233
.MUSCULO-SKELETAL SYSTEM.....	470	<i>Allewyn Ag Adhesive 66800075 (SN)</i>	
<i>Alendrobell 70mg (GQ)</i>		.Repatriation Schedule.....	1233
.MUSCULO-SKELETAL SYSTEM.....	470	<i>Allewyn Ag Adhesive 66800078 (SN)</i>	
ALENDRONATE		.Repatriation Schedule.....	1233
.MUSCULO-SKELETAL SYSTEM.....	469	<i>Allewyn Ag Gentle Border 66800460 (SN)</i>	
ALENDRONATE + COLECALCIFEROL		.Repatriation Schedule.....	1233
.MUSCULO-SKELETAL SYSTEM.....	473, 474	<i>Allewyn Ag Gentle Border 66800461 (SN)</i>	
.Repatriation Schedule.....	1214	.Repatriation Schedule.....	1233
ALENDRONATE + COLECALCIFEROL (&) CALCIUM		<i>Allewyn Ag Gentle Border 66800462 (SN)</i>	
CARBONATE		.Repatriation Schedule.....	1233
.MUSCULO-SKELETAL SYSTEM.....	475	<i>Allewyn Ag Non-Adhesive 66800086 (SN)</i>	
.Repatriation Schedule.....	1214	.Repatriation Schedule.....	1233
<i>Alendronate AN (EA)</i>		<i>Allewyn Gentle 66800248 (SN)</i>	
.MUSCULO-SKELETAL SYSTEM.....	470	.Repatriation Schedule.....	1232
<i>Alendronate plus D3-DRLA (RZ)</i>		<i>Allewyn Gentle Border 66800269 (SN)</i>	
.MUSCULO-SKELETAL SYSTEM.....	474, 475	.Repatriation Schedule.....	1232
.Repatriation Schedule.....	1214	<i>Allewyn Gentle Border 66800270 (SN)</i>	
<i>Alendronate Sandoz (SZ)</i>		.Repatriation Schedule.....	1232
.MUSCULO-SKELETAL SYSTEM.....	470	<i>Allewyn Life 66801067 (SN)</i>	
<i>Alendronate-GA (GN)</i>		.Repatriation Schedule.....	1231
.MUSCULO-SKELETAL SYSTEM.....	470	<i>Allewyn Life 66801068 (SN)</i>	
<i>Alepam 15 (AF)</i>		.Repatriation Schedule.....	1231
.NERVOUS SYSTEM.....	532	<i>Allewyn Life 66801069 (SN)</i>	
.Palliative Care.....	646	.Repatriation Schedule.....	1232

GENERIC/PROPRIETARY INDEX

<i>Allevyn Life 66801070 (SN)</i>		
.Repatriation Schedule	1232	
<i>Allevyn Plus Cavity 66047571 (SN)</i>		
.Repatriation Schedule	1233	
<i>Allevyn Plus Cavity 66047573 (SN)</i>		
.Repatriation Schedule	1233	
<i>Allevyn Thin 66047576 (SN)</i>		
.Repatriation Schedule	1234	
<i>Allevyn Thin 66047578 (SN)</i>		
.Repatriation Schedule	1234	
ALLOPURINOL		
.MUSCULO-SKELETAL SYSTEM	469	
<i>Allopurinol Sandoz (SZ)</i>		
.MUSCULO-SKELETAL SYSTEM	469	
<i>Allosig (FM)</i>		
.MUSCULO-SKELETAL SYSTEM	469	
<i>Alodorm (AF)</i>		
.NERVOUS SYSTEM.....	500, 532, 533	
.Palliative Care	647	
ALOGLIPTIN		
.ALIMENTARY TRACT AND METABOLISM.....	99	
ALOGLIPTIN + METFORMIN		
.ALIMENTARY TRACT AND METABOLISM.....	91	
<i>Aloxi (TS)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	76	
<i>Alpha Keri Bath Oil (MT)</i>		
.Repatriation Schedule	1204	
<i>Alpha Keri Lotion (MT)</i>		
.Repatriation Schedule	1204	
<i>Alphagan (AG)</i>		
.SENSORY ORGANS.....	578	
<i>Alphagan P 1.5 (AG)</i>		
.SENSORY ORGANS.....	578	
<i>Alphamox 125 (AF)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	220	
<i>Alphamox 250 (AF)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	220, 221	
<i>Alphamox 500 (AF)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	221	
<i>Alphapress 25 (AF)</i>		
.CARDIOVASCULAR SYSTEM	130	
<i>Alphapress 50 (AF)</i>		
.CARDIOVASCULAR SYSTEM	130	
<i>Alprax 0.25 (QA)</i>		
.NERVOUS SYSTEM.....	531	
<i>Alprax 0.5 (QA)</i>		
.NERVOUS SYSTEM.....	531	
<i>Alprax 1 (QA)</i>		
.NERVOUS SYSTEM.....	531	
<i>Alprax 2 (QA)</i>		
.NERVOUS SYSTEM.....	531	
ALPRAZOLAM		
.NERVOUS SYSTEM.....	531	
<i>Alprim (AF)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	232	
ALPROSTADIL		
.Repatriation Schedule	1209	
<i>Altven (FZ)</i>		
.NERVOUS SYSTEM.....	543	
ALUMINIUM HYDROXIDE + MAGNESIUM HYDROXIDE + MAGNESIUM TRISILICATE		
.ALIMENTARY TRACT AND METABOLISM.....	66	
ALUMINIUM HYDROXIDE WITH MAGNESIUM HYDROXIDE		
.ALIMENTARY TRACT AND METABOLISM.....	66	
ALUMINIUM HYDROXIDE WITH MAGNESIUM HYDROXIDE AND SIMETHICONE		
.Repatriation Schedule	1197	
<i>Alvesco 160 (NQ)</i>		
.RESPIRATORY SYSTEM.....	571	
<i>Alvesco 80 (NQ)</i>		
.RESPIRATORY SYSTEM.....	571	
<i>Alzene (AF)</i>		
.Repatriation Schedule	1221	
AMANTADINE		
.NERVOUS SYSTEM.....	511	
<i>Amaryl (SW)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	90, 91	
AMBRISENTAN		
.Section 100.....	658, 906	
AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS AND TRACE ELEMENTS WITHOUT METHIONINE AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID		
.VARIOUS.....	620	
AMINO ACID FORMULA WITH FAT, CARBOHYDRATE, VITAMINS, MINERALS AND TRACE ELEMENTS WITHOUT PHENYLALANINE AND TYROSINE, AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID		
.VARIOUS.....	620	
AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT LYSINE AND LOW IN TRYPTOPHAN		
.VARIOUS.....	620, 621	
AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT METHIONINE		
.VARIOUS.....	621	
AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT METHIONINE, THREONINE AND VALINE AND LOW IN ISOLEUCINE		
.VARIOUS.....	621	
AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT PHENYLALANINE		
.VARIOUS.....	622	
AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT PHENYLALANINE AND TYROSINE		
.VARIOUS.....	623	
AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT VALINE, LEUCINE AND ISOLEUCINE		
.VARIOUS.....	623	

GENERIC/PROPRIETARY INDEX

AMINO ACID FORMULA WITH VITAMINS AND MINERALS WITHOUT VALINE, LEUCINE AND ISOLEUCINE WITH FAT, CARBOHYDRATE AND TRACE ELEMENTS AND SUPPLEMENTED WITH DOCOSAHEXAENOIC ACID .VARIOUS.....	624
AMINO ACID FORMULA WITH VITAMINS, MINERALS AND LONG CHAIN POLYUNSATURATED FATTY ACIDS WITHOUT PHENYLALANINE .VARIOUS.....	620
AMINO ACID FORMULA WITHOUT PHENYLALANINE .VARIOUS.....	620
AMINO ACID FORMULA WITHOUT VALINE, LEUCINE AND ISOLEUCINE .VARIOUS.....	620
AMINO ACID SYNTHETIC FORMULA .VARIOUS.....	602, 603, 605
AMINO ACID SYNTHETIC FORMULA SUPPLEMENTED WITH LONG CHAIN POLYUNSATURATED FATTY ACIDS .VARIOUS.....	606, 607
AMINO ACID SYNTHETIC FORMULA SUPPLEMENTED WITH LONG CHAIN POLYUNSATURATED FATTY ACIDS AND MEDIUM CHAIN TRIGLYCERIDES .VARIOUS.....	609, 611, 612
AMIODARONE .CARDIOVASCULAR SYSTEM	127
<i>Amiodarone Sandoz (SZ)</i> .CARDIOVASCULAR SYSTEM	127
<i>Amipride 400 (QA)</i> .NERVOUS SYSTEM.....	526
<i>Amira 150 (AF)</i> .NERVOUS SYSTEM.....	540
<i>Amira 300 (AF)</i> .NERVOUS SYSTEM.....	540
AMISULPRIDE .NERVOUS SYSTEM.....	525
<i>Amisulpride 100 Winthrop (WA)</i> .NERVOUS SYSTEM.....	525
<i>Amisulpride 200 Winthrop (WA)</i> .NERVOUS SYSTEM.....	526
<i>Amisulpride 400 Winthrop (WA)</i> .NERVOUS SYSTEM.....	526
<i>Amisulpride Sandoz (SZ)</i> .NERVOUS SYSTEM.....	525, 526
AMITRIPTYLINE .NERVOUS SYSTEM.....	534
<i>Amlo 10 (QA)</i> .CARDIOVASCULAR SYSTEM	137
<i>Amlo 5 (QA)</i> .CARDIOVASCULAR SYSTEM	137
AMLODIPINE .CARDIOVASCULAR SYSTEM	137
AMLODIPINE + ATORVASTATIN .CARDIOVASCULAR SYSTEM	187
AMLODIPINE + VALSARTAN .CARDIOVASCULAR SYSTEM	156
AMLODIPINE + VALSARTAN + HYDROCHLOROTHIAZIDE .CARDIOVASCULAR SYSTEM	157
<i>Amlodipine generichealth (GQ)</i> .CARDIOVASCULAR SYSTEM	137
<i>Amlodipine Sandoz (SZ)</i> .CARDIOVASCULAR SYSTEM	137
<i>Amlodipine-DRLA (RZ)</i> .CARDIOVASCULAR SYSTEM	137
AMMONIUM + SENEGA ROOT .Repatriation Schedule	1220
AMOROLFINE .Repatriation Schedule	1203
<i>Amoxiclav AN 500/125 (EA)</i> .ANTIINFECTIVES FOR SYSTEMIC USE	224
<i>Amoxiclav AN 875/125 (EA)</i> .ANTIINFECTIVES FOR SYSTEMIC USE	225
<i>Amoxil (AS)</i> .ANTIINFECTIVES FOR SYSTEMIC USE	220, 221
<i>Amoxil Forte (AS)</i> .ANTIINFECTIVES FOR SYSTEMIC USE	221
AMOXYCILLIN .ANTIINFECTIVES FOR SYSTEMIC USE	220, 221
AMOXYCILLIN + CLAVULANIC ACID .ANTIINFECTIVES FOR SYSTEMIC USE	224
<i>Amoxycillin AN (EA)</i> .ANTIINFECTIVES FOR SYSTEMIC USE	220, 221
<i>Amoxycillin generichealth 500 (GQ)</i> .ANTIINFECTIVES FOR SYSTEMIC USE	221
<i>Amoxycillin Ranbaxy (RA)</i> .ANTIINFECTIVES FOR SYSTEMIC USE	220, 221
<i>Amoxycillin Sandoz (BG)</i> .ANTIINFECTIVES FOR SYSTEMIC USE	220
<i>Amoxycillin Sandoz (SZ)</i> .ANTIINFECTIVES FOR SYSTEMIC USE	220, 221
<i>Amoxycillin-GA (GN)</i> .ANTIINFECTIVES FOR SYSTEMIC USE	220, 221
<i>AmoxyClav GH 875/125 (GQ)</i> .ANTIINFECTIVES FOR SYSTEMIC USE	225
<i>AmoxyClav RBX 875/125 (RA)</i> .ANTIINFECTIVES FOR SYSTEMIC USE	225
AMPHOTERICIN B .ALIMENTARY TRACT AND METABOLISM.....	66
AMPICILLIN .ANTIINFECTIVES FOR SYSTEMIC USE	221
AMYLOPECTIN MODIFIED LONG CHAIN .VARIOUS.....	618
<i>Anafranil 25 (NV)</i> .NERVOUS SYSTEM.....	534
<i>Anamorph (FM)</i> .NERVOUS SYSTEM.....	484, 485
<i>Anandron (SW)</i> .ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	289
<i>Anapen (LM)</i> .CARDIOVASCULAR SYSTEM	128

GENERIC/PROPRIETARY INDEX

.RESPIRATORY SYSTEM	573	.CARDIOVASCULAR SYSTEM	139
<i>Anapen Junior (LM)</i>		<i>Antenex 2 (AF)</i>	
.CARDIOVASCULAR SYSTEM	128	.NERVOUS SYSTEM.....	531, 532
.RESPIRATORY SYSTEM	573	.Palliative Care.....	646
<i>Anaprox 550 (RO)</i>		<i>Antenex 5 (AF)</i>	
.MUSCULO-SKELETAL SYSTEM	466	.NERVOUS SYSTEM.....	531, 532
.Palliative Care	641	.Palliative Care.....	646
<i>Anastrol (QA)</i>		<i>Anthel 125 (AF)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING		.ANTIPARASITIC PRODUCTS, INSECTICIDES AND	
AGENTS	289	REPELLENTS	562
ANASTROZOLE		<i>Anthel 250 (AF)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING		.ANTIPARASITIC PRODUCTS, INSECTICIDES AND	
AGENTS	289	REPELLENTS	562
<i>Anastrozole AN (EA)</i>		<i>Antroquoril (FR)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING		.DERMATOLOGICALS	194
AGENTS	289	<i>Anusol (JT)</i>	
<i>Anastrozole GH (GQ)</i>		.Repatriation Schedule	1202
.ANTINEOPLASTIC AND IMMUNOMODULATING		<i>Anzole (UA)</i>	
AGENTS	289	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>Anastrozole RBX (RA)</i>		AGENTS	289
.ANTINEOPLASTIC AND IMMUNOMODULATING		<i>Apidra (AV)</i>	
AGENTS	289	.ALIMENTARY TRACT AND METABOLISM.....	87
<i>Anastrozole Sandoz (SZ)</i>		<i>Apidra (SW)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING		.ALIMENTARY TRACT AND METABOLISM.....	87
AGENTS	289	<i>Apidra SoloStar (SW)</i>	
<i>Anastrozole-DRLA (RZ)</i>		.ALIMENTARY TRACT AND METABOLISM.....	87
.ANTINEOPLASTIC AND IMMUNOMODULATING		APIXABAN	
AGENTS	289	.BLOOD AND BLOOD FORMING ORGANS.....	116, 117, 118
<i>Anastrozole-GA (GN)</i>		<i>APO- Hydroxychloroquine (TX)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING		.MUSCULO-SKELETAL SYSTEM	467
AGENTS	289	<i>APO- Paracetamol/Codeine 500/30 (TX)</i>	
<i>Andepra (EL)</i>		.NERVOUS SYSTEM.....	487, 488
.NERVOUS SYSTEM.....	541	<i>APO-Adefovir (TX)</i>	
<i>Andriol Testocaps (MK)</i>		.Section 100.....	716, 965
.GENITO URINARY SYSTEM AND SEX HORMONES .	201	<i>APO-Alendronate (TX)</i>	
<i>Androcur (BN)</i>		.MUSCULO-SKELETAL SYSTEM	470
.ANTINEOPLASTIC AND IMMUNOMODULATING		<i>APO-Amisulpride (TX)</i>	
AGENTS	288	.NERVOUS SYSTEM.....	525, 526
.GENITO URINARY SYSTEM AND SEX HORMONES	205, 206	<i>APO-Amlodipine (TX)</i>	
<i>Androcur-100 (BN)</i>		.CARDIOVASCULAR SYSTEM	137
.ANTINEOPLASTIC AND IMMUNOMODULATING		<i>APO-Amlodipine/Atorvastatin 10/10 (TX)</i>	
AGENTS	288	.CARDIOVASCULAR SYSTEM	187
.GENITO URINARY SYSTEM AND SEX HORMONES .	205	<i>APO-Amlodipine/Atorvastatin 10/20 (TX)</i>	
<i>Androderm (GN)</i>		.CARDIOVASCULAR SYSTEM	188
.GENITO URINARY SYSTEM AND SEX HORMONES .	201	<i>APO-Amlodipine/Atorvastatin 10/40 (TX)</i>	
<i>Anginine Stabilised (QA)</i>		.CARDIOVASCULAR SYSTEM	188
.CARDIOVASCULAR SYSTEM	128	<i>APO-Amlodipine/Atorvastatin 10/80 (TX)</i>	
<i>Angiomax (XM)</i>		.CARDIOVASCULAR SYSTEM	188
.BLOOD AND BLOOD FORMING ORGANS	114	<i>APO-Amlodipine/Atorvastatin 5/10 (TX)</i>	
<i>Anoro Ellipta 62.5/25 (GK)</i>		.CARDIOVASCULAR SYSTEM	188
.RESPIRATORY SYSTEM	570	<i>APO-Amlodipine/Atorvastatin 5/20 (TX)</i>	
<i>Anpec 40 (AF)</i>		.CARDIOVASCULAR SYSTEM	189
.CARDIOVASCULAR SYSTEM.....	139	<i>APO-Amlodipine/Atorvastatin 5/40 (TX)</i>	
<i>Anpec 80 (AF)</i>		.CARDIOVASCULAR SYSTEM	189

GENERIC/PROPRIETARY INDEX

<i>APO-Amlodipine/Atorvastatin 5/80 (TX)</i>	
.CARDIOVASCULAR SYSTEM	189
<i>APO-Amoxycillin (TX)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	220, 221
<i>APO-Amoxycillin and Clavulanic Acid (TX)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	225
<i>APO-Amoxycillin/ Clavulanic Acid 500/125 (TX)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	224
<i>APO-Anastrozole (TX)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	289
<i>APO-Atenolol (TX)</i>	
.CARDIOVASCULAR SYSTEM	133
<i>APO-Atorvastatin (TX)</i>	
.CARDIOVASCULAR SYSTEM	161, 162, 163
<i>APO-Azathioprine (TX)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	461
<i>APO-Azithromycin (TX)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	233
.Repatriation Schedule	1212
.SENSORY ORGANS	575
<i>APO-Bicalutamide (TX)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	288
<i>APO-Bisoprolol (TX)</i>	
.CARDIOVASCULAR SYSTEM	134
<i>APO-Candesartan (TX)</i>	
.CARDIOVASCULAR SYSTEM	149
<i>APO-Candesartan HCTZ 16/12.5 (TX)</i>	
.CARDIOVASCULAR SYSTEM	152
<i>APO-Candesartan HCTZ 32/12.5 (TX)</i>	
.CARDIOVASCULAR SYSTEM	153
<i>APO-Candesartan HCTZ 32/25 (TX)</i>	
.CARDIOVASCULAR SYSTEM	153
<i>APO-Captopril (TX)</i>	
.CARDIOVASCULAR SYSTEM	140
<i>APO-Carvedilol (TX)</i>	
.CARDIOVASCULAR SYSTEM	136
<i>APO-Cefaclor (TX)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	229
<i>APO-Cefaclor CD (TX)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	229
<i>APO-Celecoxib (TX)</i>	
.MUSCULO-SKELETAL SYSTEM	467
<i>APO-Cephalexin (TX)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	226, 227
<i>APO-Citalopram (TX)</i>	
.NERVOUS SYSTEM	535
<i>APO-Clarithromycin (TX)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	233
<i>APO-Clindamycin (TX)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	235
<i>APO-Clopidogrel (TX)</i>	
.BLOOD AND BLOOD FORMING ORGANS	110, 111
.Repatriation Schedule	1201
<i>APO-Clopidogrel/Aspirin 75/100 (TX)</i>	
.BLOOD AND BLOOD FORMING ORGANS	112
<i>APO-Clotrimazole 3 Day Cream (TX)</i>	
.Repatriation Schedule	1209
<i>APO-Clotrimazole 6 Day Cream (TX)</i>	
.Repatriation Schedule	1209
<i>APO-Diazepam (TX)</i>	
.NERVOUS SYSTEM	531, 532
.Palliative Care	646
<i>APO-Diclofenac (TX)</i>	
.MUSCULO-SKELETAL SYSTEM	462
.Palliative Care	638, 639
<i>APO-Dipyridamole/Aspirin 200/25 (TX)</i>	
.BLOOD AND BLOOD FORMING ORGANS	113
<i>APO-Donepezil (TX)</i>	
.NERVOUS SYSTEM	547, 548
<i>APO-Duloxetine (TX)</i>	
.NERVOUS SYSTEM	541
<i>APO-Enalapril (TX)</i>	
.CARDIOVASCULAR SYSTEM	140
<i>APO-Escitalopram (TX)</i>	
.NERVOUS SYSTEM	535, 536
<i>APO-Exemestane (TX)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	290
<i>APO-Famciclovir (TX)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	246, 247, 248
<i>APO-Finasteride (TX)</i>	
.Repatriation Schedule	1211
<i>APO-Fluconazole (TX)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	241
<i>APO-Fluvoxamine (TX)</i>	
.NERVOUS SYSTEM	538
<i>APO-Fosinopril (TX)</i>	
.CARDIOVASCULAR SYSTEM	141
<i>APO-Fosinopril HCTZ 10/12.5 (TX)</i>	
.CARDIOVASCULAR SYSTEM	146
<i>APO-Fosinopril HCTZ 20/12.5 (TX)</i>	
.CARDIOVASCULAR SYSTEM	146
<i>APO-Frusemide (TX)</i>	
.CARDIOVASCULAR SYSTEM	131, 132
<i>APO-Gabapentin (TX)</i>	
.NERVOUS SYSTEM	502
.Repatriation Schedule	1216
<i>APO-Galantamine MR (TX)</i>	
.NERVOUS SYSTEM	549, 550
<i>APO-Gliclazide MR (TX)</i>	
.ALIMENTARY TRACT AND METABOLISM	90
<i>APO-Glimepiride (TX)</i>	
.ALIMENTARY TRACT AND METABOLISM	90, 91
<i>APO-Imiquimod (TX)</i>	
.DERMATOLOGICALS	197
.Repatriation Schedule	1207
<i>APO-Indapamide SR (TX)</i>	

GENERIC/PROPRIETARY INDEX

.CARDIOVASCULAR SYSTEM	131
<i>APO-Ipratropium (TX)</i>	
.RESPIRATORY SYSTEM	571, 572
<i>APO-Irbesartan (TX)</i>	
.CARDIOVASCULAR SYSTEM	150
<i>APO-Irbesartan HCTZ (TX)</i>	
.CARDIOVASCULAR SYSTEM	154
<i>APO-Isotretinoin (TX)</i>	
.DERMATOLOGICALS	195
<i>APO-Lamotrigine (TX)</i>	
.NERVOUS SYSTEM	505, 506
<i>APO-Lansoprazole (TX)</i>	
.ALIMENTARY TRACT AND METABOLISM	69
<i>APO-Latanoprost (TX)</i>	
.SENSORY ORGANS	582
<i>APO-Latanoprost/Timolol 0.05/5 (TX)</i>	
.SENSORY ORGANS	583
<i>APO-Leflunomide (TX)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	306
<i>APO-Lercanidipine (TX)</i>	
.CARDIOVASCULAR SYSTEM	138
<i>APO-Letrozole (TX)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	291
<i>APO-Levetiracetam (TX)</i>	
.NERVOUS SYSTEM	506, 507
<i>APO-Lisinopril (TX)</i>	
.CARDIOVASCULAR SYSTEM	141
<i>APO-MACROGOL plus ELECTROLYTES (TX)</i>	
.ALIMENTARY TRACT AND METABOLISM	80
.Palliative Care	635
<i>APO-Meloxicam (TX)</i>	
.MUSCULO-SKELETAL SYSTEM	463, 464
<i>APO-Memantine (TX)</i>	
.NERVOUS SYSTEM	553, 554
<i>APO-Metformin 1000 (TX)</i>	
.ALIMENTARY TRACT AND METABOLISM	89
<i>APO-Metformin 500 (TX)</i>	
.ALIMENTARY TRACT AND METABOLISM	89
<i>APO-Metformin 850 (TX)</i>	
.ALIMENTARY TRACT AND METABOLISM	89
<i>APO-Metformin XR 500 (TX)</i>	
.ALIMENTARY TRACT AND METABOLISM	89
<i>APO-Metoclopramide (TX)</i>	
.ALIMENTARY TRACT AND METABOLISM	73
<i>Apomine (HH)</i>	
.Section 100	886, 1138
<i>Apomine PFS (HH)</i>	
.Section 100	886, 1138
<i>APO-Mirtazapine (TX)</i>	
.NERVOUS SYSTEM	542
<i>APO-Montelukast (TX)</i>	
.RESPIRATORY SYSTEM	573, 574
APOMORPHINE	
.Section 100	886, 1138
<i>APO-Mycophenolate (TX)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	307
.Section 100	771, 1024
<i>APO-Nifedipine XR (TX)</i>	
.CARDIOVASCULAR SYSTEM	138, 139
<i>APO-Olanzapine (TX)</i>	
.NERVOUS SYSTEM	518, 520, 522, 523
<i>APO-Olanzapine ODT (TX)</i>	
.NERVOUS SYSTEM	517, 519, 520
<i>APO-Omeprazole (TX)</i>	
.ALIMENTARY TRACT AND METABOLISM	69, 70
<i>APO-Ondansetron (TX)</i>	
.ALIMENTARY TRACT AND METABOLISM	75, 76
<i>APO-Osteo Paracetamol 665 mg (TX)</i>	
.NERVOUS SYSTEM	495
.Palliative Care	644, 645
<i>APO-Oxazepam (TX)</i>	
.NERVOUS SYSTEM	532
.Palliative Care	646, 647
<i>APO-Pantoprazole (TX)</i>	
.ALIMENTARY TRACT AND METABOLISM	70, 71
<i>APO-Paracetamol (TX)</i>	
.NERVOUS SYSTEM	494, 495
<i>APO-Perindopril (TX)</i>	
.CARDIOVASCULAR SYSTEM	142, 143
<i>APO-Pravastatin (TX)</i>	
.CARDIOVASCULAR SYSTEM	164, 165, 166
<i>APO-Prazosin (TX)</i>	
.CARDIOVASCULAR SYSTEM	130
<i>APO-Prochlorperazine (TX)</i>	
.ALIMENTARY TRACT AND METABOLISM	78
<i>APO-Quetiapine (TX)</i>	
.NERVOUS SYSTEM	523, 524, 525
<i>APO-Quinapril (TX)</i>	
.CARDIOVASCULAR SYSTEM	143
<i>APO-Rabeprazole (TX)</i>	
.ALIMENTARY TRACT AND METABOLISM	72
<i>APO-Raloxifene (TX)</i>	
.MUSCULO-SKELETAL SYSTEM	480
<i>APO-Ramipril (TX)</i>	
.CARDIOVASCULAR SYSTEM	143, 144, 145
<i>APO-Ranitidine (TX)</i>	
.ALIMENTARY TRACT AND METABOLISM	67
<i>APO-Riluzole (TX)</i>	
.NERVOUS SYSTEM	560
<i>APO-Risedronate (TX)</i>	
.MUSCULO-SKELETAL SYSTEM	472
.Repatriation Schedule	1214
<i>APO-Risperidone (TX)</i>	
.NERVOUS SYSTEM	527, 528, 529, 530
<i>APO-Rosuvastatin (TX)</i>	
.CARDIOVASCULAR SYSTEM	167, 168, 169
<i>APO-Roxithromycin (TX)</i>	

GENERIC/PROPRIETARY INDEX

.ANTIINFECTIVES FOR SYSTEMIC USE.....	234, 235	<i>APO-Venlafaxine XR (TX)</i>	
<i>Aporyl (TX)</i>		.NERVOUS SYSTEM.....	543
.Repatriation Schedule.....	1203	<i>APO-Ziprasidone (TX)</i>	
<i>APO-Salbutamol (TX)</i>		.NERVOUS SYSTEM.....	516
.Prescriber Bag.....	63	<i>APO-Zolmitriptan (TX)</i>	
.RESPIRATORY SYSTEM.....	564, 565	.NERVOUS SYSTEM.....	498
<i>APO-Salbutamol Inhaler (TX)</i>		APRACLONIDINE	
.Prescriber Bag.....	63	.SENSORY ORGANS.....	578
.RESPIRATORY SYSTEM.....	564	APREPITANT	
<i>APO-Sertraline (TX)</i>		.ALIMENTARY TRACT AND METABOLISM.....	77
.NERVOUS SYSTEM.....	539	<i>Aptivus (BY)</i>	
<i>APO-Sildenafil (TX)</i>		.Section 100.....	715, 964
.Repatriation Schedule.....	1209, 1210	<i>Aquacare H.P. (AG)</i>	
<i>APO-Sildenafil PHT (TX)</i>		.Repatriation Schedule.....	1204
.Section 100.....	698, 946	<i>Aquacel 403770 (CC)</i>	
<i>APO-Simvastatin (TX)</i>		.Repatriation Schedule.....	1236
.CARDIOVASCULAR SYSTEM.....	170, 171, 172	<i>Aquacel Ag 403708 (CC)</i>	
<i>APO-Sotalol (TX)</i>		.Repatriation Schedule.....	1237
.CARDIOVASCULAR SYSTEM.....	127	<i>Aquacel Ag 403710 (CC)</i>	
<i>APO-Sumatriptan (TX)</i>		.Repatriation Schedule.....	1237
.NERVOUS SYSTEM.....	497, 498	<i>Aquacel Ag 403771 (CC)</i>	
<i>APO-Telmisartan (TX)</i>		.Repatriation Schedule.....	1237
.CARDIOVASCULAR SYSTEM.....	151	<i>Aquacel Extra 420672 (CC)</i>	
<i>APO-Telmisartan HCTZ 40/12.5 (TX)</i>		.Repatriation Schedule.....	1236
.CARDIOVASCULAR SYSTEM.....	155	<i>Aquacel Extra 420673 (CC)</i>	
<i>APO-Telmisartan HCTZ 80/12.5 (TX)</i>		.Repatriation Schedule.....	1236
.CARDIOVASCULAR SYSTEM.....	155	<i>Aquaclear 900796 (HR)</i>	
<i>APO-Telmisartan HCTZ 80/25 (TX)</i>		.Repatriation Schedule.....	1238
.CARDIOVASCULAR SYSTEM.....	156	<i>Aquae (IA)</i>	
<i>APO-Temazepam (TX)</i>		.Palliative Care.....	632
.NERVOUS SYSTEM.....	533	.Repatriation Schedule.....	1197
.Palliative Care.....	647	<i>Aquae Gel (IA)</i>	
<i>APOTEX-MORPHINE MR (TX)</i>		.Palliative Care.....	632
.NERVOUS SYSTEM.....	484	<i>Aquasun Lotion SPF 18 (PF)</i>	
<i>APOTEX-Pioglitazone (TX)</i>		.Repatriation Schedule.....	1204
.ALIMENTARY TRACT AND METABOLISM.....	97, 98	<i>Aquinafil (GN)</i>	
<i>APO-Topiramate (TX)</i>		.CARDIOVASCULAR SYSTEM.....	143
.NERVOUS SYSTEM.....	508, 509	<i>Arabloc (AV)</i>	
<i>APO-Tramadol (TX)</i>		.ANTINEOPLASTIC AND IMMUNOMODULATING	
.NERVOUS SYSTEM.....	493, 494	AGENTS.....	305, 306
<i>APO-Tramadol SR (TX)</i>		ARACHIDONIC ACID AND DOCOSAHEXAENOIC ACID	
.NERVOUS SYSTEM.....	492	WITH CARBOHYDRATE	
<i>APO-Trandolapril (TX)</i>		.VARIOUS.....	624
.CARDIOVASCULAR SYSTEM.....	145	<i>Aranesp (AN)</i>	
<i>APO-Valaciclovir (TX)</i>		.Section 100.....	655, 903
.ANTIINFECTIVES FOR SYSTEMIC USE.....	248, 249	<i>Aranesp SureClick (AN)</i>	
.Section 100.....	708, 958	.Section 100.....	655, 903
<i>APO-Valsartan (TX)</i>		<i>Aratac 100 (AF)</i>	
.CARDIOVASCULAR SYSTEM.....	152	.CARDIOVASCULAR SYSTEM.....	127
<i>APO-Valsartan HCTZ 160/12.5 (TX)</i>		<i>Aratac 200 (AF)</i>	
.CARDIOVASCULAR SYSTEM.....	156	.CARDIOVASCULAR SYSTEM.....	127
<i>APO-Valsartan HCTZ 320/12.5 (TX)</i>		<i>Arava (SW)</i>	
.CARDIOVASCULAR SYSTEM.....	156	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>APO-Valsartan HCTZ 320/25 (TX)</i>		AGENTS.....	306
.CARDIOVASCULAR SYSTEM.....	156	<i>Arazil (AF)</i>	

GENERIC/PROPRIETARY INDEX

.NERVOUS SYSTEM.....	547, 548	<i>Asasantin SR (BY)</i>	
<i>ARDIX GLICLAZIDE 60mg MR (RX)</i>		.BLOOD AND BLOOD FORMING ORGANS.....	113
.ALIMENTARY TRACT AND METABOLISM.....	90	ASENAPINE	
<i>Aredia 30 mg (NV)</i>		.NERVOUS SYSTEM.....	517
.MUSCULO-SKELETAL SYSTEM	471	<i>Asmol 2.5 uni-dose (AF)</i>	
.Section 100	884, 1136	.Prescriber Bag	63
<i>Aredia 90 mg (NV)</i>		.RESPIRATORY SYSTEM.....	564
.Section 100	885, 1137	<i>Asmol 5 uni-dose (AF)</i>	
<i>Arginine 2000 (VF)</i>		.Prescriber Bag	63
.VARIOUS.....	625	.RESPIRATORY SYSTEM.....	565
<i>Arginine 500 (VF)</i>		<i>Asmol CFC-free (AL)</i>	
.VARIOUS.....	625	.Prescriber Bag	63
<i>Arginine 5000 (VF)</i>		.RESPIRATORY SYSTEM.....	564
.VARIOUS.....	625	<i>Aspalgin 40 (QA)</i>	
ARGININE WITH CARBOHYDRATE		.Repatriation Schedule	1216
.VARIOUS.....	624	<i>Aspen Ampicyn (AF)</i>	
<i>Arianna (AF)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE	221, 222
.ANTINEOPLASTIC AND IMMUNOMODULATING		<i>Aspen Methadone Syrup (QA)</i>	
AGENTS	289	.Palliative Care.....	644
<i>Aricept (PF)</i>		.Section 100.....	1161
.NERVOUS SYSTEM.....	547, 548	<i>Aspen Pharma Pty Ltd (QA)</i>	
<i>Aridon 10 (QA)</i>		.NERVOUS SYSTEM.....	499, 544
.NERVOUS SYSTEM.....	547, 548	ASPIRIN	
<i>Aridon 5 (QA)</i>		.BLOOD AND BLOOD FORMING ORGANS.....	110
.NERVOUS SYSTEM.....	547, 548	.NERVOUS SYSTEM.....	494
<i>Aridon APN 10 (FM)</i>		.Repatriation Schedule	1201
.NERVOUS SYSTEM.....	547, 548	ASPIRIN + CODEINE	
<i>Aridon APN 5 (FM)</i>		.Repatriation Schedule	1216
.NERVOUS SYSTEM.....	547, 548	<i>Astrix (YN)</i>	
<i>Arimidex (AP)</i>		.BLOOD AND BLOOD FORMING ORGANS.....	110
.ANTINEOPLASTIC AND IMMUNOMODULATING		.Repatriation Schedule	1201
AGENTS	289	<i>Astromide (GN)</i>	
ARIPIRAZOLE		.ANTINEOPLASTIC AND IMMUNOMODULATING	
.NERVOUS SYSTEM.....	526	AGENTS	251, 252, 253
<i>Aristocort 0.02% (QA)</i>		<i>Atacand (AP)</i>	
.DERMATOLOGICALS.....	193	.CARDIOVASCULAR SYSTEM	149, 150
<i>Arixtra (AS)</i>		<i>Atacand Plus 16/12.5 (AP)</i>	
.BLOOD AND BLOOD FORMING ORGANS	122	.CARDIOVASCULAR SYSTEM	152
<i>Aromasin (PF)</i>		<i>Atacand Plus 32/12.5 (AP)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING		.CARDIOVASCULAR SYSTEM	153
AGENTS	290	<i>Atacand Plus 32/25 (AP)</i>	
<i>Aropax (AS)</i>		.CARDIOVASCULAR SYSTEM	153
.NERVOUS SYSTEM.....	539	ATAZANAVIR	
<i>Artane (QA)</i>		.Section 100.....	709, 958
.NERVOUS SYSTEM.....	510	ATENOLOL	
<i>Artelac (BU)</i>		.CARDIOVASCULAR SYSTEM	133, 134
.SENSORY ORGANS.....	588	<i>Atenolol AN (EA)</i>	
ARTEMETHER + LUMEFANTRINE		.CARDIOVASCULAR SYSTEM	133
.ANTIPARASITIC PRODUCTS, INSECTICIDES AND		<i>Atenolol GH (GQ)</i>	
REPELLENTS.....	561	.CARDIOVASCULAR SYSTEM	134
<i>Arthrexin (AF)</i>		<i>Atenolol Sandoz (SZ)</i>	
.MUSCULO-SKELETAL SYSTEM	463	.CARDIOVASCULAR SYSTEM	134
.Palliative Care	639	<i>Atenolol-AFT (AE)</i>	
<i>Arthrotec 50 (PF)</i>		.CARDIOVASCULAR SYSTEM	134
.Repatriation Schedule	1214	<i>Atenolol-GA (GN)</i>	

GENERIC/PROPRIETARY INDEX

.CARDIOVASCULAR SYSTEM	134	.ANTINEOPLASTIC AND IMMUNOMODULATING	
ATOMOXETINE		AGENTS	308
.NERVOUS SYSTEM.....	544	<i>Augmentin (AS)</i>	
<i>Atorvachol (GN)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE	224
.CARDIOVASCULAR SYSTEM.....	161, 162, 163	<i>Augmentin Duo (AS)</i>	
ATORVASTATIN		.ANTIINFECTIVES FOR SYSTEMIC USE	224, 225
.CARDIOVASCULAR SYSTEM	161, 162	<i>Augmentin Duo 400 (AS)</i>	
ATORVASTATIN (&) EZETIMIBE		.ANTIINFECTIVES FOR SYSTEMIC USE	224
.CARDIOVASCULAR SYSTEM	176, 179	<i>Augmentin Duo forte (AS)</i>	
<i>Atorvastatin AN (EA)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE	225
.CARDIOVASCULAR SYSTEM.....	161, 162, 163	AURANOFIN	
<i>Atorvastatin GH (GQ)</i>		.MUSCULO-SKELETAL SYSTEM	467
.CARDIOVASCULAR SYSTEM.....	161, 162, 163	<i>Auro-Amlodipine 10 (DO)</i>	
<i>Atorvastatin Pfizer (FZ)</i>		.CARDIOVASCULAR SYSTEM	137
.CARDIOVASCULAR SYSTEM.....	161, 162, 163	<i>Auro-Amlodipine 5 (DO)</i>	
<i>Atorvastatin Sandoz (SZ)</i>		.CARDIOVASCULAR SYSTEM	137
.CARDIOVASCULAR SYSTEM	161, 162, 163	<i>Auro-Candesartan 16 (DO)</i>	
<i>Atorvastatin SCP 10 (RZ)</i>		.CARDIOVASCULAR SYSTEM	149
.CARDIOVASCULAR SYSTEM	161, 162	<i>Auro-Candesartan 32 (DO)</i>	
<i>Atorvastatin SCP 20 (RZ)</i>		.CARDIOVASCULAR SYSTEM	149
.CARDIOVASCULAR SYSTEM	162, 163	<i>Auro-Candesartan 4 (DO)</i>	
<i>Atorvastatin SCP 40 (RZ)</i>		.CARDIOVASCULAR SYSTEM	149
.CARDIOVASCULAR SYSTEM	162, 163	<i>Auro-Candesartan 8 (DO)</i>	
<i>Atorvastatin SCP 80 (RZ)</i>		.CARDIOVASCULAR SYSTEM	149
.CARDIOVASCULAR SYSTEM	162, 163	<i>Auro-Citalopram 20 (DO)</i>	
<i>Atorvastatin SZ (HX)</i>		.NERVOUS SYSTEM.....	535
.CARDIOVASCULAR SYSTEM	161, 162, 163	<i>Auro-Citalopram 40 (DO)</i>	
ATOVAQUONE		.NERVOUS SYSTEM.....	535
.ANTIPARASITIC PRODUCTS, INSECTICIDES AND		<i>Auro-Famciclovir 250 (DO)</i>	
REPELLENTS.....	561	.ANTIINFECTIVES FOR SYSTEMIC USE	247
ATOVAQUONE + PROGUANIL		<i>Auro-Famciclovir 500 (DO)</i>	
.ANTIPARASITIC PRODUCTS, INSECTICIDES AND		.ANTIINFECTIVES FOR SYSTEMIC USE	248
REPELLENTS.....	561	<i>Auro-Lisinopril 10 (DO)</i>	
<i>Atozet Composite Pack (MK)</i>		.CARDIOVASCULAR SYSTEM	141
.CARDIOVASCULAR SYSTEM	179, 182	<i>Auro-Lisinopril 20 (DO)</i>	
<i>Atrauman 499513 (HR)</i>		.CARDIOVASCULAR SYSTEM	141
.Repatriation Schedule.....	1238	<i>Auro-Lisinopril 5 (DO)</i>	
<i>Atrauman Ag 499572 (HR)</i>		.CARDIOVASCULAR SYSTEM	141
.Repatriation Schedule.....	1239	<i>Auro-Montelukast Tabs 4 (DO)</i>	
<i>Atripila (GI)</i>		.RESPIRATORY SYSTEM.....	573
.Section 100	724, 975	<i>Auro-Montelukast Tabs 5 (DO)</i>	
ATROPINE		.RESPIRATORY SYSTEM.....	574
.ALIMENTARY TRACT AND METABOLISM.....	73	<i>Aurorix (HM)</i>	
.SENSORY ORGANS.....	584	.NERVOUS SYSTEM.....	540
<i>Atropt (QA)</i>		<i>Aurorix 300 mg (HM)</i>	
.SENSORY ORGANS.....	584	.NERVOUS SYSTEM.....	540
<i>Atrovent (BY)</i>		<i>Auro-Sertraline 100 (DO)</i>	
.RESPIRATORY SYSTEM	571, 572	.NERVOUS SYSTEM.....	539
<i>Atrovent Adult (BY)</i>		<i>Auro-Sertraline 50 (DO)</i>	
.RESPIRATORY SYSTEM	572	.NERVOUS SYSTEM.....	539, 540
<i>Atrovent Nasal Aqueous (BY)</i>		<i>Auro-Simvastatin 10 (DO)</i>	
.Repatriation Schedule.....	1220	.CARDIOVASCULAR SYSTEM	170, 171
<i>Atrovent Nasal Forte (BY)</i>		<i>Auro-Simvastatin 20 (DO)</i>	
.Repatriation Schedule.....	1220	.CARDIOVASCULAR SYSTEM	170, 171
<i>Aubagio (GZ)</i>		<i>Auro-Simvastatin 40 (DO)</i>	

GENERIC/PROPRIETARY INDEX

.CARDIOVASCULAR SYSTEM.....	170, 172	<i>Aylide 2 (AF)</i>	
<i>Auro-Simvastatin 80 (DO)</i>		.ALIMENTARY TRACT AND METABOLISM.....	90
.CARDIOVASCULAR SYSTEM.....	171, 172	<i>Aylide 3 (AF)</i>	
AUROTHIOMALATE SODIUM		.ALIMENTARY TRACT AND METABOLISM.....	90
.MUSCULO-SKELETAL SYSTEM	468	<i>Aylide 4 (AF)</i>	
<i>Aurozapine 30 (DO)</i>		.ALIMENTARY TRACT AND METABOLISM.....	91
.NERVOUS SYSTEM.....	542	AZACITIDINE	
<i>Aurozapine 45 (DO)</i>		.Section 100.....	727, 978
.NERVOUS SYSTEM.....	542	<i>Azamun (GN)</i>	
<i>Auscap Aspen (QA)</i>		.ANTINEOPLASTIC AND IMMUNOMODULATING	
.NERVOUS SYSTEM.....	538	AGENTS	461
<i>Ausfam 20 (QA)</i>		<i>Azapin (QA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	66	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>Ausfam 40 (QA)</i>		AGENTS	461
.ALIMENTARY TRACT AND METABOLISM.....	67	<i>Azarga (AQ)</i>	
<i>Ausgem (QA)</i>		.SENSORY ORGANS.....	579, 580
.CARDIOVASCULAR SYSTEM.....	173	<i>Azastrole (ER)</i>	
<i>Auspril (QA)</i>		.ANTINEOPLASTIC AND IMMUNOMODULATING	
.CARDIOVASCULAR SYSTEM.....	140	AGENTS	289
<i>Ausran (QA)</i>		AZATHIOPRINE	
.ALIMENTARY TRACT AND METABOLISM.....	67	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>Austrapen (AL)</i>		AGENTS	461
.ANTIINFECTIVES FOR SYSTEMIC USE.....	221, 222	<i>Azathioprine AN (EA)</i>	
<i>Avandamet (GK)</i>		.ANTINEOPLASTIC AND IMMUNOMODULATING	
.ALIMENTARY TRACT AND METABOLISM.....	93	AGENTS	461
<i>Avandia (GK)</i>		<i>Azathioprine Sandoz (SZ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	99	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>Avanza (MK)</i>		AGENTS	461
.NERVOUS SYSTEM.....	542, 543	<i>Azilect (LU)</i>	
<i>Avanza SolTab (MK)</i>		.NERVOUS SYSTEM.....	514
.NERVOUS SYSTEM.....	542	AZITHROMYCIN	
<i>Avapro (AV)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE	232, 233
.CARDIOVASCULAR SYSTEM.....	150	.Repatriation Schedule	1212
<i>Avapro HCT 150/12.5 (AV)</i>		.Section 100.....	708, 957
.CARDIOVASCULAR SYSTEM.....	154	.SENSORY ORGANS.....	575
<i>Avapro HCT 300/12.5 (AV)</i>		<i>Azithromycin Sandoz (SZ)</i>	
.CARDIOVASCULAR SYSTEM.....	154	.ANTIINFECTIVES FOR SYSTEMIC USE	233
<i>Avapro HCT 300/25 (AV)</i>		.Repatriation Schedule	1212
.CARDIOVASCULAR SYSTEM.....	154	.SENSORY ORGANS.....	575
<i>Avodart (GK)</i>		<i>Azithromycin-GA (UA)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	208	.ANTIINFECTIVES FOR SYSTEMIC USE	233
.Repatriation Schedule.....	1211	.Repatriation Schedule	1212
<i>Avonex (BD)</i>		.SENSORY ORGANS.....	575
.ANTINEOPLASTIC AND IMMUNOMODULATING		<i>Azol 100 (AF)</i>	
AGENTS	293	.GENITO URINARY SYSTEM AND SEX HORMONES .	206
<i>Axiron (LY)</i>		<i>Azol 200 (AF)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	201	.GENITO URINARY SYSTEM AND SEX HORMONES .	206
<i>Axit 15 (AF)</i>		<i>Azoft (AQ)</i>	
.NERVOUS SYSTEM.....	542	.SENSORY ORGANS.....	579
<i>Axit 30 (AF)</i>			
.NERVOUS SYSTEM.....	542		
<i>Axit 45 (AF)</i>			
.NERVOUS SYSTEM.....	542		
<i>Aylide 1 (AF)</i>			
.ALIMENTARY TRACT AND METABOLISM.....	90		

B

BACILLUS CALMETTE AND GUERIN-CONNAUGHT STRAIN	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	294

GENERIC/PROPRIETARY INDEX

BACILLUS CALMETTE AND GUERIN-TICE STRAIN	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	294
BACLOFEN	
.MUSCULO-SKELETAL SYSTEM	468
.Section 100	884, 1136
<i>Bactigras 7457 (SN)</i>	
.Repatriation Schedule	1233
<i>Bactrim (RO)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	232
<i>Bactrim DS (RO)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	232
<i>Bactroban (GK)</i>	
.Repatriation Schedule	1205
.RESPIRATORY SYSTEM	564
BALSALAZIDE	
.ALIMENTARY TRACT AND METABOLISM	84
BANDAGE ABSORBENT WOOL	
.Repatriation Schedule	1226
BANDAGE CALICO	
.Repatriation Schedule	1226
BANDAGE COMPRESSION	
.Repatriation Schedule	1226, 1227
BANDAGE RETENTION COHESIVE HEAVY	
.Repatriation Schedule	1227
BANDAGE RETENTION COHESIVE LIGHT	
.Repatriation Schedule	1227
BANDAGE RETENTION COTTON CREPE	
.Repatriation Schedule	1227
BANDAGE TUBULAR	
.Repatriation Schedule	1227, 1228
BANDAGE TUBULAR FINGER	
.Repatriation Schedule	1228
BANDAGE TUBULAR LIGHT WEIGHT	
.Repatriation Schedule	1228
BANDAGE TUBULAR LONG STOCKING	
.Repatriation Schedule	1228
BANDAGE TUBULAR SHORT STOCKING	
.Repatriation Schedule	1228
BANDAGE ZINC PASTE	
.Repatriation Schedule	1229
<i>Baraclude (BQ)</i>	
.Section 100	717, 966, 967
<i>Barbloc 5 (AF)</i>	
.CARDIOVASCULAR SYSTEM	133
<i>basecal 100 (VF)</i>	
.VARIOUS	625
<i>basecal 200 (VF)</i>	
.VARIOUS	625
<i>Baxter Healthcare Pty Ltd (BX)</i>	
.BLOOD AND BLOOD FORMING ORGANS	124, 125
.Repatriation Schedule	1201
BECLOMETHASONE	
.RESPIRATORY SYSTEM	570
BEE VENOM	
.VARIOUS	596
<i>BenPen (CS)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	222
.Prescriber Bag	62
BENZATHINE BENZYL PENICILLIN	
.ANTIINFECTIVES FOR SYSTEMIC USE	222
BENZHEXOL	
.NERVOUS SYSTEM	509
<i>Benztrop (PL)</i>	
.NERVOUS SYSTEM	510
BENZTROPINE	
.NERVOUS SYSTEM	510
<i>Benztropine Omega (FK)</i>	
.NERVOUS SYSTEM	510
.Prescriber Bag	62
BENZYDAMINE	
.ALIMENTARY TRACT AND METABOLISM	66
.Palliative Care	632
BENZYL PENICILLIN	
.ANTIINFECTIVES FOR SYSTEMIC USE	222
<i>Beprol 10 (DO)</i>	
.CARDIOVASCULAR SYSTEM	134
<i>Beprol 2.5 (DO)</i>	
.CARDIOVASCULAR SYSTEM	134
<i>Beprol 5 (DO)</i>	
.CARDIOVASCULAR SYSTEM	134
<i>Betachek (NA)</i>	
.VARIOUS	600
<i>Betachek G5 (NA)</i>	
.VARIOUS	600
<i>Betadine Antiseptic Liquid (SW)</i>	
.Repatriation Schedule	1206
<i>Betaferon (BN)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	294
BETAINE	
.ALIMENTARY TRACT AND METABOLISM	106
BETAINE + POLYAMINOPROPYL BIGUANIDE	
.Repatriation Schedule	1229
<i>Betaloc (AP)</i>	
.CARDIOVASCULAR SYSTEM	135
BETAMETHASONE ACETATE + BETAMETHASONE	
SODIUM PHOSPHATE	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
HORMONES AND INSULINS	210, 211
BETAMETHASONE DIPROPIONATE	
.DERMATOLOGICALS	193
BETAMETHASONE VALERATE	
.DERMATOLOGICALS	194
.Repatriation Schedule	1206
<i>betaquik (VF)</i>	
.VARIOUS	602
<i>Betavit (PP)</i>	
.ALIMENTARY TRACT AND METABOLISM	105
.Repatriation Schedule	1199

GENERIC/PROPRIETARY INDEX

BETAXOLOL	134
.SENSORY ORGANS.....	581
BETHANECHOL	
.NERVOUS SYSTEM.....	554
<i>Betnovate (QA)</i>	
.Repatriation Schedule.....	1206
<i>Betnovate 1/2 (QA)</i>	
.DERMATOLOGICALS.....	194
<i>Betnovate 1/5 (QA)</i>	
.DERMATOLOGICALS.....	194
<i>Betoptic (AQ)</i>	
.SENSORY ORGANS.....	581
<i>Betoptic S (AQ)</i>	
.SENSORY ORGANS.....	581
<i>BetoQuin (IQ)</i>	
.SENSORY ORGANS.....	581
<i>Bgramin (GN)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	220, 221
<i>BGStar (SW)</i>	
.VARIOUS.....	599, 600
<i>Biatain Adhesive 3420 (CT)</i>	
.Repatriation Schedule.....	1234
<i>Biatain Adhesive 3423 (CT)</i>	
.Repatriation Schedule.....	1234
<i>Biatain Ag 9622 (CT)</i>	
.Repatriation Schedule.....	1239
<i>Biatain Ag 9632 (CT)</i>	
.Repatriation Schedule.....	1239
<i>Biatain Non-adhesive 3410 (CT)</i>	
.Repatriation Schedule.....	1234
<i>Biatain Non-adhesive 3413 (CT)</i>	
.Repatriation Schedule.....	1234
<i>Biaxsig (AV)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	234, 235
<i>Bicalox (ER)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	288
BICALUTAMIDE	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	287
<i>Bicalutamide AN (EA)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	288
<i>Bicalutamide-GA (GN)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	288
BICARBONATE	
.GENITO URINARY SYSTEM AND SEX HORMONES .	207
BICARBONATE + CITRATE + TARTARIC ACID	
.Repatriation Schedule.....	1210
<i>Bicard 10 (QA)</i>	
.CARDIOVASCULAR SYSTEM.....	134
<i>Bicard 2.5 (QA)</i>	
.CARDIOVASCULAR SYSTEM.....	134
<i>Bicard 5 (QA)</i>	
.CARDIOVASCULAR SYSTEM.....	134
<i>Bicillin L-A (PF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	222
<i>Bicor (AL)</i>	
.CARDIOVASCULAR SYSTEM.....	134, 135
<i>Biltricide (BN)</i>	
.ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS.....	562
BIMATOPROST	
.SENSORY ORGANS.....	581
BIMATOPROST + TIMOLOL	
.SENSORY ORGANS.....	581, 582
<i>Biodone Forte (MW)</i>	
.Section 100.....	1161
<i>Bion Tears (AQ)</i>	
.SENSORY ORGANS.....	591
<i>Bionime Rightest (QB)</i>	
.VARIOUS.....	600, 601
BIPERIDEN	
.NERVOUS SYSTEM.....	510
BISACODYL	
.ALIMENTARY TRACT AND METABOLISM.....	79, 81
.Palliative Care.....	633, 635, 636
<i>Bisalax (AS)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	79, 81
.Palliative Care.....	633, 636
<i>Biso 10 (GN)</i>	
.CARDIOVASCULAR SYSTEM.....	134
<i>Biso 2.5 (GN)</i>	
.CARDIOVASCULAR SYSTEM.....	134
<i>Biso 5 (GN)</i>	
.CARDIOVASCULAR SYSTEM.....	134
BISOPROLOL	
.CARDIOVASCULAR SYSTEM.....	134
<i>Bisoprolol AN (EA)</i>	
.CARDIOVASCULAR SYSTEM.....	134
<i>Bisoprolol GH (GQ)</i>	
.CARDIOVASCULAR SYSTEM.....	134
<i>Bisoprolol Sandoz (SZ)</i>	
.CARDIOVASCULAR SYSTEM.....	134
<i>Bispro 10 (AF)</i>	
.CARDIOVASCULAR SYSTEM.....	134
<i>Bispro 2.5 (AF)</i>	
.CARDIOVASCULAR SYSTEM.....	134
<i>Bispro 5 (AF)</i>	
.CARDIOVASCULAR SYSTEM.....	134
BIVALIRUDIN	
.BLOOD AND BLOOD FORMING ORGANS.....	114
<i>Blooms the Chemist Amlodipine/Atorvastatin 10/10 (IB)</i>	
.CARDIOVASCULAR SYSTEM.....	188
<i>Blooms the Chemist Amlodipine/Atorvastatin 10/20 (IB)</i>	
.CARDIOVASCULAR SYSTEM.....	188
<i>Blooms the Chemist Amlodipine/Atorvastatin 10/40 (IB)</i>	
.CARDIOVASCULAR SYSTEM.....	188
<i>Blooms the Chemist Amlodipine/Atorvastatin 10/80 (IB)</i>	
.CARDIOVASCULAR SYSTEM.....	188

GENERIC/PROPRIETARY INDEX

.CARDIOVASCULAR SYSTEM	188
<i>Blooms the Chemist Amlodipine/Atorvastatin 5/10 (IB)</i>	
.CARDIOVASCULAR SYSTEM	188
<i>Blooms the Chemist Amlodipine/Atorvastatin 5/20 (IB)</i>	
.CARDIOVASCULAR SYSTEM	189
<i>Blooms the Chemist Amlodipine/Atorvastatin 5/40 (IB)</i>	
.CARDIOVASCULAR SYSTEM	189
<i>Blooms the Chemist Amlodipine/Atorvastatin 5/80 (IB)</i>	
.CARDIOVASCULAR SYSTEM	189
<i>Blooms the Chemist Celecoxib (IB)</i>	
.MUSCULO-SKELETAL SYSTEM	467
<i>Blooms the Chemist Osteo Pain Relief Paracetamol 665 mg (IB)</i>	
.NERVOUS SYSTEM.....	495
.Palliative Care	644, 645
BOCEPREVIR	
.Section 100	709, 958
<i>Bondronat (RO)</i>	
.MUSCULO-SKELETAL SYSTEM	471
.Section 100	884, 1136
<i>Bonefos (BN)</i>	
.MUSCULO-SKELETAL SYSTEM	470
<i>Bonefos 800 mg (BN)</i>	
.MUSCULO-SKELETAL SYSTEM	470
BOSENTAN	
.Section 100	663, 670, 911, 918
<i>Botox (AG)</i>	
.Section 100	1155
BOTULINUM TOXIN TYPE A	
.Section 100	1152
<i>Breo Ellipta 100/25 (GK)</i>	
.RESPIRATORY SYSTEM	569
<i>Breo Ellipta 200/25 (GK)</i>	
.RESPIRATORY SYSTEM	569
<i>Bretaris Genuair (FK)</i>	
.RESPIRATORY SYSTEM	571
<i>Brevinor (PF)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	200
<i>Brevinor-1 (PF)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	200
<i>Bricanyl (AP)</i>	
.Prescriber Bag	64
.RESPIRATORY SYSTEM	573
<i>Bricanyl Turbuhaler (AP)</i>	
.RESPIRATORY SYSTEM	565
<i>Brilinta (AP)</i>	
.BLOOD AND BLOOD FORMING ORGANS	113
BRIMONIDINE	
.SENSORY ORGANS.....	578
BRIMONIDINE + TIMOLOL	
.SENSORY ORGANS.....	578
BRINZOLAMIDE	
.SENSORY ORGANS.....	579
BRINZOLAMIDE + TIMOLOL	
.SENSORY ORGANS.....	579, 580
<i>BrinzoQuin (IQ)</i>	
.SENSORY ORGANS.....	579
BROMAZEPAM	
.Repatriation Schedule	1217
BROMOCRIPTINE	
.GENITO URINARY SYSTEM AND SEX HORMONES	198, 199
.NERVOUS SYSTEM.....	512
<i>bronchitol (XA)</i>	
.Section 100.....	893, 1145
<i>Brufen (AB)</i>	
.MUSCULO-SKELETAL SYSTEM	465
.Palliative Care.....	639, 640
<i>BSN 2902165 (BV)</i>	
.Repatriation Schedule	1239
<i>Budamax Aqueous (PM)</i>	
.Repatriation Schedule	1220
<i>Budenofalk (OA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	83
BUDESONIDE	
.ALIMENTARY TRACT AND METABOLISM.....	83
.Repatriation Schedule	1220
.RESPIRATORY SYSTEM.....	570, 571
BUDESONIDE + EFOMOTEROL	
.RESPIRATORY SYSTEM.....	565, 566
BUPRENORPHINE	
.NERVOUS SYSTEM.....	491
.Section 100.....	1161
BUPRENORPHINE + NALOXONE	
.Section 100.....	1161
BUPROPION	
.NERVOUS SYSTEM.....	554
<i>Buscopan (BY)</i>	
.Palliative Care.....	633
.Prescriber Bag	62
.Repatriation Schedule	1197
<i>Buspar (QA)</i>	
.Repatriation Schedule	1217
BUSPIRONE	
.Repatriation Schedule	1217
BUSULFAN	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	251
<i>Butamol 2.5 (QA)</i>	
.Prescriber Bag	63
.RESPIRATORY SYSTEM.....	564
<i>Butamol 5 (QA)</i>	
.Prescriber Bag	64
.RESPIRATORY SYSTEM.....	565
<i>Byetta 10 microgram (AP)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	104
<i>Byetta 5 microgram (AP)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	104

GENERIC/PROPRIETARY INDEX

C

<i>Cabaser (PF)</i>	
.NERVOUS SYSTEM.....	512
CABERGOLINE	
.GENITO URINARY SYSTEM AND SEX HORMONES .	199
.NERVOUS SYSTEM.....	512
<i>Cadatin 10/10 (FZ)</i>	
.CARDIOVASCULAR SYSTEM.....	188
<i>Cadatin 10/20 (FZ)</i>	
.CARDIOVASCULAR SYSTEM.....	188
<i>Cadatin 10/40 (FZ)</i>	
.CARDIOVASCULAR SYSTEM.....	188
<i>Cadatin 10/80 (FZ)</i>	
.CARDIOVASCULAR SYSTEM.....	188
<i>Cadatin 5/10 (FZ)</i>	
.CARDIOVASCULAR SYSTEM.....	188
<i>Cadatin 5/20 (FZ)</i>	
.CARDIOVASCULAR SYSTEM.....	189
<i>Cadatin 5/40 (FZ)</i>	
.CARDIOVASCULAR SYSTEM.....	189
<i>Cadatin 5/80 (FZ)</i>	
.CARDIOVASCULAR SYSTEM.....	189
CADEXOMER-IODINE	
.Repatriation Schedule.....	1229
<i>Cadivast 10/10 (AF)</i>	
.CARDIOVASCULAR SYSTEM.....	188
<i>Cadivast 10/20 (AF)</i>	
.CARDIOVASCULAR SYSTEM.....	188
<i>Cadivast 10/40 (AF)</i>	
.CARDIOVASCULAR SYSTEM.....	188
<i>Cadivast 10/80 (AF)</i>	
.CARDIOVASCULAR SYSTEM.....	188
<i>Cadivast 5/10 (AF)</i>	
.CARDIOVASCULAR SYSTEM.....	188
<i>Cadivast 5/20 (AF)</i>	
.CARDIOVASCULAR SYSTEM.....	189
<i>Cadivast 5/40 (AF)</i>	
.CARDIOVASCULAR SYSTEM.....	189
<i>Cadivast 5/80 (AF)</i>	
.CARDIOVASCULAR SYSTEM.....	189
<i>Caduet 10/10 (PF)</i>	
.CARDIOVASCULAR SYSTEM.....	188
<i>Caduet 10/20 (PF)</i>	
.CARDIOVASCULAR SYSTEM.....	188
<i>Caduet 10/40 (PF)</i>	
.CARDIOVASCULAR SYSTEM.....	188
<i>Caduet 10/80 (PF)</i>	
.CARDIOVASCULAR SYSTEM.....	188
<i>Caduet 5/10 (PF)</i>	
.CARDIOVASCULAR SYSTEM.....	188
<i>Caduet 5/20 (PF)</i>	
.CARDIOVASCULAR SYSTEM.....	189
<i>Caduet 5/40 (PF)</i>	
.CARDIOVASCULAR SYSTEM.....	189
<i>Caduet 5/80 (PF)</i>	
.CARDIOVASCULAR SYSTEM.....	189
<i>Caelyx (JC)</i>	
.Section 100.....	728, 979
<i>Cal-500 (PP)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	105
.Repatriation Schedule.....	1199
<i>CAL-600 (PP)</i>	
.Repatriation Schedule.....	1199, 1200
CALCIPOTRIOL	
.DERMATOLOGICALS.....	191
CALCIPOTRIOL + BETAMETHASONE DIPROPIONATE	
.DERMATOLOGICALS.....	191, 192
<i>Calciprox (ER)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	105
.MUSCULO-SKELETAL SYSTEM.....	478
<i>Calci-Tab 600 (AE)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	105
CALCITRIOL	
.ALIMENTARY TRACT AND METABOLISM.....	104
.MUSCULO-SKELETAL SYSTEM.....	478
<i>Calcitriol AN (EA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	105
.MUSCULO-SKELETAL SYSTEM.....	478
<i>Calcitriol Sandoz (SZ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	105
.MUSCULO-SKELETAL SYSTEM.....	478
<i>Calcitriol-GA (UA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	105
.MUSCULO-SKELETAL SYSTEM.....	478
CALCIUM	
.ALIMENTARY TRACT AND METABOLISM.....	105
.Repatriation Schedule.....	1199
CALCIUM CARBONATE + GLYCINE	
.Repatriation Schedule.....	1197
<i>Calcium Folate Ebewe (SZ)</i>	
.VARIOUS.....	597
<i>Calmurid (OL)</i>	
.Repatriation Schedule.....	1204
<i>Cal-Sup (IA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	105
.Repatriation Schedule.....	1199, 1200
<i>Calutex (QA)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS.....	288
<i>Camino Pro Bettermilk (QH)</i>	
.VARIOUS.....	626
<i>Camino Pro Complete (QH)</i>	
.VARIOUS.....	626
<i>Camino Pro Restore (QH)</i>	
.VARIOUS.....	626
<i>Campral (AF)</i>	
.NERVOUS SYSTEM.....	558
CANAGLIFLOZIN	
.ALIMENTARY TRACT AND METABOLISM.....	102

GENERIC/PROPRIETARY INDEX

CANDESARTAN	
.CARDIOVASCULAR SYSTEM	149
CANDESARTAN + HYDROCHLOROTHIAZIDE	
.CARDIOVASCULAR SYSTEM	152
<i>Candesartan AN (EA)</i>	
.CARDIOVASCULAR SYSTEM	149
<i>Candesartan Aspen 16 (QA)</i>	
.CARDIOVASCULAR SYSTEM	149
<i>Candesartan Aspen 32 (QA)</i>	
.CARDIOVASCULAR SYSTEM	149
<i>Candesartan Aspen 4 (QA)</i>	
.CARDIOVASCULAR SYSTEM	149
<i>Candesartan Aspen 8 (QA)</i>	
.CARDIOVASCULAR SYSTEM	149
<i>Candesartan Combi Aspen 16/12.5 (QA)</i>	
.CARDIOVASCULAR SYSTEM	152
<i>Candesartan Combi Aspen 32/12.5 (QA)</i>	
.CARDIOVASCULAR SYSTEM	153
<i>Candesartan Combi Aspen 32/25 (QA)</i>	
.CARDIOVASCULAR SYSTEM	153
<i>Candesartan GH (GQ)</i>	
.CARDIOVASCULAR SYSTEM	149
<i>Candesartan HCT GH 16/12.5 (GQ)</i>	
.CARDIOVASCULAR SYSTEM	152
<i>Candesartan HCT GH 32/12.5 (GQ)</i>	
.CARDIOVASCULAR SYSTEM	153
<i>Candesartan HCT GH 32/25 (GQ)</i>	
.CARDIOVASCULAR SYSTEM	153
<i>Candesartan HCTZ AN 16/12.5 (EA)</i>	
.CARDIOVASCULAR SYSTEM	152
<i>Candesartan HCTZ AN 32/12.5 (EA)</i>	
.CARDIOVASCULAR SYSTEM	153
<i>Candesartan HCTZ AN 32/25 (EA)</i>	
.CARDIOVASCULAR SYSTEM	153
<i>Candesartan HCTZ RBX 16/12.5 (RA)</i>	
.CARDIOVASCULAR SYSTEM	152
<i>Candesartan HCTZ RBX 32/12.5 (RA)</i>	
.CARDIOVASCULAR SYSTEM	153
<i>Candesartan HCTZ RBX 32/25 (RA)</i>	
.CARDIOVASCULAR SYSTEM	153
<i>Candesartan HCTZ-GA 16/12.5 (GN)</i>	
.CARDIOVASCULAR SYSTEM	152
<i>Candesartan HCTZ-GA 32/12.5 (GN)</i>	
.CARDIOVASCULAR SYSTEM	153
<i>Candesartan HCTZ-GA 32/25 (GN)</i>	
.CARDIOVASCULAR SYSTEM	153
<i>Candesartan RBX (RA)</i>	
.CARDIOVASCULAR SYSTEM	149
<i>Candesartan Sandoz (SZ)</i>	
.CARDIOVASCULAR SYSTEM	149
<i>Candesartan/HCT Sandoz (SZ)</i>	
.CARDIOVASCULAR SYSTEM	152, 153
<i>Candesartan-GA (GN)</i>	
.CARDIOVASCULAR SYSTEM	149
CAPECITABINE	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	253
<i>Capecitabine Actavis (GN)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	254
<i>Capecitabine Alphapharm (AF)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	254
<i>Capecitabine Apotex (TX)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	254
<i>Capecitabine GH (GQ)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	254
<i>Capecitabine Sandoz (SZ)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	254
<i>Capecitabine-DRLA (RZ)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	254
<i>Capoten (QA)</i>	
.CARDIOVASCULAR SYSTEM	140
CAPTOPRIL	
.CARDIOVASCULAR SYSTEM	139, 140
<i>Captopril Sandoz (SZ)</i>	
.CARDIOVASCULAR SYSTEM	140
<i>Carafate (AS)</i>	
.ALIMENTARY TRACT AND METABOLISM	73
CARBAMAZEPINE	
.NERVOUS SYSTEM	500, 501
<i>Carbamazepine Sandoz (SZ)</i>	
.NERVOUS SYSTEM	500, 501
CARBAMIDE PEROXIDE	
.Repatriation Schedule	1222
<i>Carbimazol ARISTO (PQ)</i>	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
HORMONES AND INSULINS	215
CARBIMAZOLE	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
HORMONES AND INSULINS	214
<i>CarboFLEX 403202 (CC)</i>	
.Repatriation Schedule	1229
<i>CarboFLEX 403204 (CC)</i>	
.Repatriation Schedule	1230
<i>Carbohydrate Free Mixture (SB)</i>	
.VARIOUS	627
CARBOHYDRATE, FAT, VITAMINS, MINERALS AND TRACE	
ELEMENTS	
.VARIOUS	625
CARBOHYDRATES, FAT, VITAMINS, MINERALS, TRACE	
ELEMENTS AND SUPPLEMENTED WITH ARACHIDONIC	
ACID AND DOCOSAHEXAENOIC ACID	
.VARIOUS	625
CARBOMER + TRIGLYCERIDE LIPIDS	
.SENSORY ORGANS	588

GENERIC/PROPRIETARY INDEX

CARBOMER-974		
.SENSORY ORGANS.....	588	
CARBOMER-980		
.SENSORY ORGANS.....	588, 589	
<i>carbzero (VF)</i>		
.VARIOUS.....	601	
<i>Cardiprin 100 (RC)</i>		
.Repatriation Schedule.....	1201	
<i>Cardizem (SW)</i>		
.CARDIOVASCULAR SYSTEM.....	139	
<i>Cardizem CD (SW)</i>		
.CARDIOVASCULAR SYSTEM.....	139	
<i>Cardol (AF)</i>		
.CARDIOVASCULAR SYSTEM.....	127	
<i>CareSens (LB)</i>		
.VARIOUS.....	600, 601	
<i>CareSens N (LB)</i>		
.VARIOUS.....	599, 601	
CARMELLOSE SODIUM		
.Palliative Care	632	
.Repatriation Schedule.....	1197	
.SENSORY ORGANS.....	589	
CARMELLOSE SODIUM + GELATIN + PECTIN		
.Repatriation Schedule.....	1204	
CARMELLOSE SODIUM + GLYCEROL		
.SENSORY ORGANS.....	590	
CARMUSTINE		
.ANTINEOPLASTIC AND IMMUNOMODULATING		
AGENTS	251	
<i>Cartia (AS)</i>		
.Repatriation Schedule.....	1201	
CARVEDILOL		
.CARDIOVASCULAR SYSTEM.....	136	
<i>Carvedilol AN (EA)</i>		
.CARDIOVASCULAR SYSTEM.....	136, 137	
<i>Carvedilol generichealth (GQ)</i>		
.CARDIOVASCULAR SYSTEM.....	136, 137	
<i>Carvedilol Sandoz (SZ)</i>		
.CARDIOVASCULAR SYSTEM.....	136, 137	
<i>Catapres (BY)</i>		
.CARDIOVASCULAR SYSTEM.....	130	
<i>Catapres 100 (BY)</i>		
.CARDIOVASCULAR SYSTEM.....	130	
<i>Caverject (PF)</i>		
.Repatriation Schedule.....	1209	
<i>Cavicare 4563 (SN)</i>		
.Repatriation Schedule.....	1231	
<i>Cavstat (AF)</i>		
.CARDIOVASCULAR SYSTEM.....	166, 167, 168, 169	
<i>Ceclor (AS)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	229	
<i>Ceclor CD (AS)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	229, 230	
CEFACTOR		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	229	
<i>Cefaclor GH (GQ)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	229	
<i>Cefaclor-GA (GN)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	229	
<i>Cefalexin Sandoz (SZ)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	226, 227	
<i>Cefalotin Sandoz (SZ)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	228	
<i>Cefazolin Sandoz (SZ)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	228, 229	
<i>Cefazolin-AFT (AE)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	228, 229	
CEFEPIME		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	232	
<i>Cefepime Alphapharm (AF)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	232	
<i>Cefepime Sandoz (SZ)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	232	
<i>Cefepime-AFT (AE)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	232	
CEFOTAXIME		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	230, 231	
<i>Cefotaxime Sandoz (SZ)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	230, 231	
CEFTRIAXONE		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	231	
<i>Ceftriaxone Alphapharm (AF)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	231	
<i>Ceftriaxone ICP (PP)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	231, 232	
<i>Ceftriaxone Sandoz (SZ)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	231	
<i>Ceftriaxone-AFT (AE)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	231	
CEFUROXIME		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	230	
<i>Celapram (AF)</i>		
.NERVOUS SYSTEM.....	535	
<i>Celaxib (AF)</i>		
.MUSCULO-SKELETAL SYSTEM	467	
<i>Celebrex (PF)</i>		
.MUSCULO-SKELETAL SYSTEM	467	
CELECOXIB		
.MUSCULO-SKELETAL SYSTEM	466	
<i>Celecoxib Actavis (GN)</i>		
.MUSCULO-SKELETAL SYSTEM	467	
<i>Celecoxib AN (EA)</i>		
.MUSCULO-SKELETAL SYSTEM	467	
<i>Celecoxib GH (GQ)</i>		
.MUSCULO-SKELETAL SYSTEM	467	
<i>Celecoxib RBX (RA)</i>		
.MUSCULO-SKELETAL SYSTEM	467	
<i>Celecoxib Sandoz (SZ)</i>		
.MUSCULO-SKELETAL SYSTEM	467	
<i>Celestone Chronodose (MK)</i>		

GENERIC/PROPRIETARY INDEX

.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS.....	211	<i>C-Flox 500 (AL)</i> .ANTIINFECTIVES FOR SYSTEMIC USE.....	237
<i>Celestone-M (MK)</i> .DERMATOLOGICALS.....	194	<i>C-Flox 750 (AL)</i> .ANTIINFECTIVES FOR SYSTEMIC USE.....	237
<i>Celexi (QA)</i> .MUSCULO-SKELETAL SYSTEM	467	<i>Champix (PF)</i> .NERVOUS SYSTEM.....	557, 558
<i>Celica (RA)</i> .NERVOUS SYSTEM.....	535	<i>Chem mart Aciclovir (CH)</i> .ANTIINFECTIVES FOR SYSTEMIC USE.....	245
<i>CellCept (RO)</i> .ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	307	<i>Chem mart Alendronate 70mg (CH)</i> .MUSCULO-SKELETAL SYSTEM	470
.Section 100	771, 772, 1024	<i>Chem mart Allopurinol (CH)</i> .MUSCULO-SKELETAL SYSTEM	469
<i>Cellufresh (AG)</i> .SENSORY ORGANS.....	589, 590	<i>Chem mart Alprazolam (CH)</i> .NERVOUS SYSTEM.....	531
<i>Celluvisc (AG)</i> .SENSORY ORGANS.....	589	<i>Chem mart Amiodarone (CH)</i> .CARDIOVASCULAR SYSTEM	127
<i>Celsentri (VI)</i> .Section 100	725, 976	<i>Chem mart Amlodipine (CH)</i> .CARDIOVASCULAR SYSTEM	137
<i>Cephalex 250 (CR)</i> .ANTIINFECTIVES FOR SYSTEMIC USE.....	226, 227	<i>Chem mart Amlodipine/Atorvastatin 10/10 (CH)</i> .CARDIOVASCULAR SYSTEM	188
<i>Cephalex 500 (NJ)</i> .ANTIINFECTIVES FOR SYSTEMIC USE.....	227	<i>Chem mart Amlodipine/Atorvastatin 10/20 (CH)</i> .CARDIOVASCULAR SYSTEM	188
CEPHALEXIN .ANTIINFECTIVES FOR SYSTEMIC USE.....	226, 227	<i>Chem mart Amlodipine/Atorvastatin 10/40 (CH)</i> .CARDIOVASCULAR SYSTEM	188
<i>Cephalexin AN (EA)</i> .ANTIINFECTIVES FOR SYSTEMIC USE.....	226, 227	<i>Chem mart Amlodipine/Atorvastatin 10/80 (CH)</i> .CARDIOVASCULAR SYSTEM	188
<i>Cephalexin generichealth (GQ)</i> .ANTIINFECTIVES FOR SYSTEMIC USE.....	226, 227	<i>Chem mart Amlodipine/Atorvastatin 5/10 (CH)</i> .CARDIOVASCULAR SYSTEM	188
CEPHALOTHIN .ANTIINFECTIVES FOR SYSTEMIC USE.....	228	<i>Chem mart Amlodipine/Atorvastatin 5/20 (CH)</i> .CARDIOVASCULAR SYSTEM	189
CEPHAZOLIN .ANTIINFECTIVES FOR SYSTEMIC USE.....	228	<i>Chem mart Amlodipine/Atorvastatin 5/40 (CH)</i> .CARDIOVASCULAR SYSTEM	189
<i>Cephazolin Alphapharm (AF)</i> .ANTIINFECTIVES FOR SYSTEMIC USE.....	228, 229	<i>Chem mart Amlodipine/Atorvastatin 5/80 (CH)</i> .CARDIOVASCULAR SYSTEM	189
<i>Ceptolate (AF)</i> .ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	307	<i>Chem mart Amoxicillin (CH)</i> .ANTIINFECTIVES FOR SYSTEMIC USE.....	220, 221
.Section 100	771, 772, 1023, 1024	<i>Chem mart Amoxicillin and Clavulanic Acid (CH)</i> .ANTIINFECTIVES FOR SYSTEMIC USE.....	225
<i>Certican (NV)</i> .ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	305	<i>Chem mart Anastrozole (CH)</i> .ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	290
.Section 100	770, 771, 1023	<i>Chem mart Atenolol (CH)</i> .CARDIOVASCULAR SYSTEM	134
CERTOLIZUMAB PEGOL .ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	364, 370	<i>Chem mart Atorvastatin (CH)</i> .CARDIOVASCULAR SYSTEM	161, 162, 163
<i>Cerumol (UN)</i> .Repatriation Schedule.....	1222	<i>Chem mart Azithromycin (CH)</i> .ANTIINFECTIVES FOR SYSTEMIC USE.....	233
CETIRIZINE .Repatriation Schedule.....	1221	.Repatriation Schedule.....	1212
CETRORELIX .Section 100	1158	.SENSORY ORGANS.....	575
<i>Cetrotide (SG)</i> .Section 100	1158	<i>Chem mart Bisoprolol (CH)</i> .CARDIOVASCULAR SYSTEM	134
<i>C-Flox 250 (AL)</i> .ANTIINFECTIVES FOR SYSTEMIC USE.....	237	<i>Chem mart Candesartan (CH)</i> .CARDIOVASCULAR SYSTEM	149
		<i>Chem mart Candesartan HCTZ 16/12.5 (CH)</i> .CARDIOVASCULAR SYSTEM	152

GENERIC/PROPRIETARY INDEX

<i>Chem mart Candesartan HCTZ 32/12.5 (CH)</i>	.CARDIOVASCULAR SYSTEM..... 153
<i>Chem mart Candesartan HCTZ 32/25 (CH)</i>	.CARDIOVASCULAR SYSTEM..... 153
<i>Chem mart Carvedilol 12.5 mg (CH)</i>	.CARDIOVASCULAR SYSTEM..... 136
<i>Chem mart Carvedilol 25 mg (CH)</i>	.CARDIOVASCULAR SYSTEM..... 136
<i>Chem mart Carvedilol 3.125 mg (CH)</i>	.CARDIOVASCULAR SYSTEM..... 136
<i>Chem mart Carvedilol 6.25 mg (CH)</i>	.CARDIOVASCULAR SYSTEM..... 137
<i>Chem mart Cefaclor CD (CH)</i>	.ANTIINFECTIVES FOR SYSTEMIC USE..... 229
<i>Chem mart Celecoxib (CH)</i>	.MUSCULO-SKELETAL SYSTEM 467
<i>Chem mart Cephalexin (CH)</i>	.ANTIINFECTIVES FOR SYSTEMIC USE..... 226, 227, 228
<i>Chem mart Citalopram (CH)</i>	.NERVOUS SYSTEM..... 535
<i>Chem mart Clarithromycin (CH)</i>	.ANTIINFECTIVES FOR SYSTEMIC USE..... 233
<i>Chem mart Clindamycin (CH)</i>	.ANTIINFECTIVES FOR SYSTEMIC USE..... 235
<i>Chem mart Clomipramine (CH)</i>	.NERVOUS SYSTEM..... 534
<i>Chem mart Clopidogrel (CH)</i>	.BLOOD AND BLOOD FORMING ORGANS 111
	.Repatriation Schedule..... 1201
<i>Chem mart Clopidogrel/Aspirin 75/100 (CH)</i>	.BLOOD AND BLOOD FORMING ORGANS 112
<i>Chem mart Diclofenac (CH)</i>	.MUSCULO-SKELETAL SYSTEM 462
	.Palliative Care 638, 639
<i>Chem mart Diltiazem CD (CH)</i>	.CARDIOVASCULAR SYSTEM..... 139
<i>Chem mart Donepezil (CH)</i>	.NERVOUS SYSTEM..... 547, 548
<i>Chem mart Doxycycline (CH)</i>	.ANTIINFECTIVES FOR SYSTEMIC USE..... 218, 219
<i>Chem mart Duloxetine (CH)</i>	.NERVOUS SYSTEM..... 541
<i>Chem mart Enalapril (CH)</i>	.CARDIOVASCULAR SYSTEM..... 140, 141
<i>Chem mart Escitalopram (CH)</i>	.NERVOUS SYSTEM..... 535, 536
<i>Chem mart Famciclovir (CH)</i>	.ANTIINFECTIVES FOR SYSTEMIC USE..... 247, 248
<i>Chem mart Famotidine (CH)</i>	.ALIMENTARY TRACT AND METABOLISM..... 66, 67
<i>Chem mart Fluoxetine (CH)</i>	.NERVOUS SYSTEM..... 538
<i>Chem mart Furosemide (CH)</i>	.CARDIOVASCULAR SYSTEM..... 131, 132
<i>Chem mart Gemfibrozil (CH)</i>	.CARDIOVASCULAR SYSTEM..... 173
<i>Chem mart Glipizide (CH)</i>	.ALIMENTARY TRACT AND METABOLISM..... 90
<i>Chem mart Glipizide MR (CH)</i>	.ALIMENTARY TRACT AND METABOLISM..... 90
<i>Chem mart Hydroxychloroquine (CH)</i>	.MUSCULO-SKELETAL SYSTEM 467
<i>Chem mart Indapamide (CH)</i>	.CARDIOVASCULAR SYSTEM..... 131
<i>Chem mart Indapamide SR (CH)</i>	.CARDIOVASCULAR SYSTEM..... 131
<i>Chem mart Irbesartan (CH)</i>	.CARDIOVASCULAR SYSTEM..... 150, 151
<i>Chem mart Irbesartan HCTZ (CH)</i>	.CARDIOVASCULAR SYSTEM..... 154
<i>Chem mart Isosorbide Mononitrate (CH)</i>	.CARDIOVASCULAR SYSTEM..... 129
<i>Chem mart Latanoprost (CH)</i>	.SENSORY ORGANS..... 582
<i>Chem mart Lercanidipine (CH)</i>	.CARDIOVASCULAR SYSTEM..... 138
<i>Chem mart Letrozole (CH)</i>	.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS 291
<i>Chem mart Levetiracetam (CH)</i>	.NERVOUS SYSTEM..... 506, 507
<i>Chem mart Lisinopril (CH)</i>	.CARDIOVASCULAR SYSTEM..... 141
<i>Chem mart Meloxicam (CH)</i>	.MUSCULO-SKELETAL SYSTEM 463, 464
<i>Chem mart Meloxicam 15 mg (CH)</i>	.MUSCULO-SKELETAL SYSTEM 463
<i>Chem mart Meloxicam 7.5 mg (CH)</i>	.MUSCULO-SKELETAL SYSTEM 464
<i>Chem mart Metformin (CH)</i>	.ALIMENTARY TRACT AND METABOLISM..... 89
<i>Chem mart Metformin 1000 (CH)</i>	.ALIMENTARY TRACT AND METABOLISM..... 89
<i>Chem mart Metformin XR 500 (CH)</i>	.ALIMENTARY TRACT AND METABOLISM..... 89
<i>Chem mart Metoprolol (CH)</i>	.CARDIOVASCULAR SYSTEM..... 135
<i>Chem mart Mirtazapine (CH)</i>	.NERVOUS SYSTEM..... 542
<i>Chem mart Moclobemide (CH)</i>	.NERVOUS SYSTEM..... 540
<i>Chem mart Montelukast (CH)</i>	.RESPIRATORY SYSTEM..... 573, 574
<i>Chem mart Olanzapine (CH)</i>	.NERVOUS SYSTEM..... 518, 520, 522, 523
<i>Chem mart Olanzapine ODT (CH)</i>	.NERVOUS SYSTEM..... 517, 518, 519, 520
<i>Chem mart Omeprazole (CH)</i>	.ALIMENTARY TRACT AND METABOLISM..... 69, 70
<i>Chem mart Pantoprazole (CH)</i>	

GENERIC/PROPRIETARY INDEX

.ALIMENTARY TRACT AND METABOLISM.....	70, 71	<i>Chem mart Tramadol SR (CH)</i>	
<i>Chem mart Paroxetine (CH)</i>		.NERVOUS SYSTEM.....	492
.NERVOUS SYSTEM.....	538	<i>Chem mart Valaciclovir (CH)</i>	
<i>Chem mart Perindopril (CH)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE	248, 249
.CARDIOVASCULAR SYSTEM.....	142, 143	<i>Chem mart Venlafaxine XR (CH)</i>	
<i>Chem mart Perindopril/ Indapamide 4/1.25 (CH)</i>		.NERVOUS SYSTEM.....	543
.CARDIOVASCULAR SYSTEM.....	147	CHLORAMBUCIL	
<i>Chem mart Pharmacy Osteo Relief Paracetamol 665 mg (CH)</i>		.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	251
.NERVOUS SYSTEM.....	495	CHLORAMPHENICOL	
.Palliative Care	644, 645	.SENSORY ORGANS.....	575, 594
<i>Chem mart Pioglitazone (CH)</i>		CHLORHEXIDINE	
.ALIMENTARY TRACT AND METABOLISM.....	97, 98	.Repatriation Schedule	1197
<i>Chem mart Piroxicam (CH)</i>		<i>Chloromycetin (PF)</i>	
.MUSCULO-SKELETAL SYSTEM	464, 465	.SENSORY ORGANS.....	575, 594
<i>Chem mart Pravastatin (CH)</i>		CHLORPROMAZINE	
.CARDIOVASCULAR SYSTEM.....	164, 165, 166	.NERVOUS SYSTEM.....	515
<i>Chem mart Prazosin (CH)</i>		<i>Chlorsig (QA)</i>	
.CARDIOVASCULAR SYSTEM.....	130	.SENSORY ORGANS.....	575
<i>Chem mart Quetiapine (CH)</i>		CHLORTHALIDONE	
.NERVOUS SYSTEM.....	523, 524, 525	.CARDIOVASCULAR SYSTEM	131
<i>Chem mart Rabeprazole (CH)</i>		<i>Chlorvescent (AS)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	72	.ALIMENTARY TRACT AND METABOLISM.....	106
<i>Chem mart Raloxifene (CH)</i>		CHOLESTYRAMINE	
.MUSCULO-SKELETAL SYSTEM	480	.CARDIOVASCULAR SYSTEM	173
<i>Chem mart Ramipril (CH)</i>		<i>Cholstat 10 (AF)</i>	
.CARDIOVASCULAR SYSTEM.....	143, 144, 145	.CARDIOVASCULAR SYSTEM	164, 165
<i>Chem mart Ranitidine (CH)</i>		<i>Cholstat 20 (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	67	.CARDIOVASCULAR SYSTEM	164, 165
<i>Chem mart Risedronate (CH)</i>		<i>Cholstat 40 (AF)</i>	
.MUSCULO-SKELETAL SYSTEM	472	.CARDIOVASCULAR SYSTEM	164, 165
<i>Chem mart Rosuvastatin (CH)</i>		<i>Cholvastin (RA)</i>	
.CARDIOVASCULAR SYSTEM.....	167, 168, 169	.CARDIOVASCULAR SYSTEM	164, 165
<i>Chem mart Roxithromycin (CH)</i>		CHORIOGONADOTROPIN ALFA	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	234, 235	.Section 100.....	1158
<i>Chem mart Sertraline (CH)</i>		<i>Cialis (LY)</i>	
.NERVOUS SYSTEM.....	539	.Repatriation Schedule	1210
<i>Chem mart Sildenafil (CH)</i>		<i>Ciazil (UA)</i>	
.Repatriation Schedule	1209	.NERVOUS SYSTEM.....	535
<i>Chem mart Simvastatin (CH)</i>		CICLESONIDE	
.CARDIOVASCULAR SYSTEM.....	170, 171, 172	.RESPIRATORY SYSTEM.....	571
<i>Chem mart Sotalol (CH)</i>		CICLOPIROX	
.CARDIOVASCULAR SYSTEM.....	127	.Repatriation Schedule	1203
<i>Chem mart Sumatriptan (CH)</i>		CIDOFOVIR	
.NERVOUS SYSTEM.....	497, 498	.Section 100.....	708, 957
<i>Chem mart Telmisartan (CH)</i>		<i>Cifran (RA)</i>	
.CARDIOVASCULAR SYSTEM.....	151	.ANTIINFECTIVES FOR SYSTEMIC USE	237, 238
<i>Chem mart Telmisartan HCTZ 40/12.5 (CH)</i>		<i>Cilamox (QA)</i>	
.CARDIOVASCULAR SYSTEM.....	155	.ANTIINFECTIVES FOR SYSTEMIC USE	220, 221
<i>Chem mart Telmisartan HCTZ 80/12.5 (CH)</i>		<i>Cilex (GN)</i>	
.CARDIOVASCULAR SYSTEM.....	155	.ANTIINFECTIVES FOR SYSTEMIC USE	226, 227, 228
<i>Chem mart Telmisartan HCTZ 80/25 (CH)</i>		<i>Cilicaine (QA)</i>	
.CARDIOVASCULAR SYSTEM.....	156	.ANTIINFECTIVES FOR SYSTEMIC USE	223
<i>Chem mart Tramadol (CH)</i>		.Prescriber Bag	62
.NERVOUS SYSTEM.....	493, 494	<i>Cilicaine V (FM)</i>	

GENERIC/PROPRIETARY INDEX

.ANTIINFECTIVES FOR SYSTEMIC USE.....	222	<i>Citalopram AN (EA)</i>	
<i>Cilicaine VK (FM)</i>		.NERVOUS SYSTEM.....	535
.ANTIINFECTIVES FOR SYSTEMIC USE.....	222, 223	<i>Citalopram generichealth (GQ)</i>	
<i>Cilopam-S (ER)</i>		.NERVOUS SYSTEM.....	535
.NERVOUS SYSTEM.....	535, 536	<i>Citalopram Sandoz (SZ)</i>	
<i>Cilopen VK (GN)</i>		.NERVOUS SYSTEM.....	535
.ANTIINFECTIVES FOR SYSTEMIC USE.....	222, 223	<i>Citalopram-GA (GN)</i>	
<i>CiloQuin (IQ)</i>		.NERVOUS SYSTEM.....	535
.SENSORY ORGANS.....	576	<i>Citrulline 1000 (VF)</i>	
<i>Ciloxan (AQ)</i>		.VARIOUS.....	625
.SENSORY ORGANS.....	576, 594	CITRULLINE WITH CARBOHYDRATE	
CIMETIDINE		.VARIOUS.....	625
.ALIMENTARY TRACT AND METABOLISM.....	66	<i>Clamoxyl (AL)</i>	
<i>Cimzia (UC)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE.....	224
.ANTINEOPLASTIC AND IMMUNOMODULATING		<i>Clamoxyl Duo (AL)</i>	
AGENTS	370, 380	.ANTIINFECTIVES FOR SYSTEMIC USE.....	224
CINACALCET		<i>Clamoxyl Duo 400 (AL)</i>	
.Section 100	707, 955	.ANTIINFECTIVES FOR SYSTEMIC USE.....	224
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX		<i>Clamoxyl Duo forte (AL)</i>	
HORMONES AND INSULINS.....	216	.ANTIINFECTIVES FOR SYSTEMIC USE.....	225
<i>Cipramil (LU)</i>		<i>Clarac (GN)</i>	
.NERVOUS SYSTEM.....	535	.ANTIINFECTIVES FOR SYSTEMIC USE.....	233
CIPROFLOXACIN		<i>Claratyne (MK)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	237	.Repatriation Schedule	1221
.SENSORY ORGANS.....	576, 594	<i>Clarithexal (HX)</i>	
<i>Ciprofloxacin 500 (CR)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE.....	233
.ANTIINFECTIVES FOR SYSTEMIC USE.....	237	<i>Clarithro 250 (QA)</i>	
<i>Ciprofloxacin 750 (CR)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE.....	233
.ANTIINFECTIVES FOR SYSTEMIC USE.....	238	CLARITHROMYCIN	
<i>Ciprofloxacin AN (EA)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE.....	233
.ANTIINFECTIVES FOR SYSTEMIC USE.....	237, 238	.Section 100.....	708, 957
<i>Ciprofloxacin Sandoz (SZ)</i>		<i>Clarithromycin AN (EA)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	237, 238	.ANTIINFECTIVES FOR SYSTEMIC USE.....	233
<i>Ciprofloxacin-BW (GQ)</i>		<i>Clarithromycin Sandoz (SZ)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	237, 238	.ANTIINFECTIVES FOR SYSTEMIC USE.....	233
<i>Ciprofloxacin-DRLA (RZ)</i>		<i>Clavam 875 mg/125 mg (NJ)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	237, 238	.ANTIINFECTIVES FOR SYSTEMIC USE.....	225
<i>Ciprofloxacin-GA (GN)</i>		<i>Cleocin (FZ)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	237, 238	.ANTIINFECTIVES FOR SYSTEMIC USE.....	235
<i>Ciprol 250 (QA)</i>		<i>Clexane (SW)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	237	.BLOOD AND BLOOD FORMING ORGANS.....	109
<i>Ciprol 500 (QA)</i>		<i>Climara 100 (BN)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	237	.GENITO URINARY SYSTEM AND SEX HORMONES .	201
<i>Ciprol 750 (QA)</i>		<i>Climara 25 (BN)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	238	.GENITO URINARY SYSTEM AND SEX HORMONES .	202
<i>Ciproxin 250 (BN)</i>		<i>Climara 50 (BN)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	237	.GENITO URINARY SYSTEM AND SEX HORMONES .	202
<i>Ciproxin 500 (BN)</i>		<i>Climara 75 (BN)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	237	.GENITO URINARY SYSTEM AND SEX HORMONES .	202
<i>Ciproxin 750 (BN)</i>		CLINDAMYCIN	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	238	.ANTIINFECTIVES FOR SYSTEMIC USE.....	235
CITALOPRAM		<i>Clobemix (GN)</i>	
.NERVOUS SYSTEM.....	535	.NERVOUS SYSTEM.....	540
<i>Citalopram Actavis (UA)</i>		CLOBETASOL	
.NERVOUS SYSTEM.....	535	.DERMATOLOGICALS	195

GENERIC/PROPRIETARY INDEX

<i>Clobex (GA)</i>		
.DERMATOLOGICALS	195	
<i>CLODRONATE</i>		
.MUSCULO-SKELETAL SYSTEM	470	
<i>Clofen 10 (AF)</i>		
.MUSCULO-SKELETAL SYSTEM	468	
<i>Clofen 25 (AF)</i>		
.MUSCULO-SKELETAL SYSTEM	468	
<i>Clomid (SW)</i>		
.GENITO URINARY SYSTEM AND SEX HORMONES .	205	
<i>CLOMIPHENE</i>		
.GENITO URINARY SYSTEM AND SEX HORMONES .	205	
<i>CLOMIPRAMINE</i>		
.NERVOUS SYSTEM.....	534	
<i>Clonac 25 (QA)</i>		
.MUSCULO-SKELETAL SYSTEM	462	
.Palliative Care	638	
<i>Clonac 50 (QA)</i>		
.MUSCULO-SKELETAL SYSTEM	462	
.Palliative Care	638, 639	
<i>CLONAZEPAM</i>		
.NERVOUS SYSTEM.....	499, 500	
.Palliative Care	645	
<i>Clonea (AF)</i>		
.Repatriation Schedule.....	1203	
<i>CLONIDINE</i>		
.CARDIOVASCULAR SYSTEM.....	130	
<i>CLOPIDOGREL</i>		
.BLOOD AND BLOOD FORMING ORGANS	110, 111	
.Repatriation Schedule.....	1201	
<i>CLOPIDOGREL + ASPIRIN</i>		
.BLOOD AND BLOOD FORMING ORGANS	112	
<i>Clopidogrel Actavis (UA)</i>		
.BLOOD AND BLOOD FORMING ORGANS	112	
<i>Clopidogrel AN (EA)</i>		
.BLOOD AND BLOOD FORMING ORGANS	110, 111	
<i>Clopidogrel GH (GQ)</i>		
.BLOOD AND BLOOD FORMING ORGANS	112	
.Repatriation Schedule.....	1201	
<i>Clopidogrel RBX (RA)</i>		
.BLOOD AND BLOOD FORMING ORGANS	111	
<i>Clopidogrel Sandoz (SZ)</i>		
.BLOOD AND BLOOD FORMING ORGANS	111	
<i>Clopidogrel Winthrop (WA)</i>		
.BLOOD AND BLOOD FORMING ORGANS	110, 111	
<i>Clopidogrel Winthrop plus aspirin (WA)</i>		
.BLOOD AND BLOOD FORMING ORGANS	112	
<i>Clopidogrel-DRLA (RZ)</i>		
.BLOOD AND BLOOD FORMING ORGANS	111	
<i>Clopidogrel-GA (GN)</i>		
.BLOOD AND BLOOD FORMING ORGANS	110, 112	
<i>Clopine 100 (HH)</i>		
.Section 100	886, 1138	
<i>Clopine 200 (HH)</i>		
.Section 100	886, 1138	
<i>Clopine 25 (HH)</i>		
.Section 100.....	886, 1138	
<i>Clopine 50 (HH)</i>		
.Section 100.....	886, 1138	
<i>Clopine Suspension (HH)</i>		
.Section 100.....	886, 1138	
<i>Clopixol Depot (LU)</i>		
.NERVOUS SYSTEM.....	517	
<i>CLOSTRIDIUM BOTULINUM TYPE A TOXIN- HAEMAGGLUTININ COMPLEX</i>		
.Section 100.....	1155	
<i>CLOTTRIMAZOLE</i>		
.Repatriation Schedule	1203, 1209	
<i>Clovix 75 (QA)</i>		
.BLOOD AND BLOOD FORMING ORGANS.....	110, 112	
<i>CLOZAPINE</i>		
.Section 100.....	886, 1138	
<i>Clozaril 100 (NV)</i>		
.Section 100.....	886, 1138	
<i>Clozaril 25 (NV)</i>		
.Section 100.....	886, 1138	
<i>COAL TAR PREPARED</i>		
.DERMATOLOGICALS	191	
<i>COAL TAR SOLUTION + PHENOL + SULFUR-PRECIPI-TATED</i>		
.Repatriation Schedule	1205	
<i>COAL TAR SOLUTION + TAR + SALICYLIC ACID</i>		
.Repatriation Schedule	1206	
<i>Coban 1584 (MM)</i>		
.Repatriation Schedule	1227	
<i>Coban 2 (MM)</i>		
.Repatriation Schedule	1227	
<i>Cobasol (GN)</i>		
.NERVOUS SYSTEM.....	512	
<i>Codalgin (FM)</i>		
.Repatriation Schedule	1216	
<i>Codalgin Forte (FM)</i>		
.NERVOUS SYSTEM.....	487, 488	
<i>Codapane Forte (AL)</i>		
.NERVOUS SYSTEM.....	487, 488	
<i>CODEINE</i>		
.NERVOUS SYSTEM.....	482	
.RESPIRATORY SYSTEM.....	574	
<i>Co-Diovan 160/12.5 (NV)</i>		
.CARDIOVASCULAR SYSTEM	156	
<i>Co-Diovan 160/25 (NV)</i>		
.CARDIOVASCULAR SYSTEM	156	
<i>Co-Diovan 320/12.5 (NV)</i>		
.CARDIOVASCULAR SYSTEM	156	
<i>Co-Diovan 320/25 (NV)</i>		
.CARDIOVASCULAR SYSTEM	156	
<i>Co-Diovan 80/12.5 (NV)</i>		
.CARDIOVASCULAR SYSTEM	156	
<i>Cogentin (FK)</i>		
.NERVOUS SYSTEM.....	510	
.Prescriber Bag	62	

GENERIC/PROPRIETARY INDEX

<i>Colazide (PK)</i>	515
.ALIMENTARY TRACT AND METABOLISM.....	84
COLCHICINE	
.MUSCULO-SKELETAL SYSTEM	469
<i>Colese (AF)</i>	
.Repatriation Schedule.....	1197
<i>Colestid (PF)</i>	
.CARDIOVASCULAR SYSTEM.....	174
COLESTIPOL HYDROCHLORIDE	
.CARDIOVASCULAR SYSTEM.....	174
<i>Colgout (AS)</i>	
.MUSCULO-SKELETAL SYSTEM	469
<i>Colifoam (HM)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	83
<i>Colofac (AB)</i>	
.Repatriation Schedule.....	1197
<i>Coloxyl 50 (FM)</i>	
.Repatriation Schedule.....	1198
<i>Coloxyl with Senna (FM)</i>	
.Repatriation Schedule.....	1198
<i>CombiDERM 651027 (CC)</i>	
.Repatriation Schedule.....	1234
<i>CombiDERM 651031 (CC)</i>	
.Repatriation Schedule.....	1234
<i>Combigan (AG)</i>	
.SENSORY ORGANS.....	578, 579
<i>Combivir (VI)</i>	
.Section 100	723, 973
<i>Comfarol Forte (SZ)</i>	
.NERVOUS SYSTEM.....	487, 488
<i>Comfeel Paste 4701 (CT)</i>	
.Repatriation Schedule.....	1235
<i>Comfeel Plus Pressure Relieving 3350 (CT)</i>	
.Repatriation Schedule.....	1236
<i>Comfeel Plus Pressure Relieving 3353 (CT)</i>	
.Repatriation Schedule.....	1236
<i>Comfeel Plus Transparent 3530 (CT)</i>	
.Repatriation Schedule.....	1235
<i>Comfeel Plus Transparent 3533 (CT)</i>	
.Repatriation Schedule.....	1235
<i>Comfeel Plus Transparent 3536 (CT)</i>	
.Repatriation Schedule.....	1235
<i>Comfeel Plus Ulcer Dressing 3110 (CT)</i>	
.Repatriation Schedule.....	1236
<i>Comfeel Purilon Gel 3900 (CT)</i>	
.Repatriation Schedule.....	1237
<i>Comfeel SeaSorb Dressing 3705 (CT)</i>	
.Repatriation Schedule.....	1230
<i>Comfeel SeaSorb Dressing 3710 (CT)</i>	
.Repatriation Schedule.....	1230
<i>Comfeel SeaSorb Filler 3740 (CT)</i>	
.Repatriation Schedule.....	1230
<i>Comprilan 01027-00 (BV)</i>	
.Repatriation Schedule.....	1226
<i>Comtan (NV)</i>	
.NERVOUS SYSTEM.....	515
<i>Concerta (JC)</i>	
.NERVOUS SYSTEM.....	545
<i>Condyline Paint (NQ)</i>	
.Repatriation Schedule.....	1205
<i>Contour (IK)</i>	
.VARIOUS.....	599, 600
<i>Contour next (IK)</i>	
.VARIOUS.....	599, 600
<i>Copaxone (CS)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	294
<i>Coperin (AF)</i>	
.NERVOUS SYSTEM.....	541
<i>CoPlavix (SW)</i>	
.BLOOD AND BLOOD FORMING ORGANS.....	112
<i>Coralan (SE)</i>	
.CARDIOVASCULAR SYSTEM	130
<i>Corbeton 40 (AF)</i>	
.CARDIOVASCULAR SYSTEM	133
<i>Cordarone X 100 (SW)</i>	
.CARDIOVASCULAR SYSTEM	127
<i>Cordarone X 200 (SW)</i>	
.CARDIOVASCULAR SYSTEM	127
<i>Cordilox 180 SR (KN)</i>	
.CARDIOVASCULAR SYSTEM	139
<i>Cordilox SR (KN)</i>	
.CARDIOVASCULAR SYSTEM	139
CORIFOLLITROPIN ALFA	
.Section 100.....	1158
<i>Cortate (AS)</i>	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS	211
<i>Cortic-DS 1% (FM)</i>	
.DERMATOLOGICALS	193
CORTISONE	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS	211
<i>Cortival 1/2 (FM)</i>	
.DERMATOLOGICALS.....	194
<i>Cortival 1/5 (FM)</i>	
.DERMATOLOGICALS.....	194
<i>Cosamide (AF)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	288
<i>Co-Senna (PP)</i>	
.Repatriation Schedule.....	1198
<i>Cosopt (MK)</i>	
.SENSORY ORGANS.....	580
<i>Cosudex (AP)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	288
<i>Coumadin (QA)</i>	
.BLOOD AND BLOOD FORMING ORGANS.....	108
<i>Coveram 10/10 (SE)</i>	

GENERIC/PROPRIETARY INDEX

.CARDIOVASCULAR SYSTEM	148	.ANTIINFECTIVES FOR SYSTEMIC USE	224
<i>Coveram 10/5 (SE)</i>		<i>Curam Duo Forte 875/125 (SZ)</i>	
.CARDIOVASCULAR SYSTEM	148	.ANTIINFECTIVES FOR SYSTEMIC USE	225
<i>Coveram 5/10 (SE)</i>		<i>Curity 4112 (KE)</i>	
.CARDIOVASCULAR SYSTEM	148	.Repatriation Schedule	1233
<i>Coveram 5/5 (SE)</i>		<i>Cutifilm Plus 36361370 (SN)</i>	
.CARDIOVASCULAR SYSTEM	148	.Repatriation Schedule	1231
<i>Coversyl 10mg (SE)</i>		<i>Cutifilm Plus 36361371 (SN)</i>	
.CARDIOVASCULAR SYSTEM	142	.Repatriation Schedule	1231
<i>Coversyl 2.5mg (SE)</i>		<i>Cutilin Non-Stick Wound Pad 36361374 (SN)</i>	
.CARDIOVASCULAR SYSTEM	142	.Repatriation Schedule	1238
<i>Coversyl 5mg (SE)</i>		<i>Cutilin Non-Stick Wound Pad 36361375 (SN)</i>	
.CARDIOVASCULAR SYSTEM	142	.Repatriation Schedule	1238
<i>Coversyl Plus 5mg/1.25mg (SE)</i>		<i>Cutinova Hydro 66047441 (SN)</i>	
.CARDIOVASCULAR SYSTEM	147	.Repatriation Schedule	1235
<i>Coversyl Plus LD 2.5mg/0.625mg (SE)</i>		<i>Cutinova Hydro 66047443 (SN)</i>	
.CARDIOVASCULAR SYSTEM	146	.Repatriation Schedule	1235
<i>Cozavan (AF)</i>		CYANOCOBALAMIN + FERRIC PYROPHOSPHATE + LYSINE + PYRIDOXINE + THIAMINE	
.CARDIOVASCULAR SYSTEM	151	.Repatriation Schedule	1199
<i>Creon 10,000 (AB)</i>		<i>Cycloblastin (PF)</i>	
.ALIMENTARY TRACT AND METABOLISM	86	.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	251
<i>Creon 25,000 (AB)</i>		CYCLOPHOSPHAMIDE	
.ALIMENTARY TRACT AND METABOLISM	86	.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	251
<i>Creon 40,000 (AB)</i>		CYCLOSPORIN	
.ALIMENTARY TRACT AND METABOLISM	86	.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	459
<i>Creon Micro (AB)</i>		.Section 100	868, 869, 1121
.ALIMENTARY TRACT AND METABOLISM	86	<i>Cyclosporin Sandoz (SZ)</i>	
<i>Crestor (AP)</i>		.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	460
.CARDIOVASCULAR SYSTEM	166, 167, 168, 169	.Section 100	869, 1121
<i>Crinone 8% (SG)</i>		<i>Cyklokapron (PF)</i>	
.Section 100	1160	.BLOOD AND BLOOD FORMING ORGANS	122
<i>Crixivan 400 mg (MK)</i>		<i>Cymbalta (LY)</i>	
.Section 100	712, 961	.NERVOUS SYSTEM	541
CROMOGLYCATE		<i>Cymevene (RO)</i>	
.Repatriation Schedule	1220	.Section 100	708, 957
.RESPIRATORY SYSTEM	572	<i>Cyprocur 100 (QA)</i>	
.SENSORY ORGANS	584	.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	288
<i>Cromolux (AE)</i>		.GENITO URINARY SYSTEM AND SEX HORMONES	205
.SENSORY ORGANS	584	<i>Cyprocur 50 (QA)</i>	
<i>Crosuva 10 (ZP)</i>		.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	288
.CARDIOVASCULAR SYSTEM	166, 167, 168	.GENITO URINARY SYSTEM AND SEX HORMONES	205, 206
<i>Crosuva 20 (ZP)</i>		CYPROHEPTADINE	
.CARDIOVASCULAR SYSTEM	166, 167, 169	.NERVOUS SYSTEM	498
<i>Crosuva 40 (ZP)</i>		<i>Cyprone (AF)</i>	
.CARDIOVASCULAR SYSTEM	166, 168, 169	.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	288
<i>Crosuva 5 (ZP)</i>			
.CARDIOVASCULAR SYSTEM	166, 167, 168		
<i>Crysanal (MD)</i>			
.MUSCULO-SKELETAL SYSTEM	466		
.Palliative Care	641		
<i>Curam (SZ)</i>			
.ANTIINFECTIVES FOR SYSTEMIC USE	224		
<i>Curam Duo (SZ)</i>			
.ANTIINFECTIVES FOR SYSTEMIC USE	224		
<i>Curam Duo 500/125 (SZ)</i>			

GENERIC/PROPRIETARY INDEX

.GENITO URINARY SYSTEM AND SEX HORMONES	205, 206
<i>Cyprostat (SY)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	288
.GENITO URINARY SYSTEM AND SEX HORMONES	205, 206
<i>Cyprostat-100 (SY)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	288
.GENITO URINARY SYSTEM AND SEX HORMONES	205
CYPROTERONE	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	288
.GENITO URINARY SYSTEM AND SEX HORMONES	205
<i>Cyproterone AN (EA)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	288
.GENITO URINARY SYSTEM AND SEX HORMONES	205, 206
<i>Cyproterone Sandoz (HX)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	288
.GENITO URINARY SYSTEM AND SEX HORMONES	205, 206
<i>Cyrotone (ER)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	288
.GENITO URINARY SYSTEM AND SEX HORMONES	205
<i>Cystadane (EU)</i>	
.ALIMENTARY TRACT AND METABOLISM	106
<i>Cystine 500 (VF)</i>	
.VARIOUS	625
CYSTINE WITH CARBOHYDRATE	
.VARIOUS	625

D

<i>Dalacin C (PF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	235
DALTEPARIN SODIUM	
.BLOOD AND BLOOD FORMING ORGANS	108, 109
DANAZOL	
.GENITO URINARY SYSTEM AND SEX HORMONES	206
<i>Dantrium (PF)</i>	
.MUSCULO-SKELETAL SYSTEM	468
DANTROLENE	
.MUSCULO-SKELETAL SYSTEM	468
<i>Daonil (SW)</i>	
.ALIMENTARY TRACT AND METABOLISM	90
DAPAGLIFLOZIN	
.ALIMENTARY TRACT AND METABOLISM	102
<i>Dapa-Tabs (AF)</i>	
.CARDIOVASCULAR SYSTEM	131
DAPSONE	
.ANTIINFECTIVES FOR SYSTEMIC USE	244
.DERMATOLOGICALS	196
<i>Daraprim (AS)</i>	
.ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS	561
DARBEPOETIN ALFA	
.Section 100	655, 903
DARUNAVIR	
.Section 100	711, 960
DASATINIB	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	256, 257, 259
<i>DBL Cefepime (HH)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	232
<i>DBL Gabapentin (HH)</i>	
.Repatriation Schedule	1216
<i>DBL Metronidazole Intravenous Infusion (HH)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	239, 240
<i>Deca-Durabolin (AS)</i>	
.ALIMENTARY TRACT AND METABOLISM	106
DEFERASIROX	
.Section 100	897, 1150
DEFERIPRONE	
.Section 100	897, 1150
DEGARELIX	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	292
<i>Delucon 100 (DO)</i>	
.NERVOUS SYSTEM	523
<i>Delucon 200 (DO)</i>	
.NERVOUS SYSTEM	524
<i>Delucon 25 (DO)</i>	
.NERVOUS SYSTEM	525
<i>Delucon 300 (DO)</i>	
.NERVOUS SYSTEM	524
DENOSUMAB	
.MUSCULO-SKELETAL SYSTEM	478, 479
<i>Denpax (AF)</i>	
DABIGATRAN	
.BLOOD AND BLOOD FORMING ORGANS	115, 116
DABRAFENIB	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	255
<i>Daivobet (LO)</i>	
.DERMATOLOGICALS	192
<i>Daivobet 50/500 gel (LO)</i>	
.DERMATOLOGICALS	192
<i>Daivonex (LO)</i>	
.DERMATOLOGICALS	191
<i>Daktarin (JT)</i>	
.DERMATOLOGICALS	190
.Repatriation Schedule	1203
<i>Daktarin Tincture (JT)</i>	
.DERMATOLOGICALS	190
.Repatriation Schedule	1203

GENERIC/PROPRIETARY INDEX

.NERVOUS SYSTEM.....	488, 489, 490
<i>Densate 70 (DO)</i>	
.MUSCULO-SKELETAL SYSTEM	470
<i>Deotine 30 (SZ)</i>	
.NERVOUS SYSTEM.....	541
<i>Deotine 60 (SZ)</i>	
.NERVOUS SYSTEM.....	541
<i>Depo-Medrol (PF)</i>	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS.....	213
<i>Depo-Nisalone (FZ)</i>	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS.....	213
<i>Depo-Provera (PF)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	200
<i>Depo-Ralovera (FZ)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	200
<i>Deptran 10 (AF)</i>	
.NERVOUS SYSTEM.....	534
<i>Deptran 25 (AF)</i>	
.NERVOUS SYSTEM.....	534
<i>Deptran 50 (AF)</i>	
.NERVOUS SYSTEM.....	534
<i>Deralin 10 (AF)</i>	
.CARDIOVASCULAR SYSTEM	133
<i>Deralin 160 (AF)</i>	
.CARDIOVASCULAR SYSTEM	133
<i>Deralin 40 (AF)</i>	
.CARDIOVASCULAR SYSTEM	133
<i>Dermatane (ER)</i>	
.DERMATOLOGICALS.....	195, 196
<i>Desferal 2 g (NV)</i>	
.Section 100	897, 1150
<i>Desferal 500 mg (NV)</i>	
.Section 100	897, 1150
DESFERRIOXAMINE	
.Section 100	897, 1150
DESMOPRESSIN	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS.....	209, 210
DESVENLAFAXINE	
.NERVOUS SYSTEM.....	540
DEXAMETHASONE	
.SENSORY ORGANS.....	577
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS.....	211
DEXAMETHASONE + FRAMYCETIN SULFATE + GRAMICIDIN	
.SENSORY ORGANS.....	594
DEXAMETHASONE SODIUM PHOSPHATE	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS.....	211
DEXAMPHETAMINE	
.NERVOUS SYSTEM.....	544
<i>Dexamethsone (AF)</i>	
.Prescriber Bag	62
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS	211
<i>Dexamethsone (AS)</i>	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS	211
DEXTRAN-70 + HYPROMELLOSE	
.SENSORY ORGANS.....	590, 591
<i>Diabex (AL)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>Diabex 1000 (AL)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>Diabex 850 (AL)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	90
<i>Diabex XR (AL)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>Diabex XR 1000 (AL)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>Diaformin (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>Diaformin 1000 (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>Diaformin 850 (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>Diaformin XR (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>Diaformin XR 1000 (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>Dialamine (SB)</i>	
.VARIOUS.....	626
<i>Diamcron 60mg MR (SE)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	90
<i>Diamox (QA)</i>	
.SENSORY ORGANS.....	579
<i>Diapride 1 (QA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	90
<i>Diapride 2 (QA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	90
<i>Diapride 3 (QA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	90
<i>Diapride 4 (QA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	91
<i>Diastix (BN)</i>	
.VARIOUS.....	599
DIAZEPAM	
.NERVOUS SYSTEM.....	531
.Palliative Care.....	646
<i>Diazepam Elixir (ON)</i>	
.NERVOUS SYSTEM.....	531
<i>Diazepam-GA (GN)</i>	
.NERVOUS SYSTEM.....	531, 532
.Palliative Care.....	646
<i>Dibenyline (GH)</i>	
.CARDIOVASCULAR SYSTEM	133
.GENITO URINARY SYSTEM AND SEX HORMONES .	207

GENERIC/PROPRIETARY INDEX

<i>Dibenzylamine (BZ)</i>		.CARDIOVASCULAR SYSTEM..... 133
		.GENITO URINARY SYSTEM AND SEX HORMONES . 207
<i>Dicarz (AF)</i>		.CARDIOVASCULAR SYSTEM..... 136, 137
DICHLOROBENZENE WITH CHLORBUTOL AND ARACHIS OIL		.Repatriation Schedule..... 1222
DICLOFENAC		.MUSCULO-SKELETAL SYSTEM..... 462
		.Palliative Care..... 638
		.Repatriation Schedule..... 1207
DICLOFENAC + MISOPROSTOL		.Repatriation Schedule..... 1214
<i>Diclofenac AN (EA)</i>		.MUSCULO-SKELETAL SYSTEM..... 462
		.Palliative Care..... 638, 639
<i>Diclofenac Sandoz (SZ)</i>		.MUSCULO-SKELETAL SYSTEM..... 462
		.Palliative Care..... 638, 639
<i>Diclofenac-GA (GN)</i>		.MUSCULO-SKELETAL SYSTEM..... 462
		.Palliative Care..... 638, 639
DICLOXACILLIN		.ANTIINFECTIVES FOR SYSTEMIC USE..... 223
DIDANOSINE		.Section 100..... 716, 965
<i>Diffiam (IA)</i>		.ALIMENTARY TRACT AND METABOLISM..... 66
		.Palliative Care..... 632
<i>Diflucan (PF)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE..... 241
<i>Digestelact (SJ)</i>		.VARIOUS..... 619
DIGOXIN		.CARDIOVASCULAR SYSTEM..... 126
<i>Dilantin (PF)</i>		.NERVOUS SYSTEM..... 499
<i>Dilantin Infatabs (PF)</i>		.NERVOUS SYSTEM..... 499
<i>Dilantin Sodium (PF)</i>		.NERVOUS SYSTEM..... 499
<i>Dilatrend 12.5 (RO)</i>		.CARDIOVASCULAR SYSTEM..... 136
<i>Dilatrend 25 (RO)</i>		.CARDIOVASCULAR SYSTEM..... 136
<i>Dilatrend 3.125 (RO)</i>		.CARDIOVASCULAR SYSTEM..... 136
<i>Dilatrend 6.25 (RO)</i>		.CARDIOVASCULAR SYSTEM..... 137
<i>Dilaudid (MF)</i>		.NERVOUS SYSTEM..... 482, 483
<i>Dilaudid-HP (MF)</i>		.NERVOUS SYSTEM..... 482, 483
DILTIAZEM		.CARDIOVASCULAR SYSTEM..... 139
<i>Diltiazem Actavis (UA)</i>		.CARDIOVASCULAR SYSTEM..... 139
<i>Diltiazem AN (EA)</i>		.CARDIOVASCULAR SYSTEM..... 139
<i>Diltiazem Sandoz (SZ)</i>		.CARDIOVASCULAR SYSTEM..... 139
<i>Diltiazem Sandoz CD (SZ)</i>		.CARDIOVASCULAR SYSTEM..... 139
<i>Dilzem 60 mg (GN)</i>		.CARDIOVASCULAR SYSTEM..... 139
DIMETHICONE-350 + GLYCEROL		.Repatriation Schedule..... 1204
DIMETHYL FUMARATE		.NERVOUS SYSTEM..... 558, 559
<i>Dimetriose (SW)</i>		.GENITO URINARY SYSTEM AND SEX HORMONES . 206
<i>Dimirel (AV)</i>		.ALIMENTARY TRACT AND METABOLISM..... 90, 91
<i>Diovan (NV)</i>		.CARDIOVASCULAR SYSTEM..... 152
<i>Dipentum (IX)</i>		.ALIMENTARY TRACT AND METABOLISM..... 85
DIPHENOXYLATE + ATROPINE SULFATE		.ALIMENTARY TRACT AND METABOLISM..... 83
<i>Diphereline (IS)</i>		.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS..... 287
DIPHThERIA TOXOID + TETANUS TOXOID		.ANTIINFECTIVES FOR SYSTEMIC USE..... 250
<i>Diprosone (MK)</i>		.DERMATOLOGICALS..... 193, 194
DIPYRIDAMOLE		.BLOOD AND BLOOD FORMING ORGANS..... 112
DIPYRIDAMOLE + ASPIRIN		.BLOOD AND BLOOD FORMING ORGANS..... 112
DISOPYRAMIDE		.CARDIOVASCULAR SYSTEM..... 126
<i>Distaph 250 (AF)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE..... 223
<i>Distaph 500 (AF)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE..... 223
<i>Dithiazide (PL)</i>		.CARDIOVASCULAR SYSTEM..... 131
<i>Ditropan (SW)</i>		.GENITO URINARY SYSTEM AND SEX HORMONES . 207
<i>Dizole 100 (AF)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE..... 241
<i>Dizole 200 (AF)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE..... 241
<i>Dizole 50 (AF)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE..... 241
<i>docomega (VF)</i>		.VARIOUS..... 625
DOCOSAHEXAENOIC ACID WITH CARBOHYDRATE		

GENERIC/PROPRIETARY INDEX

.VARIOUS.....	625	DOXORUBICIN HYDROCHLORIDE-PEGYLATED	
DOCUSATE		LIPOSOMAL	
.Repatriation Schedule.....	1197, 1222	.Section 100.....	728, 979
DOCUSATE + SENNOSIDE B		<i>Doxsig (QA)</i>	
.Repatriation Schedule.....	1198	.ANTIINFECTIVES FOR SYSTEMIC USE.....	218, 219
DOCUSATE + SENNOSIDES		<i>Doxy-100 (GN)</i>	
.Repatriation Schedule.....	1198	.ANTIINFECTIVES FOR SYSTEMIC USE.....	218, 219
<i>Dolapril 0.5 (QA)</i>		<i>Doxy-50 (GN)</i>	
.CARDIOVASCULAR SYSTEM.....	145	.ANTIINFECTIVES FOR SYSTEMIC USE.....	219
<i>Dolapril 1 (QA)</i>		DOXYCYCLINE	
.CARDIOVASCULAR SYSTEM.....	145	.ANTIINFECTIVES FOR SYSTEMIC USE.....	218, 219
<i>Dolapril 2 (QA)</i>		<i>Doxycycline AN (EA)</i>	
.CARDIOVASCULAR SYSTEM.....	145	.ANTIINFECTIVES FOR SYSTEMIC USE.....	218, 219
<i>Dolapril 4 (QA)</i>		<i>Doxycycline Sandoz (HX)</i>	
.CARDIOVASCULAR SYSTEM.....	145	.ANTIINFECTIVES FOR SYSTEMIC USE.....	218, 219
DOLUTEGRAVIR		<i>Doxylin 100 (AF)</i>	
.Section 100	725, 975	.ANTIINFECTIVES FOR SYSTEMIC USE.....	218, 219
DOMPERIDONE		<i>Doxylin 50 (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	73	.ANTIINFECTIVES FOR SYSTEMIC USE.....	219
DONEPEZIL		<i>D-Penamamine (AL)</i>	
.NERVOUS SYSTEM.....	546, 547	.MUSCULO-SKELETAL SYSTEM	468
<i>Donepezil AN (EA)</i>		DRESSING ACTIVATED CHARCOAL MALODOROUS	
.NERVOUS SYSTEM.....	547, 548	WOUND	
<i>Donepezil generichealth (GQ)</i>		.Repatriation Schedule.....	1229
.NERVOUS SYSTEM.....	547, 548	DRESSING ALGINATE CAVITY WOUND	
<i>Donepezil RBX (RA)</i>		.Repatriation Schedule	1230
.NERVOUS SYSTEM.....	547, 548, 549	DRESSING ALGINATE SUPERFICIAL WOUND	
<i>Donepezil Sandoz (SZ)</i>		.Repatriation Schedule	1230
.NERVOUS SYSTEM.....	547, 548, 549	DRESSING FILM	
<i>Donepezil-DRLA (RZ)</i>		.Repatriation Schedule	1230, 1231
.NERVOUS SYSTEM.....	547, 548	DRESSING FILM ISLAND	
<i>Donepezil-GA (GN)</i>		.Repatriation Schedule	1231
.NERVOUS SYSTEM.....	547, 548	DRESSING FOAM HEAVY EXUDATE	
DORNASE ALFA		.Repatriation Schedule	1231
.Section 100	891, 1143	DRESSING FOAM MODERATE EXUDATE	
<i>Doryx (YN)</i>		.Repatriation Schedule	1231
.ANTIINFECTIVES FOR SYSTEMIC USE.....	218, 219	DRESSING FOAM WITH SILICONE	
DORZOLAMIDE		.Repatriation Schedule	1231
.SENSORY ORGANS.....	580	DRESSING FOAM WITH SILICONE AND SILVER	
DORZOLAMIDE + TIMOLOL		.Repatriation Schedule	1232
.SENSORY ORGANS.....	580	DRESSING FOAM WITH SILICONE HEAVY EXUDATE	
<i>Dorzolamide/Timolol Sandoz 20/5 (SZ)</i>		.Repatriation Schedule	1232
.SENSORY ORGANS.....	580	DRESSING FOAM WITH SILICONE LIGHT EXUDATE	
<i>Dostan (GN)</i>		.Repatriation Schedule	1232
.GENITO URINARY SYSTEM AND SEX HORMONES .	199	DRESSING FOAM WITH SILICONE MODERATE EXUDATE	
<i>Dostinex (PF)</i>		.Repatriation Schedule	1232
.GENITO URINARY SYSTEM AND SEX HORMONES .	199	DRESSING FOAM WITH SILVER	
<i>Dothep 25 (AF)</i>		.Repatriation Schedule	1233
.NERVOUS SYSTEM.....	534	DRESSING GAUZE ABSORBENT	
<i>Dothep 75 (AF)</i>		.Repatriation Schedule	1233
.NERVOUS SYSTEM.....	534	DRESSING GAUZE EYE	
DOTHIEPIN		.Repatriation Schedule	1233
.NERVOUS SYSTEM.....	534	DRESSING GAUZE PARAFFIN	
DOXEPIN		.Repatriation Schedule	1233
.NERVOUS SYSTEM.....	534		

GENERIC/PROPRIETARY INDEX

DRESSING GAUZE PARAFFIN WITH CHLORHEXIDINE ACETATE .Repatriation Schedule.....	1233	.ALIMENTARY TRACT AND METABOLISM.....	79
DRESSING HYDROACTIVE CAVITY WOUND .Repatriation Schedule.....	1233	.Palliative Care.....	633
DRESSING HYDROACTIVE DEBRIDEMENT .Repatriation Schedule.....	1234	DULOXETINE	
DRESSING HYDROACTIVE SUPERFICIAL WOUND HIGH EXUDATE SEMI-PERMEABLE ABSORBENT FOAM .Repatriation Schedule.....	1234	.NERVOUS SYSTEM.....	541
DRESSING HYDROACTIVE SUPERFICIAL WOUND LIGHT EXUDATE .Repatriation Schedule.....	1234	<i>Duloxetine AN (EA)</i> .NERVOUS SYSTEM.....	541
DRESSING HYDROACTIVE SUPERFICIAL WOUND MODERATE EXUDATE .Repatriation Schedule.....	1234	<i>Duloxetine GH (GQ)</i> .NERVOUS SYSTEM.....	541
DRESSING HYDROCOLLOID CAVITY WOUND .Repatriation Schedule.....	1235	<i>Duloxetine RBX (RA)</i> .NERVOUS SYSTEM.....	541
DRESSING HYDROCOLLOID SUPERFICIAL WOUND LIGHT EXUDATE .Repatriation Schedule.....	1235	<i>Duloxetine-DRLA (RZ)</i> .NERVOUS SYSTEM.....	541
DRESSING HYDROCOLLOID SUPERFICIAL WOUND MODERATE EXUDATE .Repatriation Schedule.....	1235, 1236	<i>Duocal (SB)</i> .VARIOUS.....	628
DRESSING HYDROFIBRE ALTERNATE TO ALGINATES .Repatriation Schedule.....	1236	<i>DuoCover (AV)</i> .BLOOD AND BLOOD FORMING ORGANS.....	112
DRESSING HYDROFIBRE GELLING FIBRE .Repatriation Schedule.....	1236	<i>Duodart 500ug/400ug (GK)</i> .GENITO URINARY SYSTEM AND SEX HORMONES .	207
DRESSING HYDROFIBRE WITH SILVER .Repatriation Schedule.....	1237	.Repatriation Schedule	1210
DRESSING HYDROGEL .Repatriation Schedule.....	1237	<i>DuoDERM CGF H7660 (CC)</i> .Repatriation Schedule	1236
DRESSING HYDROGEL AMORPHOUS .Repatriation Schedule.....	1237	<i>DuoDERM CGF H7662 (CC)</i> .Repatriation Schedule	1236
DRESSING HYDROGEL FOAM .Repatriation Schedule.....	1237	<i>DuoDERM Extra Thin H7955 (CC)</i> .Repatriation Schedule	1235
DRESSING HYDROGEL RIBBON .Repatriation Schedule.....	1237	<i>DuoDERM Gel H7987 (CC)</i> .Repatriation Schedule	1237
DRESSING HYDROGEL SHEET .Repatriation Schedule.....	1238	<i>DuoDERM Gel H7990 (CC)</i> .Repatriation Schedule	1237
DRESSING NON ADHERENT .Repatriation Schedule.....	1238	<i>DuoDERM Paste H7930 (CC)</i> .Repatriation Schedule	1235
DRESSING TULLE NON GAUZE PARAFFIN .Repatriation Schedule.....	1238	<i>Duodopa (VE)</i> .NERVOUS SYSTEM.....	511
DRESSING WITH SILVER .Repatriation Schedule.....	1239	.Section 100.....	886, 1138
<i>Drixine (MK)</i> .Repatriation Schedule.....	1220	<i>Duofilm Solution (GK)</i> .Repatriation Schedule	1206
<i>Dronalen Plus (GN)</i> .MUSCULO-SKELETAL SYSTEM	474	<i>DuoPlidogrel (GZ)</i> .BLOOD AND BLOOD FORMING ORGANS.....	112
<i>Dronalen Plus D-Cal (FR)</i> .MUSCULO-SKELETAL SYSTEM	476	<i>Duotrav (AQ)</i> .SENSORY ORGANS.....	584
<i>Drulox (GN)</i> .NERVOUS SYSTEM.....	541	<i>Durafiber 66800560 (SN)</i> .Repatriation Schedule	1236
<i>Dulcolax (BY)</i>		<i>Durafiber 66800561 (SN)</i> .Repatriation Schedule	1236
		<i>Durafiber 66800563 (SN)</i> .Repatriation Schedule	1236
		<i>Duratears (AQ)</i> .SENSORY ORGANS.....	592
		<i>Duride (AF)</i> .CARDIOVASCULAR SYSTEM	129
		<i>Durogesic 100 (JC)</i> .NERVOUS SYSTEM.....	488
		<i>Durogesic 12 (JC)</i> .NERVOUS SYSTEM.....	489
		<i>Durogesic 25 (JC)</i>	

GENERIC/PROPRIETARY INDEX

.NERVOUS SYSTEM.....	489
<i>Durogesic 50 (JC)</i>	
.NERVOUS SYSTEM.....	490
<i>Durogesic 75 (JC)</i>	
.NERVOUS SYSTEM.....	490
<i>Duro-K (NM)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	105
<i>Duro-Tuss (IA)</i>	
.Repatriation Schedule	1221
DUTASTERIDE	
.GENITO URINARY SYSTEM AND SEX HORMONES .	207
.Repatriation Schedule	1211
DUTASTERIDE + TAMSULOSIN	
.GENITO URINARY SYSTEM AND SEX HORMONES .	207
.Repatriation Schedule	1210
<i>Dutran 100 (GN)</i>	
.NERVOUS SYSTEM.....	488
<i>Dutran 12 (GN)</i>	
.NERVOUS SYSTEM.....	489
<i>Dutran 25 (GN)</i>	
.NERVOUS SYSTEM.....	489
<i>Dutran 50 (GN)</i>	
.NERVOUS SYSTEM.....	490
<i>Dutran 75 (GN)</i>	
.NERVOUS SYSTEM.....	490
<i>Dysport (IS)</i>	
.Section 100	1155

E

<i>E.E.S. 200 (LM)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	234
<i>E.E.S. 400 Filmtab (LM)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	234
<i>E.E.S. Granules (LM)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	234
<i>EAA Supplement (VF)</i>	
.VARIOUS.....	626
<i>Ear Clear for Ear Wax Removal (KY)</i>	
.Repatriation Schedule	1222
<i>Easiphen (SB)</i>	
.VARIOUS.....	622
<i>EasyMate II (WI)</i>	
.VARIOUS.....	599, 600
<i>Ebixa (LU)</i>	
.NERVOUS SYSTEM.....	553, 554
ECULIZUMAB	
.Section 100	760, 761, 762, 1012, 1020, 1021
<i>Edecrin (FK)</i>	
.CARDIOVASCULAR SYSTEM	132
<i>Edronax (PF)</i>	
.NERVOUS SYSTEM.....	543
<i>Edurant (JC)</i>	
.Section 100	722, 972
EFAVIRENZ	

.Section 100.....	720, 970
<i>Efexor-XR (PF)</i>	
.NERVOUS SYSTEM.....	543
<i>Effient (LY)</i>	
.BLOOD AND BLOOD FORMING ORGANS.....	113
EFORMOTEROL	
.RESPIRATORY SYSTEM.....	564
<i>Efudix (VT)</i>	
.Repatriation Schedule	1213
<i>Egoderm Cream (EO)</i>	
.Repatriation Schedule	1207
<i>Egoderm Ointment (EO)</i>	
.Repatriation Schedule	1207
<i>Egopsoryl-TA (EO)</i>	
.Repatriation Schedule	1205
<i>Elastoplast 2225 (BE)</i>	
.Repatriation Schedule	1228
<i>Elastoplast 2226 (BE)</i>	
.Repatriation Schedule	1228
<i>Elastoplast 2227 (BE)</i>	
.Repatriation Schedule	1228
<i>Elaxine SR 150 (ZP)</i>	
.NERVOUS SYSTEM.....	543
<i>Elaxine SR 37.5 (ZP)</i>	
.NERVOUS SYSTEM.....	543
<i>Elaxine SR 75 (ZP)</i>	
.NERVOUS SYSTEM.....	543
<i>Eldepryl (AS)</i>	
.NERVOUS SYSTEM.....	514
<i>EleCare (AB)</i>	
.VARIOUS.....	603, 605, 606
<i>EleCare LCP (AB)</i>	
.VARIOUS.....	607, 609
ELETRIPTAN	
.NERVOUS SYSTEM.....	495
<i>Eleuphrat (FR)</i>	
.DERMATOLOGICALS.....	193
<i>Eleva 100 (AF)</i>	
.NERVOUS SYSTEM.....	539
<i>Eleva 50 (AF)</i>	
.NERVOUS SYSTEM.....	539, 540
<i>Elidel (HM)</i>	
.DERMATOLOGICALS	196
<i>Eligard 1 month (TL)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	286
<i>Eligard 3 month (TL)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	286
<i>Eligard 4 month (TL)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	286
<i>Eligard 6 month (TL)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	286

GENERIC/PROPRIETARY INDEX

<i>Eliquis (BQ)</i>	
.BLOOD AND BLOOD FORMING ORGANS	117, 118
<i>Elocon (MK)</i>	
.DERMATOLOGICALS	194, 195
.Repatriation Schedule	1206
<i>Elonva (MK)</i>	
.Section 100	1158
ELTROMBOPAG	
.Section 100	651, 899
<i>Emend (MK)</i>	
.ALIMENTARY TRACT AND METABOLISM	77
EMTRICITABINE	
.Section 100	716, 966
EMTRICITABINE + RILPIVIRINE + TENOFOVIR	
.Section 100	723, 973
<i>Emtriva (GI)</i>	
.Section 100	716, 966
<i>E-Mycin (AF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	234
<i>E-Mycin 200 (AF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	234
<i>E-Mycin 400 (AF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	234
ENALAPRIL	
.CARDIOVASCULAR SYSTEM	140
ENALAPRIL + HYDROCHLOROTHIAZIDE	
.CARDIOVASCULAR SYSTEM	146
<i>Enalapril Actavis (UA)</i>	
.CARDIOVASCULAR SYSTEM	140, 141
<i>Enalapril AN (EA)</i>	
.CARDIOVASCULAR SYSTEM	140, 141
<i>Enalapril generichealth (GQ)</i>	
.CARDIOVASCULAR SYSTEM	140, 141
<i>Enalapril Sandoz (SZ)</i>	
.CARDIOVASCULAR SYSTEM	140, 141
<i>Enalapril/HCT Sandoz (SZ)</i>	
.CARDIOVASCULAR SYSTEM	146
<i>Enalapril-GA (GN)</i>	
.CARDIOVASCULAR SYSTEM	140, 141
<i>Enbrel (PF)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS 394, 400, 403, 407, 409, 412, 414, 418,	
421, 426, 429	
.Section 100	788, 789, 1041
<i>Endep 10 (AF)</i>	
.NERVOUS SYSTEM	534
<i>Endep 25 (AF)</i>	
.NERVOUS SYSTEM	534
<i>Endep 50 (AF)</i>	
.NERVOUS SYSTEM	534
<i>Endometrin (FP)</i>	
.Section 100	1160
<i>Endone (QA)</i>	
.NERVOUS SYSTEM	486
<i>Endoxan (BX)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	251
<i>Energivit (SB)</i>	
.VARIOUS	625
ENFUVIRTIDE	
.Section 100	725, 975
<i>Enidin (PE)</i>	
.SENSORY ORGANS	578
<i>Enlifax-XR (AF)</i>	
.NERVOUS SYSTEM	543
ENOXAPARIN SODIUM	
.BLOOD AND BLOOD FORMING ORGANS	109
ENTACAPONE	
.NERVOUS SYSTEM	514
ENTECAVIR	
.Section 100	716, 717, 966
ENZALUTAMIDE	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	288
<i>Epiduo (GA)</i>	
.DERMATOLOGICALS	195
<i>Epilim (SW)</i>	
.NERVOUS SYSTEM	502
<i>Epilim EC (SW)</i>	
.NERVOUS SYSTEM	502
<i>Epilim Liquid (SW)</i>	
.NERVOUS SYSTEM	502
<i>Epilim Syrup (SW)</i>	
.NERVOUS SYSTEM	502
<i>EpiPen (AL)</i>	
.CARDIOVASCULAR SYSTEM	128
.RESPIRATORY SYSTEM	573
<i>EpiPen Jr. (AL)</i>	
.CARDIOVASCULAR SYSTEM	128
.RESPIRATORY SYSTEM	573
<i>Epiramax 100 (QA)</i>	
.NERVOUS SYSTEM	508
<i>Epiramax 200 (QA)</i>	
.NERVOUS SYSTEM	508
<i>Epiramax 25 (QA)</i>	
.NERVOUS SYSTEM	509
<i>Epiramax 50 (QA)</i>	
.NERVOUS SYSTEM	509
EPLERENONE	
.CARDIOVASCULAR SYSTEM	132
EPOETIN ALFA	
.Section 100	655, 903
EPOETIN BETA	
.Section 100	656, 904
EPOETIN LAMBDA	
.Section 100	656, 904
EPOPROSTENOL	
.Section 100	676, 924
<i>Eprex 1000 (JC)</i>	
.Section 100	655, 903

GENERIC/PROPRIETARY INDEX

<i>Eprex 10000 (JC)</i>		<i>Eskazole (AS)</i>	
.Section 100	655, 903	.ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS	562
<i>Eprex 20,000 (JC)</i>		ESOMEPRAZOLE	
.Section 100	655, 904	.ALIMENTARY TRACT AND METABOLISM.....	67, 68
<i>Eprex 2000 (JC)</i>		ESOMEPRAZOLE (&) CLARITHROMYCIN (&)	
.Section 100	656, 904	AMOXYCILLIN	
<i>Eprex 3000 (JC)</i>		.ALIMENTARY TRACT AND METABOLISM.....	73
.Section 100	656, 904	<i>Esomeprazole GxP (AF)</i>	
<i>Eprex 40,000 (JC)</i>		.ALIMENTARY TRACT AND METABOLISM.....	68
.Section 100	656, 904	<i>Esomeprazole RBX (RA)</i>	
<i>Eprex 4000 (JC)</i>		.ALIMENTARY TRACT AND METABOLISM.....	68
.Section 100	656, 904	<i>Essential Amino Acid Mix (SB)</i>	
<i>Eprex 5000 (JC)</i>		.VARIOUS.....	626
.Section 100	656, 904	ESSENTIAL AMINO ACIDS FORMULA	
<i>Eprex 6000 (JC)</i>		.VARIOUS.....	625
.Section 100	656, 904	ESSENTIAL AMINO ACIDS FORMULA WITH MINERALS AND VITAMIN C	
<i>Eprex 8000 (JC)</i>		.VARIOUS.....	626
.Section 100	656, 904	ESSENTIAL AMINO ACIDS FORMULA WITH VITAMINS AND MINERALS	
EPROSARTAN		.VARIOUS.....	626
.CARDIOVASCULAR SYSTEM	150	<i>Estalis continuous 50/140 (NV)</i>	
EPROSARTAN + HYDROCHLOROTHIAZIDE		.GENITO URINARY SYSTEM AND SEX HORMONES .	203
.CARDIOVASCULAR SYSTEM	153	<i>Estalis continuous 50/250 (NV)</i>	
EPTIFIBATIDE		.GENITO URINARY SYSTEM AND SEX HORMONES .	203
.BLOOD AND BLOOD FORMING ORGANS	113	<i>Estalis sequi 50/140 (NV)</i>	
ERLOTINIB		.GENITO URINARY SYSTEM AND SEX HORMONES .	203
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	261	<i>Estalis sequi 50/250 (NV)</i>	
<i>Eryc (YN)</i>		.GENITO URINARY SYSTEM AND SEX HORMONES .	203
.ANTIINFECTIVES FOR SYSTEMIC USE.....	233	<i>Estraderm MX 100 (NV)</i>	
<i>Erythrocine-I.V. (LM)</i>		.GENITO URINARY SYSTEM AND SEX HORMONES .	201
.ANTIINFECTIVES FOR SYSTEMIC USE.....	234	<i>Estraderm MX 25 (NV)</i>	
ERYTHROMYCIN		.GENITO URINARY SYSTEM AND SEX HORMONES .	202
.ANTIINFECTIVES FOR SYSTEMIC USE.....	233	<i>Estraderm MX 50 (NV)</i>	
ERYTHROMYCIN ETHYLSUCCINATE		.GENITO URINARY SYSTEM AND SEX HORMONES .	202
.ANTIINFECTIVES FOR SYSTEMIC USE.....	234	<i>Estraderm MX 100 (NV)</i>	
ERYTHROMYCIN LACTOBIONATE		.GENITO URINARY SYSTEM AND SEX HORMONES .	201
.ANTIINFECTIVES FOR SYSTEMIC USE.....	234	<i>Estraderm MX 25 (NV)</i>	
<i>Escicor 10 (RA)</i>		.GENITO URINARY SYSTEM AND SEX HORMONES .	202
.NERVOUS SYSTEM.....	536	<i>Estraderm MX 37.5 (NV)</i>	
<i>Escicor 20 (RA)</i>		.GENITO URINARY SYSTEM AND SEX HORMONES .	202
.NERVOUS SYSTEM.....	536	<i>Estraderm MX 50 (NV)</i>	
ESCITALOPRAM		.GENITO URINARY SYSTEM AND SEX HORMONES .	202
.NERVOUS SYSTEM.....	535, 536, 537	<i>Estraderm MX 75 (NV)</i>	
<i>Escitalopram AN (EA)</i>		.GENITO URINARY SYSTEM AND SEX HORMONES .	202
.NERVOUS SYSTEM.....	536	<i>Estraderm MX 100 (NV)</i>	
<i>Escitalopram GA (GN)</i>		.GENITO URINARY SYSTEM AND SEX HORMONES .	202
.NERVOUS SYSTEM.....	536	<i>Estraderm MX 25 (NV)</i>	
<i>Escitalopram generichealth (GQ)</i>		.GENITO URINARY SYSTEM AND SEX HORMONES .	202
.NERVOUS SYSTEM.....	536	<i>Estraderm MX 37.5 (NV)</i>	
<i>Escitalopram-DRLA (RZ)</i>		.GENITO URINARY SYSTEM AND SEX HORMONES .	202
.NERVOUS SYSTEM.....	536	<i>Estraderm MX 50 (NV)</i>	
<i>Esipram (UA)</i>		.GENITO URINARY SYSTEM AND SEX HORMONES .	202
.NERVOUS SYSTEM.....	536, 537	<i>Estraderm MX 75 (NV)</i>	
<i>Esitalo (SZ)</i>		.GENITO URINARY SYSTEM AND SEX HORMONES .	202
.NERVOUS SYSTEM.....	536	ETANERCEPT	
		.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	380, 394, 400, 403, 407, 409, 412, 415, 418, 421, 426
		.Section 100.....	780, 1033
		ETHACRYNIC ACID	
		.CARDIOVASCULAR SYSTEM	132
		ETHINYLOESTRADIOL + LEVONORGESTREL	

GENERIC/PROPRIETARY INDEX

.GENITO URINARY SYSTEM AND SEX HORMONES 199, 200	.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS 290
ETHINYLOESTRADIOL + NORETHISTERONE	EXENATIDE
.GENITO URINARY SYSTEM AND SEX HORMONES . 200	.ALIMENTARY TRACT AND METABOLISM 103
ETHOSUXIMIDE	<i>Exforge 10/160 (NV)</i>
.NERVOUS SYSTEM..... 499	.CARDIOVASCULAR SYSTEM 157
ETONOGESTREL	<i>Exforge 10/320 (NV)</i>
.GENITO URINARY SYSTEM AND SEX HORMONES . 200	.CARDIOVASCULAR SYSTEM 157
ETOPOSIDE	<i>Exforge 5/160 (NV)</i>
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS 254	.CARDIOVASCULAR SYSTEM 157
ETRAVIRINE	<i>Exforge 5/320 (NV)</i>
.Section 100 721, 971	.CARDIOVASCULAR SYSTEM 157
<i>Eucerin (BE)</i>	<i>Exforge 5/80 (NV)</i>
.Repatriation Schedule..... 1204	.CARDIOVASCULAR SYSTEM 157
<i>Eutroxsig (FM)</i>	<i>Exforge HCT 10/160/12.5 (NV)</i>
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS..... 214	.CARDIOVASCULAR SYSTEM 158
<i>Evelyn 150/30 ED (GQ)</i>	<i>Exforge HCT 10/160/25 (NV)</i>
.GENITO URINARY SYSTEM AND SEX HORMONES . 199	.CARDIOVASCULAR SYSTEM 158
EVEROLIMUS	<i>Exforge HCT 10/320/25 (NV)</i>
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS 262, 263, 264, 305	.CARDIOVASCULAR SYSTEM 158
.Section 100 770, 1023	<i>Exforge HCT 5/160/12.5 (NV)</i>
<i>Evifyne (EL)</i>	.CARDIOVASCULAR SYSTEM 158
.MUSCULO-SKELETAL SYSTEM 480	<i>Exjade (NV)</i>
<i>Eviplera (GI)</i>	.Section 100..... 897, 1150
.Section 100 723, 973	<i>Exorex (GN)</i>
<i>Evista (LY)</i>	.DERMATOLOGICALS 191
.MUSCULO-SKELETAL SYSTEM 480	<i>Extine 20 (QA)</i>
<i>Exaccord (RA)</i>	.NERVOUS SYSTEM..... 539
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS 290	<i>Eylea (BN)</i>
<i>Exelon (NV)</i>	.SENSORY ORGANS..... 586
.NERVOUS SYSTEM..... 551, 552	EZETIMIBE
<i>Exelon Patch 10 (NV)</i>	.CARDIOVASCULAR SYSTEM 174
.NERVOUS SYSTEM..... 551, 552	EZETIMIBE + SIMVASTATIN
<i>Exelon Patch 5 (NV)</i>	.CARDIOVASCULAR SYSTEM 182, 185
.NERVOUS SYSTEM..... 551, 552	<i>Ezetrol (MK)</i>
EXEMESTANE	.CARDIOVASCULAR SYSTEM 176
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS 290	<i>Ezovir (AF)</i>
<i>Exemestane AN (EA)</i>	.ANTIINFECTIVES FOR SYSTEMIC USE 246, 247, 248
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS 290	
<i>Exemestane GH (GQ)</i>	F
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS 290	FAMCICLOVIR
<i>Exemestane Pfizer (FZ)</i>	.ANTIINFECTIVES FOR SYSTEMIC USE 246, 247
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS 290	<i>Famciclovir AN (EA)</i>
<i>Exemestane Sandoz (SZ)</i>	.ANTIINFECTIVES FOR SYSTEMIC USE 246, 247, 248
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS 290	<i>Famciclovir generichealth 250 (GQ)</i>
<i>Exemestane-GA (GN)</i>	.ANTIINFECTIVES FOR SYSTEMIC USE 247
	<i>Famciclovir generichealth 500 (GQ)</i>
	.ANTIINFECTIVES FOR SYSTEMIC USE 248
	<i>Famciclovir Sandoz (SZ)</i>
	.ANTIINFECTIVES FOR SYSTEMIC USE 246, 247, 248
	<i>Famciclovir SCP 250 (CR)</i>
	.ANTIINFECTIVES FOR SYSTEMIC USE 247

GENERIC/PROPRIETARY INDEX

<i>Famciclovir-GA (GN)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	246, 247, 248
<i>Famlo (RA)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	247
FAMOTIDINE	
.ALIMENTARY TRACT AND METABOLISM.....	66
<i>Famotidine AN (EA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	66, 67
<i>Famotidine Sandoz (SZ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	66, 67
<i>Famvir (NV)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	246, 247, 248
<i>Fareston (MK)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	287
<i>Fasigyn (PF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	240
<i>Faverin 100 (QA)</i>	
.NERVOUS SYSTEM.....	538
<i>Faverin 50 (QA)</i>	
.NERVOUS SYSTEM.....	538
<i>Favic 125 (QA)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	246
<i>Favic 250 (QA)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	246, 247
<i>Favic 500 (QA)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	247, 248
<i>Fawns and McAllan Proprietary Limited (FM)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	244
.NERVOUS SYSTEM.....	482, 499
.RESPIRATORY SYSTEM	574
<i>Febridol (GN)</i>	
.NERVOUS SYSTEM.....	494, 495
<i>Feldene (PF)</i>	
.MUSCULO-SKELETAL SYSTEM	464, 465
<i>Feldene-D (PF)</i>	
.MUSCULO-SKELETAL SYSTEM	465
<i>Felodil XR 10 (QA)</i>	
.CARDIOVASCULAR SYSTEM	138
<i>Felodil XR 5 (QA)</i>	
.CARDIOVASCULAR SYSTEM	138
FELODIPINE	
.CARDIOVASCULAR SYSTEM	138
<i>Felodur ER 10 mg (TX)</i>	
.CARDIOVASCULAR SYSTEM	138
<i>Felodur ER 2.5 mg (TX)</i>	
.CARDIOVASCULAR SYSTEM	138
<i>Felodur ER 5 mg (TX)</i>	
.CARDIOVASCULAR SYSTEM	138
<i>Femara 2.5 mg (NV)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	291
<i>Femme-Tab ED 20/100 (AE)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	200
<i>Femme-Tab ED 30/150 (AE)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	199
<i>Femolet (AF)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	291
<i>Femoston 1/10 (AB)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	203
<i>Femoston 2/10 (AB)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	203
<i>Femoston-Conti (AB)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	203
<i>Fenac (AF)</i>	
.MUSCULO-SKELETAL SYSTEM	462
.Palliative Care.....	638, 639
<i>Fenac 25 (AF)</i>	
.MUSCULO-SKELETAL SYSTEM	462
.Palliative Care.....	638, 639
<i>Fendex ER (AF)</i>	
.CARDIOVASCULAR SYSTEM	138
FENOFIBRATE	
.CARDIOVASCULAR SYSTEM	172
<i>Fenpatch 100 (ZP)</i>	
.NERVOUS SYSTEM.....	488
<i>Fenpatch 12 (ZP)</i>	
.NERVOUS SYSTEM.....	489
<i>Fenpatch 25 (ZP)</i>	
.NERVOUS SYSTEM.....	489
<i>Fenpatch 50 (ZP)</i>	
.NERVOUS SYSTEM.....	490
<i>Fenpatch 75 (ZP)</i>	
.NERVOUS SYSTEM.....	490
FENTANYL	
.NERVOUS SYSTEM.....	488, 489, 490
.Palliative Care.....	642, 643
<i>Fentanyl Sandoz (SZ)</i>	
.NERVOUS SYSTEM.....	488, 489, 490
<i>Fera (QA)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	291
<i>ferinject (VL)</i>	
.BLOOD AND BLOOD FORMING ORGANS.....	122
<i>Ferriprox (TX)</i>	
.Section 100.....	897, 1150
<i>Ferro-f-tab (AE)</i>	
.BLOOD AND BLOOD FORMING ORGANS.....	123
<i>Ferro-Liquid (AE)</i>	
.BLOOD AND BLOOD FORMING ORGANS.....	122
<i>Ferrosig (SI)</i>	
.BLOOD AND BLOOD FORMING ORGANS.....	122, 123
<i>Ferro-tab (AE)</i>	
.BLOOD AND BLOOD FORMING ORGANS.....	122
FERROUS FUMARATE	
.BLOOD AND BLOOD FORMING ORGANS.....	122
FERROUS FUMARATE + FOLIC ACID	
.BLOOD AND BLOOD FORMING ORGANS.....	123
FERROUS SULFATE	

GENERIC/PROPRIETARY INDEX

.BLOOD AND BLOOD FORMING ORGANS	122
<i>Ferrum H (AS)</i>	
.BLOOD AND BLOOD FORMING ORGANS	123
<i>Fexal (SZ)</i>	
.Repatriation Schedule.....	1221
FEXOFENADINE	
.Repatriation Schedule.....	1221
<i>Fibre Health Natural Granular (PP)</i>	
.Repatriation Schedule.....	1198
<i>Fibsol 10 (QA)</i>	
.CARDIOVASCULAR SYSTEM.....	141
<i>Fibsol 20 (QA)</i>	
.CARDIOVASCULAR SYSTEM.....	141
<i>Fibsol 5 (QA)</i>	
.CARDIOVASCULAR SYSTEM.....	142
FILGRASTIM	
.Section 100	728, 979
<i>Finasta (SZ)</i>	
.Repatriation Schedule.....	1211
FINASTERIDE	
.Repatriation Schedule.....	1211
<i>Finasteride Alphapharm (AF)</i>	
.Repatriation Schedule.....	1211
<i>Finasteride GH 5 (GQ)</i>	
.Repatriation Schedule.....	1211
<i>Finasteride RBX (RA)</i>	
.Repatriation Schedule.....	1211
<i>Finasteride-GA 5 (GN)</i>	
.Repatriation Schedule.....	1211
FINGOLIMOD	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	305
<i>Finnacar (QA)</i>	
.Repatriation Schedule.....	1211
<i>Finpro (RZ)</i>	
.Repatriation Schedule.....	1211
<i>Firazyr (ZI)</i>	
.BLOOD AND BLOOD FORMING ORGANS	125
<i>Firmagon 120mg (FP)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	292
<i>Firmagon 80mg (FP)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	292
<i>Flagyl (SW)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	239
<i>Flagyl S (SW)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	239
<i>Flamazine (SN)</i>	
.DERMATOLOGICALS.....	193
<i>Flarex (AQ)</i>	
.SENSORY ORGANS.....	577
FLECAINIDE	
.CARDIOVASCULAR SYSTEM.....	126
<i>Flecatag (AF)</i>	
.CARDIOVASCULAR SYSTEM.....	127
<i>Flexidress 650941 (CC)</i>	
.Repatriation Schedule.....	1229
<i>Flixotide (GK)</i>	
.RESPIRATORY SYSTEM.....	571
<i>Flixotide Accuhaler (GK)</i>	
.RESPIRATORY SYSTEM.....	571
<i>Flixotide Junior (GK)</i>	
.RESPIRATORY SYSTEM.....	571
<i>Flixotide Junior Accuhaler (GK)</i>	
.RESPIRATORY SYSTEM.....	571
<i>Flolan Kit (GK)</i>	
.Section 100.....	681, 929
<i>Flomaxtra (CS)</i>	
.Repatriation Schedule.....	1210
<i>Flophen (AS)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	223, 224
<i>Florinef (QA)</i>	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
HORMONES AND INSULINS.....	210
<i>Fluanxol Concentrated Depot (LU)</i>	
.NERVOUS SYSTEM.....	516
<i>Fluanxol Depot (LU)</i>	
.NERVOUS SYSTEM.....	516
<i>Flubiclox (GN)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	223
<i>Flucil (AS)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	223
<i>Flucil (LN)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	223, 224
FLUCLOXACILLIN	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	223
<i>Flucon (AQ)</i>	
.SENSORY ORGANS.....	577
FLUCONAZOLE	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	240, 241
<i>Fluconazole Alphapharm (AF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	241
<i>Fluconazole Hexal (HX)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	241
<i>Fluconazole Sandoz (SZ)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	241
<i>Fluconazole-Clarix (AE)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	241
<i>Fludara (GZ)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	253
FLUDARABINE	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	253
FLUDROCORTISONE ACETATE	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
HORMONES AND INSULINS.....	210
FLUNITRAZEPAM	
.Repatriation Schedule.....	1217

GENERIC/PROPRIETARY INDEX

FLUOROMETHOLONE		
.SENSORY ORGANS.....	577	
FLUOROMETHOLONE ACETATE		
.SENSORY ORGANS.....	577	
FLUOROURACIL		
.Repatriation Schedule.....	1213	
FLUOXETINE		
.NERVOUS SYSTEM.....	538	
<i>Fluoxetine 20 (CR)</i>		
.NERVOUS SYSTEM.....	538	
<i>Fluoxetine AN (EA)</i>		
.NERVOUS SYSTEM.....	538	
<i>Fluoxetine generichealth (GQ)</i>		
.NERVOUS SYSTEM.....	538	
<i>Fluoxetine RBX (RA)</i>		
.NERVOUS SYSTEM.....	538	
<i>Fluoxetine Sandoz (SZ)</i>		
.NERVOUS SYSTEM.....	538	
<i>Fluoxetine-GA (GN)</i>		
.NERVOUS SYSTEM.....	538	
FLUPENTHIXOL DECANOATE		
.NERVOUS SYSTEM.....	516	
FLUPHENAZINE DECANOATE		
.NERVOUS SYSTEM.....	515	
FLURBIPROFEN		
.SENSORY ORGANS.....	578	
FLUTAMIDE		
.ANTINEOPLASTIC AND IMMUNOMODULATING		
AGENTS	289	
<i>Flutamin (AF)</i>		
.ANTINEOPLASTIC AND IMMUNOMODULATING		
AGENTS	289	
FLUTICASONE		
.RESPIRATORY SYSTEM	571	
FLUTICASONE + EFOMOTEROL		
.RESPIRATORY SYSTEM	567	
FLUTICASONE + SALMETEROL		
.RESPIRATORY SYSTEM	567, 568	
FLUTICASONE + VILANTEROL		
.RESPIRATORY SYSTEM	568, 569	
<i>flutiform 125/5 (MF)</i>		
.RESPIRATORY SYSTEM	567	
<i>flutiform 250/10 (MF)</i>		
.RESPIRATORY SYSTEM	567	
<i>flutiform 50/5 (MF)</i>		
.RESPIRATORY SYSTEM	567	
FLUVASTATIN		
.CARDIOVASCULAR SYSTEM.....	163, 164	
FLUVOXAMINE		
.NERVOUS SYSTEM.....	538	
<i>Fluvoxamine GA (GN)</i>		
.NERVOUS SYSTEM.....	538	
<i>Fluzole 200 (QA)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	241	
<i>FML Liquifilm (AG)</i>		
.SENSORY ORGANS.....	577	
FOLIC ACID		
.BLOOD AND BLOOD FORMING ORGANS.....	123, 124	
FOLINIC ACID		
.VARIOUS.....	597	
FOLLITROPIN ALFA		
.GENITO URINARY SYSTEM AND SEX HORMONES .	204	
.Section 100.....	1158	
FOLLITROPIN BETA		
.GENITO URINARY SYSTEM AND SEX HORMONES .	204	
.Section 100.....	1158	
<i>Foltabs 500 (PP)</i>		
.BLOOD AND BLOOD FORMING ORGANS.....	124	
<i>Fonat (AL)</i>		
.MUSCULO-SKELETAL SYSTEM	470	
<i>Fonat Plus (AF)</i>		
.MUSCULO-SKELETAL SYSTEM	474	
<i>FonatPlus (AF)</i>		
.MUSCULO-SKELETAL SYSTEM	475	
FONDAPARINUX		
.BLOOD AND BLOOD FORMING ORGANS.....	122	
<i>Foradile (NV)</i>		
.RESPIRATORY SYSTEM.....	564	
<i>Formet 1000 (QA)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	89	
<i>Formet Aspen 500 (AS)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	89	
<i>Formet Aspen 850 (AS)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	89	
<i>Forteo (LY)</i>		
.MUSCULO-SKELETAL SYSTEM	481	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX		
HORMONES AND INSULINS	216	
<i>Forxiga (AP)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	103	
<i>Fosamax Plus (MK)</i>		
.MUSCULO-SKELETAL SYSTEM	475	
.Repatriation Schedule.....	1214	
<i>Fosamax Plus 70 mg/140 mcg (MK)</i>		
.MUSCULO-SKELETAL SYSTEM	474	
.Repatriation Schedule.....	1214	
<i>Fosamax Plus D-Cal (MK)</i>		
.MUSCULO-SKELETAL SYSTEM	476	
.Repatriation Schedule.....	1215	
FOSAMPRENAVIR		
.Section 100.....	711, 960	
FOSCARNET		
.Section 100.....	709, 958	
<i>Foscavir (IX)</i>		
.Section 100.....	709, 958	
<i>Fosetic 20/12.5 (ZP)</i>		
.CARDIOVASCULAR SYSTEM	146	
FOSINOPRIL		
.CARDIOVASCULAR SYSTEM	141	
FOSINOPRIL + HYDROCHLOROTHIAZIDE		

GENERIC/PROPRIETARY INDEX

.CARDIOVASCULAR SYSTEM	146
<i>Fosinopril/HCT Actavis 20/12.5 (UA)</i>	
.CARDIOVASCULAR SYSTEM	146
<i>Fosipril 10 (QA)</i>	
.CARDIOVASCULAR SYSTEM	141
<i>Fosipril 20 (QA)</i>	
.CARDIOVASCULAR SYSTEM	141
<i>Fosrenol (ZI)</i>	
.Section 100	897, 1150, 1151
.VARIOUS	596
<i>Fragmin (PF)</i>	
.BLOOD AND BLOOD FORMING ORGANS	108, 109
<i>Frakas (QA)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	219
FRAMYCETIN SULFATE	
.SENSORY ORGANS	595
<i>FreeStyle Lite (MS)</i>	
.VARIOUS	599, 600
<i>FreeStyle Optium (MS)</i>	
.VARIOUS	599, 600
<i>FruitiVits (VF)</i>	
.VARIOUS	629
<i>Frusax (ER)</i>	
.CARDIOVASCULAR SYSTEM	131
FRUSEMIDE	
.CARDIOVASCULAR SYSTEM	131, 132
<i>Frusemide AN (EA)</i>	
.CARDIOVASCULAR SYSTEM	131, 132
<i>Frusemide Sandoz (SZ)</i>	
.CARDIOVASCULAR SYSTEM	131
.Prescriber Bag	62
<i>Frusemide-Clarix (AE)</i>	
.CARDIOVASCULAR SYSTEM	131
.Prescriber Bag	62
<i>Frusid (GN)</i>	
.CARDIOVASCULAR SYSTEM	132
<i>Frusid (UA)</i>	
.CARDIOVASCULAR SYSTEM	131
<i>Fucidin (CS)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	239
<i>Fungilin (QA)</i>	
.ALIMENTARY TRACT AND METABOLISM	66
FUSIDATE	
.ANTIINFECTIVES FOR SYSTEMIC USE	239
<i>Fuzeon (RO)</i>	
.Section 100	725, 975
<i>Fybogel (RC)</i>	
.Repatriation Schedule	1198
<i>Fycompa (EI)</i>	
.NERVOUS SYSTEM	507, 508

G

<i>GA express 15 (VF)</i>	
.VARIOUS	621

<i>GA gel (VF)</i>	
.VARIOUS	620
<i>GA Tramadol 50mg (GN)</i>	
.NERVOUS SYSTEM	493, 494
<i>GA Tramadol SR 100mg (GN)</i>	
.NERVOUS SYSTEM	492
<i>GA Tramadol SR 150mg (GN)</i>	
.NERVOUS SYSTEM	492
<i>GA Tramadol SR 200mg (GN)</i>	
.NERVOUS SYSTEM	492
<i>GA1 Anamax infant (SB)</i>	
.VARIOUS	621
<i>GA-Amclav 125/31.25 (GN)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	224
<i>GA-Amclav 500/125 (GN)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	224
<i>GA-Amclav Forte 400/57 (GN)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	224
<i>GA-Amclav Forte 875/125 (GN)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	225
<i>Gabacor (NJ)</i>	
.NERVOUS SYSTEM	502, 503
GABAPENTIN	
.NERVOUS SYSTEM	502
.Repatriation Schedule	1216
<i>Gabapentin 300 (CR)</i>	
.NERVOUS SYSTEM	503
.Repatriation Schedule	1216
<i>Gabapentin 400 (CR)</i>	
.NERVOUS SYSTEM	503
.Repatriation Schedule	1216
<i>Gabapentin AN (EA)</i>	
.NERVOUS SYSTEM	503
<i>Gabapentin Aspen 100 (FM)</i>	
.NERVOUS SYSTEM	502
.Repatriation Schedule	1216
<i>Gabapentin Aspen 300 (FM)</i>	
.NERVOUS SYSTEM	503
.Repatriation Schedule	1216
<i>Gabapentin Aspen 400 (FM)</i>	
.NERVOUS SYSTEM	503
.Repatriation Schedule	1216
<i>Gabapentin Aspen 600 (FM)</i>	
.NERVOUS SYSTEM	503
.Repatriation Schedule	1217
<i>Gabapentin Aspen 800 (FM)</i>	
.NERVOUS SYSTEM	503
.Repatriation Schedule	1217
<i>Gabapentin Sandoz (SZ)</i>	
.NERVOUS SYSTEM	503
<i>Gabapentin-GA (UA)</i>	
.NERVOUS SYSTEM	503
<i>Gabaran (RA)</i>	
.NERVOUS SYSTEM	503
<i>Gabatine 100 (QA)</i>	

GENERIC/PROPRIETARY INDEX

.NERVOUS SYSTEM.....	502	.ANTINEOPLASTIC AND IMMUNOMODULATING	
.Repatriation Schedule.....	1216	AGENTS	264
<i>Gabatine 300 (QA)</i>		GELATIN-SUCCINYLATED	
.NERVOUS SYSTEM.....	503	.BLOOD AND BLOOD FORMING ORGANS.....	124
.Repatriation Schedule.....	1216	<i>Gelofusine (BR)</i>	
<i>Gabatine 400 (QA)</i>		.BLOOD AND BLOOD FORMING ORGANS.....	124
.NERVOUS SYSTEM.....	503	GEMFIBROZIL	
.Repatriation Schedule.....	1216	.CARDIOVASCULAR SYSTEM	173
<i>Gabatine 600 (QA)</i>		<i>Gemfibrozil-GA (UA)</i>	
.NERVOUS SYSTEM.....	503	.CARDIOVASCULAR SYSTEM	173
.Repatriation Schedule.....	1217	<i>Gemhexal (SZ)</i>	
<i>Gabatine 800 (QA)</i>		.CARDIOVASCULAR SYSTEM	173
.NERVOUS SYSTEM.....	503	<i>Generic Health Pty Ltd (GQ)</i>	
.Repatriation Schedule.....	1217	.NERVOUS SYSTEM.....	494, 495
<i>Gabitril (OA)</i>		<i>Genlac (QA)</i>	
.NERVOUS SYSTEM.....	501	.ALIMENTARY TRACT AND METABOLISM.....	79
GALANTAMINE		.Palliative Care.....	634
.NERVOUS SYSTEM.....	549	<i>Genoptic (AG)</i>	
<i>Galantamine AN SR (EA)</i>		.SENSORY ORGANS.....	575
.NERVOUS SYSTEM.....	549, 550	<i>Genotropin (PF)</i>	
<i>Galantyl (AF)</i>		.Section 100.....	1157
.NERVOUS SYSTEM.....	549, 550	<i>Genotropin GoQuick (PF)</i>	
<i>Galvumet 50/1000 (NV)</i>		.Section 100.....	1156
.ALIMENTARY TRACT AND METABOLISM.....	95	<i>Genotropin MiniQuick (PF)</i>	
<i>Galvumet 50/500 (NV)</i>		.Section 100.....	1156, 1157
.ALIMENTARY TRACT AND METABOLISM.....	95	<i>Genox 10 (AF)</i>	
<i>Galvumet 50/850 (NV)</i>		.ANTINEOPLASTIC AND IMMUNOMODULATING	
.ALIMENTARY TRACT AND METABOLISM.....	95	AGENTS	287
<i>Galvus (NV)</i>		<i>Genox 20 (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	102	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>Gamine XR (QA)</i>		AGENTS	287
.NERVOUS SYSTEM.....	549, 550	<i>GenRx Aciclovir (GX)</i>	
GANCICLOVIR		.ANTIINFECTIVES FOR SYSTEMIC USE	245, 246
.Section 100	708, 957	<i>GenRx Allopurinol (GX)</i>	
<i>Ganfort 0.3/5 (AG)</i>		.MUSCULO-SKELETAL SYSTEM	469
.SENSORY ORGANS.....	582	<i>GenRx Alprazolam (GX)</i>	
<i>GANfort PF 0.3/5 (AG)</i>		.NERVOUS SYSTEM.....	531
.SENSORY ORGANS.....	582	<i>GenRx Amiodarone (GX)</i>	
GANIRELIX		.CARDIOVASCULAR SYSTEM	127
.Section 100	1159	<i>GenRx Amoxycillin (GX)</i>	
<i>Gantin (GN)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE	220, 221
.NERVOUS SYSTEM.....	503	<i>GenRx Amoxycillin and Clavulanic Acid (GX)</i>	
.Repatriation Schedule.....	1216, 1217	.ANTIINFECTIVES FOR SYSTEMIC USE	225
<i>Gastrex (CR)</i>		<i>GenRx Azathioprine (GX)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	83	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>Gastrogel (FM)</i>		AGENTS	461
.ALIMENTARY TRACT AND METABOLISM.....	66	<i>GenRx Calcitriol (GX)</i>	
<i>Gastro-Stop Loperamide (AS)</i>		.ALIMENTARY TRACT AND METABOLISM.....	105
.ALIMENTARY TRACT AND METABOLISM.....	83	.MUSCULO-SKELETAL SYSTEM	478
GAUZE AND COTTON TISSUE COMBINE ROLL		<i>GenRx Captopril (GX)</i>	
.Repatriation Schedule.....	1239	.CARDIOVASCULAR SYSTEM	140
<i>Gaviscon P (RC)</i>		<i>GenRx Cefaclor (GX)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	73	.ANTIINFECTIVES FOR SYSTEMIC USE	229
GEFITINIB		<i>GenRx Cefaclor CD (GX)</i>	
		.ANTIINFECTIVES FOR SYSTEMIC USE	229

GENERIC/PROPRIETARY INDEX

<i>GenRx Cephalexin (GX)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	226, 227, 228
<i>GenRx Ciprofloxacin (GX)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	237, 238
<i>GenRx Clomipramine (GX)</i>	
.NERVOUS SYSTEM.....	534
<i>GenRx Cyproterone Acetate (GX)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	288
.GENITO URINARY SYSTEM AND SEX HORMONES	205,
	206
<i>GenRx Diltiazem CD (GX)</i>	
.CARDIOVASCULAR SYSTEM.....	139
<i>GenRx Doxycycline (GX)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	218, 219
<i>GenRx Enalapril (GX)</i>	
.CARDIOVASCULAR SYSTEM.....	140, 141
<i>GenRx Famotidine (GX)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	66, 67
<i>GenRx Fluoxetine (GX)</i>	
.NERVOUS SYSTEM.....	538
<i>GenRx Fosinopril (GX)</i>	
.CARDIOVASCULAR SYSTEM.....	141
<i>GenRx Frusemide (GX)</i>	
.CARDIOVASCULAR SYSTEM.....	132
<i>GenRx Gabapentin (GX)</i>	
.NERVOUS SYSTEM.....	503
.Repatriation Schedule.....	1216, 1217
<i>GenRx Gemfibrozil (GX)</i>	
.CARDIOVASCULAR SYSTEM.....	173
<i>GenRx Glipizide (GX)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	90
<i>GenRx Indapamide (GX)</i>	
.CARDIOVASCULAR SYSTEM.....	131
<i>GenRx Isosorbide Mononitrate (GX)</i>	
.CARDIOVASCULAR SYSTEM.....	129
<i>GenRx Isotretinoin (GX)</i>	
.DERMATOLOGICALS.....	195
<i>GenRx Lamotrigine (GX)</i>	
.NERVOUS SYSTEM.....	505, 506
<i>GenRx Meloxicam (GX)</i>	
.MUSCULO-SKELETAL SYSTEM	463, 464
<i>GenRx Metformin (GX)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>GenRx Metoprolol (GX)</i>	
.CARDIOVASCULAR SYSTEM.....	135
<i>GenRx Mirtazapine (GX)</i>	
.NERVOUS SYSTEM.....	542
<i>GenRx Moclobemide (GX)</i>	
.NERVOUS SYSTEM.....	540
<i>GenRx Nifedipine (GX)</i>	
.CARDIOVASCULAR SYSTEM.....	138
<i>GenRx Norfloxacin (GX)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	238
<i>GenRx Paroxetine (GX)</i>	
.NERVOUS SYSTEM.....	539
<i>GenRx Perindopril/ Indapamide 4/1.25 (GX)</i>	
.CARDIOVASCULAR SYSTEM	147
<i>GenRx Piroxicam (GX)</i>	
.MUSCULO-SKELETAL SYSTEM	464, 465
<i>GenRx Ramipril (GX)</i>	
.CARDIOVASCULAR SYSTEM	144
<i>GenRx Ranitidine (GX)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	67
<i>GenRx Salbutamol (GX)</i>	
.Prescriber Bag	63
.RESPIRATORY SYSTEM.....	565
<i>GenRx Sertraline (GX)</i>	
.NERVOUS SYSTEM.....	539
<i>GenRx Simvastatin (GX)</i>	
.CARDIOVASCULAR SYSTEM	170, 171
<i>GenRx Sotalol (GX)</i>	
.CARDIOVASCULAR SYSTEM	127
<i>GenRx Tamoxifen (GX)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	287
<i>GenRx Terbinafine (GX)</i>	
.DERMATOLOGICALS	190, 191
.Repatriation Schedule	1204
GENTAMICIN	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	235
.SENSORY ORGANS.....	575
<i>Genteal (AQ)</i>	
.SENSORY ORGANS.....	591
<i>Genteal gel (AQ)</i>	
.SENSORY ORGANS.....	591
GESTRINONE	
.GENITO URINARY SYSTEM AND SEX HORMONES	206
<i>Gilenya (NV)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	305
GLATIRAMER ACETATE	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	294
<i>Gliadel (OA)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	251
GLIBENCLAMIDE	
.ALIMENTARY TRACT AND METABOLISM.....	90
GLICLAZIDE	
.ALIMENTARY TRACT AND METABOLISM.....	90
<i>Glime (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	90
GLIMEPIRIDE	
.ALIMENTARY TRACT AND METABOLISM.....	90
<i>Glimepiride AN (EA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	90, 91
<i>Glimepiride GA 1 (GN)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	90
<i>Glimepiride GA 2 (GN)</i>	

GENERIC/PROPRIETARY INDEX

.ALIMENTARY TRACT AND METABOLISM.....	90
<i>Glimepiride GA 3 (GN)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	90
<i>Glimepiride GA 4 (GN)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	91
<i>Glimepiride Sandoz (SZ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	90, 91
GLIPIZIDE	
.ALIMENTARY TRACT AND METABOLISM.....	91
<i>Glivec (NV)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	266, 267, 269, 270, 271, 272, 273, 274
<i>GlucaGen Hypokit (NO)</i>	
.Prescriber Bag	62
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
HORMONES AND INSULINS.....	215
GLUCAGON HYDROCHLORIDE	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
HORMONES AND INSULINS.....	215
<i>Glucobay 100 (BN)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	96
<i>Glucobay 50 (BN)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	96
<i>Glucobete 1000 (DO)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>Glucobete 500 (DO)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>Glucobete 850 (DO)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>GlucoDr (OZ)</i>	
.VARIOUS.....	600, 601
<i>Glucoflex-R (NA)</i>	
.VARIOUS.....	600, 601
<i>Glucophage (MQ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	90
GLUCOSE	
.BLOOD AND BLOOD FORMING ORGANS	124
GLUCOSE AND KETONE INDICATOR URINE	
.VARIOUS.....	598
GLUCOSE INDICATOR BLOOD	
.VARIOUS.....	599, 600, 601
GLUCOSE INDICATOR URINE	
.VARIOUS.....	599
<i>Glucovance 250mg/1.25mg (AL)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	92
<i>Glucovance 500mg/2.5mg (AL)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	92
<i>Glucovance 500mg/5mg (AL)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	92
<i>Glyade (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	90
<i>Glyade MR (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	90
GLYCEROL	
.ALIMENTARY TRACT AND METABOLISM.....	81
.Palliative Care.....	637
.Repatriation Schedule	1198
GLYCERYL TRINITRATE	
.CARDIOVASCULAR SYSTEM	128
GLYCINE WITH CARBOHYDRATE	
.VARIOUS.....	626
<i>Glycine500 (VF)</i>	
.VARIOUS.....	626
GLYCOMACROPEPTIDE AND ESSENTIAL AMINO ACIDS	
.VARIOUS.....	626
GLYCOMACROPEPTIDE AND ESSENTIAL AMINO ACIDS	
WITH VITAMINS AND MINERALS	
.VARIOUS.....	626
GLYCOPYRRONIUM	
.RESPIRATORY SYSTEM.....	571
<i>Glycosade (VF)</i>	
.VARIOUS.....	618
<i>GN-Carvedilol (GN)</i>	
.CARDIOVASCULAR SYSTEM	136, 137
<i>Gold Cross (BI)</i>	
.Repatriation Schedule	1214, 1220, 1221
GOLIMUMAB	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	429, 436, 440, 442, 445, 449
GONADOTROPHIN CHORIONIC HUMAN	
.GENITO URINARY SYSTEM AND SEX HORMONES .	204
.Section 100.....	1159
GONADOTROPHIN-MENOPAUSAL HUMAN	
.Section 100.....	1159
<i>Gonal-f Pen (SG)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	204
.Section 100.....	1158
<i>GoodLife (JN)</i>	
.VARIOUS.....	599, 600
<i>Gopten (AB)</i>	
.CARDIOVASCULAR SYSTEM	145, 146
GOSERELIN	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	286
GOSERELIN (&) BICALUTAMIDE	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	286
GRANISETRON	
.ALIMENTARY TRACT AND METABOLISM.....	74
<i>Granisetron Kabi (PK)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	74
<i>Granisetron-AFT (AE)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	74
<i>Granocyte 13 (HH)</i>	
.Section 100.....	730, 982
<i>Granocyte 34 (HH)</i>	
.Section 100.....	730, 982
GRISEOFULVIN	
.DERMATOLOGICALS	190
<i>Grisovin (QA)</i>	

GENERIC/PROPRIETARY INDEX

.DERMATOLOGICALS.....	190
<i>Grisovin 500 (QA)</i>	
.DERMATOLOGICALS.....	190
<i>GyMiso (XH)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	198
<i>Gynotril (ER)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	291

H

<i>Haldol decanoate (JC)</i>	
.NERVOUS SYSTEM.....	516
HALOPERIDOL	
.NERVOUS SYSTEM.....	515
HALOPERIDOL DECANOATE	
.NERVOUS SYSTEM.....	516
<i>Hamilton Skin Therapy Oil (KY)</i>	
.Repatriation Schedule.....	1204
<i>Hamilton Skin Therapy Wash (KY)</i>	
.Repatriation Schedule.....	1207
<i>Hamilton Sunscreen Family Sunscreen Milk SPF 15 (KY)</i>	
.Repatriation Schedule.....	1204
<i>Handy 36361414 (BV)</i>	
.Repatriation Schedule.....	1226
<i>Handy 71117-05 (BV)</i>	
.Repatriation Schedule.....	1233
<i>Handy 71117-06 (BV)</i>	
.Repatriation Schedule.....	1233
<i>Handygauze Cohesive 8631 (BV)</i>	
.Repatriation Schedule.....	1227
<i>Handygauze Cohesive 8633 (BV)</i>	
.Repatriation Schedule.....	1227
<i>Handygauze Cohesive 8635 (BV)</i>	
.Repatriation Schedule.....	1227
<i>HCU Anamix infant (SB)</i>	
.VARIOUS.....	621
<i>HCU Anamix junior LQ (SB)</i>	
.VARIOUS.....	620
<i>HCU cooler 10 (VF)</i>	
.VARIOUS.....	621
<i>HCU cooler 15 (VF)</i>	
.VARIOUS.....	621
<i>HCU cooler 20 (VF)</i>	
.VARIOUS.....	621
<i>HCU express 15 (VF)</i>	
.VARIOUS.....	621
<i>HCU gel (VF)</i>	
.VARIOUS.....	621
<i>HCU Lophlex LQ 20 (SB)</i>	
.VARIOUS.....	621
HEPARIN SODIUM	
.BLOOD AND BLOOD FORMING ORGANS	109
<i>Hepsera (GI)</i>	
.Section 100	716, 965

HEXAMINE HIPPURATE	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	240
HIGH FAT FORMULA WITH VITAMINS, MINERALS AND	
TRACE ELEMENTS AND LOW IN PROTEIN AND	
CARBOHYDRATE	
.VARIOUS.....	626, 627
<i>Hiprex (IA)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	240
HOMATROPINE	
.SENSORY ORGANS.....	584
<i>Hospira Ceftriaxone (HH)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	231
<i>Hospira Pty Limited (HH)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	78
.ANTIINFECTIVES FOR SYSTEMIC USE	223, 228, 230,
231, 237, 238, 239	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	253, 461
.BLOOD AND BLOOD FORMING ORGANS.....	109
.NERVOUS SYSTEM.....	485, 531
.Prescriber Bag	62, 63
.RESPIRATORY SYSTEM.....	574
.Section 100.....	707, 897, 955, 1150
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
HORMONES AND INSULINS	211, 212
<i>HPMC PAA (IQ)</i>	
.SENSORY ORGANS.....	591
<i>Humalog (LY)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	87
<i>Humalog KwikPen (KP)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	87
<i>Humalog Mix25 (LY)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	88
<i>Humalog Mix25 KwikPen (KP)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	88
<i>Humalog Mix50 (LY)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	88
<i>Humalog Mix50 KwikPen (KP)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	88
<i>Humatrope (LY)</i>	
.Section 100.....	1156, 1157
<i>Humira (VE)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	314, 317, 320, 323, 330, 333, 336, 338,
342, 345, 351, 356, 361, 364	
.Section 100.....	780, 1033
<i>Humulin 30/70 (LY)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	88
<i>Humulin NPH (LY)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	88
<i>Humulin R (LY)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	87
<i>Hycor (QA)</i>	
.SENSORY ORGANS.....	577
<i>Hydopa (AF)</i>	

GENERIC/PROPRIETARY INDEX

.CARDIOVASCULAR SYSTEM.....	130	.Palliative Care.....	632
HYDRALAZINE		.SENSORY ORGANS.....	591
.CARDIOVASCULAR SYSTEM.....	130	HYPROMELLOSE + CARBOMER-980	
<i>Hydrea (BQ)</i>		.SENSORY ORGANS.....	591
.ANTINEOPLASTIC AND IMMUNOMODULATING		<i>Hypurin Isophane (AS)</i>	
AGENTS	285	.ALIMENTARY TRACT AND METABOLISM.....	88
<i>Hydrene 25/50 (AF)</i>		<i>Hypurin Neutral (AS)</i>	
.CARDIOVASCULAR SYSTEM.....	133	.ALIMENTARY TRACT AND METABOLISM.....	87
HYDROCHLOROTHIAZIDE		<i>Hysone 20 (AF)</i>	
.CARDIOVASCULAR SYSTEM.....	131	.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
HYDROCHLOROTHIAZIDE + AMILORIDE		HORMONES AND INSULINS	212
.CARDIOVASCULAR SYSTEM.....	133	<i>Hysone 4 (AF)</i>	
HYDROCHLOROTHIAZIDE + TRIAMTERENE		.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
.CARDIOVASCULAR SYSTEM.....	133	HORMONES AND INSULINS	212
<i>Hydrocoll 900744 (HR)</i>		<i>Hytrin (AB)</i>	
.Repatriation Schedule.....	1236	.Repatriation Schedule	1211
<i>Hydrocoll 900936 (HR)</i>			
.Repatriation Schedule.....	1236		
<i>Hydrocoll Thin 900758 (HR)</i>			
.Repatriation Schedule.....	1235		
HYDROCORTISONE			
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX			
HORMONES AND INSULINS.....	212		
HYDROCORTISONE ACETATE			
.ALIMENTARY TRACT AND METABOLISM.....	83		
.DERMATOLOGICALS.....	193		
.SENSORY ORGANS.....	577		
HYDROCORTISONE SODIUM SUCCINATE			
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX			
HORMONES AND INSULINS.....	212		
HYDROMORPHONE			
.NERVOUS SYSTEM.....	482, 483		
<i>Hydroxo-B12 (AS)</i>			
.BLOOD AND BLOOD FORMING ORGANS	123		
HYDROXOCOBALAMIN			
.BLOOD AND BLOOD FORMING ORGANS	123		
HYDROXYCHLOROQUINE			
.MUSCULO-SKELETAL SYSTEM	467		
<i>Hydroxychloroquine Actavis (GN)</i>			
.MUSCULO-SKELETAL SYSTEM	467		
HYDROXYUREA			
.ANTINEOPLASTIC AND IMMUNOMODULATING			
AGENTS	285		
<i>Hygroton 25 (LM)</i>			
.CARDIOVASCULAR SYSTEM.....	131		
<i>Hylo-Forte (AE)</i>			
.SENSORY ORGANS.....	594		
<i>Hylo-Fresh (AE)</i>			
.SENSORY ORGANS.....	594		
HYOSCINE BUTYLBROMIDE			
.Palliative Care	633		
.Repatriation Schedule.....	1197		
<i>Hypnodorm (AF)</i>			
.Repatriation Schedule.....	1217		
HYPROMELLOSE			

I

<i>Iallex (LN)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	226, 227, 228
IBANDRONIC ACID	
.MUSCULO-SKELETAL SYSTEM	470
.Section 100.....	884, 1136
<i>Ibilex 125 (AF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	226
<i>Ibilex 250 (AF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	226, 227, 228
<i>Ibilex 500 (AF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	227
<i>Ibimicyn (GN)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	222
IBUPROFEN	
.MUSCULO-SKELETAL SYSTEM	465
.Palliative Care.....	639
ICATIBANT	
.BLOOD AND BLOOD FORMING ORGANS.....	125
ICHTHAMMOL	
.Repatriation Schedule	1207
ICHTHAMMOL + ZINC OXIDE	
.Repatriation Schedule	1207
<i>Idaprex 2 (SZ)</i>	
.CARDIOVASCULAR SYSTEM	142
<i>Idaprex 4 (SZ)</i>	
.CARDIOVASCULAR SYSTEM	143
<i>Idaprex 8 (SZ)</i>	
.CARDIOVASCULAR SYSTEM	142
<i>Idaprex Combi 4/1.25 (SZ)</i>	
.CARDIOVASCULAR SYSTEM	147
IDARUBICIN	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	254
<i>Ikorel (SW)</i>	
.CARDIOVASCULAR SYSTEM	129
ILOPROST	

GENERIC/PROPRIETARY INDEX

.Section 100	681, 929	.CARDIOVASCULAR SYSTEM	131
IMATINIB		<i>Indapamide-GA (GN)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING		.CARDIOVASCULAR SYSTEM	131
AGENTS	265, 266, 267, 269, 270, 271, 272, 273	<i>Inderal (AP)</i>	
<i>Imazan (ER)</i>		.CARDIOVASCULAR SYSTEM	133
.ANTINEOPLASTIC AND IMMUNOMODULATING		INDINAVIR	
AGENTS	461	.Section 100.....	712, 961
<i>Imdur 120 mg (AP)</i>		<i>Indocid (AS)</i>	
.CARDIOVASCULAR SYSTEM	129	.MUSCULO-SKELETAL SYSTEM	463
<i>Imdur Durule (AP)</i>		.Palliative Care.....	639
.CARDIOVASCULAR SYSTEM	129	INDOMETHACIN	
<i>Imigran (AS)</i>		.MUSCULO-SKELETAL SYSTEM	462, 463
.NERVOUS SYSTEM.....	497	.Palliative Care.....	639
<i>Imigran (LN)</i>		<i>Indopril 2 (QA)</i>	
.NERVOUS SYSTEM.....	497	.CARDIOVASCULAR SYSTEM	142
<i>Imigran FDT (AS)</i>		<i>Indopril 4 (QA)</i>	
.NERVOUS SYSTEM.....	497	.CARDIOVASCULAR SYSTEM	143
IMIPRAMINE		<i>Indopril 8 (QA)</i>	
.NERVOUS SYSTEM.....	534	.CARDIOVASCULAR SYSTEM	142
IMIQUIMOD		<i>Indosyl Combi 4/1.25 (QA)</i>	
.DERMATOLOGICALS.....	196	.CARDIOVASCULAR SYSTEM	147
.Repatriation Schedule.....	1207	<i>Indosyl Mono 2 (FM)</i>	
<i>ImmuCyst (SW)</i>		.CARDIOVASCULAR SYSTEM	142
.ANTINEOPLASTIC AND IMMUNOMODULATING		<i>Indosyl Mono 4 (FM)</i>	
AGENTS	294	.CARDIOVASCULAR SYSTEM	143
<i>Imodium (JT)</i>		<i>Indosyl Mono 8 (FM)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	83	.CARDIOVASCULAR SYSTEM	142
<i>Imovane (SW)</i>		INFLIXIMAB	
.Repatriation Schedule.....	1218	.Repatriation Schedule	1213
<i>Implanon NXT (MK)</i>		.Section 100....	789, 793, 803, 809, 812, 815, 824, 830,
.GENITO URINARY SYSTEM AND SEX HORMONES .	200	1041, 1042, 1045, 1051, 1061, 1063, 1067, 1077,	
<i>Imrest (AF)</i>		1083	
.Repatriation Schedule.....	1218	INGENOL MEBUTATE	
<i>Imtrate 60 mg (GN)</i>		.Repatriation Schedule	1205
.CARDIOVASCULAR SYSTEM	129	<i>iNova Pharmaceuticals (Australia) Pty Ltd (IA)</i>	
<i>Imukin (BY)</i>		.NERVOUS SYSTEM.....	560
.Section 100	732, 984	<i>Insig (QA)</i>	
<i>Imuran (AS)</i>		.CARDIOVASCULAR SYSTEM	131
.ANTINEOPLASTIC AND IMMUNOMODULATING		<i>Inspra (PF)</i>	
AGENTS	461	.CARDIOVASCULAR SYSTEM	132
<i>In a Wink Moisturising (IQ)</i>		INSULIN ASPART	
.SENSORY ORGANS.....	591	.ALIMENTARY TRACT AND METABOLISM.....	87
<i>Incivo (JC)</i>		INSULIN ASPART + INSULIN ASPART PROTAMINE	
.Section 100	715, 964	.ALIMENTARY TRACT AND METABOLISM.....	88
<i>Incruse Ellipta (GK)</i>		INSULIN DETEMIR	
.RESPIRATORY SYSTEM	572	.ALIMENTARY TRACT AND METABOLISM.....	88
INDACATEROL		INSULIN GLARGINE	
.RESPIRATORY SYSTEM	564	.ALIMENTARY TRACT AND METABOLISM.....	88
INDACATEROL + GLYCOPYRROLONIUM		INSULIN GLULISINE	
.RESPIRATORY SYSTEM	569	.ALIMENTARY TRACT AND METABOLISM.....	87
INDAPAMIDE		INSULIN ISOPHANE BOVINE	
.CARDIOVASCULAR SYSTEM	131	.ALIMENTARY TRACT AND METABOLISM.....	87
<i>Indapamide AN (EA)</i>		INSULIN ISOPHANE HUMAN	
.CARDIOVASCULAR SYSTEM	131	.ALIMENTARY TRACT AND METABOLISM.....	88
<i>Indapamide Sandoz (SZ)</i>			

GENERIC/PROPRIETARY INDEX

INSULIN ISOPHANE HUMAN + INSULIN NEUTRAL HUMAN	
.ALIMENTARY TRACT AND METABOLISM.....	88
INSULIN LISPRO	
.ALIMENTARY TRACT AND METABOLISM.....	87
INSULIN LISPRO + INSULIN LISPRO PROTAMINE	
.ALIMENTARY TRACT AND METABOLISM.....	88
INSULIN NEUTRAL BOVINE	
.ALIMENTARY TRACT AND METABOLISM.....	87
INSULIN NEUTRAL HUMAN	
.ALIMENTARY TRACT AND METABOLISM.....	87
<i>Intal CFC-Free (SW)</i>	
.RESPIRATORY SYSTEM	572
<i>Intal Forte CFC-Free (SW)</i>	
.RESPIRATORY SYSTEM	572
<i>Intal Spincaps (GN)</i>	
.RESPIRATORY SYSTEM	572
<i>Integrilin (MK)</i>	
.BLOOD AND BLOOD FORMING ORGANS	113
<i>Intelence (JC)</i>	
.Section 100	721, 971
INTERFERON ALFA-2A	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	292
.Section 100	731, 983
INTERFERON ALFA-2B	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	293
.Section 100	732, 984
INTERFERON BETA-1A	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	293
INTERFERON BETA-1B	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	293
INTERFERON GAMMA-1B	
.Section 100	732, 984
<i>Intrasite Gel 7313 (SN)</i>	
.Repatriation Schedule	1237
<i>Intron A (MK)</i>	
.Section 100	732, 984
<i>Intron A Redipen (MK)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	293
.Section 100	732, 984
<i>Invenga (JC)</i>	
.NERVOUS SYSTEM.....	526
<i>Invenga Sustenna (JC)</i>	
.NERVOUS SYSTEM.....	526
<i>Invirase (RO)</i>	
.Section 100	712, 962
<i>Invokana (JC)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	102
<i>Inza 250 (AF)</i>	
.MUSCULO-SKELETAL SYSTEM	465
.Palliative Care.....	640
<i>Inza 500 (AF)</i>	
.MUSCULO-SKELETAL SYSTEM	465, 466
.Palliative Care.....	640
<i>Iodosorb 66051330 (SN)</i>	
.Repatriation Schedule	1229
<i>Iodosorb 66051340 (SN)</i>	
.Repatriation Schedule	1229
<i>Iodosorb 66051360 (SN)</i>	
.Repatriation Schedule	1229
<i>Iodosorb Ointment 66051230 (SN)</i>	
.Repatriation Schedule	1229
<i>Iodosorb Ointment 66051240 (SN)</i>	
.Repatriation Schedule	1229
<i>Iodosorb Powder 66051070 (SN)</i>	
.Repatriation Schedule	1229
<i>Ionil-T (GA)</i>	
.Repatriation Schedule	1206
<i>Iopidine 0.5% (AQ)</i>	
.SENSORY ORGANS.....	578
<i>I-Pantoprazole (CR)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	70, 71
<i>Ipratrin (AF)</i>	
.RESPIRATORY SYSTEM.....	571
<i>Ipratrin Adult (AF)</i>	
.RESPIRATORY SYSTEM.....	572
IPRATROPIUM	
.Repatriation Schedule	1220
.RESPIRATORY SYSTEM.....	571
IRBESARTAN	
.CARDIOVASCULAR SYSTEM	150
IRBESARTAN + HYDROCHLOROTHIAZIDE	
.CARDIOVASCULAR SYSTEM	153
<i>Irbesartan Actavis 300 (UA)</i>	
.CARDIOVASCULAR SYSTEM	150
<i>Irbesartan Actavis 75 (UA)</i>	
.CARDIOVASCULAR SYSTEM	151
<i>Irbesartan AN (EA)</i>	
.CARDIOVASCULAR SYSTEM	150, 151
<i>Irbesartan GH (GQ)</i>	
.CARDIOVASCULAR SYSTEM	150, 151
<i>Irbesartan HCT Actavis 150/12.5 (UA)</i>	
.CARDIOVASCULAR SYSTEM	154
<i>Irbesartan HCT Actavis 300/25 (UA)</i>	
.CARDIOVASCULAR SYSTEM	154
<i>Irbesartan HCT GH 150/12.5 (GQ)</i>	
.CARDIOVASCULAR SYSTEM	154
<i>Irbesartan HCT GH 300/12.5 (GQ)</i>	
.CARDIOVASCULAR SYSTEM	154
<i>Irbesartan HCT GH 300/25 (GQ)</i>	
.CARDIOVASCULAR SYSTEM	154
<i>Irbesartan HCT Winthrop 150/12.5 (WA)</i>	
.CARDIOVASCULAR SYSTEM	154
<i>Irbesartan HCT Winthrop 300/12.5 (WA)</i>	
.CARDIOVASCULAR SYSTEM	154

GENERIC/PROPRIETARY INDEX

<i>Irbesartan HCT Winthrop 300/25 (WA)</i>	.VARIOUS.....627
.CARDIOVASCULAR SYSTEM.....	154
<i>Irbesartan HCTZ AN 150/12.5 (EA)</i>	.VARIOUS.....627
.CARDIOVASCULAR SYSTEM.....	154
<i>Irbesartan HCTZ AN 300/12.5 (EA)</i>	.VARIOUS.....627
.CARDIOVASCULAR SYSTEM.....	154
<i>Irbesartan HCTZ AN 300/25 (EA)</i>	.CARDIOVASCULAR SYSTEM.....129
.CARDIOVASCULAR SYSTEM.....	154
<i>Irbesartan HCTZ-GA 150/12.5 (GN)</i>	ISONIAZID
.CARDIOVASCULAR SYSTEM.....	.ANTIINFECTIVES FOR SYSTEMIC USE.....244
<i>Irbesartan HCTZ-GA 300/12.5 (GN)</i>	<i>Isoptin (AB)</i>
.CARDIOVASCULAR SYSTEM.....	.CARDIOVASCULAR SYSTEM.....139
<i>Irbesartan HCTZ-GA 300/25 (GN)</i>	<i>Isoptin 180 SR (AB)</i>
.CARDIOVASCULAR SYSTEM.....	.CARDIOVASCULAR SYSTEM.....139
<i>Irbesartan RBX (RA)</i>	<i>Isoptin SR (AB)</i>
.CARDIOVASCULAR SYSTEM.....	.CARDIOVASCULAR SYSTEM.....139
150, 151	<i>Isopto Carpine (AQ)</i>
<i>Irbesartan Sandoz (SZ)</i>	.SENSORY ORGANS.....579
.CARDIOVASCULAR SYSTEM.....	<i>Isopto Homatropine (AQ)</i>
150, 151	.SENSORY ORGANS.....584
<i>Irbesartan Winthrop (WA)</i>	<i>Isordil Sublingual (QA)</i>
.CARDIOVASCULAR SYSTEM.....	.CARDIOVASCULAR SYSTEM.....129
150, 151	<i>Isosorbide AN (EA)</i>
<i>Irbesartan/HCT Sandoz (SZ)</i>	.CARDIOVASCULAR SYSTEM.....129
.CARDIOVASCULAR SYSTEM.....	ISOSORBIDE DINITRATE
154	.CARDIOVASCULAR SYSTEM.....128
<i>Irbesartan/HCTZ RBX 150/12.5 (RA)</i>	ISOSORBIDE MONONITRATE
.CARDIOVASCULAR SYSTEM.....	.CARDIOVASCULAR SYSTEM.....129
154	ISOTRETINOIN
<i>Irbesartan/HCTZ RBX 300/12.5 (RA)</i>	.DERMATOLOGICALS.....195
.CARDIOVASCULAR SYSTEM.....	<i>Isotretinoin AN (EA)</i>
154	.DERMATOLOGICALS.....195
<i>Irbesartan/HCTZ RBX 300/25 (RA)</i>	<i>Isotretinoin SCP 10 (CR)</i>
.CARDIOVASCULAR SYSTEM.....	.DERMATOLOGICALS.....195
154	<i>Isotretinoin SCP 20 (CR)</i>
<i>Irbesartan-DRLA (RZ)</i>	.DERMATOLOGICALS.....195
.CARDIOVASCULAR SYSTEM.....	ISPAGHULA HUSK DRY
150, 151	.Repatriation Schedule.....1198
<i>Irbesartan-GA (GN)</i>	ITRACONAZOLE
.CARDIOVASCULAR SYSTEM.....	.ANTIINFECTIVES FOR SYSTEMIC USE.....241
150, 151	IVABRADINE
<i>Ircal (PE)</i>	.CARDIOVASCULAR SYSTEM.....129
.SENSORY ORGANS.....	IVACAFTOR
591, 592	.Section 100.....893, 1146
<i>Iressa (AP)</i>	IVERMECTIN
.ANTINEOPLASTIC AND IMMUNOMODULATING	.ANTIPARASITIC PRODUCTS, INSECTICIDES AND
AGENTS.....	REPELLENTS.....562, 563
265	
IRON	
.BLOOD AND BLOOD FORMING ORGANS.....	
122	
IRON POLYMALTOSE	
.BLOOD AND BLOOD FORMING ORGANS.....	
122, 123	
IRON SUCROSE	
.BLOOD AND BLOOD FORMING ORGANS.....	
123	
<i>Irprestan 150 (ZP)</i>	
.CARDIOVASCULAR SYSTEM.....	
150	
<i>Irprestan 300 (ZP)</i>	
.CARDIOVASCULAR SYSTEM.....	
150	
<i>Irprestan 75 (ZP)</i>	
.CARDIOVASCULAR SYSTEM.....	
151	
<i>Iscover (AV)</i>	
.BLOOD AND BLOOD FORMING ORGANS.....	
110, 111	
.Repatriation Schedule.....	
1201	
<i>Isentress (MK)</i>	
.Section 100.....	
726, 976	
<i>Isoleucine 1000 (VF)</i>	

J

<i>Janumet (MK)</i>	.ALIMENTARY TRACT AND METABOLISM.....95
<i>Janumet XR (MK)</i>	.ALIMENTARY TRACT AND METABOLISM.....95
<i>Januvia (MK)</i>	.ALIMENTARY TRACT AND METABOLISM.....101

GENERIC/PROPRIETARY INDEX

<i>Jelonet 7404 (SN)</i>	
.Repatriation Schedule.....	1233
<i>Jezil (GN)</i>	
.CARDIOVASCULAR SYSTEM.....	173
<i>JJ 12010 (JJ)</i>	
.Repatriation Schedule.....	1239
<i>Jurnista (JC)</i>	
.NERVOUS SYSTEM.....	483

K

<i>Kaletra (VE)</i>	
.Section 100	724, 974
<i>Kalixocin (AF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	233
<i>Kalma 0.25 (AF)</i>	
.NERVOUS SYSTEM.....	531
<i>Kalma 0.5 (AF)</i>	
.NERVOUS SYSTEM.....	531
<i>Kalma 1 (AF)</i>	
.NERVOUS SYSTEM.....	531
<i>Kalma 2 (AF)</i>	
.NERVOUS SYSTEM.....	531
<i>Kaltostat 168117 (CC)</i>	
.Repatriation Schedule.....	1230
<i>Kaltostat 168210 (CC)</i>	
.Repatriation Schedule.....	1230
<i>Kaltostat 168212 (CC)</i>	
.Repatriation Schedule.....	1230
<i>Kalydeco (VR)</i>	
.Section 100	896, 1149
<i>Kapanol (YN)</i>	
.NERVOUS SYSTEM.....	483
<i>Kaptan (ER)</i>	
.NERVOUS SYSTEM.....	523, 524, 525
<i>Karbesat 150 (QA)</i>	
.CARDIOVASCULAR SYSTEM.....	150
<i>Karbesat 300 (QA)</i>	
.CARDIOVASCULAR SYSTEM.....	150
<i>Karbesat 75 (QA)</i>	
.CARDIOVASCULAR SYSTEM.....	151
<i>Karicare Aptamil Gold De-Lact (NU)</i>	
.VARIOUS.....	619
<i>Karicare Aptamil Pepti-Junior Gold (NU)</i>	
.VARIOUS.....	617
<i>Karlor CD (LN)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	229
<i>Karvea (SW)</i>	
.CARDIOVASCULAR SYSTEM.....	150, 151
<i>Karvezide 150/12.5 (SW)</i>	
.CARDIOVASCULAR SYSTEM.....	154
<i>Karvezide 300/12.5 (SW)</i>	
.CARDIOVASCULAR SYSTEM.....	154
<i>Karvezide 300/25 (SW)</i>	
.CARDIOVASCULAR SYSTEM.....	155

<i>Keflex (AS)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	226, 227, 228
<i>Keflor (AF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	229
<i>Keflor CD (AF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	229
<i>Kenacomb Otic (QA)</i>	
.SENSORY ORGANS.....	595
<i>Kenacort-A10 (QA)</i>	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS	213, 214
<i>Kepcet (GN)</i>	
.NERVOUS SYSTEM.....	506, 507
<i>Keppra (UC)</i>	
.NERVOUS SYSTEM.....	506, 507
<i>Kerron 1000 (DO)</i>	
.NERVOUS SYSTEM.....	506
<i>Kerron 250 (DO)</i>	
.NERVOUS SYSTEM.....	506
<i>Kerron 500 (DO)</i>	
.NERVOUS SYSTEM.....	507
<i>KetoCal 3</i>	
1 (SB)	
.VARIOUS.....	626
<i>KetoCal 4</i>	
1 (SB)	
.VARIOUS.....	627
1 LQ (SB)	
.VARIOUS.....	627
KETOCONAZOLE	
.DERMATOLOGICALS	190
.Repatriation Schedule.....	1203
<i>Keto-Diabur- Test 5000 (RD)</i>	
.VARIOUS.....	598
<i>Keto-Diastix (BN)</i>	
.VARIOUS.....	598, 599
KETOPROFEN	
.MUSCULO-SKELETAL SYSTEM	465
<i>Kevtam (AF)</i>	
.NERVOUS SYSTEM.....	506, 507
<i>keyomega (VF)</i>	
.VARIOUS.....	624
<i>Kindergen (SB)</i>	
.VARIOUS.....	630
<i>Kinson (AF)</i>	
.NERVOUS SYSTEM.....	510
<i>Kivexa (VI)</i>	
.Section 100.....	722, 972
<i>Klacid (AB)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	233
.Section 100.....	708, 957
<i>Kombiglyze XR 2.5/1000 (AP)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	94
<i>Kombiglyze XR 5/1000 (AP)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	94

GENERIC/PROPRIETARY INDEX

<i>Kombiglyze XR 5/500 (AP)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	94
<i>Kosteo (QA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	105
.MUSCULO-SKELETAL SYSTEM	478
<i>Krypton 2.5 (AF)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	199
.NERVOUS SYSTEM.....	512
<i>KSART HCT 150/12.5 (QA)</i>	
.CARDIOVASCULAR SYSTEM	154
<i>KSART HCT 300/12.5 (QA)</i>	
.CARDIOVASCULAR SYSTEM	154
<i>KSART HCT 300/25 (QA)</i>	
.CARDIOVASCULAR SYSTEM	155
<i>Kudeq (FZ)</i>	
.MUSCULO-SKELETAL SYSTEM	467
<i>Kuvan (SG)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	107
<i>Kytril (RO)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	74

L

LABETALOL	
.CARDIOVASCULAR SYSTEM	137
LACOSAMIDE	
.NERVOUS SYSTEM.....	503, 504
LACTATE + SODIUM CHLORIDE + POTASSIUM CHLORIDE + CALCIUM CHLORIDE DIHYDRATE	
.BLOOD AND BLOOD FORMING ORGANS	124
LACTIC ACID + SALICYLIC ACID	
.Repatriation Schedule	1206
LACTULOSE	
.ALIMENTARY TRACT AND METABOLISM.....	79
.Palliative Care	634
<i>Lamictal (AS)</i>	
.NERVOUS SYSTEM.....	505, 506
<i>Lamidus (RA)</i>	
.NERVOUS SYSTEM.....	505, 506
<i>Lamisil (NC)</i>	
.DERMATOLOGICALS	190
.Repatriation Schedule	1203
<i>Lamisil (Novartis Pharmaceuticals Australia Pty Limited) (NV)</i>	
.DERMATOLOGICALS	191
.Repatriation Schedule	1204
<i>Lamisil DermGel (NC)</i>	
.Repatriation Schedule	1203
LAMIVUDINE	
.Section 100	717, 718, 967
LAMIVUDINE + ZIDOVUDINE	
.Section 100	723, 973
<i>Lamivudine 150 mg + Zidovudine 300 mg Alphapharm (AF)</i>	
.Section 100	723, 973

<i>Lamivudine Alphapharm (AF)</i>	
.Section 100.....	717, 967
<i>Lamivudine RBX (RA)</i>	
.Section 100.....	717, 967
<i>Lamogine (AF)</i>	
.NERVOUS SYSTEM.....	505, 506
LAMOTRIGINE	
.NERVOUS SYSTEM.....	505
<i>Lamotrigine AN (EA)</i>	
.NERVOUS SYSTEM.....	505, 506
<i>Lamotrigine Aspen 100 (FM)</i>	
.NERVOUS SYSTEM.....	505
<i>Lamotrigine Aspen 200 (FM)</i>	
.NERVOUS SYSTEM.....	505
<i>Lamotrigine Aspen 25 (FM)</i>	
.NERVOUS SYSTEM.....	505
<i>Lamotrigine Aspen 5 (FM)</i>	
.NERVOUS SYSTEM.....	506
<i>Lamotrigine Aspen 50 (FM)</i>	
.NERVOUS SYSTEM.....	506
<i>Lamotrigine generichealth (GQ)</i>	
.NERVOUS SYSTEM.....	505, 506
<i>Lamotrigine Sandoz (SZ)</i>	
.NERVOUS SYSTEM.....	505, 506
<i>Lamotrigine-GA (GN)</i>	
.NERVOUS SYSTEM.....	505, 506
<i>Lamotrast 100 (CR)</i>	
.NERVOUS SYSTEM.....	505
<i>Lamotrast 200 (CR)</i>	
.NERVOUS SYSTEM.....	505
<i>Lamotrast 25 (CR)</i>	
.NERVOUS SYSTEM.....	506
<i>Lamotrast 50 (CR)</i>	
.NERVOUS SYSTEM.....	506
<i>Lanoxin (QA)</i>	
.CARDIOVASCULAR SYSTEM	126
<i>Lanoxin-PG (QA)</i>	
.CARDIOVASCULAR SYSTEM	126
LANREOTIDE	
.Section 100.....	705, 953
LANSOPRAZOLE	
.ALIMENTARY TRACT AND METABOLISM.....	68, 69
LANTHANUM	
.Section 100.....	897, 1150
.VARIOUS.....	596
<i>Lantus (SW)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	88
<i>Lantus SoloStar (AV)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	88
<i>Lanvis (AS)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	253
<i>Lanzek (EL)</i>	
.NERVOUS SYSTEM.....	518, 520, 522, 523
<i>Lanzek Zydis (EL)</i>	

GENERIC/PROPRIETARY INDEX

.NERVOUS SYSTEM.....	519, 522	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>Lanzopran (RA)</i>		AGENTS	306
.ALIMENTARY TRACT AND METABOLISM.....	69	LENALIDOMIDE	
LAPATINIB		.Section 100.....	869, 871, 1122, 1123
.ANTINEOPLASTIC AND IMMUNOMODULATING		<i>Lengout (LN)</i>	
AGENTS	274	.MUSCULO-SKELETAL SYSTEM	469
<i>Largactil (SW)</i>		LENOGRASTIM	
.NERVOUS SYSTEM.....	515	.Section 100.....	730, 981
.Prescriber Bag	62	<i>Lercadip (GN)</i>	
<i>Lasix (SW)</i>		.CARDIOVASCULAR SYSTEM	138
.CARDIOVASCULAR SYSTEM.....	131, 132	<i>Lercan (QA)</i>	
.Prescriber Bag	62	.CARDIOVASCULAR SYSTEM	138
<i>Lasix-M (SW)</i>		LERCANIDIPINE	
.CARDIOVASCULAR SYSTEM.....	132	.CARDIOVASCULAR SYSTEM	138
<i>Latanocom (FZ)</i>		LERCANIDIPINE + ENALAPRIL	
.SENSORY ORGANS.....	583	.CARDIOVASCULAR SYSTEM	147
LATANOPROST		<i>Lercanidipine AN (EA)</i>	
.SENSORY ORGANS.....	582	.CARDIOVASCULAR SYSTEM	138
LATANOPROST + TIMOLOL		<i>Lercanidipine GH (GQ)</i>	
.SENSORY ORGANS.....	583	.CARDIOVASCULAR SYSTEM	138
<i>Latanoprost Actavis (GN)</i>		<i>Lercanidipine Sandoz (SZ)</i>	
.SENSORY ORGANS.....	582	.CARDIOVASCULAR SYSTEM	138
<i>Latanoprost GH (GQ)</i>		<i>Lescol (NV)</i>	
.SENSORY ORGANS.....	582	.CARDIOVASCULAR SYSTEM	163, 164
<i>Latanoprost Pfizer (FZ)</i>		<i>Lescol XL (NV)</i>	
.SENSORY ORGANS.....	582	.CARDIOVASCULAR SYSTEM	164
<i>Latanoprost Sandoz (SZ)</i>		LETROZOLE	
.SENSORY ORGANS.....	582, 583	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>Latanoprost/Timolol Sandoz 50/5 (SZ)</i>		AGENTS	290
.SENSORY ORGANS.....	583	<i>Letrozole Actavis (VN)</i>	
<i>LaxaCon (GN)</i>		.ANTINEOPLASTIC AND IMMUNOMODULATING	
.ALIMENTARY TRACT AND METABOLISM.....	80	AGENTS	291
.Palliative Care	635	<i>Letrozole AN (EA)</i>	
<i>lax-sachets (AE)</i>		.ANTINEOPLASTIC AND IMMUNOMODULATING	
.ALIMENTARY TRACT AND METABOLISM.....	80	AGENTS	291
.Palliative Care	635	<i>Letrozole generichealth (GQ)</i>	
<i>Lax-Tab (AE)</i>		.ANTINEOPLASTIC AND IMMUNOMODULATING	
.ALIMENTARY TRACT AND METABOLISM.....	79	AGENTS	291
.Palliative Care	633	<i>Letrozole RBX (RA)</i>	
<i>Ledip (RA)</i>		.ANTINEOPLASTIC AND IMMUNOMODULATING	
.CARDIOVASCULAR SYSTEM.....	138	AGENTS	291
LEFLUNOMIDE		<i>Letrozole Sandoz (SZ)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING		.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	305, 306	AGENTS	291
<i>Leflunomide AN (EA)</i>		<i>Letrozole-DRLA (RZ)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING		.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	306	AGENTS	291
<i>Leflunomide GH (GQ)</i>		<i>Letrozole-GA (GN)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING		.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	306	AGENTS	291
<i>Leflunomide Sandoz (SZ)</i>		<i>Leucovorin Calcium (Hospira Pty Limited) (HH)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING		.VARIOUS.....	597
AGENTS	306	<i>Leucovorin Calcium (Pfizer Australia Pty Ltd) (PF)</i>	
<i>Leflunomide-GA (GN)</i>		.VARIOUS.....	597
		<i>Leukeran (AS)</i>	

GENERIC/PROPRIETARY INDEX

.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	251
<i>Leukoflex 1124 (BV)</i>	
.Repatriation Schedule	1240
<i>Leukoplast 01071-00 (BV)</i>	
.Repatriation Schedule	1239
<i>Leukoplast 01072-00 (BV)</i>	
.Repatriation Schedule	1239
<i>Leukoplast 01073-00 (BV)</i>	
.Repatriation Schedule	1239
<i>Leukopor 2471 (BV)</i>	
.Repatriation Schedule	1240
<i>Leukopor 2472 (BV)</i>	
.Repatriation Schedule	1240
<i>Leukopor 2474 (BV)</i>	
.Repatriation Schedule	1240
<i>Leukosilk 1021 (BV)</i>	
.Repatriation Schedule	1240
<i>Leukosilk 1022 (BV)</i>	
.Repatriation Schedule	1240
<i>Leukosilk 1024 (BV)</i>	
.Repatriation Schedule	1240
LEUPRORELIN	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	286
<i>Levactam (ER)</i>	
.NERVOUS SYSTEM	506, 507
<i>Levecetam 1000 (RZ)</i>	
.NERVOUS SYSTEM	506
<i>Levecetam 250 (RZ)</i>	
.NERVOUS SYSTEM	507
<i>Levecetam 500 (RZ)</i>	
.NERVOUS SYSTEM	507
<i>Levemir FlexPen (NF)</i>	
.ALIMENTARY TRACT AND METABOLISM	88
<i>Levemir Penfill (NO)</i>	
.ALIMENTARY TRACT AND METABOLISM	88
LEVETIRACETAM	
.NERVOUS SYSTEM	506, 507
<i>Levetiracetam AN (EA)</i>	
.NERVOUS SYSTEM	506, 507
<i>Levetiracetam generichealth (GQ)</i>	
.NERVOUS SYSTEM	506, 507
<i>Levetiracetam SZ (SZ)</i>	
.NERVOUS SYSTEM	506, 507
<i>Levi 1000 (FM)</i>	
.NERVOUS SYSTEM	506
<i>Levi 250 (FM)</i>	
.NERVOUS SYSTEM	507
<i>Levi 500 (FM)</i>	
.NERVOUS SYSTEM	507
<i>Levitaccord (RA)</i>	
.NERVOUS SYSTEM	506, 507
<i>Levitam 1000 (QA)</i>	
.NERVOUS SYSTEM	506
<i>Levitam 250 (QA)</i>	
.NERVOUS SYSTEM	507
<i>Levitam 500 (QA)</i>	
.NERVOUS SYSTEM	507
<i>Levitra (BN)</i>	
.Repatriation Schedule	1210
<i>Levlen ED (SY)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	200
<i>Levo/Carbidopa Sandoz (SZ)</i>	
.NERVOUS SYSTEM	510
LEVOCABASTINE	
.Repatriation Schedule	1220, 1222
LEVODOPA + BENSERAZIDE	
.NERVOUS SYSTEM	510
LEVODOPA + CARBIDOPA ANHYDROUS	
.NERVOUS SYSTEM	510, 511
.Section 100	886, 1138
LEVODOPA + CARBIDOPA ANHYDROUS + ENTACAPONE	
.NERVOUS SYSTEM	511
LEVONORGESTREL	
.GENITO URINARY SYSTEM AND SEX HORMONES	198, 200
<i>Lexam 10 (QA)</i>	
.NERVOUS SYSTEM	536
<i>Lexam 20 (QA)</i>	
.NERVOUS SYSTEM	536
<i>Lexapro (LU)</i>	
.NERVOUS SYSTEM	536, 537, 538
<i>Lexotan (RO)</i>	
.Repatriation Schedule	1217
<i>Lezole (UA)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	291
<i>Lifeline Attest (OI)</i>	
.VARIOUS	600, 601
LIGNOCAINE	
.CARDIOVASCULAR SYSTEM	126
.Repatriation Schedule	1205
LINAGLIPTIN	
.ALIMENTARY TRACT AND METABOLISM	99
LINAGLIPTIN + METFORMIN	
.ALIMENTARY TRACT AND METABOLISM	92
<i>Lincocin (PF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	235
LINCOMYCIN	
.ANTIINFECTIVES FOR SYSTEMIC USE	235
<i>Link Medical Products Pty Ltd (LM)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	244
.CARDIOVASCULAR SYSTEM	127
.DERMATOLOGICALS	196
.Prescriber Bag	62
.RESPIRATORY SYSTEM	572
<i>Lioresal 10 (NV)</i>	
.MUSCULO-SKELETAL SYSTEM	468
<i>Lioresal 25 (NV)</i>	

GENERIC/PROPRIETARY INDEX

.MUSCULO-SKELETAL SYSTEM	468	.Repatriation Schedule	1220, 1222
<i>Lioresal Intrathecal (NV)</i>		<i>Locasol (SB)</i>	
.Section 100	884, 1136	.VARIOUS.....	620
LIOTHYRONINE		<i>Loceryl (GA)</i>	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX		.Repatriation Schedule	1203
HORMONES AND INSULINS.....	214	<i>Lodam SR 100 (ZP)</i>	
<i>Lipex 10 (FR)</i>		.NERVOUS SYSTEM.....	492
.CARDIOVASCULAR SYSTEM	170, 171	<i>Lodam SR 150 (ZP)</i>	
<i>Lipex 20 (FR)</i>		.NERVOUS SYSTEM.....	492
.CARDIOVASCULAR SYSTEM	170, 172	<i>Lodam SR 200 (ZP)</i>	
<i>Lipex 40 (FR)</i>		.NERVOUS SYSTEM.....	493
.CARDIOVASCULAR SYSTEM	171, 172	<i>Lofenoxal (IA)</i>	
<i>Lipex 80 (FR)</i>		.ALIMENTARY TRACT AND METABOLISM.....	83
.CARDIOVASCULAR SYSTEM	171, 172	<i>Logicin Rapid Relief (QA)</i>	
<i>Lipidil (AB)</i>		.Repatriation Schedule	1220
.CARDIOVASCULAR SYSTEM	172, 173	<i>Logicin Sinus (QA)</i>	
<i>Lipigem (AF)</i>		.Repatriation Schedule	1220
.CARDIOVASCULAR SYSTEM	173	<i>Logynon ED (SY)</i>	
<i>Lipistart (VF)</i>		.GENITO URINARY SYSTEM AND SEX HORMONES .	200
.VARIOUS.....	618	<i>Lomotil (IV)</i>	
<i>Lipitor (PF)</i>		.ALIMENTARY TRACT AND METABOLISM.....	83
.CARDIOVASCULAR SYSTEM	161, 162, 163	<i>Loniten (PF)</i>	
<i>Liposomal Doxorubicin SUN (ZF)</i>		.CARDIOVASCULAR SYSTEM	131
.Section 100	728, 979	LOPERAMIDE	
<i>Lipostat 10 (QA)</i>		.ALIMENTARY TRACT AND METABOLISM.....	83
.CARDIOVASCULAR SYSTEM	164, 165	<i>Lophlex (SB)</i>	
<i>Lipostat 20 (QA)</i>		.VARIOUS.....	623
.CARDIOVASCULAR SYSTEM	164, 165	LOPINAVIR + RITONAVIR	
<i>Lipostat 40 (QA)</i>		.Section 100.....	723, 974
.CARDIOVASCULAR SYSTEM	164, 165	<i>Lopresor 100 (NV)</i>	
<i>Lipostat 80 (QA)</i>		.CARDIOVASCULAR SYSTEM	135
.CARDIOVASCULAR SYSTEM	165, 166	<i>Lopresor 50 (NV)</i>	
<i>Liquifilm Forte (AG)</i>		.CARDIOVASCULAR SYSTEM	135
.SENSORY ORGANS.....	593	<i>Lorano (SZ)</i>	
<i>Liquifilm Tears (AG)</i>		.Repatriation Schedule	1221
.SENSORY ORGANS.....	593	LORATADINE	
<i>Liquigen (SB)</i>		.Repatriation Schedule	1221
.VARIOUS.....	602	<i>Lorstat 10 (AF)</i>	
LISINAPRIL		.CARDIOVASCULAR SYSTEM	161, 163
.CARDIOVASCULAR SYSTEM	141	<i>Lorstat 20 (AF)</i>	
<i>Lisinopril AN (EA)</i>		.CARDIOVASCULAR SYSTEM	162, 163
.CARDIOVASCULAR SYSTEM	141, 142	<i>Lorstat 40 (AF)</i>	
<i>Lisinopril generichealth (GQ)</i>		.CARDIOVASCULAR SYSTEM	162, 163
.CARDIOVASCULAR SYSTEM	141, 142	<i>Lorstat 80 (AF)</i>	
<i>Lisinopril Sandoz (SZ)</i>		.CARDIOVASCULAR SYSTEM	162, 163
.CARDIOVASCULAR SYSTEM	141, 142	LOSARTAN	
<i>Lisinopril-DRLA (RZ)</i>		.CARDIOVASCULAR SYSTEM	151
.CARDIOVASCULAR SYSTEM	141, 142	<i>Losec Tablets (AP)</i>	
<i>Lisinopril-GA (GN)</i>		.ALIMENTARY TRACT AND METABOLISM.....	69, 70
.CARDIOVASCULAR SYSTEM	141, 142	<i>Lovan (AL)</i>	
<i>Lithicarb (AS)</i>		.NERVOUS SYSTEM.....	538
.NERVOUS SYSTEM.....	541	<i>Lovan 20 Tab (AL)</i>	
LITHIUM CARBONATE		.NERVOUS SYSTEM.....	538
.NERVOUS SYSTEM.....	541	<i>Lovir (GN)</i>	
<i>Livostin (JT)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE	245

GENERIC/PROPRIETARY INDEX

<i>Loxalate (AF)</i>	
.NERVOUS SYSTEM.....	536
<i>Loxip 500 (DO)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	237
<i>Loxip 750 (DO)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	238
<i>LPV (IA)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	222, 223
LUBRICATING AGENT	
.Repatriation Schedule.....	1226
<i>Lubri-Gel (PP)</i>	
.Repatriation Schedule.....	1226
<i>Lucentis (NV)</i>	
.SENSORY ORGANS.....	587
<i>Lucrin Depot 3 Month PDS (VE)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	286
<i>Lucrin Depot 4 Month PDS (VE)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	286
<i>Lucrin Depot 7.5mg PDS (VE)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	286
<i>Lukair (FR)</i>	
.RESPIRATORY SYSTEM	573, 574
<i>Lumigan (AG)</i>	
.SENSORY ORGANS.....	581
<i>Lumigan PF (AG)</i>	
.SENSORY ORGANS.....	581
<i>Lumin 10 (AF)</i>	
.NERVOUS SYSTEM.....	542
<i>Lumin 20 (AF)</i>	
.NERVOUS SYSTEM.....	542
<i>Lunava 10 (ZP)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	306
<i>Lunava 20 (ZP)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	306
<i>Luvox (AB)</i>	
.NERVOUS SYSTEM.....	538
<i>Lycinate (FM)</i>	
.CARDIOVASCULAR SYSTEM.....	128
<i>Lyclear (JT)</i>	
.ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS.....	563
<i>Lyrice (PF)</i>	
.NERVOUS SYSTEM.....	495

M

<i>Mabthera (RO)</i>	
.Section 100	882, 1135
MACITENTAN	
.Section 100	687, 935

<i>Macrodantin (PF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	240
MACROGOL-3350	
.ALIMENTARY TRACT AND METABOLISM	79
.Palliative Care.....	634
MACROGOL-3350 + SODIUM CHLORIDE + POTASSIUM CHLORIDE + BICARBONATE	
.ALIMENTARY TRACT AND METABOLISM	80
.Palliative Care.....	635
<i>Macrovic (QA)</i>	
.ALIMENTARY TRACT AND METABOLISM	80
.Palliative Care.....	635
<i>Madopar (RO)</i>	
.NERVOUS SYSTEM.....	510
<i>Madopar 125 (RO)</i>	
.NERVOUS SYSTEM.....	510
<i>Madopar 62.5 (RO)</i>	
.NERVOUS SYSTEM.....	510
<i>Madopar HBS (RO)</i>	
.NERVOUS SYSTEM.....	510
<i>Madopar Rapid 125 (RO)</i>	
.NERVOUS SYSTEM.....	510
<i>Madopar Rapid 62.5 (RO)</i>	
.NERVOUS SYSTEM.....	510
<i>Magicul 400 (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM	66
<i>Magmin (BB)</i>	
.Repatriation Schedule	1200
<i>MagMin (PBS) (BB)</i>	
.ALIMENTARY TRACT AND METABOLISM	106
MAGNESIUM ASPARTATE DIHYDRATE	
.ALIMENTARY TRACT AND METABOLISM	106
.Repatriation Schedule	1200
<i>Mag-Sup (PP)</i>	
.ALIMENTARY TRACT AND METABOLISM	106
.Repatriation Schedule	1200
<i>Malarone (GK)</i>	
.ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS	561
<i>Malean (FM)</i>	
.CARDIOVASCULAR SYSTEM.....	140, 141
MANNITOL	
.Section 100.....	892, 1144
MARAVIROC	
.Section 100.....	725, 975
<i>Marevan (FM)</i>	
.BLOOD AND BLOOD FORMING ORGANS.....	108
<i>Max Pharma Ceftriaxone (GQ)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	231
<i>Maxalt (MK)</i>	
.NERVOUS SYSTEM.....	497
<i>Maxamox (SZ)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	220, 221
<i>Maxidex (AQ)</i>	
.SENSORY ORGANS.....	577

GENERIC/PROPRIETARY INDEX

<i>Maxolon (IA)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	73	
.Prescriber Bag	63	
<i>Maxor (AF)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	69, 70	
<i>Mayne Pharma Aspirin (YT)</i>		
.BLOOD AND BLOOD FORMING ORGANS	110	
<i>Mayne Pharma Doxycycline (YT)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	218, 219	
<i>Mayne Pharma Erythromycin (YT)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	233	
<i>MCT Oil (SB)</i>		
.VARIOUS.....	602	
<i>MCT Pro-Cal (VF)</i>		
.VARIOUS.....	628	
MEBENDAZOLE		
.Repatriation Schedule.....	1219	
MEBEVERINE		
.Repatriation Schedule.....	1197	
<i>MediHealth ClearLax (ON)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	80	
.Palliative Care	634, 635	
<i>Medipore 2961 (MM)</i>		
.Repatriation Schedule.....	1239	
MEDROXYPROGESTERONE		
.ANTINEOPLASTIC AND IMMUNOMODULATING		
AGENTS	285	
.GENITO URINARY SYSTEM AND SEX HORMONES 200,		
202		
<i>Medroxyprogesterone Sandoz (SZ)</i>		
.GENITO URINARY SYSTEM AND SEX HORMONES .	202	
MEFENAMIC ACID		
.MUSCULO-SKELETAL SYSTEM	466	
<i>Mefix 310250 (MH)</i>		
.Repatriation Schedule.....	1239	
<i>Megace (QA)</i>		
.ANTINEOPLASTIC AND IMMUNOMODULATING		
AGENTS	285	
<i>Megafol 0.5 (AF)</i>		
.BLOOD AND BLOOD FORMING ORGANS	124	
<i>Megafol 5 (AF)</i>		
.BLOOD AND BLOOD FORMING ORGANS	124	
MEGESTROL		
.ANTINEOPLASTIC AND IMMUNOMODULATING		
AGENTS	285	
<i>Melizide (AF)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	91	
<i>Melolin 36361357 (SN)</i>		
.Repatriation Schedule.....	1238	
<i>Melolin 66974933 (SN)</i>		
.Repatriation Schedule.....	1238	
<i>Melox 15 (GN)</i>		
.MUSCULO-SKELETAL SYSTEM	463	
<i>Melox 7.5 (GN)</i>		
.MUSCULO-SKELETAL SYSTEM	464	
<i>Meloxiauro 15 (DO)</i>		
.MUSCULO-SKELETAL SYSTEM	463	
<i>Meloxiauro 7.5 (DO)</i>		
.MUSCULO-SKELETAL SYSTEM	464	
<i>Meloxibell (GQ)</i>		
.MUSCULO-SKELETAL SYSTEM	463, 464	
MELOXICAM		
.MUSCULO-SKELETAL SYSTEM	463	
<i>Meloxicam AN (EA)</i>		
.MUSCULO-SKELETAL SYSTEM	463, 464	
<i>Meloxicam Ranbaxy (RA)</i>		
.MUSCULO-SKELETAL SYSTEM	463, 464	
<i>Meloxicam Sandoz (SZ)</i>		
.MUSCULO-SKELETAL SYSTEM	463, 464	
<i>Meloxicam-GA (GN)</i>		
.MUSCULO-SKELETAL SYSTEM	463, 464	
MELPHALAN		
.ANTINEOPLASTIC AND IMMUNOMODULATING		
AGENTS	251	
MEMANTINE		
.NERVOUS SYSTEM.....	552, 553	
<i>Memantine generichealth (GQ)</i>		
.NERVOUS SYSTEM.....	553, 554	
<i>Memanza (QA)</i>		
.NERVOUS SYSTEM.....	553, 554	
<i>Menopur 1200 (FP)</i>		
.Section 100.....	1159	
<i>Menopur 600 (FP)</i>		
.Section 100.....	1159	
<i>Mepilex 294100 (MH)</i>		
.Repatriation Schedule.....	1232	
<i>Mepilex Ag (MH)</i>		
.Repatriation Schedule.....	1232	
<i>Mepilex Border 295200 (MH)</i>		
.Repatriation Schedule.....	1232	
<i>Mepilex Border 295300 (MH)</i>		
.Repatriation Schedule.....	1232	
<i>Mepilex Border Ag (MH)</i>		
.Repatriation Schedule.....	1232	
<i>Mepilex Lite 284000 (MH)</i>		
.Repatriation Schedule.....	1232	
<i>Mepilex Lite 284100 (MH)</i>		
.Repatriation Schedule.....	1232	
<i>Mepitac 298300 (MH)</i>		
.Repatriation Schedule.....	1240	
<i>Mepitac 298400 (MH)</i>		
.Repatriation Schedule.....	1240	
<i>Mepitel 290510 (MH)</i>		
.Repatriation Schedule.....	1238	
<i>Mepitel 290710 (MH)</i>		
.Repatriation Schedule.....	1238	
<i>Meprazol (SZ)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	69, 70	
MERCAPTOPYRINE		

GENERIC/PROPRIETARY INDEX

.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	253
MESALAZINE	
.ALIMENTARY TRACT AND METABOLISM.....	84, 85
<i>Mesasal (AS)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	85
MESNA	
.VARIOUS.....	597
<i>Mestinon (IA)</i>	
.NERVOUS SYSTEM.....	554
<i>Mestinon Timespan (IA)</i>	
.NERVOUS SYSTEM.....	554
MESTRANOL + NORETHISTERONE	
.GENITO URINARY SYSTEM AND SEX HORMONES .	200
<i>Metalyse (BY)</i>	
.BLOOD AND BLOOD FORMING ORGANS	114
<i>Metamucil Natural Granular (PY)</i>	
.Repatriation Schedule	1198
<i>Metamucil Orange Smooth (PY)</i>	
.Repatriation Schedule	1198
<i>Metatar (FM)</i>	
.CARDIOVASCULAR SYSTEM	135
<i>Metex XR (QA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
METFORMIN	
.ALIMENTARY TRACT AND METABOLISM.....	89
METFORMIN + GLIBENCLAMIDE	
.ALIMENTARY TRACT AND METABOLISM.....	92
<i>Metformin 500 (CR)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>Metformin 850 (CR)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>Metformin AN (EA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>Metformin generichealth (GQ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>Metformin generichealth 1000 (GQ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>Metformin Ranbaxy (RA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>Metformin Ranbaxy 1000 (RA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>Metformin Sandoz (SZ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>Metformin-GA (GN)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	89
<i>Methaccord (GN)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	253
METHADONE	
.NERVOUS SYSTEM.....	490
.Palliative Care	644
.Section 100	1161
<i>Methoblastin (PF)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	253, 461
<i>Methopt (QA)</i>	
.SENSORY ORGANS.....	591
METHOTREXATE	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	253, 461
METHOXY POLYETHYLENE GLYCOL-EPOETIN BETA	
.Section 100.....	656, 904
METHYL SALICYLATE	
.Repatriation Schedule	1214
METHYL SALICYLATE + MENTHOL + EUCALYPTUS OIL	
.Repatriation Schedule	1214
METHYLDOPA	
.CARDIOVASCULAR SYSTEM	130
METHYLNALTREXONE	
.Palliative Care.....	636
METHYLPHENIDATE	
.NERVOUS SYSTEM.....	544, 545
<i>Methylpred (AL)</i>	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS	212
METHYLPREDNISOLONE	
.DERMATOLOGICALS	194
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS	212
<i>Methylprednisolone Alphapharm (AF)</i>	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS	212
METOCLOPRAMIDE	
.ALIMENTARY TRACT AND METABOLISM.....	73
<i>Metoclopramide Actavis (GN)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	73
<i>Metoclopramide AN (EA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	73
<i>Metoprolol Actavis (GN)</i>	
.CARDIOVASCULAR SYSTEM	135
<i>Metoprolol AN (EA)</i>	
.CARDIOVASCULAR SYSTEM	135
<i>Metoprolol Sandoz (SZ)</i>	
.CARDIOVASCULAR SYSTEM	135
METOPROLOL SUCCINATE	
.CARDIOVASCULAR SYSTEM	135
METOPROLOL TARTRATE	
.CARDIOVASCULAR SYSTEM	135
<i>Metrogyl 200 (AF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	239
<i>Metrogyl 400 (AF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	239
<i>Metrol 100 (QA)</i>	
.CARDIOVASCULAR SYSTEM	135
<i>Metrol 50 (QA)</i>	
.CARDIOVASCULAR SYSTEM	135
<i>Metrol-XL 190 (QA)</i>	
.CARDIOVASCULAR SYSTEM	135

GENERIC/PROPRIETARY INDEX

<i>Metrol-XL 23.75 (QA)</i>		
.CARDIOVASCULAR SYSTEM	135	
<i>Metrol-XL 47.5 (QA)</i>		
.CARDIOVASCULAR SYSTEM	135	
<i>Metrol-XL 95 (QA)</i>		
.CARDIOVASCULAR SYSTEM	135	
METRONIDAZOLE		
.ANTIINFECTIVES FOR SYSTEMIC USE	239, 240	
<i>Metronidazole Sandoz IV (SZ)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE	239, 240	
<i>Metronidazole-Clarix (AE)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE	240	
<i>Metronide 200 (AV)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE	239	
<i>Metronide 400 (AV)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE	239	
<i>Mezavant (ZI)</i>		
.ALIMENTARY TRACT AND METABOLISM	84	
<i>Miacalcic 100 (NV)</i>		
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS	216	
<i>Miacalcic 50 (NV)</i>		
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS	216	
MIANSERIN		
.NERVOUS SYSTEM	541	
<i>Micardis (BY)</i>		
.CARDIOVASCULAR SYSTEM	151	
<i>Micardis Plus 40/12.5 mg (BY)</i>		
.CARDIOVASCULAR SYSTEM	155	
<i>Micardis Plus 80/12.5 mg (BY)</i>		
.CARDIOVASCULAR SYSTEM	155	
<i>Micardis Plus 80/25 mg (BY)</i>		
.CARDIOVASCULAR SYSTEM	156	
<i>Micolette (AE)</i>		
.ALIMENTARY TRACT AND METABOLISM	81	
.Palliative Care	636	
.Repatriation Schedule	1198	
MICONAZOLE		
.DERMATOLOGICALS	190	
.Repatriation Schedule	1203	
<i>Microgynon 30 ED (BN)</i>		
.GENITO URINARY SYSTEM AND SEX HORMONES .	200	
<i>Microgynon 50 ED (BN)</i>		
.GENITO URINARY SYSTEM AND SEX HORMONES .	200	
<i>Microlax (JT)</i>		
.ALIMENTARY TRACT AND METABOLISM	81	
.Palliative Care	636	
.Repatriation Schedule	1198	
<i>Microlut 28 (BN)</i>		
.GENITO URINARY SYSTEM AND SEX HORMONES .	200	
<i>Micronelle 30 ED (TX)</i>		
.GENITO URINARY SYSTEM AND SEX HORMONES .	200	
<i>Micronor (JC)</i>		
.GENITO URINARY SYSTEM AND SEX HORMONES .	200	
MIFEPRISTONE		
.GENITO URINARY SYSTEM AND SEX HORMONES .	206	
<i>Mifepristone Linepharma (XH)</i>		
.GENITO URINARY SYSTEM AND SEX HORMONES .	206	
<i>Milivin OD 15 (DO)</i>		
.NERVOUS SYSTEM	542	
<i>Milivin OD 30 (DO)</i>		
.NERVOUS SYSTEM	542	
<i>Milivin OD 45 (DO)</i>		
.NERVOUS SYSTEM	542	
MILK POWDER LACTOSE FREE FORMULA		
.VARIOUS	618	
MILK POWDER LACTOSE FREE FORMULA PREDIGESTED		
.VARIOUS	618, 619	
MILK POWDER LACTOSE MODIFIED PREDIGESTED		
.VARIOUS	619	
MILK POWDER SYNTHETIC LOW CALCIUM		
.VARIOUS	620	
MILK PROTEIN AND FAT FORMULA WITH VITAMINS AND MINERALS CARBOHYDRATE FREE		
.VARIOUS	627	
<i>Minax 100 (AF)</i>		
.CARDIOVASCULAR SYSTEM	135	
<i>Minax 50 (AF)</i>		
.CARDIOVASCULAR SYSTEM	135	
<i>Minax XL (AF)</i>		
.CARDIOVASCULAR SYSTEM	135	
<i>Minidiab (PF)</i>		
.ALIMENTARY TRACT AND METABOLISM	91	
<i>Minipress (PF)</i>		
.CARDIOVASCULAR SYSTEM	130	
<i>Minirin (FP)</i>		
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS	209, 210	
<i>Minirin Melt (FP)</i>		
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS	209	
<i>Minirin Nasal Spray (FP)</i>		
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS	209, 210	
<i>Minitran 10 (IA)</i>		
.CARDIOVASCULAR SYSTEM	128	
<i>Minitran 15 (IA)</i>		
.CARDIOVASCULAR SYSTEM	128	
<i>Minitran 5 (IA)</i>		
.CARDIOVASCULAR SYSTEM	128	
MINOCYCLINE		
.ANTIINFECTIVES FOR SYSTEMIC USE	219	
<i>Minomycin-50 (QA)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE	219	
MINOXIDIL		
.CARDIOVASCULAR SYSTEM	131	
<i>Mircera (RO)</i>		
.Section 100	656, 657, 905	
<i>Mirena (BN)</i>		

GENERIC/PROPRIETARY INDEX

.GENITO URINARY SYSTEM AND SEX HORMONES . 198	
MIRTAZAPINE	
.NERVOUS SYSTEM..... 542	
<i>Mirtazapine AN (EA)</i>	
.NERVOUS SYSTEM..... 542	
<i>Mirtazapine AN ODT (EA)</i>	
.NERVOUS SYSTEM..... 542	
<i>Mirtazapine GH (GQ)</i>	
.NERVOUS SYSTEM..... 542	
<i>Mirtazapine Sandoz (SZ)</i>	
.NERVOUS SYSTEM..... 542	
<i>Mirtazapine Sandoz ODT 15 (SZ)</i>	
.NERVOUS SYSTEM..... 542	
<i>Mirtazapine Sandoz ODT 30 (SZ)</i>	
.NERVOUS SYSTEM..... 542	
<i>Mirtazapine Sandoz ODT 45 (SZ)</i>	
.NERVOUS SYSTEM..... 542	
<i>Mirtazapine-GA (GN)</i>	
.NERVOUS SYSTEM..... 542	
<i>Mirtazon (QA)</i>	
.NERVOUS SYSTEM..... 542	
MISOPROSTOL	
.GENITO URINARY SYSTEM AND SEX HORMONES . 198	
<i>Mistrom (ER)</i>	
.CARDIOVASCULAR SYSTEM..... 135	
<i>Mixtard 30/70 InnoLet (NI)</i>	
.ALIMENTARY TRACT AND METABOLISM..... 88	
<i>Mixtard 30/70 Penfill 3 mL (NO)</i>	
.ALIMENTARY TRACT AND METABOLISM..... 88	
<i>Mixtard 50/50 Penfill 3 mL (NO)</i>	
.ALIMENTARY TRACT AND METABOLISM..... 88	
<i>Mizart (AF)</i>	
.CARDIOVASCULAR SYSTEM..... 151	
<i>Mizart HCT 40/12.5 mg (AF)</i>	
.CARDIOVASCULAR SYSTEM..... 155	
<i>Mizart HCT 80/12.5 mg (AF)</i>	
.CARDIOVASCULAR SYSTEM..... 155	
<i>Mizart HCT 80/25 mg (AF)</i>	
.CARDIOVASCULAR SYSTEM..... 156	
<i>MMA/PA Anamix infant (SB)</i>	
.VARIOUS..... 622	
<i>MMA/PA cooler 15 (VF)</i>	
.VARIOUS..... 622	
<i>MMA/PA express 15 (VF)</i>	
.VARIOUS..... 622	
<i>MMA/PA gel (VF)</i>	
.VARIOUS..... 622	
<i>Mobic (BY)</i>	
.MUSCULO-SKELETAL SYSTEM 463, 464	
<i>Mobilis 10 (AF)</i>	
.MUSCULO-SKELETAL SYSTEM 464	
<i>Mobilis 20 (AF)</i>	
.MUSCULO-SKELETAL SYSTEM 464, 465	
<i>Mobilis D-10 (AF)</i>	
.MUSCULO-SKELETAL SYSTEM 464	
<i>Mobilis D-20 (AF)</i>	
.MUSCULO-SKELETAL SYSTEM 465	
MOCLOBEMIDE	
.NERVOUS SYSTEM..... 540	
<i>Moclobemide AN (EA)</i>	
.NERVOUS SYSTEM..... 540	
<i>Moclobemide Sandoz (SZ)</i>	
.NERVOUS SYSTEM..... 540	
MODAFINIL	
.NERVOUS SYSTEM..... 545	
<i>Modavigil (CS)</i>	
.NERVOUS SYSTEM..... 546	
<i>Modecate (BQ)</i>	
.NERVOUS SYSTEM..... 515	
<i>Moduretic (AS)</i>	
.CARDIOVASCULAR SYSTEM 133	
<i>Mogadon (IA)</i>	
.NERVOUS SYSTEM..... 500, 532, 533	
.Palliative Care..... 647	
<i>Mohexal (HX)</i>	
.NERVOUS SYSTEM..... 540	
<i>Molaxole (HM)</i>	
.ALIMENTARY TRACT AND METABOLISM..... 81	
.Palliative Care..... 635	
<i>Momasone (QA)</i>	
.DERMATOLOGICALS 194	
MOMETASONE	
.DERMATOLOGICALS 194	
.Repatriation Schedule 1206	
<i>Momex SR 10 (QA)</i>	
.NERVOUS SYSTEM..... 484	
<i>Momex SR 100 (QA)</i>	
.NERVOUS SYSTEM..... 484	
<i>Momex SR 30 (QA)</i>	
.NERVOUS SYSTEM..... 484	
<i>Momex SR 60 (QA)</i>	
.NERVOUS SYSTEM..... 484	
<i>Monace 10 (AF)</i>	
.CARDIOVASCULAR SYSTEM 141	
<i>Monace 20 (AF)</i>	
.CARDIOVASCULAR SYSTEM 141	
<i>Monodur 120 mg (PM)</i>	
.CARDIOVASCULAR SYSTEM 129	
<i>Monodur 60 mg (PM)</i>	
.CARDIOVASCULAR SYSTEM 129	
<i>Monofeme 28 (FZ)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES . 200	
<i>Monogen (SB)</i>	
.VARIOUS..... 618	
<i>Monoplus 10/12.5 (BQ)</i>	
.CARDIOVASCULAR SYSTEM 146	
<i>Monoplus 20/12.5 (BQ)</i>	
.CARDIOVASCULAR SYSTEM 146	
<i>Monopril (BQ)</i>	
.CARDIOVASCULAR SYSTEM 141	

GENERIC/PROPRIETARY INDEX

<i>Montair 4 (GN)</i>		.NERVOUS SYSTEM.....484
.RESPIRATORY SYSTEM	573	
<i>Montair 5 (GN)</i>		.NERVOUS SYSTEM.....484
.RESPIRATORY SYSTEM	574	
MONTELUKAST		.NERVOUS SYSTEM.....485
.RESPIRATORY SYSTEM	573, 574	
<i>Montelukast AN (EA)</i>		<i>MS Contin Suspension 30 mg (MF)</i>
.RESPIRATORY SYSTEM	573, 574	.NERVOUS SYSTEM.....483
<i>Montelukast GH (GQ)</i>		<i>MS Contin Suspension 60 mg (MF)</i>
.RESPIRATORY SYSTEM	573, 574	.NERVOUS SYSTEM.....484
<i>Montelukast RBX (RA)</i>		<i>MS Mono (MF)</i>
.RESPIRATORY SYSTEM	573, 574	.NERVOUS SYSTEM.....484
<i>Montelukast Sandoz 4 (SZ)</i>		<i>MSUD AID III (SB)</i>
.RESPIRATORY SYSTEM	573	.VARIOUS.....624
<i>Montelukast Sandoz 5 (SZ)</i>		<i>MSUD amino5 (VF)</i>
.RESPIRATORY SYSTEM	574	.VARIOUS.....620
MORPHINE		<i>MSUD Anamix infant (SB)</i>
.NERVOUS SYSTEM.....	483, 484, 485	.VARIOUS.....624
.Palliative Care	642	<i>MSUD Anamix Junior (SB)</i>
.Repatriation Schedule.....	1216	.VARIOUS.....624
<i>MORPHINE MR APOTEX (TX)</i>		<i>MSUD Anamix Junior LQ (SB)</i>
.NERVOUS SYSTEM.....	484	.VARIOUS.....624
<i>Motilium (JC)</i>		<i>MSUD cooler 10 (VF)</i>
.ALIMENTARY TRACT AND METABOLISM.....	73	.VARIOUS.....624
<i>Movalis 15 (QA)</i>		<i>MSUD cooler 15 (VF)</i>
.MUSCULO-SKELETAL SYSTEM	463	.VARIOUS.....624
<i>Movalis 7.5 (QA)</i>		<i>MSUD cooler 20 (VF)</i>
.MUSCULO-SKELETAL SYSTEM	464	.VARIOUS.....624
<i>Movicol (NE)</i>		<i>MSUD express 15 (VF)</i>
.ALIMENTARY TRACT AND METABOLISM.....	81	.VARIOUS.....624
.Palliative Care	635	<i>MSUD express 20 (VF)</i>
<i>Movicol Liquid (NE)</i>		.VARIOUS.....623
.ALIMENTARY TRACT AND METABOLISM.....	81	<i>MSUD gel (VF)</i>
.Palliative Care	635	.VARIOUS.....624
<i>Movox 100 (AF)</i>		<i>MSUD Lophlex LQ 20 (SB)</i>
.NERVOUS SYSTEM.....	538	.VARIOUS.....623
<i>Movox 50 (AL)</i>		<i>MSUD Maxamaid (SB)</i>
.NERVOUS SYSTEM.....	538	.VARIOUS.....624
<i>Moxicam 15 (AF)</i>		<i>MSUD Maxamum (SB)</i>
.MUSCULO-SKELETAL SYSTEM	463	.VARIOUS.....624
<i>Moxicam 7.5 (AF)</i>		MUPIROCIN
.MUSCULO-SKELETAL SYSTEM	464	.Repatriation Schedule
<i>Moxiclav Duo 500/125 (QA)</i>		1205
.ANTIINFECTIVES FOR SYSTEMIC USE.....	224	.RESPIRATORY SYSTEM.....
<i>Moxiclav Duo Forte 875/125 (QA)</i>		564
.ANTIINFECTIVES FOR SYSTEMIC USE.....	225	<i>Murelax (FM)</i>
MOXONIDINE		.NERVOUS SYSTEM.....532
.CARDIOVASCULAR SYSTEM	130	.Palliative Care.....
<i>Mozobil (GZ)</i>		646, 647
.Section 100	749, 1001	<i>Mycobutin (PF)</i>
<i>MS Contin (MF)</i>		.Section 100.....
.NERVOUS SYSTEM.....	484, 485	708, 957
.Palliative Care	642	MYCOPHENOLATE
.Repatriation Schedule.....	1216	.ANTINEOPLASTIC AND IMMUNOMODULATING
<i>MS Contin Suspension 100 mg (MF)</i>		AGENTS
		306, 307
		.Section 100.....
		771, 1023, 1024
		<i>Mycophenolate Sandoz (SZ)</i>
		.ANTINEOPLASTIC AND IMMUNOMODULATING
		AGENTS
		307
		.Section 100.....
		771, 772, 1024

GENERIC/PROPRIETARY INDEX

<i>Mycostatin (FM)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	66
.DERMATOLOGICALS.....	190
.Repatriation Schedule.....	1203
<i>Myfortic (NV)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	306, 307
.Section 100	771, 1023
<i>MyGlucoHealth (EH)</i>	
.VARIOUS.....	600, 601
<i>Mylanta Double Strength (JT)</i>	
.Repatriation Schedule.....	1197
<i>Mylanta P (JT)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	66
<i>Myleran (AS)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	251
<i>Myocrisin (SW)</i>	
.MUSCULO-SKELETAL SYSTEM	468
<i>Mysoline (LM)</i>	
.NERVOUS SYSTEM.....	499

N

NAFARELIN	
.Section 100	1159
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
HORMONES AND INSULINS.....	210
NALOXONE	
.VARIOUS.....	596
<i>Naloxone minijet (UC)</i>	
.Prescriber Bag	63
.VARIOUS.....	596
NALTREXONE	
.NERVOUS SYSTEM.....	558
<i>Naltrexone GH (GQ)</i>	
.NERVOUS SYSTEM.....	558
NANDROLONE DECANOATE	
.ALIMENTARY TRACT AND METABOLISM.....	106
NAPHAZOLINE	
.Repatriation Schedule.....	1222
NAPHAZOLINE + ANTAZOLINE	
.Repatriation Schedule.....	1222
<i>Naprosyn (RO)</i>	
.MUSCULO-SKELETAL SYSTEM	465, 466
.Palliative Care	640
<i>Naprosyn SR1000 (RO)</i>	
.MUSCULO-SKELETAL SYSTEM	465
.Palliative Care	640
<i>Naprosyn SR750 (RO)</i>	
.MUSCULO-SKELETAL SYSTEM	466
.Palliative Care	640
NAPROXEN	
.MUSCULO-SKELETAL SYSTEM	465, 466
.Palliative Care	640, 641

<i>Naramig (AS)</i>	
.NERVOUS SYSTEM.....	496, 497
NARATRIPTAN	
.NERVOUS SYSTEM.....	496
<i>Nardil (LM)</i>	
.NERVOUS SYSTEM.....	540
NATALIZUMAB	
.Section 100.....	772, 1024
<i>Natrilix (SE)</i>	
.CARDIOVASCULAR SYSTEM	131
<i>Natrilix SR (SE)</i>	
.CARDIOVASCULAR SYSTEM	131
<i>Navelbine (FB)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	254
<i>Nebilet (FK)</i>	
.CARDIOVASCULAR SYSTEM	136
NEBIVOLOL	
.CARDIOVASCULAR SYSTEM	135
NEDOCROMIL	
.RESPIRATORY SYSTEM.....	572
<i>Neo-B12 (HH)</i>	
.BLOOD AND BLOOD FORMING ORGANS.....	123
<i>Neocate Advance (SB)</i>	
.VARIOUS.....	603, 605
<i>Neocate Advance Vanilla (SB)</i>	
.VARIOUS.....	603, 605, 606
<i>Neocate Gold (SB)</i>	
.VARIOUS.....	609, 612, 614
<i>Neocate LCP (SB)</i>	
.VARIOUS.....	607, 608
<i>Neo-Mercazole (LM)</i>	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
HORMONES AND INSULINS	215
<i>Neoral (NV)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	460
.Section 100.....	869, 1121
<i>Neoral 10 (NV)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	460
.Section 100.....	868, 1121
<i>Neoral 100 (NV)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	460
.Section 100.....	869, 1121
<i>Neoral 25 (NV)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	460
.Section 100.....	869, 1121
<i>Neoral 50 (NV)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	460
.Section 100.....	869, 1121
<i>NeoRecormon (RO)</i>	

GENERIC/PROPRIETARY INDEX

.Section 100	656, 904	<i>Nicorette Patch (JT)</i>	
<i>Neotigason (UA)</i>		.Repatriation Schedule	1218
.DERMATOLOGICALS	192	NICOTINE	
<i>Nesina (TK)</i>		.NERVOUS SYSTEM	555, 556
.ALIMENTARY TRACT AND METABOLISM	99	.Repatriation Schedule	1218
<i>Nesina Met 12.5/1000 (TK)</i>		<i>Nicotinell Step 1 (NC)</i>	
.ALIMENTARY TRACT AND METABOLISM	91	.NERVOUS SYSTEM	555, 557
<i>Nesina Met 12.5/500 (TK)</i>		<i>Nicotinell Step 2 (NC)</i>	
.ALIMENTARY TRACT AND METABOLISM	91	.NERVOUS SYSTEM	555
<i>Nesina Met 12.5/850 (TK)</i>		<i>Nicotinell Step 3 (NC)</i>	
.ALIMENTARY TRACT AND METABOLISM	91	.NERVOUS SYSTEM	555
<i>Neulactil (SW)</i>		<i>Nidem (QA)</i>	
.NERVOUS SYSTEM	515	.ALIMENTARY TRACT AND METABOLISM	90
<i>Neulasta (AN)</i>		NIFEDIPINE	
.Section 100	731, 983	.CARDIOVASCULAR SYSTEM	138
<i>Neupogen (AN)</i>		<i>Nifehexal (SZ)</i>	
.Section 100	729, 730, 981	.CARDIOVASCULAR SYSTEM	138
<i>Neupro (UC)</i>		NILOTINIB	
.NERVOUS SYSTEM	514	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>Neurontin (PF)</i>		AGENTS	275, 276
.NERVOUS SYSTEM	502, 503	<i>Nilstat (QA)</i>	
.Repatriation Schedule	1216, 1217	.ALIMENTARY TRACT AND METABOLISM	66, 82
<i>Nevipin (GN)</i>		.Repatriation Schedule	1209
.Section 100	721, 971	NILUTAMIDE	
NEVIRAPINE		.ANTINEOPLASTIC AND IMMUNOMODULATING	
.Section 100	721, 971	AGENTS	289
<i>Nevirapine Alphapharm (AF)</i>		NITRAZEPAM	
.Section 100	721, 971	.NERVOUS SYSTEM	500, 532, 533
<i>Nevirapine RBX (RA)</i>		.Palliative Care	647
.Section 100	721, 971	<i>Nitro-Dur 10 (MK)</i>	
<i>Nexavar (BN)</i>		.CARDIOVASCULAR SYSTEM	128
.ANTINEOPLASTIC AND IMMUNOMODULATING		<i>Nitro-Dur 15 (MK)</i>	
AGENTS	282	.CARDIOVASCULAR SYSTEM	128
<i>Nexcare Durable Cloth First Aid Tape 799 (MM)</i>		<i>Nitro-Dur 5 (MK)</i>	
.Repatriation Schedule	1240	.CARDIOVASCULAR SYSTEM	128
<i>Nexcare Gentle Paper First Aid Tape 789 (MM)</i>		NITROFURANTOIN	
.Repatriation Schedule	1240	.ANTIINFECTIVES FOR SYSTEMIC USE	240
<i>Nexcare Tegaderm Transparent H1624 (MM)</i>		<i>Nitrolingual Pumpspray (SW)</i>	
.Repatriation Schedule	1231	.CARDIOVASCULAR SYSTEM	128
<i>Nexcare Tegaderm Transparent H1626 (MM)</i>		.Prescriber Bag	62
.Repatriation Schedule	1231	<i>Nivestim (HH)</i>	
<i>Nexium (AP)</i>		.Section 100	729, 730, 981
.ALIMENTARY TRACT AND METABOLISM	68	<i>Nizac (LN)</i>	
<i>Nexium Hp7 (AP)</i>		.ALIMENTARY TRACT AND METABOLISM	67
.ALIMENTARY TRACT AND METABOLISM	73	NIZATIDINE	
<i>Nicabate CQ 14 (GC)</i>		.ALIMENTARY TRACT AND METABOLISM	67
.Repatriation Schedule	1218	<i>Nizoral 1% (JT)</i>	
<i>Nicabate CQ 21 (GC)</i>		.DERMATOLOGICALS	190
.Repatriation Schedule	1218	<i>Nizoral 2% (JT)</i>	
<i>Nicabate P (GC)</i>		.DERMATOLOGICALS	190
.NERVOUS SYSTEM	556	.Repatriation Schedule	1203
NICORANDIL		<i>Nizoral 2% Cream (JT)</i>	
.CARDIOVASCULAR SYSTEM	129	.DERMATOLOGICALS	190
<i>nicorette 16hr Invisipatch (JT)</i>		<i>Nolvadex-D (AP)</i>	
.NERVOUS SYSTEM	556		

GENERIC/PROPRIETARY INDEX

.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	287
<i>Nordette 28 (PF)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES . 200	
<i>Nordip (AF)</i>	
.CARDIOVASCULAR SYSTEM	137
<i>Norditropin FlexPro (NO)</i>	
.Section 100	1157
<i>Norditropin SimpleXx (NO)</i>	
.Section 100	1156, 1157
NORETHISTERONE	
.GENITO URINARY SYSTEM AND SEX HORMONES 200,	
203	
NORETHISTERONE ACETATE + OESTRADIOL	
.GENITO URINARY SYSTEM AND SEX HORMONES . 203	
NORETHISTERONE ACETATE + OESTRADIOL (&)	
OESTRADIOL	
.GENITO URINARY SYSTEM AND SEX HORMONES . 203	
NORFLOXACIN	
.ANTIINFECTIVES FOR SYSTEMIC USE	238
<i>Norfloxacin AN (EA)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	238
<i>Norfloxacin Sandoz (SZ)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	238
<i>Norfloxacin-GA (GN)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	238
<i>Noriday 28 Day (PF)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES . 200	
<i>Norimin 28 Day (FZ)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES . 200	
<i>Norimin-1 28 Day (FZ)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES . 200	
<i>Norinyl-1/28 (PF)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES . 200	
<i>Normacol Plus (NE)</i>	
.ALIMENTARY TRACT AND METABOLISM	79
.Palliative Care	633, 634
.Repatriation Schedule	1198
<i>Normison (QA)</i>	
.NERVOUS SYSTEM	533
.Palliative Care	647
<i>Norprolac (FP)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES . 199	
<i>Norspan (MF)</i>	
.NERVOUS SYSTEM	491
NORTRIPTYLINE	
.NERVOUS SYSTEM	535
<i>Norvapine (GN)</i>	
.CARDIOVASCULAR SYSTEM	137
<i>Norvasc (PF)</i>	
.CARDIOVASCULAR SYSTEM	137, 138
<i>Norvir (VE)</i>	
.Section 100	712, 961, 962
<i>Noten (AF)</i>	
.CARDIOVASCULAR SYSTEM	134
<i>Novasone (FR)</i>	
.DERMATOLOGICALS	194
<i>Novatin (TX)</i>	
.DERMATOLOGICALS	192
<i>Novicrit (NV)</i>	
.Section 100	656, 904
<i>NovoMix 30 FlexPen (NF)</i>	
.ALIMENTARY TRACT AND METABOLISM	88
<i>NovoMix 30 Penfill 3 mL (NO)</i>	
.ALIMENTARY TRACT AND METABOLISM	88
<i>NovoRapid (NO)</i>	
.ALIMENTARY TRACT AND METABOLISM	87
<i>NovoRapid FlexPen (NF)</i>	
.ALIMENTARY TRACT AND METABOLISM	87
<i>NovoRapid Penfill 3 mL (NO)</i>	
.ALIMENTARY TRACT AND METABOLISM	87
<i>Noxafil (MK)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	242
<i>Nplate (AN)</i>	
.Section 100	655, 903
<i>Nuelin (IA)</i>	
.RESPIRATORY SYSTEM	573
<i>Nuelin-SR 200 (IA)</i>	
.RESPIRATORY SYSTEM	573
<i>Nuelin-SR 250 (IA)</i>	
.RESPIRATORY SYSTEM	573
<i>Nuelin-SR 300 (IA)</i>	
.RESPIRATORY SYSTEM	573
<i>Nufloxib (AF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	238
<i>Nu-Gel 2497 (JJ)</i>	
.Repatriation Schedule	1238
<i>Nupentin 100 (AF)</i>	
.NERVOUS SYSTEM	502
.Repatriation Schedule	1216
<i>Nupentin 300 (AF)</i>	
.NERVOUS SYSTEM	503
.Repatriation Schedule	1216
<i>Nupentin 400 (AF)</i>	
.NERVOUS SYSTEM	503
.Repatriation Schedule	1217
<i>Nupentin Tabs (AF)</i>	
.NERVOUS SYSTEM	503
.Repatriation Schedule	1217
<i>NutropinAq (IS)</i>	
.Section 100	1157
<i>Nyogel (AS)</i>	
.SENSORY ORGANS	581
NYSTATIN	
.ALIMENTARY TRACT AND METABOLISM	66, 82
.DERMATOLOGICALS	190
.Repatriation Schedule	1203, 1209

GENERIC/PROPRIETARY INDEX

O

<i>O.R.S. (AS)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	83
<i>OCTREOTIDE</i>	
.Section 100	706, 954
<i>Octreotide (SUN) (ZF)</i>	
.Section 100	707, 955
<i>Octreotide MaxRx (GQ)</i>	
.Section 100	707, 955
<i>Ocufen (AG)</i>	
.SENSORY ORGANS.....	578
<i>Ocuflox (AG)</i>	
.SENSORY ORGANS.....	576, 577
<i>OESTRADIOL</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES	201, 202
<i>OESTRADIOL (&) OESTRADIOL + DYDROGESTERONE</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES	. 203
<i>OESTRADIOL + DYDROGESTERONE</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES	. 203
<i>OESTRIOL</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES	. 202
<i>OFLOXACIN</i>	
.SENSORY ORGANS.....	576, 577
<i>OLANZAPINE</i>	
.NERVOUS SYSTEM.....	517, 518, 519, 520, 521, 522
<i>Olanzapine AN (EA)</i>	
.NERVOUS SYSTEM.....	518, 520, 522, 523
<i>Olanzapine AN ODT (EA)</i>	
.NERVOUS SYSTEM.....	517, 518, 519, 520
<i>Olanzapine generichealth 10 (GQ)</i>	
.NERVOUS SYSTEM.....	518
<i>Olanzapine generichealth 2.5 (GQ)</i>	
.NERVOUS SYSTEM.....	520
<i>Olanzapine generichealth 5 (GQ)</i>	
.NERVOUS SYSTEM.....	521
<i>Olanzapine generichealth 7.5 (GQ)</i>	
.NERVOUS SYSTEM.....	522
<i>Olanzapine GH (GQ)</i>	
.NERVOUS SYSTEM.....	518, 522, 523
<i>Olanzapine ODT generichealth 10 (GQ)</i>	
.NERVOUS SYSTEM.....	517
<i>Olanzapine ODT generichealth 5 (GQ)</i>	
.NERVOUS SYSTEM.....	518
<i>Olanzapine ODT-DRLA (RZ)</i>	
.NERVOUS SYSTEM.....	517, 518
<i>Olanzapine RBX (RA)</i>	
.NERVOUS SYSTEM.....	518, 520, 522, 523
<i>Olanzapine RBX ODT (RA)</i>	
.NERVOUS SYSTEM.....	517, 518
<i>Olanzapine Sandoz (SZ)</i>	
.NERVOUS SYSTEM.....	518, 520, 522, 523
<i>Olanzapine Sandoz ODT 10 (SZ)</i>	
.NERVOUS SYSTEM.....	517
<i>Olanzapine Sandoz ODT 5 (SZ)</i>	
.NERVOUS SYSTEM.....	518
<i>Olanzapine-DRLA (RZ)</i>	
.NERVOUS SYSTEM.....	518, 520, 522, 523
<i>Olanzapine-GA (GN)</i>	
.NERVOUS SYSTEM.....	518, 520, 522, 523
<i>Olanzapine-GA ODT (GN)</i>	
.NERVOUS SYSTEM.....	517, 518
<i>OLMESARTAN + AMLODIPINE + HYDROCHLOROTHIAZIDE</i>	
.CARDIOVASCULAR SYSTEM	158
<i>OLMESARTAN MEDOXOMIL</i>	
.CARDIOVASCULAR SYSTEM	151
<i>OLMESARTAN MEDOXOMIL + AMLODIPINE</i>	
.CARDIOVASCULAR SYSTEM	157
<i>OLMESARTAN MEDOXOMIL + HYDROCHLOROTHIAZIDE</i>	
.CARDIOVASCULAR SYSTEM	155
<i>Olmetec (MK)</i>	
.CARDIOVASCULAR SYSTEM	151
<i>Olmetec Plus (MK)</i>	
.CARDIOVASCULAR SYSTEM	155
<i>OLSALAZINE</i>	
.ALIMENTARY TRACT AND METABOLISM.....	85
<i>Olysio (JC)</i>	
.Section 100.....	714, 963
<i>OMALIZUMAB</i>	
.Section 100.....	887, 1139
<i>Omegapharm Pty Ltd (OE)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	232
<i>Omepral (TX)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	70
<i>OMEPRAZOLE</i>	
.ALIMENTARY TRACT AND METABOLISM.....	69, 70
<i>Omeprazole AN (EA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	69, 70
<i>Omeprazole generichealth (GQ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	70
<i>Omeprazole RBX (RA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	70
<i>Omeprazole Sandoz (HX)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	69, 70
<i>Omeprazole Sandoz (SZ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	70
<i>Omeprazole-GA (GN)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	70
<i>Omepro-GA (GN)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	69, 70
<i>Omnitrope (SZ)</i>	
.Section 100.....	1156
<i>Onbrez (NV)</i>	
.RESPIRATORY SYSTEM.....	564
<i>OncoTICE (MK)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	294
<i>ONDANSETRON</i>	
.ALIMENTARY TRACT AND METABOLISM.....	74, 75, 76

GENERIC/PROPRIETARY INDEX

<i>Ondansetron Alphapharm (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	75, 76
<i>Ondansetron AN (EA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	75, 76
<i>Ondansetron AN ODT (EA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	74, 75
<i>Ondansetron Kabi (PK)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	75, 76
<i>Ondansetron ODT-DRLA (RZ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	74, 75
<i>Ondansetron-Claris (AE)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	75, 76
<i>Ondansetron-DRLA (RZ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	75, 76
<i>Ondaz (SZ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	75, 76
<i>Ondaz Zydys (SZ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	74, 75
<i>OneTouch Select (JJ)</i>	
.VARIOUS.....	599, 600
<i>OneTouch Verio (JJ)</i>	
.VARIOUS.....	600, 601
<i>Onglyza (AP)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	100
<i>Onsetron (ZP)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	76
<i>Onsetron 4 (ZP)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	75, 76
<i>Onsetron 8 (ZP)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	76
<i>Onsetron ODT 4 (GN)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	74, 75
<i>Onsetron ODT 8 (GN)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	75
<i>Op-Site Flexigrid 4629 (SN)</i>	
.Repatriation Schedule.....	1230
<i>Opsumit (AT)</i>	
.Section 100	692, 940
<i>Opticrom (SW)</i>	
.SENSORY ORGANS.....	584
<i>Optifresh eye gel (PP)</i>	
.SENSORY ORGANS.....	589
<i>Optifresh Plus (PP)</i>	
.SENSORY ORGANS.....	589
<i>Optifresh Tears (PP)</i>	
.SENSORY ORGANS.....	589, 590
<i>Optium Omega (MS)</i>	
.VARIOUS.....	600
<i>Optive (AG)</i>	
.SENSORY ORGANS.....	590
<i>Orabase (QA)</i>	
.Repatriation Schedule.....	1204
<i>Oratane (GN)</i>	
.DERMATOLOGICALS.....	195, 196
<i>Ordine 10 (MF)</i>	
.NERVOUS SYSTEM.....	484, 485
<i>Ordine 2 (MF)</i>	
.NERVOUS SYSTEM.....	484, 485
<i>Ordine 5 (MF)</i>	
.NERVOUS SYSTEM.....	484, 485
<i>Orencia (BQ)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	301, 305
.Section 100.....	760, 1012
<i>Orgalutran (MK)</i>	
.Section 100.....	1159
<i>Orion Temozolomide (ON)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	251, 252, 253
<i>Oriprio (ON)</i>	
.Section 100.....	1160
ORLISTAT	
.Repatriation Schedule	1198
<i>Oroxine (QA)</i>	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
HORMONES AND INSULINS	214
<i>Orudis (SW)</i>	
.MUSCULO-SKELETAL SYSTEM	465
<i>Orudis SR 200 (SW)</i>	
.MUSCULO-SKELETAL SYSTEM	465
<i>Oruvail SR (AV)</i>	
.MUSCULO-SKELETAL SYSTEM	465
<i>OsmoLax (KY)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	80
.Palliative Care.....	634, 635
<i>Ospolot (PL)</i>	
.NERVOUS SYSTEM.....	508
<i>Ossmax 70mg (RA)</i>	
.MUSCULO-SKELETAL SYSTEM	470
<i>Osteomol 665 Paracetamol (CR)</i>	
.NERVOUS SYSTEM.....	495
.Palliative Care.....	644, 645
<i>Otocomb Otic (FM)</i>	
.SENSORY ORGANS.....	595
<i>Otodex (AV)</i>	
.SENSORY ORGANS.....	594
<i>Ovestin (AS)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	202
<i>Ovestin Ovula (AS)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	202
<i>Ovidrel (SG)</i>	
.Section 100.....	1158
OXAZEPAM	
.NERVOUS SYSTEM.....	532
.Palliative Care.....	646
OXCARBAZEPINE	
.NERVOUS SYSTEM.....	501
<i>Oxis Turbuhaler (AP)</i>	
.RESPIRATORY SYSTEM.....	564
OXPRENOLOL	

GENERIC/PROPRIETARY INDEX

.CARDIOVASCULAR SYSTEM	133
OXYBUTYNIN	
.GENITO URINARY SYSTEM AND SEX HORMONES .	207
<i>Oxybutynin Sandoz (SZ)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	207
<i>Oxybutynin Winthrop (WA)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	207
OXYCODONE	
.NERVOUS SYSTEM.....	485, 486
OXYCODONE + NALOXONE	
.NERVOUS SYSTEM.....	487
<i>Oxycodone Sandoz (SZ)</i>	
.NERVOUS SYSTEM.....	486, 487
<i>OxyContin (MF)</i>	
.NERVOUS SYSTEM.....	487
OXYMETAZOLINE	
.Repatriation Schedule.....	1220
<i>OxyNorm (MF)</i>	
.NERVOUS SYSTEM.....	486
<i>OxyNorm Liquid 5mg/5mL (MF)</i>	
.NERVOUS SYSTEM.....	486
<i>Oxytrol (GN)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	207
<i>Ozapace (RA)</i>	
.CARDIOVASCULAR SYSTEM	142, 143
<i>Ozcef (RA)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	229
<i>Oziclide MR (RA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	90
<i>Ozidal (RA)</i>	
.NERVOUS SYSTEM.....	527, 528, 529, 530
<i>Ozin 10 (DO)</i>	
.NERVOUS SYSTEM.....	518
<i>Ozin 2.5 (DO)</i>	
.NERVOUS SYSTEM.....	520
<i>Ozin 5 (DO)</i>	
.NERVOUS SYSTEM.....	522
<i>Ozin 7.5 (DO)</i>	
.NERVOUS SYSTEM.....	523
<i>Ozlodip (RA)</i>	
.CARDIOVASCULAR SYSTEM	137
<i>Ozmep (ZP)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	70
<i>Ozole (RA)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	241
<i>Ozpan (RA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	70, 71
<i>Ozvir (RA)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	245

P

<i>PAA (IQ)</i>	
.SENSORY ORGANS.....	589
<i>Paediatric Seravit (SB)</i>	

.VARIOUS.....	629
<i>Palexia SR (CS)</i>	
.NERVOUS SYSTEM.....	492
PALIPERIDONE	
.NERVOUS SYSTEM.....	526
PALONOSETRON	
.ALIMENTARY TRACT AND METABOLISM.....	76
<i>Pamacid 20 (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	66
<i>Pamacid 40 (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	67
PAMIDRONATE DISODIUM	
.MUSCULO-SKELETAL SYSTEM	471
.Section 100.....	884, 1136, 1137
<i>Pamisol (HH)</i>	
.MUSCULO-SKELETAL SYSTEM	471
.Section 100.....	884, 885, 1136, 1137
<i>Panadeine Forte (SW)</i>	
.NERVOUS SYSTEM.....	487, 488
<i>Panadol (GC)</i>	
.Palliative Care.....	644, 645
<i>Panadol Osteo (GC)</i>	
.NERVOUS SYSTEM.....	495
.Palliative Care.....	645
<i>Panafcort (AS)</i>	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS	213
<i>Panafcortelone (AS)</i>	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS	213
<i>Panamax (SW)</i>	
.NERVOUS SYSTEM.....	494, 495
<i>Panamax 240 Elixir (SW)</i>	
.NERVOUS SYSTEM.....	494
<i>Panamax Co. 40 (SW)</i>	
.Repatriation Schedule	1216
PANCREATIC EXTRACT	
.ALIMENTARY TRACT AND METABOLISM.....	86
PANCRELIPASE	
.ALIMENTARY TRACT AND METABOLISM.....	87
PANTHENOL	
.Repatriation Schedule	1207
<i>Panthron (ER)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	70, 71
<i>Panto (TK)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	71
<i>Pantofast 20 (RZ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	71
<i>Pantofast 40 (RZ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	71
PANTOPRAZOLE	
.ALIMENTARY TRACT AND METABOLISM.....	70, 71
<i>Pantoprazole Actavis (GN)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	71
<i>Pantoprazole AN (EA)</i>	

GENERIC/PROPRIETARY INDEX

.ALIMENTARY TRACT AND METABOLISM.....	71
<i>Pantoprazole generichealth (GQ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	71
<i>Pantoprazole Sandoz (SZ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	71
<i>Pantoprazole-GA (GN)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	71
<i>Pantoprazole-GA (UA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	71
<i>Panzytrat 25000 (TM)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	87
PAPER WASP VENOM	
.VARIOUS.....	596
PARACETAMOL	
.NERVOUS SYSTEM.....	494, 495
.Palliative Care	644, 645
<i>Paracetamol (Sandoz) (SZ)</i>	
.NERVOUS SYSTEM.....	494, 495
PARACETAMOL + CODEINE	
.NERVOUS SYSTEM.....	487, 488
.Repatriation Schedule	1216
<i>Paracetamol/Codeine GH 500/30 (GQ)</i>	
.NERVOUS SYSTEM.....	487, 488
PARAFFIN	
.SENSORY ORGANS.....	591, 592
PARAFFIN LIGHT LIQUID + COCOAMPHODIACETATE	
DISODIUM	
.Repatriation Schedule	1207
<i>Paralgin (FM)</i>	
.NERVOUS SYSTEM.....	494, 495
<i>Parapane (AF)</i>	
.NERVOUS SYSTEM.....	494, 495
<i>Pariet (JC)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	72
<i>Parlodel (NV)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES	198, 199
.NERVOUS SYSTEM.....	512
<i>Parnate (GH)</i>	
.NERVOUS SYSTEM.....	540
PAROXETINE	
.NERVOUS SYSTEM.....	538
<i>Paroxetine AN (EA)</i>	
.NERVOUS SYSTEM.....	539
<i>Paroxetine generichealth (GQ)</i>	
.NERVOUS SYSTEM.....	539
<i>Paroxetine Sandoz (SZ)</i>	
.NERVOUS SYSTEM.....	539
<i>Paroxetine-GA (GN)</i>	
.NERVOUS SYSTEM.....	539
<i>Parzol 10 (ZP)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	72
<i>Parzol 20 (ZP)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	72
<i>Paxam 0.5 (AF)</i>	
.NERVOUS SYSTEM.....	500
.Palliative Care.....	645
<i>Paxam 2 (AF)</i>	
.NERVOUS SYSTEM.....	500
.Palliative Care.....	645
<i>Paxtine (AF)</i>	
.NERVOUS SYSTEM.....	539
PAZOPANIB	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	278, 279, 280, 281
<i>Peg 7420 (MM)</i>	
.Repatriation Schedule	1227
<i>Peg 7422 (MM)</i>	
.Repatriation Schedule	1227
<i>Peg 7423 (MM)</i>	
.Repatriation Schedule	1227
<i>Peg 7425 (MM)</i>	
.Repatriation Schedule	1227
<i>Pegasys (RO)</i>	
.Section 100.....	733, 985
<i>Pegasys RBV (RO)</i>	
.Section 100.....	737, 989
<i>Pegatron (MK)</i>	
.Section 100.....	744, 749, 996, 1001
PEGFILGRASTIM	
.Section 100.....	730, 982
PEGINTERFERON ALFA-2A	
.Section 100.....	732, 984
PEGINTERFERON ALFA-2A (&) RIBAVIRIN	
.Section 100.....	733, 985
PEGINTERFERON ALFA-2B (&) RIBAVIRIN	
.Section 100.....	737, 744, 989, 997
<i>Pemzo (QA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	69, 70
PENICILLAMINE	
.MUSCULO-SKELETAL SYSTEM	468
<i>Pentasa (FP)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	84, 85
PENTASTARCH + SODIUM CHLORIDE	
.BLOOD AND BLOOD FORMING ORGANS.....	124
<i>Penthrox (DV)</i>	
.Prescriber Bag	63
<i>Peptamen Junior (NT)</i>	
.VARIOUS.....	618
<i>Pepzan (GN)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	67
PERAMPANEL	
.NERVOUS SYSTEM.....	507, 508
PERHEXILINE	
.CARDIOVASCULAR SYSTEM	129
<i>Periactin (AS)</i>	
.NERVOUS SYSTEM.....	498
PERICYAZINE	
.NERVOUS SYSTEM.....	515
<i>Perindo (AF)</i>	

GENERIC/PROPRIETARY INDEX

.CARDIOVASCULAR SYSTEM	142, 143
<i>Perindo Combi 4/1.25 (AF)</i>	
.CARDIOVASCULAR SYSTEM	147
PERINDOPRIL	
.CARDIOVASCULAR SYSTEM	142
PERINDOPRIL + AMLODIPINE	
.CARDIOVASCULAR SYSTEM	147
PERINDOPRIL + INDAPAMIDE	
.CARDIOVASCULAR SYSTEM	146
<i>Perindopril Actavis 2 (UA)</i>	
.CARDIOVASCULAR SYSTEM	142
<i>Perindopril Actavis 4 (UA)</i>	
.CARDIOVASCULAR SYSTEM	143
<i>Perindopril Actavis 8 (UA)</i>	
.CARDIOVASCULAR SYSTEM	142
<i>Perindopril and Indapamide CH 4/1.25 (EA)</i>	
.CARDIOVASCULAR SYSTEM	147
<i>Perindopril CH (EA)</i>	
.CARDIOVASCULAR SYSTEM	142, 143
<i>Perindopril Combi Actavis 4/1.25 (GN)</i>	
.CARDIOVASCULAR SYSTEM	147
<i>Perindopril generichealth (GQ)</i>	
.CARDIOVASCULAR SYSTEM	142, 143
<i>Perindopril/ Indapamide GH 4/1.25 (GQ)</i>	
.CARDIOVASCULAR SYSTEM	147
PERMETHRIN	
.ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS	563
<i>Persantin SR (BY)</i>	
.BLOOD AND BLOOD FORMING ORGANS	112
<i>Petrus Bisacodyl Suppositories (PP)</i>	
.ALIMENTARY TRACT AND METABOLISM	79
.Palliative Care	633
<i>Petrus Pharmaceuticals Pty Ltd (PP)</i>	
.ALIMENTARY TRACT AND METABOLISM	82
.Palliative Care	637
.Repatriation Schedule	1198
<i>Pexsig (QA)</i>	
.CARDIOVASCULAR SYSTEM	129
<i>Pfizer Australia Pty Ltd (PF)</i>	
.ALIMENTARY TRACT AND METABOLISM	73
.ANTIINFECTIVES FOR SYSTEMIC USE	235, 237
.BLOOD AND BLOOD FORMING ORGANS	109
.CARDIOVASCULAR SYSTEM	126
.Prescriber Bag	62, 63
<i>Pharmacor AmoxyClav 500/125 (CR)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	224, 225
<i>Pharmacor AmoxyClav 875/125 (CR)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	225
<i>Pharmacor Anastrozole 1 (CR)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	290
<i>Pharmacor Candesartan 16 (CR)</i>	
.CARDIOVASCULAR SYSTEM	149
<i>Pharmacor Candesartan 32 (CR)</i>	
.CARDIOVASCULAR SYSTEM	149
<i>Pharmacor Candesartan 4 (CR)</i>	
.CARDIOVASCULAR SYSTEM	149
<i>Pharmacor Candesartan 8 (CR)</i>	
.CARDIOVASCULAR SYSTEM	149
<i>Pharmacor Candesartan HCT 16/12.5 (CR)</i>	
.CARDIOVASCULAR SYSTEM	152
<i>Pharmacor Candesartan HCT 32/12.5 (CR)</i>	
.CARDIOVASCULAR SYSTEM	153
<i>Pharmacor Candesartan HCT 32/25 (CR)</i>	
.CARDIOVASCULAR SYSTEM	153
<i>Pharmacor Cephalexin 500 (CR)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	227
<i>Pharmacor Citalo 20 (CR)</i>	
.NERVOUS SYSTEM	535
<i>Pharmacor Donepezil 10 (CR)</i>	
.NERVOUS SYSTEM	547, 548
<i>Pharmacor Donepezil 5 (CR)</i>	
.NERVOUS SYSTEM	547, 549
<i>Pharmacor Duloxetine 30 (CR)</i>	
.NERVOUS SYSTEM	541
<i>Pharmacor Duloxetine 60 (CR)</i>	
.NERVOUS SYSTEM	541
<i>Pharmacor Escitalopram 10 (CR)</i>	
.NERVOUS SYSTEM	536
<i>Pharmacor Escitalopram 20 (CR)</i>	
.NERVOUS SYSTEM	536
<i>Pharmacor Finasteride 5 (CR)</i>	
.Repatriation Schedule	1211
<i>Pharmacor Gabapentin 600 (CR)</i>	
.NERVOUS SYSTEM	503
<i>Pharmacor Gabapentin 800 (CR)</i>	
.NERVOUS SYSTEM	503
<i>Pharmacor Letrozole 2.5 (CR)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	291
<i>Pharmacor Meloxicam 15 (CR)</i>	
.MUSCULO-SKELETAL SYSTEM	463
<i>Pharmacor Meloxicam 7.5 (CR)</i>	
.MUSCULO-SKELETAL SYSTEM	464
<i>Pharmacor Metformin 1000 (CR)</i>	
.ALIMENTARY TRACT AND METABOLISM	89
<i>Pharmacor Montelukast 4 (CR)</i>	
.RESPIRATORY SYSTEM	573
<i>Pharmacor Montelukast 5 (CR)</i>	
.RESPIRATORY SYSTEM	574
<i>Pharmacor Mycophenolate 250 (CR)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	307
.Section 100	771, 1024
<i>Pharmacor Mycophenolate 500 (CR)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	307
.Section 100	772, 1024
<i>Pharmacor Olanzapine 10 (CR)</i>	

GENERIC/PROPRIETARY INDEX

.NERVOUS SYSTEM.....	518	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>Pharmacor Olanzapine 2.5 (CR)</i>		AGENTS	460
.NERVOUS SYSTEM.....	520	.Section 100.....	869, 1122
<i>Pharmacor Olanzapine 5 (CR)</i>		<i>Pharmacor Telmisartan 40 (CR)</i>	
.NERVOUS SYSTEM.....	522	.CARDIOVASCULAR SYSTEM	151
<i>Pharmacor Olanzapine 7.5 (CR)</i>		<i>Pharmacor Telmisartan 80 (CR)</i>	
.NERVOUS SYSTEM.....	523	.CARDIOVASCULAR SYSTEM	151
<i>Pharmacor Omeprazole 20 (CR)</i>		<i>Pharmacy Action Anti-Fungal Cream (GQ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	69, 70	.Repatriation Schedule	1203
<i>Pharmacor Pioglitazone 15 (CR)</i>		<i>Pharmacy Action Cetrelief (GQ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	97	.Repatriation Schedule	1221
<i>Pharmacor Pioglitazone 30 (CR)</i>		<i>Pharmacy Action FemCream (GQ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	98	.Repatriation Schedule	1209
<i>Pharmacor Pioglitazone 45 (CR)</i>		<i>Pharmacy Action Laxative with Senna (GQ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	98	.Repatriation Schedule	1198
<i>Pharmacor Pravastat 10 (CR)</i>		<i>Pharmacy Action Lorastyne (GQ)</i>	
.CARDIOVASCULAR SYSTEM	164, 165	.Repatriation Schedule	1221
<i>Pharmacor Pravastat 20 (CR)</i>		<i>Pharmacy Action Low Dose Aspirin (GQ)</i>	
.CARDIOVASCULAR SYSTEM	164, 165	.Repatriation Schedule	1201
<i>Pharmacor Pravastat 40 (CR)</i>		<i>Pharmacy Action Paracetamol Plus Codeine (GQ)</i>	
.CARDIOVASCULAR SYSTEM	164, 165	.Repatriation Schedule	1216
<i>Pharmacor Prozine 5 (CR)</i>		<i>Pharmacy Action Sinus & Nasal Decongestant Relief (GQ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	78	.Repatriation Schedule	1220
<i>Pharmacor Quetiapine 100 (CR)</i>		<i>Pharmacy Choice Anastrozole (RI)</i>	
.NERVOUS SYSTEM.....	523	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>Pharmacor Quetiapine 200 (CR)</i>		AGENTS	290
.NERVOUS SYSTEM.....	524	<i>Pharmacy Choice Finasteride (RI)</i>	
<i>Pharmacor Quetiapine 25 (CR)</i>		.Repatriation Schedule	1211
.NERVOUS SYSTEM.....	525	<i>Pharmacy Choice Letrozole (RI)</i>	
<i>Pharmacor Quetiapine 300 (CR)</i>		.ANTINEOPLASTIC AND IMMUNOMODULATING	
.NERVOUS SYSTEM.....	524	AGENTS	291
<i>Pharmacor Ramipril 10 (CR)</i>		<i>Pharmacy Choice Olanzapine (RI)</i>	
.CARDIOVASCULAR SYSTEM	144	.NERVOUS SYSTEM.....	518, 520, 522, 523
<i>Pharmacor Ramipril 5 (CR)</i>		<i>Pharmacy Choice Olanzapine ODT (RI)</i>	
.CARDIOVASCULAR SYSTEM	145	.NERVOUS SYSTEM.....	517, 518
<i>Pharmacor Riluzole (CR)</i>		<i>Pharmacy Choice Quetiapine (RI)</i>	
.NERVOUS SYSTEM.....	560	.NERVOUS SYSTEM.....	523, 524, 525
<i>Pharmacor Salbutamol 2.5 (CR)</i>		<i>Pharmacy Choice Terbinafine (RI)</i>	
.Prescriber Bag	63	.DERMATOLOGICALS	191
.RESPIRATORY SYSTEM	565	<i>Phebra Naproxen Suspension (PL)</i>	
<i>Pharmacor Salbutamol 5 (CR)</i>		.MUSCULO-SKELETAL SYSTEM	466
.Prescriber Bag	63	.Palliative Care.....	640, 641
.RESPIRATORY SYSTEM	565	PHENELZINE	
<i>Pharmacor Sumatriptan 50 (CR)</i>		.NERVOUS SYSTEM.....	540
.NERVOUS SYSTEM.....	498	PHENOBARBITONE	
<i>Pharmacor Tacrolimus 0.5 (CR)</i>		.NERVOUS SYSTEM.....	499
.ANTINEOPLASTIC AND IMMUNOMODULATING		PHENOXYBENZAMINE	
AGENTS	460	.CARDIOVASCULAR SYSTEM	133
.Section 100	869, 1122	.GENITO URINARY SYSTEM AND SEX HORMONES .	207
<i>Pharmacor Tacrolimus 1 (CR)</i>		PHENOXYMETHYLPENICILLIN	
.ANTINEOPLASTIC AND IMMUNOMODULATING		.ANTIINFECTIVES FOR SYSTEMIC USE	222, 223
AGENTS	460	<i>Phenoxymethylpenicillin-AFT (AE)</i>	
.Section 100	869, 1121	.ANTIINFECTIVES FOR SYSTEMIC USE	222
<i>Pharmacor Tacrolimus 5 (CR)</i>		<i>Phenylalanine 50 (VF)</i>	
		.VARIOUS.....	628

GENERIC/PROPRIETARY INDEX

PHENYLALANINE WITH CARBOHYDRATE		
.VARIOUS.....	627	
PHENYLEPHRINE + PREDNISOLONE ACETATE		
.SENSORY ORGANS.....	577	
PHENYTOIN		
.NERVOUS SYSTEM.....	499	
<i>Phlexy-10 (SB)</i>		
.VARIOUS.....	620	
<i>Phlexy-10 Drink Mix (SB)</i>		
.VARIOUS.....	620	
PHOLCODINE		
.Repatriation Schedule.....	1220	
<i>Phosphate Sandoz (NV)</i>		
.VARIOUS.....	598	
PHOSPHORUS		
.VARIOUS.....	598	
<i>Physeptone (QA)</i>		
.NERVOUS SYSTEM.....	491	
<i>Physiotens (AB)</i>		
.CARDIOVASCULAR SYSTEM.....	130	
<i>Piax (AF)</i>		
.BLOOD AND BLOOD FORMING ORGANS	110, 111	
.Repatriation Schedule.....	1201	
<i>Picato (LO)</i>		
.Repatriation Schedule.....	1205, 1206	
PILOCARPINE		
.SENSORY ORGANS.....	579	
PIMECROLIMUS		
.DERMATOLOGICALS.....	196	
PINDOLOL		
.CARDIOVASCULAR SYSTEM.....	133	
PINE TAR WITH TRIETHANOLAMINE LAURYL SULFATE		
.Repatriation Schedule.....	1205	
<i>Pinetarsol (EO)</i>		
.Repatriation Schedule.....	1205	
PIOGLITAZONE		
.ALIMENTARY TRACT AND METABOLISM.....	96	
<i>Pioglitazone AN (EA)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	97, 98	
<i>Pioglitazone generichealth 15 (GQ)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	97	
<i>Pioglitazone generichealth 30 (GQ)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	98	
<i>Pioglitazone generichealth 45 (GQ)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	98	
<i>Pioglitazone Sandoz (SZ)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	97, 98	
<i>Pioglitazone-GA (GN)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	97, 98	
PIROXICAM		
.MUSCULO-SKELETAL SYSTEM	464	
<i>Pizaccord (RA)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	97, 98	
PIZOTIFEN		
.NERVOUS SYSTEM.....	498	
<i>PKU Anamix infant (SB)</i>		
.VARIOUS.....	620	
<i>PKU Anamix Junior (SB)</i>		
.VARIOUS.....	623	
<i>PKU Anamix Junior LQ (SB)</i>		
.VARIOUS.....	622	
<i>PKU Cooler 10 (VF)</i>		
.VARIOUS.....	622	
<i>PKU Cooler 15 (VF)</i>		
.VARIOUS.....	622	
<i>PKU Cooler 20 (VF)</i>		
.VARIOUS.....	622	
<i>PKU express 15 (VF)</i>		
.VARIOUS.....	622	
<i>PKU express 20 (VF)</i>		
.VARIOUS.....	622	
<i>PKU gel (VF)</i>		
.VARIOUS.....	622	
<i>PKU Lophlex LQ 10 (SB)</i>		
.VARIOUS.....	622	
<i>PKU Lophlex LQ 20 (SB)</i>		
.VARIOUS.....	622	
<i>PKU Lophlex Sensation 20 (SB)</i>		
.VARIOUS.....	623	
<i>PKU squeeze (VF)</i>		
.VARIOUS.....	622	
<i>Placil (AF)</i>		
.NERVOUS SYSTEM.....	534	
<i>Plaqacide (OB)</i>		
.Repatriation Schedule.....	1197	
<i>Plaquenil (SW)</i>		
.MUSCULO-SKELETAL SYSTEM	467	
<i>Plasma-Lyte 148 (BX)</i>		
.BLOOD AND BLOOD FORMING ORGANS.....	125	
<i>Plavacor 75 (CR)</i>		
.BLOOD AND BLOOD FORMING ORGANS.....	111	
<i>Plavix (SW)</i>		
.BLOOD AND BLOOD FORMING ORGANS.....	110, 111	
.Repatriation Schedule.....	1201	
<i>Plendil ER (GX)</i>		
.CARDIOVASCULAR SYSTEM	138	
PLERIXAFOR		
.Section 100.....	749, 1001	
PNEUMOCOCCAL PURIFIED CAPSULAR		
POLYSACCHARIDES		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	250	
<i>Pneumovax 23 (CS)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	250	
PODOPHYLLOTOXIN		
.Repatriation Schedule.....	1205	
<i>Poly Gel (AQ)</i>		
.SENSORY ORGANS.....	588	
<i>Poly Visc (IQ)</i>		
.SENSORY ORGANS.....	591, 592	
POLYETHYLENE GLYCOL-400 + PROPYLENE GLYCOL		

GENERIC/PROPRIETARY INDEX

.SENSORY ORGANS.....	592, 593	.CARDIOVASCULAR SYSTEM	164, 166
POLYLACTIC ACID		<i>Pravastatin-GA 80 (GN)</i>	
.VARIOUS.....	598	.CARDIOVASCULAR SYSTEM	165, 166
POLYSTYRENE SULFONATE SODIUM		PRAZIQUANTEL	
.Repatriation Schedule.....	1223	.ANTIPARASITIC PRODUCTS, INSECTICIDES AND	
<i>Polytar (GK)</i>		REPELLENTS	562
.Repatriation Schedule.....	1206	PRAZOSIN	
<i>Poly-Tears (IQ)</i>		.CARDIOVASCULAR SYSTEM	130
.SENSORY ORGANS.....	590	<i>PredMix (LN)</i>	
POLYVINYL ALCOHOL		.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
.SENSORY ORGANS.....	593	HORMONES AND INSULINS	213
<i>Posstan (PF)</i>		<i>Prednefrin Forte (AG)</i>	
.MUSCULO-SKELETAL SYSTEM	466	.SENSORY ORGANS.....	577, 578
POSACONAZOLE		PREDNISOLONE	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	242	.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
POTASSIUM CHLORIDE		HORMONES AND INSULINS	213
.ALIMENTARY TRACT AND METABOLISM.....	105	PREDNISOLONE SODIUM PHOSPHATE	
POTASSIUM CHLORIDE + POTASSIUM BICARBONATE +		.ALIMENTARY TRACT AND METABOLISM.....	83
POTASSIUM CARBONATE		.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
.ALIMENTARY TRACT AND METABOLISM.....	106	HORMONES AND INSULINS	213
POVIDONE-IODINE		PREDNISONE	
.Repatriation Schedule.....	1206	.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
<i>Prabez (AF)</i>		HORMONES AND INSULINS	213
.ALIMENTARY TRACT AND METABOLISM.....	72	<i>Predsol (QA)</i>	
<i>Pradaxa (BY)</i>		.ALIMENTARY TRACT AND METABOLISM.....	83, 84
.BLOOD AND BLOOD FORMING ORGANS	115, 116	<i>Predsolone (LN)</i>	
<i>Pramin (AF)</i>		.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
.ALIMENTARY TRACT AND METABOLISM.....	73	HORMONES AND INSULINS	213
PRAMIPEXOLE		<i>Predstone (LN)</i>	
.NERVOUS SYSTEM.....	512, 513	.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
<i>Pramipexole AN (EA)</i>		HORMONES AND INSULINS	213
.NERVOUS SYSTEM.....	512, 513	PREGABALIN	
PRASUGREL		.NERVOUS SYSTEM.....	495
.BLOOD AND BLOOD FORMING ORGANS	113	<i>Pregnyl (MK)</i>	
<i>Pravachol (FM)</i>		.GENITO URINARY SYSTEM AND SEX HORMONES .	205
.CARDIOVASCULAR SYSTEM	164, 165, 166	.Section 100.....	1159
PRAVASTATIN		<i>Presolol 100 (AF)</i>	
.CARDIOVASCULAR SYSTEM	164, 165	.CARDIOVASCULAR SYSTEM	137
<i>Pravastatin Actavis 10 (UA)</i>		<i>Presolol 200 (AF)</i>	
.CARDIOVASCULAR SYSTEM	164, 165	.CARDIOVASCULAR SYSTEM	137
<i>Pravastatin Actavis 20 (UA)</i>		<i>Prexaton (GN)</i>	
.CARDIOVASCULAR SYSTEM	164, 165	.NERVOUS SYSTEM.....	554, 555
<i>Pravastatin Actavis 40 (UA)</i>		PREXUM 10 (RX)	
.CARDIOVASCULAR SYSTEM	164, 165	.CARDIOVASCULAR SYSTEM	142
<i>Pravastatin AN (EA)</i>		PREXUM 2.5 (RX)	
.CARDIOVASCULAR SYSTEM	164, 165, 166	.CARDIOVASCULAR SYSTEM	142
<i>Pravastatin generichealth (GQ)</i>		PREXUM 5 (RX)	
.CARDIOVASCULAR SYSTEM	164, 165, 166	.CARDIOVASCULAR SYSTEM	143
<i>Pravastatin Sandoz (SZ)</i>		<i>Prexum Combi 5/1.25 (RX)</i>	
.CARDIOVASCULAR SYSTEM	164, 165, 166	.CARDIOVASCULAR SYSTEM	147
<i>Pravastatin-GA 10 (GN)</i>		<i>Prezista (JC)</i>	
.CARDIOVASCULAR SYSTEM	164, 165	.Section 100.....	711, 960
<i>Pravastatin-GA 20 (GN)</i>		<i>Prilace 10 (QA)</i>	
.CARDIOVASCULAR SYSTEM	164, 165	.CARDIOVASCULAR SYSTEM	144
<i>Pravastatin-GA 40 (GN)</i>		<i>Prilace 2.5 (QA)</i>	

GENERIC/PROPRIETARY INDEX

.CARDIOVASCULAR SYSTEM	144
<i>Prilace 5 (QA)</i>	
.CARDIOVASCULAR SYSTEM	145
PRIMIDONE	
.NERVOUS SYSTEM.....	499
<i>Primolut N (BN)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	203
<i>Primoteston Depot (BN)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	201
<i>Prinivil 10 (MK)</i>	
.CARDIOVASCULAR SYSTEM	141
<i>Prinivil 20 (MK)</i>	
.CARDIOVASCULAR SYSTEM	141
<i>Prioten 15 (DO)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	97
<i>Prioten 30 (DO)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	98
<i>Prioten 45 (DO)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	98
<i>Pristiq (PF)</i>	
.NERVOUS SYSTEM.....	541
<i>Pritor Plus 40/12.5 mg (FI)</i>	
.CARDIOVASCULAR SYSTEM	155
<i>Pritor Plus 80/12.5 mg (FI)</i>	
.CARDIOVASCULAR SYSTEM	155
<i>Pritor Plus 80/25 mg (FI)</i>	
.CARDIOVASCULAR SYSTEM	156
<i>Pritor/Amlodipine (FI)</i>	
.CARDIOVASCULAR SYSTEM	157
<i>Pro-Banthine (QA)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	207
PROBENECID	
.MUSCULO-SKELETAL SYSTEM	469
<i>Probitor (SZ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	69, 70
PROCAINE PENICILLIN	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	223
<i>ProCalm (QA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	78
PROCHLORPERAZINE	
.ALIMENTARY TRACT AND METABOLISM.....	78
<i>Prochlorperazine AN (EA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	78
<i>Prochlorperazine GH (GQ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	78
<i>Prochlorperazine-GA (GN)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	78
<i>Pro-Cid (PL)</i>	
.MUSCULO-SKELETAL SYSTEM	469
<i>Procur (GN)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	288
.GENITO URINARY SYSTEM AND SEX HORMONES	205,
206	
<i>Procur 100 (GN)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	288
.GENITO URINARY SYSTEM AND SEX HORMONES .	205
<i>Prodeine 15 (SW)</i>	
.Repatriation Schedule	1216
<i>Prodeine Forte (AV)</i>	
.NERVOUS SYSTEM.....	487, 488
<i>Profore 66050016 (SN)</i>	
.Repatriation Schedule	1227
<i>Profore Lite 66050415 (SN)</i>	
.Repatriation Schedule	1227
PROGESTERONE	
.Section 100.....	1159, 1160
<i>Progout 100 (AF)</i>	
.MUSCULO-SKELETAL SYSTEM	469
<i>Progout 300 (AF)</i>	
.MUSCULO-SKELETAL SYSTEM	469
<i>Prograf (JC)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	460
.Section 100.....	869, 1121, 1122
<i>Prograf XL (JC)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	460
.Section 100.....	869, 1121, 1122
<i>Progynova (BN)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	202
<i>Proladone (PL)</i>	
.NERVOUS SYSTEM.....	486
<i>Prolia (AN)</i>	
.MUSCULO-SKELETAL SYSTEM	479
PROMETHAZINE	
.ALIMENTARY TRACT AND METABOLISM.....	78
.RESPIRATORY SYSTEM.....	574
<i>Prontosan Wound Irrigation Solution (BR)</i>	
.Repatriation Schedule	1229
PROPANTHELINE	
.GENITO URINARY SYSTEM AND SEX HORMONES .	207
PROPRANOLOL	
.CARDIOVASCULAR SYSTEM	133
PROPYLTHIOURACIL	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
HORMONES AND INSULINS	214
<i>Proscar (MK)</i>	
.Repatriation Schedule	1211
<i>Protaphane (NO)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	88
<i>Protaphane InnoLet (NI)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	88
<i>Protaphane Penfill 3 mL (NO)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	88
PROTEIN HYDROLYSATE FORMULA WITH MEDIUM	
CHAIN TRIGLYCERIDES	
.VARIOUS.....	614, 616
<i>Protos 2 g (SE)</i>	

GENERIC/PROPRIETARY INDEX

.MUSCULO-SKELETAL SYSTEM	480
<i>Provera (PF)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	285
.GENITO URINARY SYSTEM AND SEX HORMONES .	202
<i>Proxen SR 1000 (MD)</i>	
.MUSCULO-SKELETAL SYSTEM	465
.Palliative Care	640
<i>Proxen SR 750 (MD)</i>	
.MUSCULO-SKELETAL SYSTEM	466
.Palliative Care	640
<i>Prozac 20 (LY)</i>	
.NERVOUS SYSTEM.....	538
<i>Prozac Tab (LY)</i>	
.NERVOUS SYSTEM.....	538
<i>ProZero (VF)</i>	
.VARIOUS.....	628
PSEUDOEPHEDRINE	
.Repatriation Schedule	1220
PSYLLIUM HUSK POWDER	
.Repatriation Schedule	1198
<i>PTU (PL)</i>	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
HORMONES AND INSULINS.....	214
<i>Pulmicort Respules (AP)</i>	
.RESPIRATORY SYSTEM	570, 571
<i>Pulmicort Turbuhaler (AP)</i>	
.RESPIRATORY SYSTEM	571
<i>Pulmozyme (RO)</i>	
.Section 100	892, 1144
<i>Puregon 300 IU/0.36 mL (MK)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	204
.Section 100	1158
<i>Puregon 600 IU/0.72 mL (MK)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	204
.Section 100	1159
<i>Puregon 900 IU/1.08 mL (MK)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	204
.Section 100	1159
<i>Purinethol (AS)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	253
<i>PVA Forte (PE)</i>	
.SENSORY ORGANS.....	593
<i>PVA Tears (PE)</i>	
.SENSORY ORGANS.....	593
<i>Pyralin EN (FZ)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	86
PYRANTEL	
.ANTIPARASITIC PRODUCTS, INSECTICIDES AND	
REPELLENTS.....	562
PYRIDOSTIGMINE	
.NERVOUS SYSTEM.....	554
PYRIMETHAMINE	

.ANTIPARASITIC PRODUCTS, INSECTICIDES AND	
REPELLENTS.....	561

Q

<i>Qpril 10 (AF)</i>	
.CARDIOVASCULAR SYSTEM	143
<i>Qpril 20 (AF)</i>	
.CARDIOVASCULAR SYSTEM	143
<i>Qpril 5 (AF)</i>	
.CARDIOVASCULAR SYSTEM	143
<i>Qvestran Lite (QA)</i>	
.CARDIOVASCULAR SYSTEM	173, 174
<i>Quetia 100 (FM)</i>	
.NERVOUS SYSTEM.....	523
<i>Quetia 200 (FM)</i>	
.NERVOUS SYSTEM.....	524
<i>Quetia 25 (FM)</i>	
.NERVOUS SYSTEM.....	525
<i>Quetia 300 (FM)</i>	
.NERVOUS SYSTEM.....	524
<i>Quetiaccord (UA)</i>	
.NERVOUS SYSTEM.....	523, 524, 525
QUETIAPINE	
.NERVOUS SYSTEM.....	523, 524
<i>Quetiapine Actavis 100 (VN)</i>	
.NERVOUS SYSTEM.....	523
<i>Quetiapine Actavis 200 (VN)</i>	
.NERVOUS SYSTEM.....	524
<i>Quetiapine Actavis 25 (VN)</i>	
.NERVOUS SYSTEM.....	525
<i>Quetiapine Actavis 300 (VN)</i>	
.NERVOUS SYSTEM.....	524
<i>Quetiapine AN (EA)</i>	
.NERVOUS SYSTEM.....	523, 524, 525
<i>Quetiapine GH 100 (GQ)</i>	
.NERVOUS SYSTEM.....	523
<i>Quetiapine GH 200 (GQ)</i>	
.NERVOUS SYSTEM.....	524
<i>Quetiapine GH 25 (GQ)</i>	
.NERVOUS SYSTEM.....	525
<i>Quetiapine GH 300 (GQ)</i>	
.NERVOUS SYSTEM.....	524
<i>Quetiapine RBX (RA)</i>	
.NERVOUS SYSTEM.....	523, 524, 525
<i>Quetiapine Sandoz (SZ)</i>	
.NERVOUS SYSTEM.....	523, 524, 525
<i>Quetiapine-DRLA (RZ)</i>	
.NERVOUS SYSTEM.....	523, 524, 525
<i>Quetiapine-GA (GN)</i>	
.NERVOUS SYSTEM.....	523, 524, 525
<i>Quilonum SR (AS)</i>	
.NERVOUS SYSTEM.....	541
QUINAGOLIDE	
.GENITO URINARY SYSTEM AND SEX HORMONES .	199

GENERIC/PROPRIETARY INDEX

QUINAPRIL	
.CARDIOVASCULAR SYSTEM	143
QUINAPRIL + HYDROCHLOROTHIAZIDE	
.CARDIOVASCULAR SYSTEM	147
<i>Quinapril generichealth (GQ)</i>	
.CARDIOVASCULAR SYSTEM	143
<i>Quinapril-GA (UA)</i>	
.CARDIOVASCULAR SYSTEM	143
<i>Quinate (AS)</i>	
.ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS	561
QUININE	
.ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS	561
<i>QuitX (AF)</i>	
.Repatriation Schedule	1218
<i>QV Bath Oil (EO)</i>	
.Repatriation Schedule	1204
<i>Qvar 100 (IA)</i>	
.RESPIRATORY SYSTEM	570
<i>Qvar 100 Autohaler (IA)</i>	
.RESPIRATORY SYSTEM	570
<i>Qvar 50 (IA)</i>	
.RESPIRATORY SYSTEM	570
<i>Qvar 50 Autohaler (IA)</i>	
.RESPIRATORY SYSTEM	570

R

RABEPRAZOLE	
.ALIMENTARY TRACT AND METABOLISM	72
<i>Rabeprazole Actavis 20 (UA)</i>	
.ALIMENTARY TRACT AND METABOLISM	72
<i>Rabeprazole AN (EA)</i>	
.ALIMENTARY TRACT AND METABOLISM	72
<i>Rabeprazole generichealth (GQ)</i>	
.ALIMENTARY TRACT AND METABOLISM	72
<i>Rabeprazole RBX (RA)</i>	
.ALIMENTARY TRACT AND METABOLISM	72
<i>Rabeprazole Sandoz (SZ)</i>	
.ALIMENTARY TRACT AND METABOLISM	72
<i>Rabeprazole-DRLA (RZ)</i>	
.ALIMENTARY TRACT AND METABOLISM	72
<i>Rabeprazole-GA (GN)</i>	
.ALIMENTARY TRACT AND METABOLISM	72
<i>Ralovera (FZ)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	202
RALOXIFENE	
.MUSCULO-SKELETAL SYSTEM	479
<i>Raloxifene AN (EA)</i>	
.MUSCULO-SKELETAL SYSTEM	480
RALTEGRAVIR	
.Section 100	725, 726, 976
<i>Ramace 1.25 mg (AV)</i>	
.CARDIOVASCULAR SYSTEM	143

<i>Ramace 10 mg (AV)</i>	
.CARDIOVASCULAR SYSTEM	144
<i>Ramace 2.5 mg (AV)</i>	
.CARDIOVASCULAR SYSTEM	144
<i>Ramace 5 mg (AV)</i>	
.CARDIOVASCULAR SYSTEM	145
RAMIPRIL	
.CARDIOVASCULAR SYSTEM	143, 144, 145
RAMIPRIL + FELODIPINE	
.CARDIOVASCULAR SYSTEM	148
<i>Ramipril AN (EA)</i>	
.CARDIOVASCULAR SYSTEM	143, 144, 145
<i>Ramipril CH (EA)</i>	
.CARDIOVASCULAR SYSTEM	144
<i>Ramipril generichealth (GQ)</i>	
.CARDIOVASCULAR SYSTEM	144, 145
<i>Ramipril RBX Tabs (RA)</i>	
.CARDIOVASCULAR SYSTEM	144, 145
<i>Ramipril Sandoz (SZ)</i>	
.CARDIOVASCULAR SYSTEM	143, 144, 145
<i>Ramipril Winthrop (WA)</i>	
.CARDIOVASCULAR SYSTEM	143, 144, 145
<i>Ramipril-GA (GN)</i>	
.CARDIOVASCULAR SYSTEM	143, 144, 145
<i>Rancef (RA)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	226, 227, 228
<i>Rani 2 (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM	67
RANIBIZUMAB	
.SENSORY ORGANS	586
RANITIDINE	
.ALIMENTARY TRACT AND METABOLISM	67
<i>Ranitidine AN (EA)</i>	
.ALIMENTARY TRACT AND METABOLISM	67
<i>Ranitidine Sandoz (SZ)</i>	
.ALIMENTARY TRACT AND METABOLISM	67
<i>Ranmoxy (RA)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	220, 221
<i>Ranoxyl (GN)</i>	
.ALIMENTARY TRACT AND METABOLISM	67
<i>Ransim (RA)</i>	
.CARDIOVASCULAR SYSTEM	170, 171, 172
<i>Ranzepam (RA)</i>	
.NERVOUS SYSTEM	531, 532
.Palliative Care	646
<i>Rapamune (PF)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	307, 308
.Section 100	772, 1024
<i>Rapilysin 10 U (GN)</i>	
.BLOOD AND BLOOD FORMING ORGANS	114
RASAGILINE	
.NERVOUS SYSTEM	514
<i>Razit 10 (DO)</i>	
.ALIMENTARY TRACT AND METABOLISM	72

<i>Razit 20 (DO)</i>	.VARIOUS..... 629
.ALIMENTARY TRACT AND METABOLISM.....	72
<i>RBX Topiramate (RA)</i>	
.NERVOUS SYSTEM.....	508, 509
<i>RCF (AB)</i>	
.VARIOUS.....	628
<i>Reandron 1000 (BN)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	201
<i>Reaptan 10/10 (RX)</i>	
.CARDIOVASCULAR SYSTEM.....	148
<i>Reaptan 10/5 (RX)</i>	
.CARDIOVASCULAR SYSTEM.....	148
<i>Reaptan 5/10 (RX)</i>	
.CARDIOVASCULAR SYSTEM.....	148
<i>Reaptan 5/5 (RX)</i>	
.CARDIOVASCULAR SYSTEM.....	148
<i>Rebif 44 (SG)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	293
REBOXETINE	
.NERVOUS SYSTEM.....	543
<i>Redipred (AS)</i>	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS	213
<i>Reedos 100 (DO)</i>	
.NERVOUS SYSTEM.....	505
<i>Reedos 200 (DO)</i>	
.NERVOUS SYSTEM.....	505
<i>Reedos 25 (DO)</i>	
.NERVOUS SYSTEM.....	506
<i>Reedos 50 (DO)</i>	
.NERVOUS SYSTEM.....	506
<i>Refresh Liquigel (AG)</i>	
.SENSORY ORGANS.....	589
<i>Refresh Night Time (AG)</i>	
.SENSORY ORGANS.....	591, 592
<i>Refresh Tears Plus (AG)</i>	
.SENSORY ORGANS.....	589
<i>Relistor (LM)</i>	
.Palliative Care	636
<i>Relpax (PF)</i>	
.NERVOUS SYSTEM.....	496
<i>Remeron SolTab (FR)</i>	
.NERVOUS SYSTEM.....	542
<i>Remicade (JC)</i>	
.Repatriation Schedule.....	1213
.Section 100 ...	789, 793, 803, 809, 812, 815, 824, 830, 834, 1042, 1045, 1051, 1061, 1063, 1067, 1077, 1083, 1087
<i>Reminyl (JC)</i>	
.NERVOUS SYSTEM.....	549, 550
<i>Renagel (GZ)</i>	
.Section 100	898, 1151
.VARIOUS.....	597
<i>Renastart (VF)</i>	
.CARDIOVASCULAR SYSTEM.....	140
<i>RenaStart (VF)</i>	
.VARIOUS.....	629
<i>Renitec (MK)</i>	
.CARDIOVASCULAR SYSTEM	140
<i>Renitec 20 (MK)</i>	
.CARDIOVASCULAR SYSTEM	140
<i>Renitec Plus 20/6 (MK)</i>	
.CARDIOVASCULAR SYSTEM	146
<i>ReoPro (LY)</i>	
.BLOOD AND BLOOD FORMING ORGANS.....	110
<i>Repalyte New Formulation (SW)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	83
<i>Replicare Ultra 66000434 (SN)</i>	
.Repatriation Schedule	1236
<i>Resolve Thrush (EO)</i>	
.Repatriation Schedule	1203
<i>Resonium-A (SW)</i>	
.Repatriation Schedule	1223
<i>Respikast 4 (QA)</i>	
.RESPIRATORY SYSTEM.....	573
<i>Respikast 5 (QA)</i>	
.RESPIRATORY SYSTEM.....	574
<i>Resprim Forte (AF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	232
<i>restore O.R.S. (GN)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	83
RETEPLASE	
.BLOOD AND BLOOD FORMING ORGANS.....	114
<i>Retrovir (VI)</i>	
.Section 100.....	720, 970
<i>Revatio (PF)</i>	
.Section 100.....	698, 946
<i>ReVia (BQ)</i>	
.NERVOUS SYSTEM.....	558
<i>Revlimid (CI)</i>	
.Section 100.....	871, 873, 1123, 1125
<i>Revolade (GK)</i>	
.Section 100.....	652, 900
<i>Reyatatz (BQ)</i>	
.Section 100.....	709, 958
RHAMNUS FRANGULA + STERCULIA	
.ALIMENTARY TRACT AND METABOLISM.....	79
.Palliative Care.....	633, 634
.Repatriation Schedule	1198
<i>Riamet (NV)</i>	
.ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS	561
<i>Riamet 20mg/120mg Dispersible (NV)</i>	
.ANTIPARASITIC PRODUCTS, INSECTICIDES AND REPELLENTS	562
<i>Ridaura (GH)</i>	
.MUSCULO-SKELETAL SYSTEM	467, 468
RIFABUTIN	
.Section 100.....	708, 957

GENERIC/PROPRIETARY INDEX

<i>Rifadin (SW)</i>		<i>Rispericor 2 (CR)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	245	.NERVOUS SYSTEM.....	527, 529
RIFAMPICIN		<i>Rispericor 3 (CR)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	244, 245	.NERVOUS SYSTEM.....	527
RIFAXIMIN		<i>Rispericor 4 (CR)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	82	.NERVOUS SYSTEM.....	527
RILPIVIRINE		RISPERIDONE	
.Section 100	722, 972	.NERVOUS SYSTEM.....	526, 528, 529, 530
<i>Rilutek (SW)</i>		<i>Risperidone Actavis 2 (UA)</i>	
.NERVOUS SYSTEM.....	560	.NERVOUS SYSTEM.....	527, 529
RILUZOLE		<i>Risperidone Actavis 3 (UA)</i>	
.NERVOUS SYSTEM.....	560	.NERVOUS SYSTEM.....	527
<i>Riluzole Sandoz (SZ)</i>		<i>Risperidone AN (EA)</i>	
.NERVOUS SYSTEM.....	560	.NERVOUS SYSTEM.....	527, 528, 529, 530
<i>Rimycin 150 (AF)</i>		<i>Risperidone generichealth (GQ)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	245	.NERVOUS SYSTEM.....	527, 528, 529
<i>Rimycin 300 (AF)</i>		<i>Risperidone GH (GQ)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	245	.NERVOUS SYSTEM.....	530
<i>Risedro once a week (QA)</i>		<i>Risperidone Sandoz (SZ)</i>	
.MUSCULO-SKELETAL SYSTEM	472	.NERVOUS SYSTEM.....	527, 528, 529, 530
.Repatriation Schedule.....	1214	<i>Risperidone-DRLA (RZ)</i>	
RISEDRONATE		.NERVOUS SYSTEM.....	527, 528, 529, 530
.MUSCULO-SKELETAL SYSTEM	471, 472	<i>Risperidone-GA (GN)</i>	
.Repatriation Schedule.....	1214	.NERVOUS SYSTEM.....	527, 528, 529, 530
RISEDRONATE (&) CALCIUM CARBONATE		<i>Rispernia (ER)</i>	
.MUSCULO-SKELETAL SYSTEM	476	.NERVOUS SYSTEM.....	527, 528, 529, 530
.Repatriation Schedule.....	1215	<i>Ritalin 10 (NV)</i>	
RISEDRONATE (&) CALCIUM CARBONATE +		.NERVOUS SYSTEM.....	545
COLECALCIFEROL		<i>Ritalin LA (NV)</i>	
.MUSCULO-SKELETAL SYSTEM	477	.NERVOUS SYSTEM.....	545
.Repatriation Schedule.....	1215	<i>Rithmik 200 (QA)</i>	
<i>Risedronate AN (EA)</i>		.CARDIOVASCULAR SYSTEM	127
.MUSCULO-SKELETAL SYSTEM	472	RITONAVIR	
<i>Risedronate Sandoz (SZ)</i>		.Section 100.....	712, 961
.MUSCULO-SKELETAL SYSTEM	472	RITUXIMAB	
.Repatriation Schedule.....	1214	.Section 100.....	873, 1126
<i>Risedronate Winthrop EC Combi (WA)</i>		RIVAROXABAN	
.MUSCULO-SKELETAL SYSTEM	477	.BLOOD AND BLOOD FORMING ORGANS.....	118, 119,
<i>Risedronate Winthrop EC Combi D (WA)</i>		120	
.MUSCULO-SKELETAL SYSTEM	478	RIVASTIGMINE	
<i>Risedronate-GA (GN)</i>		.NERVOUS SYSTEM.....	550, 551
.MUSCULO-SKELETAL SYSTEM	472	<i>Rivotril (RO)</i>	
.Repatriation Schedule.....	1214	.NERVOUS SYSTEM.....	499, 500
<i>Rispa (QA)</i>		.Palliative Care.....	645
.NERVOUS SYSTEM.....	527, 528, 529, 530	.Prescriber Bag	62
<i>Risperdal (JC)</i>		<i>Rixadone (AF)</i>	
.NERVOUS SYSTEM.....	527, 528, 529, 530	.NERVOUS SYSTEM.....	527, 528, 529, 530
<i>Risperdal Consta (JC)</i>		RIZATRIPTAN	
.NERVOUS SYSTEM.....	529	.NERVOUS SYSTEM.....	497
<i>Risperdal Quicklet (JC)</i>		<i>Roaccutane (RO)</i>	
.NERVOUS SYSTEM.....	527, 528, 529, 530	.DERMATOLOGICALS	195, 196
<i>Rispericor 0.5 (CR)</i>		<i>Rocaltrol (RO)</i>	
.NERVOUS SYSTEM.....	530	.ALIMENTARY TRACT AND METABOLISM.....	105
<i>Rispericor 1 (CR)</i>		.MUSCULO-SKELETAL SYSTEM	478
.NERVOUS SYSTEM.....	527, 528	<i>Rocta 10 (QA)</i>	

GENERIC/PROPRIETARY INDEX

.DERMATOLOGICALS.....	195
<i>Rocta 20 (QA)</i>	
.DERMATOLOGICALS.....	196
<i>Roferon-A (RO)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	292, 293
.Section 100	732, 983, 984
ROMIPLOSTIM	
.Section 100	652, 900
ROSIGLITAZONE	
.ALIMENTARY TRACT AND METABOLISM.....	98
ROSIGLITAZONE + METFORMIN	
.ALIMENTARY TRACT AND METABOLISM.....	92
<i>Rostor 10 (DO)</i>	
.CARDIOVASCULAR SYSTEM.....	167, 168
<i>Rostor 20 (DO)</i>	
.CARDIOVASCULAR SYSTEM.....	167, 169
<i>Rostor 40 (DO)</i>	
.CARDIOVASCULAR SYSTEM.....	168, 169
<i>Rostor 5 (DO)</i>	
.CARDIOVASCULAR SYSTEM.....	168
ROSUVASTATIN	
.CARDIOVASCULAR SYSTEM.....	166, 167, 168, 169
<i>Rosuvastatin Actavis 10 (GN)</i>	
.CARDIOVASCULAR SYSTEM.....	166, 167, 168
<i>Rosuvastatin Actavis 20 (GN)</i>	
.CARDIOVASCULAR SYSTEM.....	166, 167, 169
<i>Rosuvastatin Actavis 40 (GN)</i>	
.CARDIOVASCULAR SYSTEM.....	166, 168, 169
<i>Rosuvastatin Actavis 5 (GN)</i>	
.CARDIOVASCULAR SYSTEM.....	166, 167, 168
<i>Rosuvastatin AN (EA)</i>	
.CARDIOVASCULAR SYSTEM.....	167, 168, 169
<i>Rosuvastatin GH (GQ)</i>	
.CARDIOVASCULAR SYSTEM... ..	166, 167, 168, 169, 170
<i>Rosuvastatin RBX (RA)</i>	
.CARDIOVASCULAR SYSTEM.....	167, 168, 169, 170
<i>Rosuvastatin Sandoz (SZ)</i>	
.CARDIOVASCULAR SYSTEM.....	167, 168, 169, 170
<i>Rosuvastatin-DRLA (RI)</i>	
.CARDIOVASCULAR SYSTEM... ..	166, 167, 168, 169, 170
ROTIGOTINE	
.NERVOUS SYSTEM.....	514
<i>Roxar 150 (QA)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	234
<i>Roxar 300 (QA)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	235
<i>Roxet 20 (DO)</i>	
.NERVOUS SYSTEM.....	539
<i>Roximycin (AF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	234, 235
<i>Roxin (QA)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	238
ROXITHROMYCIN	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	234

<i>Roxithromycin AN (EA)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	234, 235
<i>Roxithromycin GH (GQ)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	234, 235
<i>Roxithromycin Sandoz (SZ)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	234, 235
<i>Roxithromycin SCP 150 (CR)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	234
<i>Roxithromycin SCP 300 (CR)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	235
<i>Roxithromycin-GA (GN)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	234, 235
<i>Rulide (SW)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	234, 235
<i>Rulide D (SW)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	235
<i>Rynacrom (SW)</i>	
.Repatriation Schedule	1220
<i>Rythmodan (SW)</i>	
.CARDIOVASCULAR SYSTEM.....	126

S

<i>S-26 LF (AS)</i>	
.VARIOUS.....	618
<i>Sabril (SW)</i>	
.NERVOUS SYSTEM.....	502
<i>Saflutan (MK)</i>	
.SENSORY ORGANS.....	583
<i>Saizen (SG)</i>	
.Section 100.....	1156, 1157
<i>Saizen 8 mg click.easy (SG)</i>	
.Section 100.....	1156
<i>Salazopyrin (PF)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	86
<i>Salazopyrin-EN (PF)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	86
SALBUTAMOL	
.RESPIRATORY SYSTEM.....	564, 565, 573
<i>Salbutamol Actavis (UA)</i>	
.Prescriber Bag	63, 64
.RESPIRATORY SYSTEM.....	565
<i>Salbutamol Sandoz (SZ)</i>	
.Prescriber Bag	63, 64
.RESPIRATORY SYSTEM.....	565
<i>Salbutamol-GA (GN)</i>	
.Prescriber Bag	63
.RESPIRATORY SYSTEM.....	565
SALCATONIN	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS.....	216
SALICYLIC ACID + BENZALKONIUM CHLORIDE + ALCOHOL + COAL TAR SOLUTION + POLYOXYETHYLENE ETHERS	
.Repatriation Schedule	1206
SALMETEROL	

GENERIC/PROPRIETARY INDEX

.RESPIRATORY SYSTEM	565	SELEGILINE	
<i>Salofalk (OA)</i>		.NERVOUS SYSTEM.....	514
.ALIMENTARY TRACT AND METABOLISM.....	84, 85	SELENIUM SULFIDE	
<i>Salpraz (AF)</i>		.Repatriation Schedule	1206
.ALIMENTARY TRACT AND METABOLISM.....	71	<i>Selgene (AF)</i>	
<i>Sandimmun (NV)</i>		.NERVOUS SYSTEM.....	514
.Section 100	869, 1121	<i>Selsun (DQ)</i>	
<i>Sandomigran 0.5 (NV)</i>		.Repatriation Schedule	1206
.NERVOUS SYSTEM.....	498	<i>Senna-Gen (PP)</i>	
<i>Sandostatin 0.05 (NV)</i>		.Repatriation Schedule	1198
.Section 100	707, 955	SENNOSIDE B	
<i>Sandostatin 0.1 (NV)</i>		.Repatriation Schedule	1198
.Section 100	707, 955	<i>Senokot (RC)</i>	
<i>Sandostatin 0.5 (NV)</i>		.Repatriation Schedule	1198
.Section 100	707, 955	<i>Sensipar (AN)</i>	
<i>Sandostatin LAR (NV)</i>		.Section 100.....	707, 955
.Section 100	706, 954	.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
<i>Sandrena (AS)</i>		HORMONES AND INSULINS	217
.GENITO URINARY SYSTEM AND SEX HORMONES .	201	<i>SensoCard (PX)</i>	
<i>Saphris (LU)</i>		.VARIOUS.....	600, 601
.NERVOUS SYSTEM.....	517	<i>Septtrin (QA)</i>	
SAPROPTERIN		.ANTIINFECTIVES FOR SYSTEMIC USE	232
.ALIMENTARY TRACT AND METABOLISM.....	106, 107	<i>Septtrin Forte (QA)</i>	
SAQUINAVIR		.ANTIINFECTIVES FOR SYSTEMIC USE	232
.Section 100	712, 962	<i>Sequase (PM)</i>	
<i>Savacol Mouth and Throat Rinse (OM)</i>		.NERVOUS SYSTEM.....	523, 524, 525
.Repatriation Schedule	1197	<i>Serenace (QA)</i>	
SAXAGLIPTIN		.NERVOUS SYSTEM.....	516
.ALIMENTARY TRACT AND METABOLISM.....	100	.Prescriber Bag	62
SAXAGLIPTIN + METFORMIN		<i>Serepax (QA)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	93	.NERVOUS SYSTEM.....	532
<i>Sculptra (SW)</i>		.Palliative Care.....	646, 647
.VARIOUS.....	598	<i>Seretide Accuhaler 100/50 (GK)</i>	
<i>Seaze 100 (QA)</i>		.RESPIRATORY SYSTEM.....	567
.NERVOUS SYSTEM.....	505	<i>Seretide Accuhaler 250/50 (GK)</i>	
<i>Seaze 200 (QA)</i>		.RESPIRATORY SYSTEM.....	568
.NERVOUS SYSTEM.....	505	<i>Seretide Accuhaler 500/50 (GK)</i>	
<i>Seaze 25 (QA)</i>		.RESPIRATORY SYSTEM.....	568
.NERVOUS SYSTEM.....	506	<i>Seretide MDI 125/25 (GK)</i>	
<i>Seaze 5 (QA)</i>		.RESPIRATORY SYSTEM.....	568
.NERVOUS SYSTEM.....	506	<i>Seretide MDI 250/25 (GK)</i>	
<i>Seaze 50 (QA)</i>		.RESPIRATORY SYSTEM.....	568
.NERVOUS SYSTEM.....	506	<i>Seretide MDI 50/25 (GK)</i>	
<i>Sebifin 250 (RA)</i>		.RESPIRATORY SYSTEM.....	568
.DERMATOLOGICALS.....	191	<i>Serevent Accuhaler (GK)</i>	
<i>SebiRinse (EO)</i>		.RESPIRATORY SYSTEM.....	565
.Repatriation Schedule	1207	<i>Seronia 100 (QA)</i>	
<i>Sebitar (EO)</i>		.NERVOUS SYSTEM.....	523
.Repatriation Schedule	1206	<i>Seronia 200 (QA)</i>	
<i>Sebivo (NV)</i>		.NERVOUS SYSTEM.....	524
.Section 100	718, 968	<i>Seronia 25 (QA)</i>	
<i>Sebizole (GN)</i>		.NERVOUS SYSTEM.....	525
.Repatriation Schedule	1203	<i>Seronia 300 (QA)</i>	
<i>seebri breezhaler (NV)</i>		.NERVOUS SYSTEM.....	524
.RESPIRATORY SYSTEM	571	<i>Serophene (SG)</i>	

GENERIC/PROPRIETARY INDEX

.GENITO URINARY SYSTEM AND SEX HORMONES . 205	.MUSCULO-SKELETAL SYSTEM 478
<i>Seroquel (AP)</i>	<i>Sifrol (BY)</i>
.NERVOUS SYSTEM..... 523, 524, 525	.NERVOUS SYSTEM..... 512, 513, 514
<i>Seroquel XR (AP)</i>	<i>Sifrol ER (BY)</i>
.NERVOUS SYSTEM..... 523, 524	.NERVOUS SYSTEM..... 513
<i>Sertra 100 (QA)</i>	<i>Sigmacort (QA)</i>
.NERVOUS SYSTEM..... 539	.DERMATOLOGICALS 193
<i>Sertra 50 (QA)</i>	<i>Sigmaxin (FM)</i>
.NERVOUS SYSTEM..... 539	.CARDIOVASCULAR SYSTEM 126
<i>Sertracor 100 (CR)</i>	<i>Sigmaxin-PG (FM)</i>
.NERVOUS SYSTEM..... 539	.CARDIOVASCULAR SYSTEM 126
<i>Sertracor 50 (CR)</i>	<i>Silaran (RA)</i>
.NERVOUS SYSTEM..... 539	.Repatriation Schedule 1209
SERTRALINE	SILDENAFIL
.NERVOUS SYSTEM..... 539	.Repatriation Schedule 1209
<i>Sertraline Actavis (UA)</i>	.Section 100..... 692, 940
.NERVOUS SYSTEM..... 539, 540	<i>Sildenafil GH (GQ)</i>
<i>Sertraline AN (EA)</i>	.Repatriation Schedule 1209
.NERVOUS SYSTEM..... 539, 540	<i>Sildenafil Sandoz PHT 20 (SZ)</i>
<i>Sertraline generichealth (GQ)</i>	.Section 100..... 698, 946
.NERVOUS SYSTEM..... 539	<i>Silic 15 (EO)</i>
<i>Sertraline Sandoz (SZ)</i>	.Repatriation Schedule 1204
.NERVOUS SYSTEM..... 539	SIMEPREVIR
<i>Sertraline-DRLA (RZ)</i>	.Section 100..... 713, 962
.NERVOUS SYSTEM..... 539	<i>Simipex 0.125 (QA)</i>
<i>Setopress 3505 (MH)</i>	.NERVOUS SYSTEM..... 513
.Repatriation Schedule 1226	<i>Simipex 0.25 (QA)</i>
<i>Setrona (RA)</i>	.NERVOUS SYSTEM..... 513
.NERVOUS SYSTEM..... 539	<i>Simipex 1 (QA)</i>
SEVELAMER	.NERVOUS SYSTEM..... 512
.Section 100 897, 1151	<i>Simplotan (FZ)</i>
.VARIOUS..... 596	.ANTIINFECTIVES FOR SYSTEMIC USE 240
<i>Sevikar 20/5 (MK)</i>	<i>Simponi (JC)</i>
.CARDIOVASCULAR SYSTEM 157	.ANTINEOPLASTIC AND IMMUNOMODULATING
<i>Sevikar 40/10 (MK)</i>	AGENTS 436, 439, 442, 445, 449, 451
.CARDIOVASCULAR SYSTEM 157	<i>Simpral (AF)</i>
<i>Sevikar 40/5 (MK)</i>	.NERVOUS SYSTEM..... 512, 513, 514
.CARDIOVASCULAR SYSTEM 157	<i>Simvacor 10 (CR)</i>
<i>Sevikar HCT 20/5/12.5 (MK)</i>	.CARDIOVASCULAR SYSTEM 170, 171
.CARDIOVASCULAR SYSTEM 158	<i>Simvacor 20 (CR)</i>
<i>Sevikar HCT 40/10/12.5 (MK)</i>	.CARDIOVASCULAR SYSTEM 170, 171
.CARDIOVASCULAR SYSTEM 158	<i>Simvacor 40 (CR)</i>
<i>Sevikar HCT 40/10/25 (MK)</i>	.CARDIOVASCULAR SYSTEM 170, 172
.CARDIOVASCULAR SYSTEM 158	<i>Simvacor 80 (CR)</i>
<i>Sevikar HCT 40/5/12.5 (MK)</i>	.CARDIOVASCULAR SYSTEM 171, 172
.CARDIOVASCULAR SYSTEM 158	<i>Simvar 10 (QA)</i>
<i>Sevikar HCT 40/5/25 (MK)</i>	.CARDIOVASCULAR SYSTEM 170, 171
.CARDIOVASCULAR SYSTEM 158	<i>Simvar 20 (QA)</i>
<i>Sevredol (MF)</i>	.CARDIOVASCULAR SYSTEM 170, 171
.NERVOUS SYSTEM..... 485	<i>Simvar 40 (QA)</i>
.Palliative Care 642	.CARDIOVASCULAR SYSTEM 170, 172
<i>Shilova 500 (DO)</i>	<i>Simvar 80 (QA)</i>
.ANTIINFECTIVES FOR SYSTEMIC USE 249	.CARDIOVASCULAR SYSTEM 171, 172
<i>Sical (AF)</i>	SIMVASTATIN
.ALIMENTARY TRACT AND METABOLISM..... 105	.CARDIOVASCULAR SYSTEM 170, 171

GENERIC/PROPRIETARY INDEX

<i>Simvastatin AN (EA)</i>		
.CARDIOVASCULAR SYSTEM.....	170, 171, 172	
<i>Simvastatin generichealth (GQ)</i>		
.CARDIOVASCULAR SYSTEM.....	170, 171, 172	
<i>Simvastatin Sandoz (SZ)</i>		
.CARDIOVASCULAR SYSTEM.....	170, 171, 172	
<i>Simvastatin-DP (UA)</i>		
.CARDIOVASCULAR SYSTEM.....	170, 171, 172	
<i>Simvastatin-DRLA (RZ)</i>		
.CARDIOVASCULAR SYSTEM.....	170, 171, 172	
<i>Simvastatin-GA 10 (GN)</i>		
.CARDIOVASCULAR SYSTEM.....	170, 171	
<i>Simvastatin-GA 20 (GN)</i>		
.CARDIOVASCULAR SYSTEM.....	170, 171	
<i>Simvastatin-GA 40 (GN)</i>		
.CARDIOVASCULAR SYSTEM.....	170, 172	
<i>Simvastatin-GA 80 (GN)</i>		
.CARDIOVASCULAR SYSTEM.....	171, 172	
<i>Sinemet (MK)</i>		
.NERVOUS SYSTEM.....	510	
<i>Sinemet 100/25 (MK)</i>		
.NERVOUS SYSTEM.....	510	
<i>Sinemet CR (MK)</i>		
.NERVOUS SYSTEM.....	511	
<i>Sinequan (PF)</i>		
.NERVOUS SYSTEM.....	534	
<i>Singulair (MK)</i>		
.RESPIRATORY SYSTEM	574	
SIROLIMUS		
.ANTINEOPLASTIC AND IMMUNOMODULATING		
AGENTS	307	
.Section 100	772, 1024	
SITAGLIPTIN		
.ALIMENTARY TRACT AND METABOLISM.....	100	
SITAGLIPTIN + METFORMIN		
.ALIMENTARY TRACT AND METABOLISM.....	94	
<i>Skelid (SW)</i>		
.MUSCULO-SKELETAL SYSTEM	472	
SKIN EMOLLIENT		
.Repatriation Schedule.....	1204	
<i>Slow-K (NV)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	105	
<i>Sno-Pro (SB)</i>		
.VARIOUS.....	628	
<i>Sodibic (AS)</i>		
.GENITO URINARY SYSTEM AND SEX HORMONES .	207	
SODIUM CHLORIDE		
.BLOOD AND BLOOD FORMING ORGANS	124	
.Repatriation Schedule.....	1201	
SODIUM CHLORIDE + GLUCOSE		
.BLOOD AND BLOOD FORMING ORGANS	124	
SODIUM CHLORIDE + POTASSIUM CHLORIDE + CALCIUM		
CHLORIDE DIHYDRATE		
.BLOOD AND BLOOD FORMING ORGANS	125	
SODIUM CHLORIDE + POTASSIUM CHLORIDE + GLUCOSE		
MONOHYDRATE + CITRATE		
.ALIMENTARY TRACT AND METABOLISM.....	82	
SODIUM GLUCONATE + SODIUM CHLORIDE +		
POTASSIUM CHLORIDE + MAGNESIUM CHLORIDE +		
SODIUM ACETATE TRIHYDRATE + GLUCOSE		
.BLOOD AND BLOOD FORMING ORGANS.....	125	
SODIUM HYALURONATE		
.SENSORY ORGANS.....	593, 594	
<i>Sodium Valproate Sandoz (SZ)</i>		
.NERVOUS SYSTEM.....	502	
<i>Soflax (GN)</i>		
.Repatriation Schedule	1198	
<i>Sofradex (SW)</i>		
.SENSORY ORGANS.....	595	
<i>Soframycin (SW)</i>		
.SENSORY ORGANS.....	595	
<i>Solaraze 3% Gel (CS)</i>		
.Repatriation Schedule	1207	
<i>Solavert (QA)</i>		
.CARDIOVASCULAR SYSTEM	127	
<i>Solian 100 (SW)</i>		
.NERVOUS SYSTEM.....	525	
<i>Solian 200 (SW)</i>		
.NERVOUS SYSTEM.....	526	
<i>Solian 400 (SW)</i>		
.NERVOUS SYSTEM.....	526	
<i>Solian Solution (SW)</i>		
.NERVOUS SYSTEM.....	526	
<i>Soliris (XI)</i>		
.Section 100.....	761, 762, 770, 1020, 1021, 1022	
<i>Solone (IA)</i>		
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX		
HORMONES AND INSULINS	213	
<i>SoloSite Gel 36361338 (SN)</i>		
.Repatriation Schedule	1237	
<i>Solprin (RC)</i>		
.BLOOD AND BLOOD FORMING ORGANS.....	110	
.NERVOUS SYSTEM.....	494	
<i>Solu-Cortef (PF)</i>		
.Prescriber Bag	62	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX		
HORMONES AND INSULINS	212	
<i>Solugel 10336 (JJ)</i>		
.Repatriation Schedule	1237	
<i>Solu-Medrol (PF)</i>		
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX		
HORMONES AND INSULINS	212	
<i>Somac (NQ)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	71	
SOMATROPIN		
.Section 100.....	1156, 1157	
<i>Somatuline Autogel (IS)</i>		
.Section 100.....	705, 953	
<i>Somatuline LA (IS)</i>		

GENERIC/PROPRIETARY INDEX

.Section 100	706, 954	<i>Stalevo 125/31.25/200mg (NV)</i>	
<i>Sone (IA)</i>		.NERVOUS SYSTEM.....	511
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX		<i>Stalevo 150/37.5/200mg (NV)</i>	
HORMONES AND INSULINS.....	213	.NERVOUS SYSTEM.....	511
SORAFENIB		<i>Stalevo 200/50/200mg (NV)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING		.NERVOUS SYSTEM.....	511
AGENTS	282	<i>Stalevo 50/12.5/200mg (NV)</i>	
<i>Sorbact Absorption Dressing S98222 (QL)</i>		.NERVOUS SYSTEM.....	511
.Repatriation Schedule	1237	<i>Stalevo 75/18.75/200mg (NV)</i>	
<i>Sorbact Foam Dressing S98310 (QL)</i>		.NERVOUS SYSTEM.....	511
.Repatriation Schedule	1237	<i>Staphylex 250 (AF)</i>	
<i>Sorbact Ribbon Gauze S98118 (QL)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE	223
.Repatriation Schedule	1237	<i>Staphylex 500 (AF)</i>	
<i>Sorbact Ribbon Gauze S98120 (QL)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE	224
.Repatriation Schedule	1237	STAVUDINE	
SORBITOL + CITRATE + LAURYL SULFOACETATE SODIUM		.Section 100.....	718, 967
.ALIMENTARY TRACT AND METABOLISM.....	81	<i>Stelara (JC)</i>	
.Palliative Care	636	.ANTINEOPLASTIC AND IMMUNOMODULATING	
.Repatriation Schedule	1198	AGENTS	456, 459
<i>Sorbsan 1410 (UM)</i>		<i>Stelax 10 (QA)</i>	
.Repatriation Schedule	1230	.MUSCULO-SKELETAL SYSTEM	468
<i>Sorbsan 1411 (UM)</i>		<i>Stelax 25 (QA)</i>	
.Repatriation Schedule	1230	.MUSCULO-SKELETAL SYSTEM	468
<i>Sotacor (FM)</i>		<i>Stelazine (GH)</i>	
.CARDIOVASCULAR SYSTEM	127	.NERVOUS SYSTEM.....	515
SOTALOL		<i>Stemetil (SW)</i>	
.CARDIOVASCULAR SYSTEM	127	.ALIMENTARY TRACT AND METABOLISM.....	78
<i>Sotalol Sandoz (SZ)</i>		.Prescriber Bag	63
.CARDIOVASCULAR SYSTEM	127	<i>Stemzine (AV)</i>	
SOY LECITHIN + TOCOPHEROLS + VITAMIN A		.ALIMENTARY TRACT AND METABOLISM.....	78
.SENSORY ORGANS.....	594	<i>Steripaste 3610 (MH)</i>	
SOY PROTEIN AND FAT FORMULA WITH VITAMINS AND		.Repatriation Schedule	1229
MINERALS CARBOHYDRATE FREE		<i>Stieprox Liquid (GK)</i>	
.VARIOUS.....	628	.Repatriation Schedule	1203
<i>Sozol (QA)</i>		<i>Stocrin (MK)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	71, 72	.Section 100.....	721, 970, 971
<i>Span-K (AS)</i>		<i>Strattera (LY)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	105	.NERVOUS SYSTEM.....	544
<i>Spiractin 100 (AF)</i>		<i>Stribild (GI)</i>	
.CARDIOVASCULAR SYSTEM	132	.Section 100.....	725, 975
<i>Spiractin 25 (AF)</i>		<i>Stromectol (MK)</i>	
.CARDIOVASCULAR SYSTEM	132	.ANTIPARASITIC PRODUCTS, INSECTICIDES AND	
<i>Spiriva (BY)</i>		REPELLENTS	563
.RESPIRATORY SYSTEM	572	STRONTIUM	
SPIRONOLACTONE		.MUSCULO-SKELETAL SYSTEM	480
.CARDIOVASCULAR SYSTEM	132	<i>Suboxone Film 2/0.5 (RC)</i>	
<i>Sporanox (JC)</i>		.Section 100.....	1161
.ANTIINFECTIVES FOR SYSTEMIC USE.....	242	<i>Suboxone Film 8/2 (RC)</i>	
<i>Spren 100 (QA)</i>		.Section 100.....	1161
.BLOOD AND BLOOD FORMING ORGANS	110	<i>Subutex (RC)</i>	
<i>Sprycel (BQ)</i>		.Section 100.....	1161
.ANTINEOPLASTIC AND IMMUNOMODULATING		SUCRALFATE	
AGENTS	257, 259, 260, 261	.ALIMENTARY TRACT AND METABOLISM.....	73
<i>Stalevo 100/25/200mg (NV)</i>		SULFADIAZINE SILVER	
.NERVOUS SYSTEM.....	511	.DERMATOLOGICALS	192

GENERIC/PROPRIETARY INDEX

SULFASALAZINE	
.ALIMENTARY TRACT AND METABOLISM.....	86
<i>Sulprix (AF)</i>	
.NERVOUS SYSTEM.....	526
SULTHIAME	
.NERVOUS SYSTEM.....	508
<i>Sumagran Aspen 50 (AS)</i>	
.NERVOUS SYSTEM.....	497
<i>Sumatab (AF)</i>	
.NERVOUS SYSTEM.....	497
<i>Sumatran (QA)</i>	
.NERVOUS SYSTEM.....	497, 498
SUMATRIPTAN	
.NERVOUS SYSTEM.....	497
<i>Sumatriptan AN (EA)</i>	
.NERVOUS SYSTEM.....	498
<i>Sumatriptan generichealth (GQ)</i>	
.NERVOUS SYSTEM.....	498
<i>Sumatriptan RBX (RA)</i>	
.NERVOUS SYSTEM.....	498
<i>Sumatriptan Sandoz (SZ)</i>	
.NERVOUS SYSTEM.....	497, 498
<i>Sumatriptan-GA (GN)</i>	
.NERVOUS SYSTEM.....	498
SUNITINIB	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	282, 283, 284
SUNSCREENS	
.Repatriation Schedule	1204
<i>Sunsense Sensitive SPF 30+ (EO)</i>	
.Repatriation Schedule	1204
<i>SunSense Ultra SPF 30+ (EO)</i>	
.Repatriation Schedule	1205
<i>Surepress 650947 (CC)</i>	
.Repatriation Schedule	1226
<i>Surepress 650948 (CC)</i>	
.Repatriation Schedule	1226
<i>Sutent (PF)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	283, 284, 285
<i>Symbicort Rapihaler 100/3 (AP)</i>	
.RESPIRATORY SYSTEM	565
<i>Symbicort Rapihaler 200/6 (AP)</i>	
.RESPIRATORY SYSTEM	566
<i>Symbicort Rapihaler 50/3 (AP)</i>	
.RESPIRATORY SYSTEM	565
<i>Symbicort Turbuhaler 100/6 (AP)</i>	
.RESPIRATORY SYSTEM	566
<i>Symbicort Turbuhaler 200/6 (AP)</i>	
.RESPIRATORY SYSTEM	566
<i>Symbicort Turbuhaler 400/12 (AP)</i>	
.RESPIRATORY SYSTEM	567
<i>Symmetrel 100 (NV)</i>	
.NERVOUS SYSTEM.....	512
<i>Synacthen Depot 1 mg/1 mL (NV)</i>	

.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
HORMONES AND INSULINS	209
<i>Synarel (PF)</i>	
.Section 100.....	1159
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	
HORMONES AND INSULINS	210
<i>Syquet (AF)</i>	
.NERVOUS SYSTEM.....	523, 524, 525
<i>Systane (AQ)</i>	
.SENSORY ORGANS.....	592, 593

T

<i>T Lukast (AF)</i>	
.RESPIRATORY SYSTEM.....	574
<i>Tacidine (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	67
TACROLIMUS	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	460
.Section 100.....	869, 1121
<i>Tacrolimus Sandoz (SZ)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	460
.Section 100.....	869, 1121, 1122
TADALAFIL	
.Repatriation Schedule	1210
.Section 100.....	698, 946
<i>Tafinlar (GK)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	255, 256
T AFLUPROST	
.SENSORY ORGANS.....	583
<i>Talam (QA)</i>	
.NERVOUS SYSTEM.....	535
<i>Tamate (AF)</i>	
.NERVOUS SYSTEM.....	508, 509
<i>Tambacor (IA)</i>	
.CARDIOVASCULAR SYSTEM	127
<i>Tamosin (QA)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	287
<i>Tamoxen 20 mg (GN)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	287
TAMOXIFEN	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	287
<i>Tamoxifen Sandoz (SZ)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	287
<i>Tamsil (QA)</i>	
.DERMATOLOGICALS	191
.Repatriation Schedule	1204
TAMSULOSIN	

GENERIC/PROPRIETARY INDEX

.Repatriation Schedule.....	1210	.NERVOUS SYSTEM.....	500, 501
<i>Tamsulosin Sandoz SR (SZ)</i>		<i>Tegretol Liquid (NV)</i>	
.Repatriation Schedule.....	1210	.NERVOUS SYSTEM.....	500, 501
TAPE NON WOVEN RETENTION POLYACRYLATE		TELAPREVIR	
.Repatriation Schedule.....	1239	.Section 100.....	714, 963
TAPE PLASTER ADHESIVE ELASTIC		TELBIVUDINE	
.Repatriation Schedule.....	1239	.Section 100.....	718, 968
TAPE PLASTER ADHESIVE HYPOALLERGENIC		<i>Telfa 1970C (KE)</i>	
.Repatriation Schedule.....	1239, 1240	.Repatriation Schedule.....	1238
TAPE PLASTER ADHESIVE WITH SILICONE		<i>Telfa 2140C (KE)</i>	
.Repatriation Schedule.....	1240	.Repatriation Schedule.....	1238
TAPENTADOL		<i>Telfa 7650C (KE)</i>	
.NERVOUS SYSTEM.....	491	.Repatriation Schedule.....	1238
TAR + CADE OIL + COAL TAR + ARACHIS OIL EXTRACT OF		<i>Telfa 8252F (KE)</i>	
COAL TAR		.Repatriation Schedule.....	1227
.Repatriation Schedule.....	1206	<i>Telfa 8253F (KE)</i>	
<i>Tarceva (RO)</i>		.Repatriation Schedule.....	1227
.ANTINEOPLASTIC AND IMMUNOMODULATING		<i>Telfa 8254F (KE)</i>	
AGENTS	261, 262	.Repatriation Schedule.....	1227
<i>Targin 10/5mg (MF)</i>		<i>Telfast (SW)</i>	
.NERVOUS SYSTEM.....	487	.Repatriation Schedule.....	1221
<i>Targin 20/10mg (MF)</i>		<i>Telfast 120 (SW)</i>	
.NERVOUS SYSTEM.....	487	.Repatriation Schedule.....	1221
<i>Targin 40/20mg (MF)</i>		<i>Telmigen (GN)</i>	
.NERVOUS SYSTEM.....	487	.CARDIOVASCULAR SYSTEM	151, 152
<i>Targin 5/2.5mg (MF)</i>		<i>Telmigen HCT 40/12.5 (GN)</i>	
.NERVOUS SYSTEM.....	487	.CARDIOVASCULAR SYSTEM	155
<i>Tarka 2/180 (AB)</i>		<i>Telmigen HCT 80/12.5 (GN)</i>	
.CARDIOVASCULAR SYSTEM	148	.CARDIOVASCULAR SYSTEM	155
<i>Tarka 4/240 (AB)</i>		<i>Telmigen HCT 80/25 (GN)</i>	
.CARDIOVASCULAR SYSTEM	148	.CARDIOVASCULAR SYSTEM	156
<i>Tasigna (NV)</i>		TELMISARTAN	
.ANTINEOPLASTIC AND IMMUNOMODULATING		.CARDIOVASCULAR SYSTEM	151
AGENTS	276, 278	TELMISARTAN + AMLODIPINE	
<i>Tazac (AS)</i>		.CARDIOVASCULAR SYSTEM	157
.ALIMENTARY TRACT AND METABOLISM.....	67	TELMISARTAN + HYDROCHLOROTHIAZIDE	
<i>Tears Naturelle (AQ)</i>		.CARDIOVASCULAR SYSTEM	155
.SENSORY ORGANS.....	590	<i>Telmisartan AN (EA)</i>	
<i>tearsagain (RB)</i>		.CARDIOVASCULAR SYSTEM	151, 152
.SENSORY ORGANS.....	594	<i>Telmisartan GH (GQ)</i>	
<i>Tecfidera (BD)</i>		.CARDIOVASCULAR SYSTEM	151, 152
.NERVOUS SYSTEM.....	559, 560	<i>Telmisartan HCT GH 40/12.5 (GQ)</i>	
<i>Tegaderm Transparent 1628 (MM)</i>		.CARDIOVASCULAR SYSTEM	155
.Repatriation Schedule.....	1231	<i>Telmisartan HCT GH 80/12.5 (GQ)</i>	
<i>Tegaderm Transparent Island 3582 (MM)</i>		.CARDIOVASCULAR SYSTEM	156
.Repatriation Schedule.....	1231	<i>Telmisartan HCT GH 80/25 (GQ)</i>	
<i>Tegaderm Transparent Island 3586 (MM)</i>		.CARDIOVASCULAR SYSTEM	156
.Repatriation Schedule.....	1231	<i>Telmisartan HCTZ AN 40/12.5 (EA)</i>	
<i>Tegretol 100 (NV)</i>		.CARDIOVASCULAR SYSTEM	155
.NERVOUS SYSTEM.....	500	<i>Telmisartan HCTZ AN 80/12.5 (EA)</i>	
<i>Tegretol 200 (NV)</i>		.CARDIOVASCULAR SYSTEM	156
.NERVOUS SYSTEM.....	501	<i>Telmisartan HCTZ AN 80/25 (EA)</i>	
<i>Tegretol CR 200 (NV)</i>		.CARDIOVASCULAR SYSTEM	156
.NERVOUS SYSTEM.....	500, 501	<i>Telmisartan RBX (RA)</i>	
<i>Tegretol CR 400 (NV)</i>		.CARDIOVASCULAR SYSTEM	151, 152

GENERIC/PROPRIETARY INDEX

<i>Telmisartan Sandoz (SZ)</i>		<i>.Repatriation Schedule</i>	1234
<i>.CARDIOVASCULAR SYSTEM</i>	151, 152	<i>TenderWet 24 Active 609213 (HR)</i>	
<i>Telmisartan/HCT Sandoz (SZ)</i>		<i>.Repatriation Schedule</i>	1234
<i>.CARDIOVASCULAR SYSTEM</i>	155, 156	<i>TenderWet Active Cavity 609272 (HR)</i>	
<i>Telmisartan-DRLA (RZ)</i>		<i>.Repatriation Schedule</i>	1234
<i>.CARDIOVASCULAR SYSTEM</i>	151, 152	TENECTEPLASE	
<i>Teltartan (QA)</i>		<i>.BLOOD AND BLOOD FORMING ORGANS</i>	114
<i>.CARDIOVASCULAR SYSTEM</i>	151, 152	TENOFOVIR	
<i>Teltartan HCT 40/12.5 (QA)</i>		<i>.Section 100</i>	719, 968
<i>.CARDIOVASCULAR SYSTEM</i>	155	TENOFOVIR + EMTRICITABINE	
<i>Teltartan HCT 80/12.5 (QA)</i>		<i>.Section 100</i>	724, 974
<i>.CARDIOVASCULAR SYSTEM</i>	156	TENOFOVIR + EMTRICITABINE + EFAVIRENZ	
<i>Teltartan HCT 80/25 (QA)</i>		<i>.Section 100</i>	724, 974
<i>.CARDIOVASCULAR SYSTEM</i>	156	TENOFOVIR + EMTRICITABINE + ELVITEGRAVIR +	
<i>Telzir (VI)</i>		COBICISTAT	
<i>.Section 100</i>	711, 961	<i>.Section 100</i>	724, 975
<i>Temaze (AF)</i>		<i>Tenolten 50 (DO)</i>	
<i>.NERVOUS SYSTEM</i>	533	<i>.CARDIOVASCULAR SYSTEM</i>	134
<i>.Palliative Care</i>	647	<i>Tenopt (QA)</i>	
TEMAZEPAM		<i>.SENSORY ORGANS</i>	581
<i>.NERVOUS SYSTEM</i>	533	<i>Tenormin (AP)</i>	
<i>.Palliative Care</i>	647	<i>.CARDIOVASCULAR SYSTEM</i>	134
<i>Temizole 100 (QA)</i>		<i>Tensig (QA)</i>	
<i>.ANTINEOPLASTIC AND IMMUNOMODULATING</i>		<i>.CARDIOVASCULAR SYSTEM</i>	134
AGENTS	251, 252	<i>Tensocrepe 36300501 (BV)</i>	
<i>Temizole 140 (QA)</i>		<i>.Repatriation Schedule</i>	1227
<i>.ANTINEOPLASTIC AND IMMUNOMODULATING</i>		<i>Tensocrepe 36301001 (BV)</i>	
AGENTS	251, 252	<i>.Repatriation Schedule</i>	1227
<i>Temizole 20 (QA)</i>		<i>Tensocrepe 36307501 (BV)</i>	
<i>.ANTINEOPLASTIC AND IMMUNOMODULATING</i>		<i>.Repatriation Schedule</i>	1227
AGENTS	252	<i>Tensopress 71723-00 (BV)</i>	
<i>Temizole 250 (QA)</i>		<i>.Repatriation Schedule</i>	1226
<i>.ANTINEOPLASTIC AND IMMUNOMODULATING</i>		TERAZOSIN	
AGENTS	252	<i>.Repatriation Schedule</i>	1210
<i>Temizole 5 (QA)</i>		TERBINAFINE	
<i>.ANTINEOPLASTIC AND IMMUNOMODULATING</i>		<i>.DERMATOLOGICALS</i>	190, 191
AGENTS	252, 253	<i>.Repatriation Schedule</i>	1203
<i>Temodal (MK)</i>		<i>Terbinafine Actavis (VN)</i>	
<i>.ANTINEOPLASTIC AND IMMUNOMODULATING</i>		<i>.DERMATOLOGICALS</i>	191
AGENTS	251, 252, 253	<i>Terbinafine GH (GQ)</i>	
TEMOZOLOMIDE		<i>.DERMATOLOGICALS</i>	191
<i>.ANTINEOPLASTIC AND IMMUNOMODULATING</i>		<i>.Repatriation Schedule</i>	1204
AGENTS	251, 252	<i>Terbinafine Sandoz (SZ)</i>	
<i>Temozolomide Alphapharm (AF)</i>		<i>.DERMATOLOGICALS</i>	191
<i>.ANTINEOPLASTIC AND IMMUNOMODULATING</i>		<i>.Repatriation Schedule</i>	1204
AGENTS	251, 252, 253	<i>Terbinafine-DRLA (RZ)</i>	
<i>Temozolomide AN (EA)</i>		<i>.DERMATOLOGICALS</i>	191
<i>.ANTINEOPLASTIC AND IMMUNOMODULATING</i>		TERBUTALINE	
AGENTS	251, 252, 253	<i>.RESPIRATORY SYSTEM</i>	565, 573
<i>Temtabs (FM)</i>		TERIFLUNOMIDE	
<i>.NERVOUS SYSTEM</i>	533	<i>.ANTINEOPLASTIC AND IMMUNOMODULATING</i>	
<i>.Palliative Care</i>	647	AGENTS	308
<i>Tenaxil SR (QA)</i>		<i>Teril (AF)</i>	
<i>.CARDIOVASCULAR SYSTEM</i>	131	<i>.NERVOUS SYSTEM</i>	501
<i>TenderWet 24 Active 609210 (HR)</i>		TERIPARATIDE	

GENERIC/PROPRIETARY INDEX

.MUSCULO-SKELETAL SYSTEM	480	<i>Terry White Chemists Candesartan (TW)</i>	
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX HORMONES AND INSULINS	215	.CARDIOVASCULAR SYSTEM	149, 150
<i>Terry White Chemists Aciclovir (TW)</i>		<i>Terry White Chemists Candesartan HCTZ 16/12.5 (TW)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	245	.CARDIOVASCULAR SYSTEM	152
<i>Terry White Chemists Alendronate 70mg (TW)</i>		<i>Terry White Chemists Candesartan HCTZ 32/12.5 (TW)</i>	
.MUSCULO-SKELETAL SYSTEM	470	.CARDIOVASCULAR SYSTEM	153
<i>Terry White Chemists Allopurinol (TW)</i>		<i>Terry White Chemists Candesartan HCTZ 32/25 (TW)</i>	
.MUSCULO-SKELETAL SYSTEM	469	.CARDIOVASCULAR SYSTEM	153
<i>Terry White Chemists Alprazolam (TW)</i>		<i>Terry White Chemists Carvedilol 12.5 mg (TW)</i>	
.NERVOUS SYSTEM	531	.CARDIOVASCULAR SYSTEM	136
<i>Terry White Chemists Amiodarone (TW)</i>		<i>Terry White Chemists Carvedilol 25 mg (TW)</i>	
.CARDIOVASCULAR SYSTEM	127	.CARDIOVASCULAR SYSTEM	136
<i>Terry White Chemists Amlodipine (TW)</i>		<i>Terry White Chemists Carvedilol 3.125 mg (TW)</i>	
.CARDIOVASCULAR SYSTEM	137	.CARDIOVASCULAR SYSTEM	136
<i>Terry White Chemists Amlodipine/Atorvastatin 10/10 (TW)</i>		<i>Terry White Chemists Carvedilol 6.25 mg (TW)</i>	
.CARDIOVASCULAR SYSTEM	188	.CARDIOVASCULAR SYSTEM	137
<i>Terry White Chemists Amlodipine/Atorvastatin 10/20 (TW)</i>		<i>Terry White Chemists Cefaclor CD (TW)</i>	
.CARDIOVASCULAR SYSTEM	188	.ANTIINFECTIVES FOR SYSTEMIC USE	229
<i>Terry White Chemists Amlodipine/Atorvastatin 10/40 (TW)</i>		<i>Terry White Chemists Celecoxib (TW)</i>	
.CARDIOVASCULAR SYSTEM	188	.MUSCULO-SKELETAL SYSTEM	467
<i>Terry White Chemists Amlodipine/Atorvastatin 10/80 (TW)</i>		<i>Terry White Chemists Cephalexin (TW)</i>	
.CARDIOVASCULAR SYSTEM	188	.ANTIINFECTIVES FOR SYSTEMIC USE	226, 227, 228
<i>Terry White Chemists Amlodipine/Atorvastatin 5/10 (TW)</i>		<i>Terry White Chemists Citalopram (TW)</i>	
.CARDIOVASCULAR SYSTEM	189	.NERVOUS SYSTEM	535
<i>Terry White Chemists Amlodipine/Atorvastatin 5/20 (TW)</i>		<i>Terry White Chemists Clarithromycin (TW)</i>	
.CARDIOVASCULAR SYSTEM	189	.ANTIINFECTIVES FOR SYSTEMIC USE	233
<i>Terry White Chemists Amlodipine/Atorvastatin 5/40 (TW)</i>		<i>Terry White Chemists Clindamycin (TW)</i>	
.CARDIOVASCULAR SYSTEM	189	.ANTIINFECTIVES FOR SYSTEMIC USE	235
<i>Terry White Chemists Amlodipine/Atorvastatin 5/80 (TW)</i>		<i>Terry White Chemists Clomipramine (TW)</i>	
.CARDIOVASCULAR SYSTEM	189	.NERVOUS SYSTEM	534
<i>Terry White Chemists Amoxicillin (TW)</i>		<i>Terry White Chemists Clopidogrel (TW)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	220, 221	.BLOOD AND BLOOD FORMING ORGANS	111
<i>Terry White Chemists Amoxicillin and Clavulanic Acid (TW)</i>		.Repatriation Schedule	1201
.ANTIINFECTIVES FOR SYSTEMIC USE	225	<i>Terry White Chemists Clopidogrel/Aspirin 75/100 (TW)</i>	
<i>Terry White Chemists Anastrozole (TW)</i>		.BLOOD AND BLOOD FORMING ORGANS	112
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	290	<i>Terry White Chemists Diclofenac (TW)</i>	
<i>Terry White Chemists Atenolol (TW)</i>		.MUSCULO-SKELETAL SYSTEM	462
.CARDIOVASCULAR SYSTEM	134	.Palliative Care	638, 639
<i>Terry White Chemists Atorvastatin (TW)</i>		<i>Terry White Chemists Diltiazem CD (TW)</i>	
.CARDIOVASCULAR SYSTEM	161, 162, 163	.CARDIOVASCULAR SYSTEM	139
<i>Terry White Chemists Azithromycin (TW)</i>		<i>Terry White Chemists Donepezil (TW)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	233	.NERVOUS SYSTEM	547, 548, 549
.Repatriation Schedule	1212	.ANTIINFECTIVES FOR SYSTEMIC USE	218, 219
.SENSORY ORGANS	575	<i>Terry White Chemists Duloxetine (TW)</i>	
<i>Terry White Chemists Baclofen (TW)</i>		.NERVOUS SYSTEM	541
.MUSCULO-SKELETAL SYSTEM	468	<i>Terry White Chemists Enalapril (TW)</i>	
<i>Terry White Chemists Bisoprolol (TW)</i>		.CARDIOVASCULAR SYSTEM	140, 141
.CARDIOVASCULAR SYSTEM	134	<i>Terry White Chemists Escitalopram (TW)</i>	
		.NERVOUS SYSTEM	536
		<i>Terry White Chemists Famciclovir (TW)</i>	
		.ANTIINFECTIVES FOR SYSTEMIC USE	247, 248
		<i>Terry White Chemists Famotidine (TW)</i>	
		.ALIMENTARY TRACT AND METABOLISM	67
		<i>Terry White Chemists Fluoxetine (TW)</i>	

GENERIC/PROPRIETARY INDEX

.NERVOUS SYSTEM.....	538	.NERVOUS SYSTEM.....	517, 518, 519, 520
<i>Terry White Chemists Frusemide (TW)</i>		<i>Terry White Chemists Omeprazole (TW)</i>	
.CARDIOVASCULAR SYSTEM.....	132	.ALIMENTARY TRACT AND METABOLISM.....	70
<i>Terry White Chemists Gemfibrozil (TW)</i>		<i>Terry White Chemists Osteo Relief Paracetamol 665 mg (TW)</i>	
.CARDIOVASCULAR SYSTEM.....	173	.NERVOUS SYSTEM.....	495
<i>Terry White Chemists Gliclazide (TW)</i>		.Palliative Care.....	644, 645
.ALIMENTARY TRACT AND METABOLISM.....	90	<i>Terry White Chemists Pantoprazole (TW)</i>	
<i>Terry White Chemists Gliclazide MR (TW)</i>		.ALIMENTARY TRACT AND METABOLISM.....	71, 72
.ALIMENTARY TRACT AND METABOLISM.....	90	<i>Terry White Chemists Paroxetine (TW)</i>	
<i>Terry White Chemists Hydroxychloroquine (TW)</i>		.NERVOUS SYSTEM.....	539
.MUSCULO-SKELETAL SYSTEM	467	<i>Terry White Chemists Perindopril (TW)</i>	
<i>Terry White Chemists Indapamide (TW)</i>		.CARDIOVASCULAR SYSTEM	142, 143
.CARDIOVASCULAR SYSTEM.....	131	<i>Terry White Chemists Perindopril/ Indapamide 4/1.25 (TW)</i>	
<i>Terry White Chemists Indapamide SR (TW)</i>		.CARDIOVASCULAR SYSTEM	147
.CARDIOVASCULAR SYSTEM.....	131	<i>Terry White Chemists Pioglitazone (TW)</i>	
<i>Terry White Chemists Irbesartan (TW)</i>		.ALIMENTARY TRACT AND METABOLISM.....	97, 98
.CARDIOVASCULAR SYSTEM.....	150, 151	<i>Terry White Chemists Piroxicam (TW)</i>	
<i>Terry White Chemists Irbesartan HCTZ (TW)</i>		.MUSCULO-SKELETAL SYSTEM	464, 465
.CARDIOVASCULAR SYSTEM.....	154, 155	<i>Terry White Chemists Pravastatin (TW)</i>	
<i>Terry White Chemists Isosorbide Mononitrate (TW)</i>		.CARDIOVASCULAR SYSTEM	164, 165, 166
.CARDIOVASCULAR SYSTEM.....	129	<i>Terry White Chemists Prazosin (TW)</i>	
<i>Terry White Chemists Latanoprost (TW)</i>		.CARDIOVASCULAR SYSTEM	130
.SENSORY ORGANS.....	582, 583	<i>Terry White Chemists Quetiapine (TW)</i>	
<i>Terry White Chemists Lercanidipine (TW)</i>		.NERVOUS SYSTEM.....	523, 524, 525
.CARDIOVASCULAR SYSTEM.....	138	<i>Terry White Chemists Rabeprazole (TW)</i>	
<i>Terry White Chemists Letrozole (TW)</i>		.ALIMENTARY TRACT AND METABOLISM.....	72, 73
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	291	<i>Terry White Chemists Raloxifene (TW)</i>	
<i>Terry White Chemists Levetiracetam (TW)</i>		.MUSCULO-SKELETAL SYSTEM	480
.NERVOUS SYSTEM.....	506, 507	<i>Terry White Chemists Ramipril (TW)</i>	
<i>Terry White Chemists Lisinopril (TW)</i>		.CARDIOVASCULAR SYSTEM	143, 144, 145
.CARDIOVASCULAR SYSTEM.....	141, 142	<i>Terry White Chemists Ranitidine (TW)</i>	
<i>Terry White Chemists Meloxicam (TW)</i>		.ALIMENTARY TRACT AND METABOLISM.....	67
.MUSCULO-SKELETAL SYSTEM	463, 464	<i>Terry White Chemists Risedronate (TW)</i>	
<i>Terry White Chemists Meloxicam 15 mg (TW)</i>		.MUSCULO-SKELETAL SYSTEM	472
.MUSCULO-SKELETAL SYSTEM	463	<i>Terry White Chemists Rosuvastatin (TW)</i>	
<i>Terry White Chemists Meloxicam 7.5 mg (TW)</i>		.CARDIOVASCULAR SYSTEM	167, 168, 169, 170
.MUSCULO-SKELETAL SYSTEM	464	<i>Terry White Chemists Roxithromycin (TW)</i>	
<i>Terry White Chemists Metformin (TW)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE.....	234, 235
.ALIMENTARY TRACT AND METABOLISM.....	89, 90	<i>Terry White Chemists Sertraline (TW)</i>	
<i>Terry White Chemists Metformin 1000 (TW)</i>		.NERVOUS SYSTEM.....	539
.ALIMENTARY TRACT AND METABOLISM.....	89	<i>Terry White Chemists Sildenafil (TW)</i>	
<i>Terry White Chemists Metformin XR 500 (TW)</i>		.Repatriation Schedule	1209
.ALIMENTARY TRACT AND METABOLISM.....	89	<i>Terry White Chemists Simvastatin (TW)</i>	
<i>Terry White Chemists Metoprolol (TW)</i>		.CARDIOVASCULAR SYSTEM	170, 171, 172
.CARDIOVASCULAR SYSTEM.....	135	<i>Terry White Chemists Sotalol (TW)</i>	
<i>Terry White Chemists Mirtazapine (TW)</i>		.CARDIOVASCULAR SYSTEM	127
.NERVOUS SYSTEM.....	542	<i>Terry White Chemists Sumatriptan (TW)</i>	
<i>Terry White Chemists Moclobemide (TW)</i>		.NERVOUS SYSTEM.....	497, 498
.NERVOUS SYSTEM.....	540	<i>Terry White Chemists Telmisartan (TW)</i>	
<i>Terry White Chemists Montelukast (TW)</i>		.CARDIOVASCULAR SYSTEM	151, 152
.RESPIRATORY SYSTEM	574	<i>Terry White Chemists Telmisartan HCTZ 40/12.5 (TW)</i>	
<i>Terry White Chemists Olanzapine (TW)</i>		.CARDIOVASCULAR SYSTEM	155
.NERVOUS SYSTEM.....	518, 520, 522, 523	<i>Terry White Chemists Telmisartan HCTZ 80/12.5 (TW)</i>	
<i>Terry White Chemists Olanzapine ODT (TW)</i>			

GENERIC/PROPRIETARY INDEX

.CARDIOVASCULAR SYSTEM..... 156	.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX
<i>Terry White Chemists Telmisartan HCTZ 80/25 (TW)</i>	HORMONES AND INSULINS..... 209
.CARDIOVASCULAR SYSTEM..... 156	THYROXINE
<i>Terry White Chemists Tramadol (TW)</i>	.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX
.NERVOUS SYSTEM..... 493, 494	HORMONES AND INSULINS..... 214
<i>Terry White Chemists Tramadol SR (TW)</i>	TIAGABINE
.NERVOUS SYSTEM..... 492, 493	.NERVOUS SYSTEM..... 501
<i>Terry White Chemists Valaciclovir (TW)</i>	TICAGRELOR
.ANTIINFECTIVES FOR SYSTEMIC USE..... 248, 249	.BLOOD AND BLOOD FORMING ORGANS..... 113
<i>Terry White Chemists Venlafaxine XR (TW)</i>	TICARCILLIN + CLAVULANIC ACID
.NERVOUS SYSTEM..... 543	.ANTIINFECTIVES FOR SYSTEMIC USE..... 225, 226
<i>Tertroxin (QA)</i>	TICLOPIDINE
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	.BLOOD AND BLOOD FORMING ORGANS..... 113
HORMONES AND INSULINS..... 214	<i>Tielle MT2442 (JJ)</i>
<i>Testogel (HB)</i>	.Repatriation Schedule..... 1234
.GENITO URINARY SYSTEM AND SEX HORMONES . 201	<i>Tielle MTL101E (JJ)</i>
TESTOSTERONE	.Repatriation Schedule..... 1234
.GENITO URINARY SYSTEM AND SEX HORMONES . 201	<i>Tilade CFC-Free (SW)</i>
TESTOSTERONE ENANTHATE	.RESPIRATORY SYSTEM..... 572
.GENITO URINARY SYSTEM AND SEX HORMONES . 201	<i>Tilodene (AF)</i>
TESTOSTERONE UNDECANOATE	.BLOOD AND BLOOD FORMING ORGANS..... 114
.GENITO URINARY SYSTEM AND SEX HORMONES . 201	TILUDRONATE
TETRABENAZINE	.MUSCULO-SKELETAL SYSTEM 472
.NERVOUS SYSTEM..... 560	<i>Timentin (AS)</i>
TETRACOSACTRIN	.ANTIINFECTIVES FOR SYSTEMIC USE..... 225, 226
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	TIMOLOL
HORMONES AND INSULINS..... 209	.SENSORY ORGANS..... 581
<i>TevaGrastim (AS)</i>	TIMOLOL + TRAVOPROST
.Section 100 729, 730, 981	.SENSORY ORGANS..... 583, 584
<i>Teveten (AB)</i>	<i>Timoptol (FR)</i>
.CARDIOVASCULAR SYSTEM..... 150	.SENSORY ORGANS..... 581
<i>Teveten Plus 600/12.5 (AB)</i>	<i>Timoptol XE (MK)</i>
.CARDIOVASCULAR SYSTEM..... 153	.SENSORY ORGANS..... 581
THALIDOMIDE	<i>Tinaderm (MK)</i>
.Section 100 882, 1135	.Repatriation Schedule..... 1203
<i>Thalomid (CJ)</i>	<i>Tinasil (AF)</i>
.Section 100 883, 1135	.DERMATOLOGICALS..... 191
THEOPHYLLINE	.Repatriation Schedule..... 1204
.RESPIRATORY SYSTEM 573	TINIDAZOLE
<i>TheraTears (CX)</i>	.ANTIINFECTIVES FOR SYSTEMIC USE..... 240
.SENSORY ORGANS..... 589, 590	TIOTROPIUM
THIAMINE	.RESPIRATORY SYSTEM..... 572
.ALIMENTARY TRACT AND METABOLISM..... 105	TIPRANAVIR
.Repatriation Schedule..... 1199	.Section 100..... 715, 964
THIOGUANINE	TIROFIBAN
.ANTINEOPLASTIC AND IMMUNOMODULATING	.BLOOD AND BLOOD FORMING ORGANS..... 114
AGENTS 253	<i>Tirofiban AC (GN)</i>
<i>Thioprine (AF)</i>	.BLOOD AND BLOOD FORMING ORGANS..... 114
.ANTINEOPLASTIC AND IMMUNOMODULATING	<i>Titralac (MM)</i>
AGENTS 461	.Repatriation Schedule..... 1197
<i>Thyrogen (GZ)</i>	<i>Tivicay (VI)</i>
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX	.Section 100..... 725, 975
HORMONES AND INSULINS..... 209	<i>Tobi (NV)</i>
THYROTROPIN ALFA	.ANTIINFECTIVES FOR SYSTEMIC USE..... 236
	<i>TOBI podhaler (NV)</i>

GENERIC/PROPRIETARY INDEX

.ANTIINFECTIVES FOR SYSTEMIC USE..... 236	.CARDIOVASCULAR SYSTEM 161, 163
<i>Tobra-Day (PL)</i>	<i>Torvastat 20 (QA)</i>
.ANTIINFECTIVES FOR SYSTEMIC USE..... 237	.CARDIOVASCULAR SYSTEM 162, 163
TOBRAMYCIN	<i>Torvastat 40 (QA)</i>
.ANTIINFECTIVES FOR SYSTEMIC USE..... 235, 236, 237	.CARDIOVASCULAR SYSTEM 162, 163
.SENSORY ORGANS..... 575, 576	<i>Torvastat 80 (QA)</i>
<i>Tobrex (AQ)</i>	.CARDIOVASCULAR SYSTEM 162, 163
.SENSORY ORGANS..... 576	<i>Torzole 20 (VN)</i>
TOCILIZUMAB	.ALIMENTARY TRACT AND METABOLISM..... 71
.Section 100 835, 843, 852, 858, 1087, 1095, 1104, 1111	<i>Torzole 40 (VN)</i>
<i>Tofranil 10 (LM)</i>	.ALIMENTARY TRACT AND METABOLISM..... 71, 72
.NERVOUS SYSTEM..... 535	<i>Tracleer (AT)</i>
<i>Tofranil 25 (LM)</i>	.Section 100..... 670, 676, 918, 924
.NERVOUS SYSTEM..... 535	<i>Trajenta (BY)</i>
<i>Tolerade 10 (PQ)</i>	.ALIMENTARY TRACT AND METABOLISM..... 100
.NERVOUS SYSTEM..... 535	<i>Trajentamet (BY)</i>
<i>Tolerade 25 (PQ)</i>	.ALIMENTARY TRACT AND METABOLISM..... 92
.NERVOUS SYSTEM..... 535	TRAMADOL
TOLNAFTATE	.NERVOUS SYSTEM..... 492, 493, 494
.Repatriation Schedule..... 1203	<i>Tramadol ACT (GN)</i>
<i>Tolvon (MK)</i>	.NERVOUS SYSTEM..... 493
.NERVOUS SYSTEM..... 542	.Prescriber Bag 64
<i>Topamax (JC)</i>	<i>Tramadol Actavis (UA)</i>
.NERVOUS SYSTEM..... 508, 509	.NERVOUS SYSTEM..... 493, 494
<i>Topamax Sprinkle (JC)</i>	<i>Tramadol AN (EA)</i>
.NERVOUS SYSTEM..... 509	.NERVOUS SYSTEM..... 493, 494
TOPIRAMATE	<i>Tramadol AN SR (EA)</i>
.NERVOUS SYSTEM..... 508, 509	.NERVOUS SYSTEM..... 492, 493
<i>Topiramate GH (GQ)</i>	<i>Tramadol Sandoz (SZ)</i>
.NERVOUS SYSTEM..... 508, 509	.NERVOUS SYSTEM..... 493, 494
<i>Topiramate Sandoz (SZ)</i>	.Prescriber Bag 64
.NERVOUS SYSTEM..... 508, 509	<i>Tramadol Sandoz SR (SZ)</i>
<i>Topra 40 (DO)</i>	.NERVOUS SYSTEM..... 492, 493
.ALIMENTARY TRACT AND METABOLISM..... 71, 72	<i>Tramadol SCP (CR)</i>
<i>Toprol-XL 190 (AP)</i>	.NERVOUS SYSTEM..... 493, 494
.CARDIOVASCULAR SYSTEM 135	<i>Tramadol SR generichealth (GQ)</i>
<i>Toprol-XL 23.75 (AP)</i>	.NERVOUS SYSTEM..... 492, 493
.CARDIOVASCULAR SYSTEM 135	<i>Tramal (CS)</i>
<i>Toprol-XL 47.5 (AP)</i>	.NERVOUS SYSTEM..... 492, 493, 494
.CARDIOVASCULAR SYSTEM 135	<i>Tramal 100 (CS)</i>
<i>Toprol-XL 95 (AP)</i>	.NERVOUS SYSTEM..... 493
.CARDIOVASCULAR SYSTEM 135	.Prescriber Bag 64
TOREMIFENE	<i>Tramal SR 100 (CS)</i>
.ANTINEOPLASTIC AND IMMUNOMODULATING	.NERVOUS SYSTEM..... 492
AGENTS 287	<i>Tramal SR 150 (CS)</i>
<i>Torlemo DT 100 (UA)</i>	.NERVOUS SYSTEM..... 492
.NERVOUS SYSTEM..... 505	<i>Tramal SR 200 (CS)</i>
<i>Torlemo DT 200 (UA)</i>	.NERVOUS SYSTEM..... 493
.NERVOUS SYSTEM..... 505	<i>Tramal SR 50 (CS)</i>
<i>Torlemo DT 25 (UA)</i>	.NERVOUS SYSTEM..... 493
.NERVOUS SYSTEM..... 506	<i>Tramedo (AF)</i>
<i>Torlemo DT 50 (UA)</i>	.NERVOUS SYSTEM..... 493, 494
.NERVOUS SYSTEM..... 506	<i>Tramedo SR 100 (AF)</i>
<i>Torvastat 10 (QA)</i>	.NERVOUS SYSTEM..... 492
	<i>Tramedo SR 150 (AF)</i>

GENERIC/PROPRIETARY INDEX

.NERVOUS SYSTEM.....	492	TRIMETHOPRIM	
<i>Tramedo SR 200 (AF)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE	232
.NERVOUS SYSTEM.....	493	TRIMETHOPRIM + SULFAMETHOXAZOLE	
<i>Tranalpha (AF)</i>		.ANTIINFECTIVES FOR SYSTEMIC USE	232
.CARDIOVASCULAR SYSTEM	145	<i>Triphasil 28 (PF)</i>	
<i>Trandate (QA)</i>		.GENITO URINARY SYSTEM AND SEX HORMONES .	200
.CARDIOVASCULAR SYSTEM	137	<i>Triprim (QA)</i>	
TRANDOLAPRIL		.ANTIINFECTIVES FOR SYSTEMIC USE	232
.CARDIOVASCULAR SYSTEM	145	TRIPTORELIN	
TRANDOLAPRIL + VERAPAMIL		.ANTINEOPLASTIC AND IMMUNOMODULATING	
.CARDIOVASCULAR SYSTEM	148	AGENTS	287
<i>Trandolapril-DP (GN)</i>		<i>Triquilar ED (BN)</i>	
.CARDIOVASCULAR SYSTEM	145	.GENITO URINARY SYSTEM AND SEX HORMONES .	200
TRANEXAMIC ACID		<i>Tritace (SW)</i>	
.BLOOD AND BLOOD FORMING ORGANS	122	.CARDIOVASCULAR SYSTEM	144
<i>Transiderm-Nitro 25 (NV)</i>		<i>Tritace 1.25 mg (SW)</i>	
.CARDIOVASCULAR SYSTEM	128	.CARDIOVASCULAR SYSTEM	143
<i>Transiderm-Nitro 50 (NV)</i>		<i>Tritace 10 mg (SW)</i>	
.CARDIOVASCULAR SYSTEM	128	.CARDIOVASCULAR SYSTEM	144
TRANLYCYPROMINE		<i>Tritace 2.5 mg (SW)</i>	
.NERVOUS SYSTEM.....	540	.CARDIOVASCULAR SYSTEM	144
<i>Travatan (AQ)</i>		<i>Tritace 5 mg (SW)</i>	
.SENSORY ORGANS.....	584	.CARDIOVASCULAR SYSTEM	145
TRAVOPROST		<i>Tritace Titration Pack (SW)</i>	
.SENSORY ORGANS.....	584	.CARDIOVASCULAR SYSTEM	145
TRIAMCINOLONE		<i>Trizivir (VI)</i>	
.DERMATOLOGICALS.....	193	.Section 100.....	723, 973
.SYSTEMIC HORMONAL PREPARATIONS, EXCL. SEX		TROPISETRON	
HORMONES AND INSULINS.....	213	.ALIMENTARY TRACT AND METABOLISM.....	76
TRIAMCINOLONE + NEOMYCIN SULFATE + GRAMICIDIN		<i>Tropisetron-AFT (AE)</i>	
+ NYSTATIN		.ALIMENTARY TRACT AND METABOLISM.....	77
.SENSORY ORGANS.....	595	<i>Trovas (RA)</i>	
<i>Triasyn 2.5/2.5 (SW)</i>		.CARDIOVASCULAR SYSTEM	161, 162, 163
.CARDIOVASCULAR SYSTEM	148	<i>TRUEbalance (NX)</i>	
<i>Triasyn 5.0/5.0 (SW)</i>		.VARIOUS.....	599, 600
.CARDIOVASCULAR SYSTEM	148	<i>TRUEresult (NX)</i>	
<i>Tricortone (FM)</i>		.VARIOUS.....	599, 600
.DERMATOLOGICALS.....	193	<i>TRUEtrack (NX)</i>	
<i>Trifeme 28 (FZ)</i>		.VARIOUS.....	599, 600
.GENITO URINARY SYSTEM AND SEX HORMONES .	200	<i>Trusopt (MK)</i>	
TRIFLUOPERAZINE		.SENSORY ORGANS.....	580
.NERVOUS SYSTEM.....	515	<i>Truvada (GI)</i>	
TRIGLYCERIDES LONG CHAIN		.Section 100.....	724, 974
.VARIOUS.....	601	<i>Tryzan Caps 1.25 (AF)</i>	
TRIGLYCERIDES LONG CHAIN WITH GLUCOSE POLYMER		.CARDIOVASCULAR SYSTEM	143
.VARIOUS.....	628	<i>Tryzan Caps 10 (AF)</i>	
TRIGLYCERIDES MEDIUM CHAIN		.CARDIOVASCULAR SYSTEM	144
.VARIOUS.....	601, 602	<i>Tryzan Caps 2.5 (AF)</i>	
TRIGLYCERIDES MEDIUM CHAIN AND LONG CHAIN WITH		.CARDIOVASCULAR SYSTEM	144
GLUCOSE POLYMER		<i>Tryzan Caps 5 (AF)</i>	
.VARIOUS.....	628	.CARDIOVASCULAR SYSTEM	145
TRIGLYCERIDES MEDIUM CHAIN FORMULA		<i>Tryzan Tabs 1.25 (AF)</i>	
.VARIOUS.....	617, 618, 628	.CARDIOVASCULAR SYSTEM	143
<i>Trileptal (NV)</i>		<i>Tryzan Tabs 10 (AF)</i>	
.NERVOUS SYSTEM.....	501	.CARDIOVASCULAR SYSTEM	144

GENERIC/PROPRIETARY INDEX

<i>Tryzan Tabs 2.5 (AF)</i>	
.CARDIOVASCULAR SYSTEM	144
<i>Tryzan Tabs 5 (AF)</i>	
.CARDIOVASCULAR SYSTEM	145
<i>Tubegauz 0501633 (SS)</i>	
.Repatriation Schedule	1228
<i>Tubifast 2434 (MH)</i>	
.Repatriation Schedule	1228
<i>Tubifast 2436 (MH)</i>	
.Repatriation Schedule	1228
<i>Tubifast 2438 (MH)</i>	
.Repatriation Schedule	1228
<i>Tubigrip 1479 (MH)</i>	
.Repatriation Schedule	1229
<i>Tubigrip 1480 (MH)</i>	
.Repatriation Schedule	1228
<i>Tubigrip 1481 (MH)</i>	
.Repatriation Schedule	1228
<i>Tubigrip 1482 (MH)</i>	
.Repatriation Schedule	1228
<i>Tubigrip 1483 (MH)</i>	
.Repatriation Schedule	1228
<i>Tubigrip 1484 (MH)</i>	
.Repatriation Schedule	1228
<i>Tubigrip 1486 (MH)</i>	
.Repatriation Schedule	1228
<i>Tubigrip B 1520 (MH)</i>	
.Repatriation Schedule	1228
<i>Tubigrip C 1545 (MH)</i>	
.Repatriation Schedule	1228
<i>Tubigrip D 1546 (MH)</i>	
.Repatriation Schedule	1228
<i>Tubigrip E 1547 (MH)</i>	
.Repatriation Schedule	1228
<i>Tubigrip F 1548 (MH)</i>	
.Repatriation Schedule	1228
<i>Twynsta (BY)</i>	
.CARDIOVASCULAR SYSTEM	157
<i>Tykerb (GK)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	275
<i>TYR Anamix infant (SB)</i>	
.VARIOUS	623
<i>TYR Anamix Junior (SB)</i>	
.VARIOUS	623
<i>TYR Anamix junior LQ (SB)</i>	
.VARIOUS	620
<i>TYR cooler 10 (VF)</i>	
.VARIOUS	623
<i>TYR cooler 15 (VF)</i>	
.VARIOUS	623
<i>TYR cooler 20 (VF)</i>	
.VARIOUS	623
<i>TYR express 15 (VF)</i>	
.VARIOUS	623

<i>TYR gel (VF)</i>	
.VARIOUS	623
<i>TYR Lophlex LQ 20 (SB)</i>	
.VARIOUS	623
<i>Tyrosine 1000 (VF)</i>	
.VARIOUS	629
TYROSINE WITH CARBOHYDRATE	
.VARIOUS	629
<i>Tysabri (BD)</i>	
.Section 100	772, 1024

U

<i>Ulcaid (RA)</i>	
.ALIMENTARY TRACT AND METABOLISM	67
<i>Ulcye (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM	73
<i>ultibro breezhaler 110/50 (NV)</i>	
.RESPIRATORY SYSTEM	569
UMECLIDINIUM	
.RESPIRATORY SYSTEM	572
UMECLIDINIUM + VILANTEROL	
.RESPIRATORY SYSTEM	570
<i>Uracol (GN)</i>	
.Repatriation Schedule	1210
<i>Ural Sachets (QA)</i>	
.Repatriation Schedule	1210
UREA	
.Repatriation Schedule	1204
<i>Urederm (VT)</i>	
.Repatriation Schedule	1204
<i>Uremide (AF)</i>	
.CARDIOVASCULAR SYSTEM	132
<i>Urex (FM)</i>	
.CARDIOVASCULAR SYSTEM	132
<i>Urex-Forte (FM)</i>	
.CARDIOVASCULAR SYSTEM	132
<i>Urex-M (FM)</i>	
.CARDIOVASCULAR SYSTEM	132
<i>Uro-Carb (YN)</i>	
.NERVOUS SYSTEM	554
<i>Uromitexan (BX)</i>	
.VARIOUS	597
URSODEOXYCHOLIC ACID	
.ALIMENTARY TRACT AND METABOLISM	78
<i>Ursofalk (OA)</i>	
.ALIMENTARY TRACT AND METABOLISM	78
USTEKINUMAB	
.ANTINEOPLASTIC AND IMMUNOMODULATING AGENTS	451, 456

V

<i>Vaclovir (AF)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	248, 249, 250

GENERIC/PROPRIETARY INDEX

<i>Vagifem (NO)</i>		
.GENITO URINARY SYSTEM AND SEX HORMONES .	202	
VALACICLOVIR		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	248, 249	
.Section 100	708, 958	
<i>Valaciclovir Actavis (VN)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	248, 249, 250	
<i>Valaciclovir AN (EA)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	248, 249, 250	
<i>Valaciclovir GA (GN)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	248, 249, 250	
<i>Valaciclovir generichealth (GQ)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	249, 250	
<i>Valaciclovir RBX (RA)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	249, 250	
.Section 100	708, 958	
<i>Valaciclovir Sandoz (SZ)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	248, 249, 250	
<i>Valaciclovir SZ (HX)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	249	
<i>Valacor 500 (CR)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	249, 250	
<i>Valcyte (RO)</i>		
.Section 100	709, 958	
VALGANCICLOVIR		
.Section 100	709, 958	
<i>Valine 1000 (VF)</i>		
.VARIOUS.....	629	
<i>Valine 50 (VF)</i>		
.VARIOUS.....	629	
VALINE WITH CARBOHYDRATE		
.VARIOUS.....	629	
<i>Valium (RO)</i>		
.NERVOUS SYSTEM.....	531, 532	
.Palliative Care	646	
<i>Valnir (QA)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	248, 249, 250	
<i>Valpam 2 (QA)</i>		
.NERVOUS SYSTEM.....	531, 532	
.Palliative Care	646	
<i>Valpam 5 (QA)</i>		
.NERVOUS SYSTEM.....	531, 532	
.Palliative Care	646	
<i>Valprease 200 (QA)</i>		
.NERVOUS SYSTEM.....	502	
<i>Valprease 500 (QA)</i>		
.NERVOUS SYSTEM.....	502	
<i>Valpro 200 (AF)</i>		
.NERVOUS SYSTEM.....	502	
<i>Valpro 500 (AF)</i>		
.NERVOUS SYSTEM.....	502	
VALPROATE		
.NERVOUS SYSTEM.....	502	
<i>Valproate Winthrop EC 200 (WA)</i>		
.NERVOUS SYSTEM.....	502	
<i>Valproate Winthrop EC 500 (WA)</i>		
.NERVOUS SYSTEM.....	502	
VALSARTAN		
.CARDIOVASCULAR SYSTEM	152	
VALSARTAN + HYDROCHLOROTHIAZIDE		
.CARDIOVASCULAR SYSTEM	156	
<i>Valsartan/Amlodipine Sandoz 80/5 (NM)</i>		
.CARDIOVASCULAR SYSTEM	157	
<i>Valsartan/Amlodipine/HCT Sandoz 160/5/12.5 (NM)</i>		
.CARDIOVASCULAR SYSTEM	158	
<i>Valtrex (AS)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	248, 249, 250	
.Section 100.....	708, 958	
<i>Vancocin (AS)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	82	
<i>Vancocin CP (AS)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	238, 239	
VANCOMYCIN		
.ALIMENTARY TRACT AND METABOLISM.....	82	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	238	
<i>Vancomycin Alphapharm (AF)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	238, 239	
<i>Vancomycin Sandoz (SZ)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	238, 239	
VARDENAFIL		
.Repatriation Schedule	1210	
VARENICLINE		
.NERVOUS SYSTEM.....	557	
<i>Vasafil 100 (QA)</i>		
.Repatriation Schedule	1209	
<i>Vasafil 25 (QA)</i>		
.Repatriation Schedule	1209	
<i>Vasafil 50 (QA)</i>		
.Repatriation Schedule	1210	
<i>Vascalace 1.25 (DO)</i>		
.CARDIOVASCULAR SYSTEM	143	
<i>Vascalace 10 (DO)</i>		
.CARDIOVASCULAR SYSTEM	144	
<i>Vascalace 2.5 (DO)</i>		
.CARDIOVASCULAR SYSTEM	144	
<i>Vascalace 5 (DO)</i>		
.CARDIOVASCULAR SYSTEM	145	
<i>Vasocardol (AV)</i>		
.CARDIOVASCULAR SYSTEM	139	
<i>Vasocardol CD (AV)</i>		
.CARDIOVASCULAR SYSTEM	139	
<i>Vastin (NM)</i>		
.CARDIOVASCULAR SYSTEM	163, 164	
<i>Vedilol 12.5 (QA)</i>		
.CARDIOVASCULAR SYSTEM	136	
<i>Vedilol 25 (QA)</i>		
.CARDIOVASCULAR SYSTEM	136	
<i>Vedilol 3.125 (QA)</i>		
.CARDIOVASCULAR SYSTEM	136	
<i>Vedilol 6.25 (QA)</i>		

GENERIC/PROPRIETARY INDEX

.CARDIOVASCULAR SYSTEM	137	.Section 100.....	711, 960
<i>Veletri (AT)</i>		<i>Vidaza (CI)</i>	
.Section 100	681, 929	.Section 100.....	727, 728, 978, 979
<i>Venla RBX (RA)</i>		<i>Videx EC (BQ)</i>	
.NERVOUS SYSTEM.....	543	.Section 100.....	716, 966
VENLAFAXINE		VIGABATRIN	
.NERVOUS SYSTEM.....	543	.NERVOUS SYSTEM.....	502
<i>Venlafaxine Actavis XR (UA)</i>		VILDAGLIPTIN	
.NERVOUS SYSTEM.....	543	.ALIMENTARY TRACT AND METABOLISM.....	101
<i>Venlafaxine AN SR (EA)</i>		VILDAGLIPTIN + METFORMIN	
.NERVOUS SYSTEM.....	543	.ALIMENTARY TRACT AND METABOLISM.....	95
<i>Venlafaxine generichealth XR (GQ)</i>		<i>Vimpat (UC)</i>	
.NERVOUS SYSTEM.....	543	.NERVOUS SYSTEM.....	504, 505
<i>Venlafaxine Sandoz XR (SZ)</i>		VINORELBINE	
.NERVOUS SYSTEM.....	543	.ANTINEOPLASTIC AND IMMUNOMODULATING	
<i>Venlafaxine SR SCP 150 (CR)</i>		AGENTS	254
.NERVOUS SYSTEM.....	543	<i>Viramune (BY)</i>	
<i>Venlafaxine SR SCP 75 (CR)</i>		.Section 100.....	721, 971
.NERVOUS SYSTEM.....	543	<i>Viramune XR (BY)</i>	
<i>Venlexor XR (GN)</i>		.Section 100.....	722, 971
.NERVOUS SYSTEM.....	543	<i>Viread (GI)</i>	
<i>Venofer (AS)</i>		.Section 100.....	720, 970
.BLOOD AND BLOOD FORMING ORGANS	123	<i>Viscopaste 4948 (SN)</i>	
<i>Ventavis (BN)</i>		.Repatriation Schedule	1229
.Section 100	687, 935	<i>Viscotears (AQ)</i>	
<i>Ventolin (GK)</i>		.SENSORY ORGANS.....	589
.RESPIRATORY SYSTEM	573	<i>Viscotears Gel PF (AQ)</i>	
<i>Ventolin CFC-free (GK)</i>		.SENSORY ORGANS.....	588
.Prescriber Bag	63	<i>Visken 15 (NV)</i>	
.RESPIRATORY SYSTEM	564	.CARDIOVASCULAR SYSTEM	133
<i>Ventolin Nebules (GK)</i>		<i>Vistide (GI)</i>	
.Prescriber Bag	63, 64	.Section 100.....	708, 957
.RESPIRATORY SYSTEM	565	<i>Vistil (AE)</i>	
<i>Ventolin Rotacaps (GK)</i>		.SENSORY ORGANS.....	593
.RESPIRATORY SYSTEM	564	<i>Vistil Forte (AE)</i>	
<i>Vepesid (BQ)</i>		.SENSORY ORGANS.....	593
.ANTINEOPLASTIC AND IMMUNOMODULATING		<i>Visudyne (NV)</i>	
AGENTS	254	.SENSORY ORGANS.....	588
<i>Veracaps SR (QA)</i>		<i>Vita-B12 (GH)</i>	
.CARDIOVASCULAR SYSTEM	139	.BLOOD AND BLOOD FORMING ORGANS.....	123
VERAPAMIL		VITAMINS, MINERALS AND TRACE ELEMENTS WITH	
.CARDIOVASCULAR SYSTEM	139	CARBOHYDRATE	
<i>Vermox (IA)</i>		.VARIOUS.....	629
.Repatriation Schedule.....	1219	<i>VitA-POS (AE)</i>	
VERTEPORFIN		.SENSORY ORGANS.....	592
.SENSORY ORGANS.....	587	<i>Volibris (GK)</i>	
VESPULA SPP VENOM		.Section 100.....	663, 911
.VARIOUS.....	596	<i>Volirop 12.5 (DO)</i>	
<i>Vexazone (AF)</i>		.CARDIOVASCULAR SYSTEM	136
.ALIMENTARY TRACT AND METABOLISM.....	97, 98	<i>Volirop 25 (DO)</i>	
<i>Vfend (PF)</i>		.CARDIOVASCULAR SYSTEM	136
.ANTIINFECTIVES FOR SYSTEMIC USE.....	243, 244	<i>Volirop 3.125 (DO)</i>	
<i>Viagra (PF)</i>		.CARDIOVASCULAR SYSTEM	136
.Repatriation Schedule.....	1209, 1210	<i>Volirop 6.25 (DO)</i>	
<i>Victrelis (MK)</i>		.CARDIOVASCULAR SYSTEM	137

GENERIC/PROPRIETARY INDEX

<i>Voltaren 100 (NV)</i>	
.MUSCULO-SKELETAL SYSTEM	462
.Palliative Care	638
<i>Voltaren 25 (NV)</i>	
.MUSCULO-SKELETAL SYSTEM	462
.Palliative Care	638, 639
<i>Voltaren 50 (NV)</i>	
.MUSCULO-SKELETAL SYSTEM	462
.Palliative Care	638, 639
<i>Voluven 6% (PK)</i>	
.BLOOD AND BLOOD FORMING ORGANS	124
VORICONAZOLE	
.ANTIINFECTIVES FOR SYSTEMIC USE	242, 243
<i>Votrient (GK)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	279, 280, 281, 282
<i>Voxam (SZ)</i>	
.NERVOUS SYSTEM	538
<i>Vycin IV (GN)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	238, 239
<i>Vytorin (MK)</i>	
.CARDIOVASCULAR SYSTEM	184, 185, 187

W

WARFARIN	
.BLOOD AND BLOOD FORMING ORGANS	108
<i>Wartec Cream (GK)</i>	
.Repatriation Schedule	1205
<i>Waxsol (HM)</i>	
.Repatriation Schedule	1222
<i>Wellvone (AS)</i>	
.ANTIPARASITIC PRODUCTS, INSECTICIDES AND	
REPELLENTS	561
WHEY PROTEIN FORMULA SUPPLEMENTED WITH	
AMINO ACIDS, LONG CHAIN POLYUNSATURATED	
FATTY ACIDS, VITAMINS AND MINERALS, LOW IN	
PROTEIN, PHOSPHATE, POTASSIUM AND LACTOSE	
.VARIOUS	629
WHEY PROTEIN FORMULA SUPPLEMENTED WITH	
AMINO ACIDS, VITAMINS AND MINERALS, AND LOW	
IN PROTEIN, PHOSPHATE, POTASSIUM AND LACTOSE	
.VARIOUS	630
WOOL ALCOHOLS	
.Repatriation Schedule	1204

X

<i>Xalacom (PF)</i>	
.SENSORY ORGANS	583
<i>Xalatan (PF)</i>	
.SENSORY ORGANS	582, 583
<i>Xarelto (BN)</i>	
.BLOOD AND BLOOD FORMING ORGANS	118, 119,
120, 122	

<i>Xatral SR (SW)</i>	
.Repatriation Schedule	1210
<i>Xelabine (QA)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	254
<i>Xeloda (RO)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	254
<i>Xenical (RO)</i>	
.Repatriation Schedule	1199
<i>Xergic (AF)</i>	
.Repatriation Schedule	1221
<i>Xgeva (AN)</i>	
.MUSCULO-SKELETAL SYSTEM	479
<i>Xifaxan (NE)</i>	
.ALIMENTARY TRACT AND METABOLISM	82
<i>XLYS, LOW TRY Maxamaid (SB)</i>	
.VARIOUS	621
<i>XMET Maxamaid (SB)</i>	
.VARIOUS	621
<i>XMET Maxamum (SB)</i>	
.VARIOUS	621
<i>XMTVI Maxamaid (SB)</i>	
.VARIOUS	622
<i>XMTVI Maxamum (SB)</i>	
.VARIOUS	622
<i>Xolair (NV)</i>	
.Section 100	891, 1143
<i>XP Maxamaid (SB)</i>	
.VARIOUS	623
<i>XP Maxamum (SB)</i>	
.VARIOUS	623
<i>XPhen, Tyr Maxamaid (SB)</i>	
.VARIOUS	623
<i>XPhen, Tyr Maxamum (SB)</i>	
.VARIOUS	623
<i>Xtandi (LL)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	289
<i>Xydep 100 (GN)</i>	
.NERVOUS SYSTEM	539, 540
<i>Xydep 50 (GN)</i>	
.NERVOUS SYSTEM	539, 540
<i>Xyllocaine Viscous (AP)</i>	
.Repatriation Schedule	1205
<i>Xylocard 500 (AP)</i>	
.CARDIOVASCULAR SYSTEM	126

Y

<i>Yomax 250 (DO)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	220
<i>Yomax 500 (DO)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	221

GENERIC/PROPRIETARY INDEX

Z

<i>Z.S.C. (QA)</i>		
.Repatriation Schedule.....	1207	
<i>Zactin (AF)</i>		
.NERVOUS SYSTEM.....	538	
<i>Zactin Tablet (AF)</i>		
.NERVOUS SYSTEM.....	538	
<i>Zan-Extra 10/10 (AB)</i>		
.CARDIOVASCULAR SYSTEM.....	147	
<i>Zan-Extra 10/20 (AB)</i>		
.CARDIOVASCULAR SYSTEM.....	147	
<i>Zanidip (AB)</i>		
.CARDIOVASCULAR SYSTEM.....	138	
<i>Zantac (AS)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	67	
<i>Zantac Syrup (AS)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	67	
<i>Zarontin (PF)</i>		
.NERVOUS SYSTEM.....	499	
<i>Zarzio (SZ)</i>		
.Section 100	730, 981	
<i>Zatamil (EO)</i>		
.DERMATOLOGICALS.....	194, 195	
<i>Zavedos (PF)</i>		
.ANTINEOPLASTIC AND IMMUNOMODULATING		
AGENTS	255	
<i>Zedace (AF)</i>		
.CARDIOVASCULAR SYSTEM.....	140	
<i>Zedd 500 (QA)</i>		
.Repatriation Schedule.....	1212	
<i>Zeffix (AS)</i>		
.Section 100	718, 967	
<i>Zeldox (PF)</i>		
.NERVOUS SYSTEM.....	516	
<i>Zelitrex (UA)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	248, 249, 250	
.Section 100	709, 958	
<i>Zentel (AS)</i>		
.ANTIPARASITIC PRODUCTS, INSECTICIDES AND		
REPELLENTS.....	562	
<i>Zerit (BQ)</i>		
.Section 100	718, 968	
<i>Zestril (AP)</i>		
.CARDIOVASCULAR SYSTEM.....	141, 142	
<i>Zetlam (AF)</i>		
.Section 100	718, 967	
<i>Ziagen (VI)</i>		
.Section 100	715, 965	
ZIDOVUDINE		
.Section 100	720, 970	
<i>Zilarex (SZ)</i>		
.Repatriation Schedule.....	1221	
<i>Zilfojim 4 (DO)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	75	
<i>Zilfojim 8 (DO)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	76	
<i>Zimstat (AF)</i>		
.CARDIOVASCULAR SYSTEM.....	170, 171, 172	
ZINC OXIDE + MAIZE STARCH + CHLORPHENESIN + TALC- PURIFIED		
.Repatriation Schedule.....	1207	
ZINC OXIDE + PERU BALSAM + BENZYL BENZOATE		
.Repatriation Schedule.....	1202	
<i>Zinnat (AS)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	230	
<i>Zinopril 10 (AL)</i>		
.CARDIOVASCULAR SYSTEM.....	141	
<i>Zinopril 20 (AL)</i>		
.CARDIOVASCULAR SYSTEM.....	141	
<i>Zinopril 5 (AL)</i>		
.CARDIOVASCULAR SYSTEM.....	142	
ZIPRASIDONE		
.NERVOUS SYSTEM.....	516	
<i>ZipZoc 66000747 (SN)</i>		
.Repatriation Schedule.....	1229	
<i>Zircol (AF)</i>		
.CARDIOVASCULAR SYSTEM.....	138	
<i>Zithromax (PF)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	233	
.Repatriation Schedule.....	1212	
.Section 100.....	708, 957	
.SENSORY ORGANS.....	575	
<i>Zitrocin (GN)</i>		
.ANTIINFECTIVES FOR SYSTEMIC USE.....	233	
.Repatriation Schedule.....	1212	
.SENSORY ORGANS.....	575	
<i>Zocor (MK)</i>		
.CARDIOVASCULAR SYSTEM.....	170, 171, 172	
<i>Zofran (AS)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	75, 76	
<i>Zofran syrup 50 mL (AS)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	76	
<i>Zofran Zydis (AS)</i>		
.ALIMENTARY TRACT AND METABOLISM.....	74, 75	
<i>ZolaCos CP 10.8/50(28) (AP)</i>		
.ANTINEOPLASTIC AND IMMUNOMODULATING		
AGENTS	286	
<i>ZolaCos CP 10.8/50(84) (AP)</i>		
.ANTINEOPLASTIC AND IMMUNOMODULATING		
AGENTS	286	
<i>ZolaCos CP 3.6/50 (AP)</i>		
.ANTINEOPLASTIC AND IMMUNOMODULATING		
AGENTS	286	
<i>Zoladex 10.8 Implant (AP)</i>		
.ANTINEOPLASTIC AND IMMUNOMODULATING		
AGENTS	286	
<i>Zoladex Implant (AP)</i>		
.ANTINEOPLASTIC AND IMMUNOMODULATING		
AGENTS	286	

GENERIC/PROPRIETARY INDEX

ZOLEDRONIC ACID	
.MUSCULO-SKELETAL SYSTEM	472, 473
.Section 100	885, 1137
ZOLMITRIPTAN	
.NERVOUS SYSTEM.....	498
<i>Zoloft (PF)</i>	
.NERVOUS SYSTEM.....	539, 540
<i>Zoltrip (QA)</i>	
.NERVOUS SYSTEM.....	498
<i>Zomacton (FP)</i>	
.Section 100	1156
<i>Zometa (NV)</i>	
.Section 100	885, 1137
<i>Zomig (AP)</i>	
.NERVOUS SYSTEM.....	498
<i>Zonegran (SA)</i>	
.NERVOUS SYSTEM.....	509
ZONISAMIDE	
.NERVOUS SYSTEM.....	509
ZOPICLONE	
.Repatriation Schedule	1217
<i>Zopral (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	68, 69
<i>Zopral ODT (AF)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	68, 69
<i>Zoton FasTabs (PF)</i>	
.ALIMENTARY TRACT AND METABOLISM.....	68, 69
<i>Zovirax (GK)</i>	
.SENSORY ORGANS.....	576
<i>Zovirax 200 mg (GK)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE.....	245
<i>Zovirax 800 mg (GK)</i>	
.ANTIINFECTIVES FOR SYSTEMIC USE	246
ZUCLOPENTHIXOL DECANOATE	
.NERVOUS SYSTEM.....	516
<i>Zumenon (AB)</i>	
.GENITO URINARY SYSTEM AND SEX HORMONES .	202
<i>Zyban (AS)</i>	
.NERVOUS SYSTEM.....	554, 555
<i>Zydol (QA)</i>	
.NERVOUS SYSTEM.....	493, 494
<i>Zydol SR 100 (QA)</i>	
.NERVOUS SYSTEM.....	492
<i>Zydol SR 150 (QA)</i>	
.NERVOUS SYSTEM.....	492
<i>Zydol SR 200 (QA)</i>	
.NERVOUS SYSTEM.....	493
<i>Zyloprim (QA)</i>	
.MUSCULO-SKELETAL SYSTEM	469
<i>Zypine (AF)</i>	
.NERVOUS SYSTEM.....	518, 520, 522, 523
<i>Zypine ODT (AF)</i>	
.NERVOUS SYSTEM.....	519, 521, 522
<i>Zyprexa (LY)</i>	
.NERVOUS SYSTEM.....	518, 520, 522, 523
<i>Zyprexa Relprevv (LY)</i>	
.NERVOUS SYSTEM.....	521
<i>Zyprexa Zydys (LY)</i>	
.NERVOUS SYSTEM.....	519, 521, 522
<i>Zyrtec (JT)</i>	
.Repatriation Schedule	1221
<i>Zytiga (JC)</i>	
.ANTINEOPLASTIC AND IMMUNOMODULATING	
AGENTS	291

THERAPEUTIC GROUP PREMIUM POLICY

PHARMACEUTICAL BENEFIT ITEMS WHICH HAVE A THERAPEUTIC GROUP PREMIUM WITH EFFECT FROM 1 December 2014

The Schedule of Pharmaceutical Benefits shows differences in price in some therapeutic groups where alternative drugs may have a therapeutic group premium.

The Therapeutic Group Premium Policy applies within narrowly defined therapeutic sub-groups where the drugs concerned are of similar safety and health outcomes.

The Australian Government, through the PBS, subsidises up to the price of the lowest priced drug in the group. This means that consumers may have to pay for more expensive drugs (those with a therapeutic group premium). This extra amount does not count towards their PBS safety net threshold.

Therapeutic group premiums apply where a prescriber has prescribed a drug within a therapeutic group that attracts a therapeutic group premium and has not sought an exemption from Department of Human Services on clinical grounds.

The exemption provisions are:

- adverse effects occurring with all of the base-priced drugs; or
- drug interactions occurring with all of the base-priced drugs; or
- drug interactions expected to occur with all of the base-priced drugs; or
- transfer to a base-priced drug would cause patient confusion resulting in problems with compliance.

The premiums are not a Government charge but reflect the fact that the supplier(s) of the drug charge a price higher than the Government is willing to subsidise.

Under the Therapeutic Group Premium Policy drug substitution by pharmacists is not permitted.

For ease of prescribing and dispensing, and in the interests of your patients, the following list shows those PBS drugs that attract a therapeutic group premium.

Premium Priced Brand	Form and Strength	Therapeutic Group Premium \$
ANGIOTENSIN II ANTAGONISTS		
Teveten	eprosartan 400 mg tablet, 28	3.50
Teveten	eprosartan 600 mg tablet, 28	3.50
Olmetec	olmesartan medoxomil 20 mg tablet, 30	2.51
Olmetec	olmesartan medoxomil 40 mg tablet, 30	2.51

The base-priced drugs in this therapeutic group are candesartan cilexetil, irbesartan, losartan and valsartan.

BRAND PREMIUM POLICY

BRANDS OF PHARMACEUTICAL BENEFIT ITEMS WHICH HAVE A BRAND PREMIUM AND THAT MAY BE SUBSTITUTED WITH EFFECT FROM 1 November 2014

The Schedule of Pharmaceutical Benefits shows differences in price between some alternative brands of the same drug product.

Manufacturers can develop generic equivalents and apply to have them listed on the PBS. In doing this, manufacturers need to ensure that they comply with the relevant legislation applicable to patents. These brands are clinically equivalent and must undergo the same strict quality controls. Although these brands are designed to act on the body in exactly the same way, they are usually cheaper than the originator brands.

The Australian Government, through the PBS, subsidises up to the price of the lowest priced brand (except in those instances where the lowest priced brand has, as part of its price, a therapeutic group premium). This means that consumers may have to pay extra for more expensive brands (those with a brand premium). This extra amount does not count towards their PBS safety net threshold.

Brand substitution by pharmacists without reference to the prescriber is permitted for PBS prescriptions where:

- the patient agrees to the substitution;
- the brands are identified in the Schedule of Pharmaceutical Benefits as being interchangeable;
- the prescriber has not indicated on the prescription form that substitution is not to occur; and
- substitution is permitted under the relevant State or Territory legislation.

Prescription forms supplied by Department of Human Services contain a box to be ticked where brand substitution is not to take place.

Prescribers not using these prescription forms should endorse the prescription if brand substitution is not permitted. Where a stamp is used for this purpose, the prescriber will be required to initial the stamped statement.

For ease of prescribing and dispensing, and in the interests of your patients, the following list shows those PBS drugs that attract a brand premium and that can be substituted where permitted. They are listed alphabetically, by brand name, with the brand premium and benchmark brand(s) cited in the last column.

Brand Premium

Premium Priced Brand	Form and Strength	Max. Qty	Brand Premium \$	Benchmark Priced Brands
Abbocillin-V	phenoxymethylpenicillin 150 mg/5 mL oral liquid, 100 mL	2	1.90	Cilicaine V
Accupril	quinapril 10 mg tablet, 30	30	1.47	Acquin Aspen 10; APO-Quinapril; Aquinafil; Qpril 10
	quinapril 20 mg tablet, 30	30	1.46	Acquin Aspen 20; APO-Quinapril; Aquinafil; Qpril 20; Quinapril-GA; Quinapril generichealth
Actilax	quinapril 5 mg tablet, 30	30	1.45	Acquin Aspen 5; APO-Quinapril; Aquinafil; Qpril 5
	LACTULOSE Mixture 3.34 g per 5 mL, 500 mL, 1	1	0.89	Genlac
	LACTULOSE Mixture 3.34 g per 5 mL, 500 mL, 1	3	2.67	Genlac
Adalat 10	nifedipine 10 mg tablet, 60	60	0.84	Adefin 10
Adalat 20	nifedipine 20 mg tablet, 60	60	1.57	Adefin 20; GenRx Nifedipine; Nifehexal
Adalat Oros 30	nifedipine 30 mg tablet: modified release, 30 tablets	30	1.82	Addos XR 30; Adefin XL 30; APO-Nifedipine XR
Adalat Oros 60	nifedipine 60 mg tablet: modified release, 30 tablets	30	1.99	Addos XR 60; Adefin XL 60; APO-Nifedipine XR
Aldactone	spironolactone 100 mg tablet, 100	100	3.16	Spiractin 100
	spironolactone 25 mg tablet, 100	100	2.59	Spiractin 25
Aldomet	methyldopa 250 mg tablet, 100	100	3.54	Hydopa
Alphagan	brimonidine tartrate 0.2% eye drops, 5 mL	1	1.63	Enidin
Amaryl	glimepiride 1 mg tablet, 30	30	2.89	APO-Glimepiride; Aylide 1; Diapride 1; Dimirel; Glimepiride AN; Glimepiride GA 1; Glimepiride Sandoz
	glimepiride 2 mg tablet, 30	30	2.82	APO-Glimepiride; Aylide 2; Diapride 2; Dimirel; Glimepiride AN; Glimepiride GA 2; Glimepiride Sandoz
	glimepiride 3 mg tablet, 30	30	2.84	APO-Glimepiride; Aylide 3; Diapride 3; Dimirel; Glimepiride AN; Glimepiride GA 3; Glimepiride Sandoz
	glimepiride 4 mg tablet, 30	30	2.84	APO-Glimepiride; Aylide 4; Diapride 4; Dimirel; Glimepiride AN; Glimepiride GA 4; Glimepiride Sandoz
Amoxil	amoxycillin 125 mg/5 mL oral liquid: powder for, 100 mL	1	3.35	Alphamox 125; Amoxycillin Sandoz; APO-Amoxycillin; Bgramin; Chem mart Amoxycillin; GenRx Amoxycillin; Ranmoxy; Terry White Chemists Amoxycillin
	amoxycillin 250 mg capsule, 20	20	3.37	Alphamox 250; Amoxycillin AN; Amoxycillin-GA; Amoxycillin Ranbaxy; Amoxycillin Sandoz; APO-Amoxycillin; Chem mart Amoxycillin; Cilamox; Terry White Chemists Amoxycillin; Yomax 250
	amoxycillin 500 mg capsule, 20	20	3.52	Alphamox 500; Amoxycillin AN; Amoxycillin-GA; Amoxycillin generichealth 500; Amoxycillin Ranbaxy; Amoxycillin Sandoz; APO-Amoxycillin; Chem mart Amoxycillin; Cilamox; Terry White Chemists Amoxycillin; Yomax 500
Amoxil Forte	amoxycillin 250 mg/5 mL oral liquid: powder for, 100 mL	1	3.41	Alphamox 250; Amoxycillin Sandoz; APO-Amoxycillin; Bgramin; Chem mart Amoxycillin; Cilamox; GenRx Amoxycillin; Ranmoxy; Terry White Chemists Amoxycillin
Anafranil 25	clomipramine hydrochloride 25 mg tablet, 50	50	2.74	Chem mart Clomipramine; GenRx Clomipramine; Placil; Terry White Chemists Clomipramine
Anaprox 550	naproxen sodium 550 mg tablet, 50	50	2.17	Crysanal
Androcur	cyproterone acetate 50 mg tablet, 20	20	2.44	Cyprocur 50; Cyprone; Cyprostat; Cyproterone AN; Cyproterone Sandoz; GenRx Cyproterone Acetate; Procur
	cyproterone acetate 50 mg tablet, 50	100	2.24	Cyprocur 50; Cyprone; Cyprostat; Cyproterone AN; Cyproterone Sandoz; Cyrotone; GenRx Cyproterone Acetate; Procur
Androcur-100	cyproterone acetate 100 mg tablet, 50	50	0.94	Cyprocur 100; Cyprostat-100; Cyproterone AN; Cyproterone Sandoz; GenRx Cyproterone Acetate; Procur 100
Anginine Stabilised	glyceryl trinitrate 600 microgram tablet: sublingual, 100 tablets	1	2.94	Lycinate
Aristocort 0.02%	triamcinolone acetonide 0.02% (200 microgram/g) cream, 100 g	2	3.78	Tricortone
	triamcinolone acetonide 0.02% (200 microgram/g) ointment, 100 g	2	3.78	Tricortone
Aropax	paroxetine 20 mg tablet, 30	30	2.52	Chem mart Paroxetine; Extine 20; GenRx Paroxetine; Paroxetine AN; Paroxetine-GA; Paroxetine Sandoz; Paxtine; Roxet 20; Terry White Chemists Paroxetine
Astrix	aspirin 100 mg tablet, 112	112	2.32	Mayne Pharma Aspirin; Spren 100
Atacand	candesartan cilexetil 16 mg tablet, 30	30	2.00	Adesan; APO-Candesartan; Auro-Candesartan 16; Candesartan AN; Candesartan Aspen 16; Candesartan-GA; Candesartan GH; Candesartan RBX; Candesartan Sandoz; Chem mart Candesartan; Pharmacor Candesartan 16; Terry White Chemists Candesartan
	candesartan cilexetil 32 mg tablet, 30	30	2.00	Adesan; APO-Candesartan; Auro-Candesartan 32; Candesartan AN; Candesartan Aspen 32; Candesartan-GA; Candesartan GH; Candesartan RBX; Candesartan Sandoz; Chem mart Candesartan; Pharmacor Candesartan 32; Terry White Chemists Candesartan
	candesartan cilexetil 4 mg tablet, 30	30	2.00	Adesan; APO-Candesartan; Auro-Candesartan 4; Candesartan AN; Candesartan Aspen 4; Candesartan-GA; Candesartan GH; Candesartan RBX; Candesartan Sandoz; Chem mart

Brand Premium

Premium Priced Brand	Form and Strength	Max. Qty	Brand Premium \$	Benchmark Priced Brands
	candesartan cilexetil 8 mg tablet, 30	30	2.00	Candesartan; Pharmacor Candesartan 4; Terry White Chemists Candesartan
Atacand Plus 16/12.5	candesartan cilexetil 16 mg + hydrochlorothiazide 12.5 mg tablet, 30	30	2.00	Adesan; APO-Candesartan; Auro-Candesartan 8; Candesartan AN; Candesartan Aspen 8; Candesartan-GA; Candesartan GH; Candesartan RBX; Candesartan Sandoz; Chem mart Candesartan; Pharmacor Candesartan 8; Terry White Chemists Candesartan
Atacand Plus 32/12.5	candesartan cilexetil 32 mg + hydrochlorothiazide 12.5 mg tablet, 30	30	2.02	Adesan HCT 16/12.5; APO-Candesartan HCTZ 16/12.5; Candesartan/HCT Sandoz; Candesartan Combi Aspen 16/12.5; Candesartan HCT GH 16/12.5; Candesartan HCTZ AN 16/12.5; Candesartan HCTZ-GA 16/12.5; Candesartan HCTZ RBX 16/12.5; Chem mart Candesartan HCTZ 16/12.5; Pharmacor Candesartan HCT 16/12.5; Terry White Chemists Candesartan HCTZ 16/12.5
Atacand Plus 32/25	candesartan cilexetil 32 mg + hydrochlorothiazide 25 mg tablet, 30	30	2.00	Adesan HCT 32/12.5; APO-Candesartan HCTZ 32/12.5; Candesartan/HCT Sandoz; Candesartan Combi Aspen 32/12.5; Candesartan HCT GH 32/12.5; Candesartan HCTZ AN 32/12.5; Candesartan HCTZ-GA 32/12.5; Candesartan HCTZ RBX 32/12.5; Chem mart Candesartan HCTZ 32/12.5; Pharmacor Candesartan HCT 32/12.5; Terry White Chemists Candesartan HCTZ 32/12.5
Atrovent	ipratropium bromide 250 microgram/mL inhalation: solution, 30 x 1 mL ampoules	2	0.52	Aeron 250; APO-Ipratropium; Ipratrin
Atrovent Adult	ipratropium bromide 500 microgram/mL inhalation: solution, 30 x 1 mL ampoules	2	0.48	Aeron 500; APO-Ipratropium; Ipratrin Adult
Augmentin	amoxycillin 125 mg/5 mL + clavulanic acid 31.25 mg/5 mL oral liquid: powder for, 75 mL	1	3.27	Clamoxyl; Curam; GA-Amclav 125/31.25
Augmentin Duo	amoxycillin 500 mg + clavulanic acid 125 mg tablet, 10	10	4.57	Amoxiclav AN 500/125; APO-Amoxycillin/ Clavulanic Acid 500/125; Clamoxyl Duo; Curam Duo 500/125; GA-Amclav 500/125; Moxiclav Duo 500/125; Pharmacor AmoxyClav 500/125
Augmentin Duo 400	amoxycillin 400 mg/5 mL + clavulanic acid 57 mg/5 mL oral liquid: powder for, 60 mL	1	4.58	Clamoxyl Duo 400; Curam Duo; GA-Amclav Forte 400/57
Augmentin Duo forte	amoxycillin 875 mg + clavulanic acid 125 mg tablet, 10	10	5.81	Amoxiclav AN 875/125; AmoxyClav GH 875/125; AmoxyClav RBX 875/125; APO-Amoxycillin and Clavulanic Acid; Chem mart Amoxycillin and Clavulanic Acid; Clamoxyl Duo forte; Clavam 875 mg/125 mg; Curam Duo Forte 875/125; GA-Amclav Forte 875/125; GenRx Amoxycillin and Clavulanic Acid; Moxiclav Duo Forte 875/125; Pharmacor AmoxyClav 875/125; Terry White Chemists Amoxycillin and Clavulanic Acid
Aurorix	moclobemide 150 mg tablet, 60	60	0.43	Amira 150; Chem mart Moclobemide; Clobemix; GenRx Moclobemide; Moclobemide AN; Moclobemide Sandoz; Mohexal; Terry White Chemists Moclobemide
Aurorix 300 mg	moclobemide 300 mg tablet, 60	60	0.83	Amira 300; Chem mart Moclobemide; Clobemix; GenRx Moclobemide; Moclobemide AN; Moclobemide Sandoz; Terry White Chemists Moclobemide
Avanza	mirtazapine 30 mg tablet, 30	30	3.50	APO-Mirtazapine; Aurozapine 30; Axit 30; Chem mart Mirtazapine; GenRx Mirtazapine; Mirtazapine AN; Mirtazapine-GA; Mirtazapine GH; Mirtazapine Sandoz; Mirtazon; Terry White Chemists Mirtazapine
	mirtazapine 45 mg tablet, 30	30	3.50	APO-Mirtazapine; Aurozapine 45; Axit 45; Chem mart Mirtazapine; Mirtazapine AN; Mirtazapine-GA; Mirtazapine GH; Mirtazapine Sandoz; Mirtazon; Terry White Chemists Mirtazapine
Avanza SolTab	MIRTAZAPINE Tablet 15 mg (orally disintegrating), 30	30	1.20	Milivin OD 15; Mirtazapine AN ODT; Mirtazapine Sandoz ODT 15; Remeron SolTab
	MIRTAZAPINE Tablet 30 mg (orally disintegrating), 30	30	1.20	Milivin OD 30; Mirtazapine AN ODT; Mirtazapine Sandoz ODT 30; Remeron SolTab
	MIRTAZAPINE Tablet 45 mg (orally disintegrating), 30	30	1.20	Milivin OD 45; Mirtazapine AN ODT; Mirtazapine Sandoz ODT 45; Remeron SolTab
Azopt	brinzolamide 1% eye drops, 5 mL	1	1.18	BrinzoQuin
Betaloc	METOPROLOL TARTRATE Tablet 100 mg, 60	60	3.76	Chem mart Metoprolol; GenRx Metoprolol; Metoprolol Sandoz; Metrol 100; Minax 100; Terry White Chemists Metoprolol
	METOPROLOL TARTRATE Tablet 50 mg, 100	100	3.76	Chem mart Metoprolol; GenRx Metoprolol; Metoprolol Sandoz; Metrol 50; Minax 50; Terry White Chemists Metoprolol
Betnovate 1/2	betamethasone (as valerate) 0.05% (500	1	2.94	Cortival 1/2

Brand Premium

Premium Priced Brand	Form and Strength	Max. Qty	Brand Premium \$	Benchmark Priced Brands
Betnovate 1/5	microgram/g) cream, 15 g betamethasone (as valerate) 0.02% (200 microgram/g) cream, 100 g	2	6.88	Cortival 1/5
Betoptic	betaxolol 0.5% eye drops, 5 mL	1	2.08	BetoQuin
Bicor	bisoprolol fumarate 10 mg tablet, 28	28	3.00	APO-Bisoprolol; Beprol 10; Bicard 10; Biso 10; Bisoprolol AN; Bisoprolol GH; Bisoprolol Sandoz; Bispro 10; Chem mart Bisoprolol; Terry White Chemists Bisoprolol
	bisoprolol fumarate 2.5 mg tablet, 28	28	3.00	APO-Bisoprolol; Beprol 2.5; Bicard 2.5; Biso 2.5; Bisoprolol AN; Bisoprolol GH; Bisoprolol Sandoz; Bispro 2.5; Chem mart Bisoprolol; Terry White Chemists Bisoprolol
	bisoprolol fumarate 5 mg tablet, 28	28	3.00	APO-Bisoprolol; Beprol 5; Bicard 5; Biso 5; Bisoprolol AN; Bisoprolol GH; Bisoprolol Sandoz; Bispro 5; Chem mart Bisoprolol; Terry White Chemists Bisoprolol
Brevinor	ethinylloestradiol 35 microgram + norethisterone 500 microgram tablet [84] (&) inert substance tablet [28], 112 [4 x 28]	4	10.67	Norimin 28 Day
Brevinor-1	ethinylloestradiol 35 microgram + norethisterone 1 mg tablet [84] (&) inert substance tablet [28], 112 [4 x 28]	4	10.67	Norimin-1 28 Day
Capoten	captopril 25 mg tablet, 90	90	4.47	APO-Captopril; Captopril Sandoz; GenRx Captopril; Zedace
	captopril 50 mg tablet, 90	90	3.46	APO-Captopril; Captopril Sandoz; GenRx Captopril; Zedace
Carafate	sucralfate 1 g tablet, 120	120	2.30	UlcYTE
Ceclor	cefaclor 125 mg/5 mL oral liquid: powder for, 100 mL	1	5.86	Aclor 125; APO-Cefaclor; GenRx Cefaclor; Keflor
	cefaclor 250 mg/5 mL oral liquid: powder for, 75 mL	1	6.10	Aclor 250; APO-Cefaclor; GenRx Cefaclor; Keflor
Ceclor CD	cefaclor 375 mg tablet: modified release, 10	10	7.20	APO-Cefaclor CD; Cefaclor-GA; Cefaclor GH; Chem mart Cefaclor CD; GenRx Cefaclor CD; Karlor CD; Keflor CD; Ozcef; Terry White Chemists Cefaclor CD
Celestone-M	betamethasone (as valerate) 0.02% (200 microgram/g) cream, 100 g	2	2.46	Antroquoril
Cellufresh	carmellose sodium 0.5% (2 mg/0.4 mL) eye drops, 30 x 0.4 mL unit doses	3	4.77	Optifresh Tears
Celluvisc	carmellose sodium 1% (4 mg/0.4 mL) eye drops, 30 x 0.4 mL unit doses	3	4.77	Optifresh Plus
Ciloxan	ciprofloxacin 0.3% eye drops, 5 mL	2	2.06	CiloQuin
Cipramil	citalopram 20 mg tablet, 28	28	3.66	APO-Citalopram; Auro-Citalopram 20; Celapram; Celica; Chem mart Citalopram; Ciazil; Citalopram AN; Citalopram-GA; Citalopram generichealth; Citalopram Sandoz; Pharmacor Citalo 20; Talam; Terry White Chemists Citalopram
Ciproxin 250	ciprofloxacin 250 mg tablet, 14	14	0.42	C-Flox 250; Ciprofloxacin-DRLA; Ciprofloxacin Sandoz; Ciprol 250; GenRx Ciprofloxacin
Ciproxin 500	ciprofloxacin 500 mg tablet, 14	14	0.40	C-Flox 500; Cifran; Ciprofloxacin 500; Ciprofloxacin AN; Ciprofloxacin-BW; Ciprofloxacin-DRLA; Ciprofloxacin-GA; Ciprofloxacin Sandoz; Ciprol 500; GenRx Ciprofloxacin; Loxip 500
Ciproxin 750	ciprofloxacin 750 mg tablet, 14	14	0.40	C-Flox 750; Cifran; Ciprofloxacin 750; Ciprofloxacin AN; Ciprofloxacin-BW; Ciprofloxacin-DRLA; Ciprofloxacin-GA; Ciprofloxacin Sandoz; Ciprol 750; GenRx Ciprofloxacin; Loxip 750
Colgout	colchicine 500 microgram tablet, 30	30	3.33	Lengout
Coversyl 2.5mg	perindopril arginine 2.5 mg tablet, 30	30	1.95	PREXUM 2.5
Dalacin C	clindamycin 150 mg capsule, 24	24	1.71	APO-Clindamycin; Chem mart Clindamycin; Cleocin; Terry White Chemists Clindamycin
Daonil	glibenclamide 5 mg tablet, 100	100	1.44	Glimel
Depo-Medrol	methylprednisolone acetate 40 mg/mL injection, 5 x 1 mL vials	5	1.45	Depo-Nisolone
Depo-Provera	medroxyprogesterone acetate 150 mg/mL injection, 1 x 1 mL vial	1	6.19	Depo-Ralovera
Diabex	metformin hydrochloride 500 mg tablet, 100	100	2.85	APO-Metformin 500; Chem mart Metformin; Diaformin; Formet Aspen 500; GenRx Metformin; Glucobete 500; Metformin 500; Metformin AN; Metformin-GA; Metformin generichealth; Metformin Ranbaxy; Metformin Sandoz; Terry White Chemists Metformin
Diabex 1000	metformin hydrochloride 1 g tablet, 90	90	2.85	APO-Metformin 1000; Chem mart Metformin 1000; Diaformin 1000; Formet 1000; Glucobete 1000; Metformin AN; Metformin-GA; Metformin generichealth 1000; Metformin Ranbaxy 1000; Metformin Sandoz; Pharmacor Metformin 1000; Terry White Chemists Metformin 1000
Diabex 850	metformin hydrochloride 850 mg tablet, 60	60	2.85	APO-Metformin 850; Chem mart Metformin; Diaformin 850; Formet Aspen 850; GenRx Metformin; Glucobete 850; Glucophage; Metformin 850; Metformin AN; Metformin-GA; Metformin generichealth; Metformin Ranbaxy; Metformin

Brand Premium

Premium Priced Brand	Form and Strength	Max. Qty	Brand Premium \$	Benchmark Priced Brands
Diabex XR	metformin hydrochloride 500 mg tablet: modified release, 120 tablets	120	2.85	Sandoz; Terry White Chemists Metformin APO-Metformin XR 500; Chem mart Metformin XR 500; Diaformin XR; Metex XR; Terry White Chemists Metformin XR 500
Diabex XR 1000	metformin hydrochloride 1 g tablet: modified release, 60 tablets	60	2.85	Diaformin XR 1000
Diamicron 60mg MR	gliclazide 60 mg tablet: modified release, 60 tablets	60	1.94	ARDIX GLICLAZIDE 60mg MR
Diprosone	betamethasone (as dipropionate) 0.05% cream, 15 g	1	2.45	Eleuphrat
	betamethasone (as dipropionate) 0.05% ointment, 15 g	1	2.45	Eleuphrat
Doryx	doxycycline 100 mg capsule: modified release, 21 capsules	21	5.51	Mayne Pharma Doxycycline
	doxycycline 100 mg capsule: modified release, 7 capsules	7	2.34	Mayne Pharma Doxycycline
	doxycycline 100 mg capsule: modified release, 7 capsules	28	9.36	Mayne Pharma Doxycycline
	doxycycline 50 mg capsule: modified release, 25 capsules	25	3.93	Mayne Pharma Doxycycline
Dulcolax	bisacodyl 10 mg suppository, 10	3	1.50	Petrus Bisacodyl Suppositories
Duratears	paraffin 1 g/g eye ointment, 3.5 g	2	2.54	Poly Visc
E.E.S. 200	erythromycin (as ethylsuccinate) 200 mg/5 mL oral liquid: powder for, 100 mL	1	2.71	E-Mycin 200
E.E.S. 400 Filmtab	erythromycin (as ethylsuccinate) 400 mg tablet, 25	25	2.67	E-Mycin
E.E.S. Granules	erythromycin (as ethylsuccinate) 400 mg/5 mL oral liquid: powder for, 100 mL	1	2.73	E-Mycin 400
Elocon	mometasone furoate 0.1% (1 mg/g) cream, 15 g	1	3.07	Momasone; Novasone
	mometasone furoate 0.1% lotion, 30 mL	1	3.06	Novasone; Zatamil
	mometasone furoate 0.1% ointment, 15 g	1	3.07	Novasone; Zatamil
Epilim EC	valproate sodium 200 mg tablet: enteric, 100	200	2.00	Sodium Valproate Sandoz; Valprease 200; Valpro 200; Valproate Winthrop EC 200
	valproate sodium 500 mg tablet: enteric, 100	200	2.00	Sodium Valproate Sandoz; Valprease 500; Valpro 500; Valproate Winthrop EC 500
Eryc	erythromycin 250 mg capsule: enteric, 25	25	2.91	Mayne Pharma Erythromycin
Fasigyn	tinidazole 500 mg tablet, 4	4	5.41	Simplotan
Feldene	piroxicam 10 mg capsule, 50	50	3.08	Chem mart Piroxicam; GenRx Piroxicam; Mobilis 10; Terry White Chemists Piroxicam
	piroxicam 20 mg capsule, 25	25	2.86	Chem mart Piroxicam; GenRx Piroxicam; Mobilis 20; Terry White Chemists Piroxicam
Feldene-D	piroxicam 20 mg tablet: dispersible, 25	25	3.86	Mobilis D-20
Flagyl	metronidazole 200 mg tablet, 21	21	2.30	Metrogyl 200; Metronide 200
	metronidazole 400 mg tablet, 21	21	2.30	Metrogyl 400; Metronide 400
Fosamax Plus 70 mg/140 mcg	alendronate 70 mg + colecalciferol 140 microgram tablet, 4	4	2.49	Alendronate plus D3-DRLA; Dronalen Plus; Fonat Plus
Genteal	HYPROMELLOSE Eye drops 3 mg per mL (0.3%), 15 mL (contains sodium perborate as preservative), 1	1	1.95	In a Wink Moisturising
Genteal gel	hypromellose 0.3% + carbomer-980 0.2% eye gel, 10 g	1	1.95	HPMC PAA
Glucophage	metformin hydrochloride 850 mg tablet, 60	60	0.64	APO-Metformin 850; Chem mart Metformin; Diabex 850; Diaformin 850; Formet Aspen 850; GenRx Metformin; Glucobete 850; Metformin 850; Metformin AN; Metformin-GA; Metformin generichealth; Metformin Ranbaxy; Metformin Sandoz; Terry White Chemists Metformin
Gopten	trandolapril 1 mg capsule, 28	28	3.49	APO-Trandolapril; Dolapril 1; Tranalpha; Trandolapril-DP
	trandolapril 2 mg capsule, 28	28	3.50	APO-Trandolapril; Dolapril 2; Tranalpha; Trandolapril-DP
	trandolapril 4 mg capsule, 28	28	3.50	APO-Trandolapril; Dolapril 4; Tranalpha; Trandolapril-DP
	trandolapril 500 microgram capsule, 28	28	3.50	APO-Trandolapril; Dolapril 0.5; Tranalpha; Trandolapril-DP
Imdur 120 mg	isosorbide mononitrate 120 mg tablet: modified release, 30 tablets	30	3.37	Monodur 120 mg
Imdur Durule	isosorbide mononitrate 60 mg tablet: modified release, 30 tablets	30	3.37	Chem mart Isosorbide Mononitrate; Duride; GenRx Isosorbide Mononitrate; Imtrate 60 mg; Isomonit; Isosorbide AN; Monodur 60 mg; Terry White Chemists Isosorbide Mononitrate
Imigran	SUMATRIPTAN Tablet 50 mg (as succinate), 2	4	2.48	APO-Sumatriptan; Chem mart Sumatriptan; Sumagran Aspen 50; Sumatab; Sumatran; Sumatriptan Sandoz; Terry White Chemists Sumatriptan
Imodium	loperamide hydrochloride 2 mg capsule, 12	12	0.75	Gastrex; Gastro-Stop Loperamide
Indocid	indomethacin 25 mg capsule, 50	100	4.64	Arthrexin
Isoptin	verapamil hydrochloride 80 mg tablet, 100	100	3.49	Anpec 80
Isoptin 180 SR	verapamil hydrochloride 180 mg tablet: modified	30	3.50	Cordilox 180 SR

Brand Premium

Premium Priced Brand	Form and Strength	Max. Qty	Brand Premium \$	Benchmark Priced Brands
Isoptin SR	release, 30 tablets verapamil hydrochloride 240 mg tablet: modified	30	3.50	Cordilox SR
Keflex	release, 30 tablets cephalexin 125 mg/5 mL oral liquid: powder for, 100 mL	1	4.77	APO-Cephalexin; Cefalexin Sandoz; Chem mart Cephalexin; Cilex; Ialex; Ibilex 125; Terry White Chemists Cephalexin
	cephalexin 250 mg capsule, 20	20	4.32	APO-Cephalexin; Cefalexin Sandoz; Cephalax 250; Cephalexin AN; Cephalexin generichealth; Chem mart Cephalexin; Cilex; GenRx Cephalexin; Ialex; Ibilex 250; Rancef; Terry White Chemists Cephalexin
	cephalexin 250 mg capsule, 20	40	8.64	APO-Cephalexin; Cefalexin Sandoz; Cephalax 250; Cephalexin AN; Cephalexin generichealth; Chem mart Cephalexin; Cilex; GenRx Cephalexin; Ialex; Ibilex 250; Rancef; Terry White Chemists Cephalexin
	cephalexin 250 mg/5 mL oral liquid: powder for, 100 mL	1	6.23	APO-Cephalexin; Cefalexin Sandoz; Chem mart Cephalexin; Cilex; Ialex; Ibilex 250; Terry White Chemists Cephalexin
	cephalexin 500 mg capsule, 20	20	6.31	APO-Cephalexin; Cefalexin Sandoz; Cephalax 500; Cephalexin AN; Cephalexin generichealth; Chem mart Cephalexin; Cilex; GenRx Cephalexin; Ialex; Ibilex 500; Pharmacor Cephalexin 500; Rancef; Terry White Chemists Cephalexin
Kenacomb Otic	triamcinolone acetonide 0.1% + neomycin sulfate 0.25% + gramicidin 0.025% + nystatin 100 000 international units/g ointment, 5 g	1	1.95	Otocomb Otic
	triamcinolone acetonide 0.1% + neomycin sulfate 0.25% + gramicidin 0.025% + nystatin 100 000 international units/mL ear drops, 7.5 mL	1	1.95	Otocomb Otic
Klacid	clarithromycin 250 mg tablet, 14	14	3.50	APO-Clarithromycin; Chem mart Clarithromycin; Clarac; Clarihexal; Clarithro 250; Clarithromycin AN; Clarithromycin Sandoz; Kalixocin; Terry White Chemists Clarithromycin
Lamictal	lamotrigine 100 mg tablet, 56	56	3.00	APO-Lamotrigine; GenRx Lamotrigine; Lamidus; Lamogine; Lamotrigine AN; Lamotrigine Aspen 100; Lamotrigine-GA; Lamotrigine generichealth; Lamotrigine Sandoz; Lamotrust 100; Reedos 100; Seaze 100; Torlemo DT 100
	lamotrigine 200 mg tablet, 56	56	3.00	APO-Lamotrigine; GenRx Lamotrigine; Lamidus; Lamogine; Lamotrigine AN; Lamotrigine Aspen 200; Lamotrigine-GA; Lamotrigine generichealth; Lamotrigine Sandoz; Lamotrust 200; Reedos 200; Seaze 200; Torlemo DT 200
	lamotrigine 25 mg tablet, 56	56	3.38	APO-Lamotrigine; GenRx Lamotrigine; Lamidus; Lamogine; Lamotrigine AN; Lamotrigine Aspen 25; Lamotrigine-GA; Lamotrigine generichealth; Lamotrigine Sandoz; Lamotrust 25; Reedos 25; Seaze 25; Torlemo DT 25
	lamotrigine 5 mg tablet, 56	56	2.33	Lamogine; Lamotrigine Aspen 5; Seaze 5
	lamotrigine 50 mg tablet, 56	56	3.01	APO-Lamotrigine; GenRx Lamotrigine; Lamidus; Lamogine; Lamotrigine AN; Lamotrigine Aspen 50; Lamotrigine-GA; Lamotrigine generichealth; Lamotrigine Sandoz; Lamotrust 50; Reedos 50; Seaze 50; Torlemo DT 50
Lanoxin	digoxin 250 microgram tablet, 100	100	2.94	Sigmaxin
Lanoxin-PG	digoxin 62.5 microgram tablet, 200	200	2.95	Sigmaxin-PG
Lasix	frusemide 40 mg tablet, 100	100	2.41	APO-Frusemide; Chem mart Frusemide; Frusax; Frusemide AN; Frusemide Sandoz; Frusid; GenRx Frusemide; Terry White Chemists Frusemide; Uremide
Lasix-M	frusemide 20 mg tablet, 50	100	1.94	Urex-M
Lexapro	escitalopram 10 mg tablet, 28	28	5.96	APO-Escitalopram; Chem mart Escitalopram; Cilopam-S; Escicor 10; Escitalopram AN; Escitalopram-DRLA; Escitalopram GA; Escitalopram generichealth; Esipram; Esitalo; Lexam 10; LoxaLate; Pharmacor Escitalopram 10; Terry White Chemists Escitalopram
	escitalopram 20 mg tablet, 28	28	6.86	APO-Escitalopram; Chem mart Escitalopram; Cilopam-S; Escicor 20; Escitalopram AN; Escitalopram-DRLA; Escitalopram GA; Escitalopram generichealth; Esipram; Esitalo; Lexam 20; LoxaLate; Pharmacor Escitalopram 20; Terry White Chemists Escitalopram
	simvastatin 10 mg tablet, 30	30	3.33	APO-Simvastatin; Auro-Simvastatin 10; Chem mart Simvastatin; GenRx Simvastatin; Ransim; Simvacor 10; Simvar 10; Simvastatin AN; Simvastatin-DP; Simvastatin-DRLA; Simvastatin-GA 10; Simvastatin generichealth; Simvastatin Sandoz; Terry White Chemists Simvastatin; Zimstat; Zocor
Lipex 20	simvastatin 20 mg tablet, 30	30	3.33	APO-Simvastatin; Auro-Simvastatin 20; Chem mart Simvastatin; Ransim; Simvacor 20; Simvar 20; Simvastatin AN; Simvastatin-DP; Simvastatin-DRLA; Simvastatin-GA 20; Simvastatin generichealth; Simvastatin Sandoz; Terry White Chemists Simvastatin; Zimstat; Zocor
Lipex 40	simvastatin 40 mg tablet, 30	30	3.33	APO-Simvastatin; Auro-Simvastatin 40; Chem mart Simvastatin;

Brand Premium

Premium Priced Brand	Form and Strength	Max. Qty	Brand Premium \$	Benchmark Priced Brands
				Ransim; Simvacor 40; Simvar 40; Simvastatin AN; Simvastatin-DP; Simvastatin-DRLA; Simvastatin-GA 40; Simvastatin generichealth; Simvastatin Sandoz; Terry White Chemists Simvastatin; Zimstat; Zocor
Lipex 80	simvastatin 80 mg tablet, 30	30	3.33	APO-Simvastatin; Auro-Simvastatin 80; Chem mart Simvastatin; Ransim; Simvacor 80; Simvar 80; Simvastatin AN; Simvastatin-DP; Simvastatin-DRLA; Simvastatin-GA 80; Simvastatin generichealth; Simvastatin Sandoz; Terry White Chemists Simvastatin; Zimstat; Zocor
Liquifilm Forte	polyvinyl alcohol 3% eye drops, 15 mL	1	5.59	PVA Forte
Liquifilm Tears	polyvinyl alcohol 1.4% eye drops, 15 mL	1	1.60	PVA Tears
Lomotil	diphenoxylate hydrochloride 2.5 mg + atropine sulfate 25 microgram tablet, 20	20	1.73	Lofenoxal
Lopresor 100	METOPROLOL TARTRATE Tablet 100 mg, 60	60	2.00	Metatar; Metoprolol Actavis; Metoprolol AN; Mistrom
Lopresor 50	METOPROLOL TARTRATE Tablet 50 mg, 100	100	2.01	Metatar; Metoprolol Actavis; Metoprolol AN; Mistrom
Losec Tablets	omeprazole 20 mg tablet: enteric, 30 tablets	30	3.06	Acimax Tablets; Omepral; Omeprazole Sandoz
Luvox	fluvoxamine maleate 100 mg tablet, 30	30	3.50	APO-Fluvoxamine; Faverin 100; Fluvoxamine GA; Movox 100; Voxam
	fluvoxamine maleate 50 mg tablet, 30	30	3.50	APO-Fluvoxamine; Faverin 50; Fluvoxamine GA; Movox 50; Voxam
Maxamox	amoxicillin 1 g tablet, 14	14	0.48	Amoxycillin Sandoz
Maxolon	metoclopramide hydrochloride 10 mg tablet, 25	25	2.54	APO-Metoclopramide; Metoclopramide Actavis; Metoclopramide AN
Mayne Pharma Doxycycline	doxycycline 100 mg capsule: modified release, 21 capsules	21	2.25	Doryx
	doxycycline 100 mg capsule: modified release, 7 capsules	7	0.99	Doryx
	doxycycline 100 mg capsule: modified release, 7 capsules	28	3.96	Doryx
	doxycycline 50 mg capsule: modified release, 25 capsules	25	1.63	Doryx
Microgynon 30 ED	ethinyloestradiol 30 microgram + levonorgestrel 150 microgram tablet [84] (&) inert substance tablet [28], 112 [4 x 28]	4	11.41	Evelyn 150/30 ED; Femme-Tab ED 30/150; Levlen ED; Micronelle 30 ED
Minidiab	glipizide 5 mg tablet, 100	100	4.51	Melizide
Minomycin-50	minocycline 50 mg tablet, 60	60	1.89	Akamin 50
Mobic	meloxicam 15 mg capsule, 30	30	2.50	APO-Meloxicam; Chem mart Meloxicam; Melox 15; Meloxicam Sandoz; Movalis 15; Terry White Chemists Meloxicam
	meloxicam 15 mg tablet, 30	30	2.50	APO-Meloxicam; Chem mart Meloxicam 15 mg; GenRx Meloxicam; Meloxiauro 15; Meloxibell; Meloxicam AN; Meloxicam-GA; Meloxicam Ranbaxy; Meloxicam Sandoz; Movalis 15; Moxicam 15; Pharmacor Meloxicam 15; Terry White Chemists Meloxicam 15 mg
	meloxicam 7.5 mg capsule, 30	30	2.50	APO-Meloxicam; Chem mart Meloxicam; Melox 7.5; Meloxicam Sandoz; Movalis 7.5; Terry White Chemists Meloxicam
	meloxicam 7.5 mg tablet, 30	30	2.50	APO-Meloxicam; Chem mart Meloxicam 7.5 mg; GenRx Meloxicam; Meloxiauro 7.5; Meloxibell; Meloxicam AN; Meloxicam-GA; Meloxicam Ranbaxy; Meloxicam Sandoz; Movalis 7.5; Moxicam 7.5; Pharmacor Meloxicam 7.5; Terry White Chemists Meloxicam 7.5 mg
Mogadon	nitrazepam 5 mg tablet, 25	25	1.24	Alodorm
	nitrazepam 5 mg tablet, 25	50	2.48	Alodorm
Monodur 60 mg	isosorbide mononitrate 60 mg tablet: modified release, 30 tablets	30	2.47	Chem mart Isosorbide Mononitrate; Duride; GenRx Isosorbide Mononitrate; Imdur Durule; Imtrate 60 mg; Isomonit; Isosorbide AN; Terry White Chemists Isosorbide Mononitrate
Naprosyn	naproxen 250 mg tablet, 50	100	2.24	Inza 250
	naproxen 500 mg tablet, 50	50	1.28	Inza 500
Naprosyn SR1000	naproxen 1 g tablet: modified release, 28	28	1.29	Proxen SR 1000
Naprosyn SR750	naproxen 750 mg tablet: modified release, 28 tablets	28	1.22	Proxen SR 750
Natrilix	indapamide hemihydrate 2.5 mg tablet, 90	90	4.11	Chem mart Indapamide; Dapa-Tabs; GenRx Indapamide; Indapamide AN; Indapamide-GA; Indapamide Sandoz; Insig; Terry White Chemists Indapamide
Nilstat	nystatin 100 000 international units/mL oral liquid, 24 mL	1	3.01	Mycostatin
Nordette 28	ethinyloestradiol 30 microgram + levonorgestrel 150 microgram tablet [84] (&) inert substance tablet [28], 112 [4 x 28]	4	14.37	Monofeme 28
Normison	temazepam 10 mg tablet, 25	25	4.00	APO-Temazepam; Temaze; Temtabs
	temazepam 10 mg tablet, 25	50	8.00	APO-Temazepam; Temaze; Temtabs
Norvasc	amlodipine 10 mg tablet, 30	30	8.19	Amlo 10; Amlodipine-DRLA; Amlodipine generichealth;

Brand Premium

Premium Priced Brand	Form and Strength	Max. Qty	Brand Premium \$	Benchmark Priced Brands
	amlodipine 5 mg tablet, 30	30	5.54	Amlodipine Sandoz; APO-Amlodipine; Auro-Amlodipine 10; Chem mart Amlodipine; Nordip; Norvapine; Ozlodip; Terry White Chemists Amlodipine
Oroxine	thyroxine sodium 100 microgram tablet, 200	200	2.21	Amlo 5; Amlodipine-DRLA; Amlodipine generichealth; Eutroxsig
	thyroxine sodium 200 microgram tablet, 200	200	2.21	Amlodipine Sandoz; APO-Amlodipine; Auro-Amlodipine 5; Eutroxsig
	thyroxine sodium 50 microgram tablet, 200	200	2.20	Chem mart Amlodipine; Nordip; Norvapine; Ozlodip; Terry White Chemists Amlodipine
	thyroxine sodium 75 microgram tablet, 200	200	2.27	Eutroxsig
Orudis SR 200	ketoprofen 200 mg capsule: modified release, 28 capsules	28	2.21	Oruvail SR
Panadeine Forte	CODEINE PHOSPHATE with PARACETAMOL Tablet 30 mg-500 mg, 20	20	2.40	APO- Paracetamol/Codeine 500/30; Codalgin Forte; Codapane Forte; Comfarol Forte; Paracetamol/Codeine GH 500/30; Prodeine Forte
	CODEINE PHOSPHATE with PARACETAMOL Tablet 30 mg-500 mg, 20	60	7.20	APO- Paracetamol/Codeine 500/30; Codalgin Forte; Codapane Forte; Comfarol Forte; Paracetamol/Codeine GH 500/30; Prodeine Forte
Panadol Osteo	paracetamol 665 mg tablet: modified release, 96 tablets	192	1.64	APO-Osteo Paracetamol 665 mg; Blooms the Chemist Osteo Pain Relief Paracetamol 665 mg; Chem mart Pharmacy Osteo Relief Paracetamol 665 mg; Osteomol 665 Paracetamol; Terry White Chemists Osteo Relief Paracetamol 665 mg
Panafcort	prednisone 1 mg tablet, 100	100	0.91	Predsone
Panafcortelone	prednisolone 1 mg tablet, 100	100	0.82	Predsolone
Plendil ER	felodipine 10 mg tablet: modified release, 30 tablets	30	3.18	Felodil XR 10; Felodur ER 10 mg; Fendex ER
	felodipine 2.5 mg tablet: modified release, 30 tablets	30	3.16	Felodur ER 2.5 mg; Fendex ER
	felodipine 5 mg tablet: modified release, 30 tablets	30	3.15	Felodil XR 5; Felodur ER 5 mg; Fendex ER
Pravachol	pravastatin sodium 10 mg tablet, 30	30	1.65	APO-Pravastatin; Chem mart Pravastatin; Cholstat 10; Lipostat 10; Pharmacor Pravastat 10; Pravastatin Actavis 10; Pravastatin AN; Pravastatin-GA 10; Pravastatin generichealth; Pravastatin Sandoz; Terry White Chemists Pravastatin
	pravastatin sodium 20 mg tablet, 30	30	1.64	APO-Pravastatin; Chem mart Pravastatin; Cholstat 20; Cholvastin; Lipostat 20; Pharmacor Pravastat 20; Pravastatin Actavis 20; Pravastatin AN; Pravastatin-GA 20; Pravastatin generichealth; Pravastatin Sandoz; Terry White Chemists Pravastatin
	pravastatin sodium 40 mg tablet, 30	30	1.75	APO-Pravastatin; Chem mart Pravastatin; Cholstat 40; Cholvastin; Lipostat 40; Pharmacor Pravastat 40; Pravastatin Actavis 40; Pravastatin AN; Pravastatin-GA 40; Pravastatin generichealth; Pravastatin Sandoz; Terry White Chemists Pravastatin
	pravastatin sodium 80 mg tablet, 30	30	1.75	APO-Pravastatin; Chem mart Pravastatin; Lipostat 80; Pravastatin AN; Pravastatin-GA 80; Pravastatin generichealth; Pravastatin Sandoz; Terry White Chemists Pravastatin
PREXUM 2.5	perindopril arginine 2.5 mg tablet, 30	30	1.95	Coversyl 2.5mg
Prinivil 10	lisinopril 10 mg tablet, 30	30	3.75	APO-Lisinopril; Auro-Lisinopril 10; Chem mart Lisinopril; Fibsol 10; Lisinopril AN; Lisinopril-DRLA; Lisinopril-GA; Lisinopril generichealth; Lisinopril Sandoz; Terry White Chemists Lisinopril; Zestril; Zinopril 10
Prinivil 20	lisinopril 20 mg tablet, 30	30	3.75	APO-Lisinopril; Auro-Lisinopril 20; Chem mart Lisinopril; Fibsol 20; Lisinopril AN; Lisinopril-DRLA; Lisinopril-GA; Lisinopril generichealth; Lisinopril Sandoz; Terry White Chemists Lisinopril; Zestril; Zinopril 20
Provera	medroxyprogesterone acetate 10 mg tablet, 100	100	2.53	Ralovera
	medroxyprogesterone acetate 10 mg tablet, 30	30	2.46	Medroxyprogesterone Sandoz; Ralovera
	medroxyprogesterone acetate 5 mg tablet, 56	56	2.59	Ralovera
Prozac 20	fluoxetine 20 mg capsule, 28	28	2.06	Auscasp Aspen; Chem mart Fluoxetine; Fluoxetine 20; Fluoxetine AN; Fluoxetine-GA; Fluoxetine generichealth; Fluoxetine RBX; Fluoxetine Sandoz; GenRx Fluoxetine; Lovan; Terry White Chemists Fluoxetine; Zactin
Prozac Tab	fluoxetine 20 mg tablet: dispersible, 28	28	2.06	Lovan 20 Tab; Zactin Tablet
Redipred	prednisolone (as sodium phosphate) 5 mg/mL oral liquid, 30 mL	1	2.70	PredMix
Refresh Night Time	paraffin 1 g/g eye ointment, 2 x 3.5 g tubes	1	2.12	Ircal
Renitec	enalapril maleate 10 mg tablet, 30	30	4.65	Acetec; APO-Enalapril; Auspril; Chem mart Enalapril; Enalapril Actavis; Enalapril AN; Enalapril-GA; Enalapril generichealth; Enalapril Sandoz; GenRx Enalapril; Malean; Terry White Chemists Enalapril

Brand Premium

Premium Priced Brand	Form and Strength	Max. Qty	Brand Premium \$	Benchmark Priced Brands
Renitec 20	enalapril maleate 20 mg tablet, 30	30	4.65	Acetec; APO-Enalapril; Auspril; Chem mart Enalapril; Enalapril Actavis; Enalapril AN; Enalapril-GA; Enalapril generichealth; Enalapril Sandoz; GenRx Enalapril; Malean; Terry White Chemists Enalapril
Rivotril	clonazepam 2 mg tablet, 100	100	1.93	Paxam 2
	clonazepam 2 mg tablet, 100	200	3.86	Paxam 2
	clonazepam 500 microgram tablet, 100	100	1.71	Paxam 0.5
	clonazepam 500 microgram tablet, 100	200	3.42	Paxam 0.5
Rulide	roxithromycin 150 mg tablet, 10	10	2.12	APO-Roxithromycin; Biaxsig; Chem mart Roxithromycin; Roxar 150; Roximycin; Roxithromycin AN; Roxithromycin-GA; Roxithromycin GH; Roxithromycin Sandoz; Roxithromycin SCP 150; Terry White Chemists Roxithromycin
	roxithromycin 300 mg tablet, 5	5	2.12	APO-Roxithromycin; Biaxsig; Chem mart Roxithromycin; Roxar 300; Roximycin; Roxithromycin AN; Roxithromycin-GA; Roxithromycin GH; Roxithromycin Sandoz; Roxithromycin SCP 300; Terry White Chemists Roxithromycin
Salazopyrin-EN	SULFASALAZINE Tablet 500 mg (enteric coated), 100	200	2.48	Pyralin EN
Seprin Forte	trimethoprim 160 mg + sulfamethoxazole 800 mg tablet, 10	10	3.90	Bactrim DS; Resprim Forte
Serepax	oxazepam 15 mg tablet, 25	25	2.68	Alepam 15
	oxazepam 15 mg tablet, 25	50	5.36	Alepam 15
	oxazepam 30 mg tablet, 25	25	2.68	Alepam 30; APO-Oxazepam; Murelax
	oxazepam 30 mg tablet, 25	50	5.36	Alepam 30; APO-Oxazepam; Murelax
Sigmacort	hydrocortisone acetate 1% (10 mg/g) cream, 30 g	1	2.69	Cortic-DS 1%
	hydrocortisone acetate 1% (10 mg/g) cream, 50 g	1	2.70	Cortic-DS 1%
	hydrocortisone acetate 1% (10 mg/g) ointment, 30 g	1	2.69	Cortic-DS 1%
	hydrocortisone acetate 1% (10 mg/g) ointment, 50 g	1	2.70	Cortic-DS 1%
Sinemet	levodopa 250 mg + carbidopa anhydrous 25 mg tablet, 100	100	2.92	Levo/Carbidopa Sandoz
Sinemet 100/25	levodopa 100 mg + carbidopa anhydrous 25 mg tablet, 100	100	5.19	Kinson
Slow-K	potassium chloride 600 mg (8 mmol potassium) tablet: modified release, 100 tablets	200	2.94	Duro-K
Sofradex	dexamethasone 0.05% (500 microgram/mL) + framycetin sulfate 0.5% (5 mg/mL) + gramicidin 0.005% (50 microgram/mL) ear drops, 8 mL	1	1.91	Otodex
Sotacor	sotalol hydrochloride 160 mg tablet, 60	60	3.76	APO-Sotalol; Cardol; Chem mart Sotalol; GenRx Sotalol; Solavert; Sotalol Sandoz; Terry White Chemists Sotalol
	sotalol hydrochloride 80 mg tablet, 60	60	3.75	APO-Sotalol; GenRx Sotalol; Solavert; Sotalol Sandoz
Stemetil	prochlorperazine maleate 5 mg tablet, 25	25	3.08	APO-Prochlorperazine; Pharmacor Prozine 5; ProCalm; Prochlorperazine AN; Prochlorperazine-GA; Prochlorperazine GH; Stemzine
Tazac	nizatidine 150 mg capsule, 60	60	5.32	Nizac; Tacidine
	nizatidine 300 mg capsule, 30	30	5.32	Nizac; Tacidine
Tears Naturale	dextran-70 0.1% + hypromellose 0.3% eye drops, 15 mL	1	2.04	Poly-Tears
Tegretol 100	CARBAMAZEPINE Tablet 100 mg, 100	200	2.96	Carbamazepine Sandoz
Tegretol 200	CARBAMAZEPINE Tablet 200 mg, 100	200	2.96	Carbamazepine Sandoz
Tenormin	atenolol 50 mg tablet, 30	30	2.44	APO-Atenolol; Atenolol AN; Atenolol-GA; Atenolol GH; Atenolol Sandoz; Chem mart Atenolol; Noten; Tenolten 50; Tensig; Terry White Chemists Atenolol
Timoptol	timolol 0.5% (5 mg/mL) eye drops, 5 mL	1	3.03	Tenopt
Tofranil 10	imipramine hydrochloride 10 mg tablet, 50	50	2.79	Tolerade 10
Tofranil 25	imipramine hydrochloride 25 mg tablet, 50	50	2.78	Tolerade 25
Tolvon	mianserin hydrochloride 10 mg tablet, 50	50	3.29	Lumin 10
Tramal	tramadol hydrochloride 50 mg capsule, 20	20	2.41	APO-Tramadol; Chem mart Tramadol; GA Tramadol 50mg; Terry White Chemists Tramadol; Tramadol Actavis; Tramadol AN; Tramadol Sandoz; Tramadol SCP; Tramedo; Zydol
Tramal SR 100	tramadol hydrochloride 100 mg tablet: modified release, 20 tablets	20	4.49	APO-Tramadol SR; Chem mart Tramadol SR; GA Tramadol SR 100mg; Lodam SR 100; Terry White Chemists Tramadol SR; Tramadol AN SR; Tramadol Sandoz SR; Tramadol SR generichealth; Tramedo SR 100; Zydol SR 100
Tramal SR 150	tramadol hydrochloride 150 mg tablet: modified release, 20 tablets	20	5.37	APO-Tramadol SR; Chem mart Tramadol SR; GA Tramadol SR 150mg; Lodam SR 150; Terry White Chemists Tramadol SR; Tramadol AN SR; Tramadol Sandoz SR; Tramadol SR generichealth; Tramedo SR 150; Zydol SR 150
Tramal SR 200	tramadol hydrochloride 200 mg tablet: modified release, 20 tablets	20	6.09	APO-Tramadol SR; Chem mart Tramadol SR; GA Tramadol SR 200mg; Lodam SR 200; Terry White Chemists Tramadol SR; Tramadol AN SR; Tramadol Sandoz SR; Tramadol SR

Brand Premium

Premium Priced Brand	Form and Strength	Max. Qty	Brand Premium \$	Benchmark Priced Brands
				generichealth; Tramedo SR 200; Zydol SR 200
Trandate	labetalol hydrochloride 100 mg tablet, 100	100	3.13	Presolol 100
	labetalol hydrochloride 200 mg tablet, 100	100	3.14	Presolol 200
Triphasil 28	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]	4	14.37	Trifeme 28
Triprim	trimethoprim 300 mg tablet, 7	7	1.89	Alprim
	trimethoprim 300 mg tablet, 7	14	3.78	Alprim
Triquilar ED	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]	4	11.41	Logynon ED
Valium	diazepam 5 mg tablet, 50	50	0.76	Antenex 5; APO-Diazepam; Diazepam-GA; Ranzepam; Valpam 5
Vastin	fluvastatin 20 mg capsule, 28	28	3.09	Lescol
	fluvastatin 40 mg capsule, 28	28	3.38	Lescol
Ventolin CFC-free	salbutamol 100 microgram/actuation inhalation: pressurised, 200	2	2.34	APO-Salbutamol Inhaler; Asmol CFC-free
Ventolin Nebules	salbutamol 2.5 mg/2.5 mL inhalation: solution, 30 x 2.5 mL ampoules	2	1.20	APO-Salbutamol; Asmol 2.5 uni-dose; Butamol 2.5; GenRx Salbutamol; Pharmacor Salbutamol 2.5; Salbutamol Actavis; Salbutamol-GA; Salbutamol Sandoz
	salbutamol 5 mg/2.5 mL inhalation: solution, 30 x 2.5 mL ampoules	2	1.16	APO-Salbutamol; Asmol 5 uni-dose; Butamol 5; GenRx Salbutamol; Pharmacor Salbutamol 5; Salbutamol Actavis; Salbutamol-GA; Salbutamol Sandoz
Viscotears	carbomer-980 0.2% eye gel, 10 g	1	1.84	Optifresh eye gel; PAA
Voltaren 25	diclofenac sodium 25 mg tablet: enteric, 50 tablets	100	1.62	APO-Diclofenac; Chem mart Diclofenac; Clonac 25; Diclofenac AN; Diclofenac-GA; Diclofenac Sandoz; Fenac 25; Terry White Chemists Diclofenac
Voltaren 50	diclofenac sodium 50 mg tablet: enteric, 50 tablets	50	1.61	APO-Diclofenac; Chem mart Diclofenac; Clonac 50; Diclofenac AN; Diclofenac-GA; Diclofenac Sandoz; Fenac; Terry White Chemists Diclofenac
Zanidip	lercanidipine hydrochloride 10 mg tablet, 28	28	3.49	APO-Lercanidipine; Chem mart Lercanidipine; Ledip; Lercadip; Lercan; Lercanidipine AN; Lercanidipine GH; Lercanidipine Sandoz; Terry White Chemists Lercanidipine; Zircol
	lercanidipine hydrochloride 20 mg tablet, 28	28	3.50	APO-Lercanidipine; Chem mart Lercanidipine; Ledip; Lercadip; Lercan; Lercanidipine AN; Lercanidipine GH; Lercanidipine Sandoz; Terry White Chemists Lercanidipine; Zircol
Zantac	ranitidine 150 mg tablet, 60	60	1.41	APO-Ranitidine; Ausran; Chem mart Ranitidine; GenRx Ranitidine; Rani 2; Ranitidine AN; Ranitidine Sandoz; Ranoxyl; Terry White Chemists Ranitidine; Ulcaid
	ranitidine 300 mg tablet, 30	30	1.41	APO-Ranitidine; Ausran; Chem mart Ranitidine; GenRx Ranitidine; Rani 2; Ranitidine Sandoz; Ranoxyl; Terry White Chemists Ranitidine
Zestril	lisinopril 10 mg tablet, 30	30	3.28	APO-Lisinopril; Auro-Lisinopril 10; Chem mart Lisinopril; Fibsol 10; Lisinopril AN; Lisinopril-DRLA; Lisinopril-GA; Lisinopril generichealth; Lisinopril Sandoz; Prinivil 10; Terry White Chemists Lisinopril; Zinopril 10
	lisinopril 20 mg tablet, 30	30	3.31	APO-Lisinopril; Auro-Lisinopril 20; Chem mart Lisinopril; Fibsol 20; Lisinopril AN; Lisinopril-DRLA; Lisinopril-GA; Lisinopril generichealth; Lisinopril Sandoz; Prinivil 20; Terry White Chemists Lisinopril; Zinopril 20
	lisinopril 5 mg tablet, 30	30	3.29	APO-Lisinopril; Auro-Lisinopril 5; Chem mart Lisinopril; Fibsol 5; Lisinopril AN; Lisinopril-DRLA; Lisinopril-GA; Lisinopril generichealth; Lisinopril Sandoz; Terry White Chemists Lisinopril; Zinopril 5
Zocor	simvastatin 10 mg tablet, 30	30	3.33	APO-Simvastatin; Auro-Simvastatin 10; Chem mart Simvastatin; GenRx Simvastatin; Lipex 10; Ransim; Simvacor 10; Simvar 10; Simvastatin AN; Simvastatin-DP; Simvastatin-DRLA; Simvastatin-GA 10; Simvastatin generichealth; Simvastatin Sandoz; Terry White Chemists Simvastatin; Zimstat
	simvastatin 20 mg tablet, 30	30	3.33	APO-Simvastatin; Auro-Simvastatin 20; Chem mart Simvastatin; Lipex 20; Ransim; Simvacor 20; Simvar 20; Simvastatin AN; Simvastatin-DP; Simvastatin-DRLA; Simvastatin-GA 20; Simvastatin generichealth; Simvastatin Sandoz; Terry White Chemists Simvastatin; Zimstat
	simvastatin 40 mg tablet, 30	30	3.33	APO-Simvastatin; Auro-Simvastatin 40; Chem mart Simvastatin; Lipex 40; Ransim; Simvacor 40; Simvar 40; Simvastatin AN; Simvastatin-DP; Simvastatin-DRLA; Simvastatin-GA 40;

Brand Premium

Premium Priced Brand	Form and Strength	Max. Qty	Brand Premium \$	Benchmark Priced Brands
	simvastatin 80 mg tablet, 30	30	3.33	Simvastatin generichealth; Simvastatin Sandoz; Terry White Chemists Simvastatin; Zimstat APO-Simvastatin; Auro-Simvastatin 80; Chem mart Simvastatin; Lipex 80; Ransim; Simvacor 80; Simvar 80; Simvastatin AN; Simvastatin-DP; Simvastatin-DRLA; Simvastatin-GA 80; Simvastatin generichealth; Simvastatin Sandoz; Terry White Chemists Simvastatin; Zimstat
Zoloft	sertraline 100 mg tablet, 30	30	0.71	APO-Sertraline; Auro-Sertraline 100; Chem mart Sertraline; Eleva 100; GenRx Sertraline; Sertra 100; Sertracor 100; Sertraline Actavis; Sertraline AN; Sertraline-DRLA; Sertraline generichealth; Sertraline Sandoz; Setrona; Terry White Chemists Sertraline; Xydep 100
	sertraline 50 mg tablet, 30	30	0.71	APO-Sertraline; Auro-Sertraline 50; Chem mart Sertraline; Eleva 50; GenRx Sertraline; Sertra 50; Sertracor 50; Sertraline Actavis; Sertraline AN; Sertraline-DRLA; Sertraline generichealth; Sertraline Sandoz; Setrona; Terry White Chemists Sertraline; Xydep 50
Zomig	zolmitriptan 2.5 mg tablet, 2	4	2.76	APO-Zolmitriptan; Zoltrip
Zovirax 200 mg	aciclovir 200 mg tablet, 25	50	2.06	Acihexal; Acyclo-V 200; Lovir
	aciclovir 200 mg tablet, 90	90	1.49	Aciclovir 200; Aciclovir GH; Acihexal; Acyclo-V 200; Chem mart Aciclovir; GenRx Aciclovir; Lovir; Ozvir; Terry White Chemists Aciclovir
Zovirax 800 mg	aciclovir 800 mg tablet, 35	35	0.80	Aciclovir 800; Acihexal; Acyclo-V 800; GenRx Aciclovir
Zyban	bupropion hydrochloride 150 mg tablet: modified release, 30 tablets	30	0.80	Prexaton
	bupropion hydrochloride 150 mg tablet: modified release, 90 tablets	90	0.96	Prexaton
Zyloprim	allopurinol 100 mg tablet, 200	200	3.44	Allopurinol Sandoz; Allosig; Chem mart Allopurinol; GenRx Allopurinol; Terry White Chemists Allopurinol
	allopurinol 300 mg tablet, 60	60	3.43	Allopurinol Sandoz; Allosig; Chem mart Allopurinol; GenRx Allopurinol; Progout 300; Terry White Chemists Allopurinol